Bundle Audit Committee (Open) 25 July 2023

Agenda attachments

ITEM 0 Agenda Audit Committee Open 25 July 2023

0 OPENING ITEMS

1 Chair's welcome; apologies and confirmation of quorum

2 Declarations of Interest
Declarations of Interest

3 Minutes of last meeting:
3.1 02 March 2023
3.2 20 April 2023

ITEM 3.1 Audit Committee OPEN Minutes 2 March 2023
ITEM 3.2 Audit Committee OPEN Minutes 20 April 2023

4 Action Log and Matters Arising

ITEM 4 PUBLIC AUDIT COMMITTEE Action and Decisions Log

4.1 ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION

5 2022-23 Annual Accounts and Annual Report and Recommendation to Trust Board
5.1 2022-23 Annual Accounts
5.2 Audit Report, 2022-23 Accounts
(Inc. Letter of Representation)
5.3 2022-23 Annual Report

ITEM 5 2022-23 Annual Accounts Report Executive Summary -AC 25 July 23
ITEM 5.1 10 WAS NHST 2022-23 Accounts Final 18-07-2023
ITEM 5.2 3686A2023_ISA 260 WAST_Audit_Accounts
ITEM 5.2a Appendix 3 - Letter of Representation from Management 2022-23 New
ITEM 5.3 Annual Report 2022-23 for AC
ITEM 5.3a Final 2022-23 Annual Report for AC and TB v2

6 Internal Audit Items
6.1 Head of Internal Audit Annual Report and Opinion - 2022-23
Internal Audit Reports:
6.2 Risk Management & Assurance
6.3 Savings and efficiencies
6.4 Trade Union Release Time
6.5 Pain Management
6.6 IM&T Infrastructure
6.7 Follow Up Action Tracker Review

ITEM 6.1 WAST_Final Head of Internal Audit Annual Report and Opinion_22-23_for Trust
ITEM 6.2 WAST_2223-1_Risk Management Assurance_Final Internal Audit Report_for Trust
ITEM 6.3 WAST_2223-4_Savings and Efficiencies_Final Internal Audit Report_for issue
ITEM 6.4 WAST_2223-009_Trade Union Release Time_Final Internal Audit Report
ITEM 6.5 WAST_2223-012_Pain Management_Final Internal Audit Report
ITEM 6.6 WAST_2223-16_IM&T Infrastructure_Final Internal Audit Report

6.1 COMFORT BREAK

7 Audit Wales Reports
7.1 Audit Update
7.2 Final Audit Plan 2023
7.3 Our work programme

ITEM 7.1 WAST Audit Committee update 072023
ITEM 7.2 2023_detailed_audit_plan_wast_final
ITEM 7.3 our-work-programme-23

8 Risk Management and Board Assurance Framework

ITEM 8 Executive Summary Risk Management Report AC 250723
ITEM 8.1 BAF Guidance April 2023

9 Audit Tracker Report
NB ITEM 9.1 Audit Tracker spreadsheet will be circulated by e mail.

ITEM 9 Executive Summary AC Audit Tracker 250723
ITEM 9.2 WAST 23-24 Gantt chart

10 Policy Report

ITEM 10 Executive Summary Policy Report AC 250723
ITEM 10.1 Policy Tracker 140723 for Committees

11 Standards of Business Conduct Policy
ITEM 11 Standards of Business Conduct Policy for AC
ITEM 11.1 Standards of Business Conduct Policy Final v.3.0 - Audit Committee and Board for approval

12 Losses and Special Payments
ITEM 12 Executive Summary SBAR Losses and Special Payments
ITEM 12.1 Annex 1 - Losses Special and Payments 2022-23 M12
ITEM 12.2 Annex 2 - Losses Special and Payments 2023-24 M2

13 QUEST Committee Report - Clinical Audit Plan 2022/23 Approval
ITEM 13 Quest Committee Highlight Report July 2022 to Audit Committee

14 Audit Committee Cycle of Business
ITEM 14 SBAR for AC on Cycles of Business 2023-24
ITEM 14.1 Audit Committee Cycle of Business 2023-24
ITEM 14.2 Cycle notes

14.1 CONSENT ITEMS

15 Committee Priorities Report
ITEM 15 Audit Committee Priorities

16 Audit Committee Highlight report April 2023
ITEM 16 Audit Committee Highlight Report April 2023

16.1 CLOSING ITEMS

17 Reflections & Summary of Decisions and Actions

18 Key Messages for Board

19 Any Other Business

20 Date and time of next meeting: 14 September – 09:30

AGENDA

MEETING OF THE OPEN AUDIT COMMITTEE

Held in public on **25 July 2023 from 09:30 to 13:20**

Meeting held virtually via Microsoft Teams

No.	Agenda Item	Purpose	Lead	Format	Time
OPENING ITEMS					
1.	Chair's welcome; apologies and confirmation of quorum	Information	Martin Turner	Verbal	10 Mins
2.	Declarations of Interest	To State Conflicts	Martin Turner	Verbal	
3.	Minutes of last meeting: – 3.1 02 March 2023 3.2 20 April 2023	Approval	Martin Turner	Paper	
4.	Action Log and Matters Arising	Discussion	Martin Turner	Paper	
ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION					
5.	2022-23 Annual Accounts and Annual Report and Recommendation to Trust Board 5.1 2022-23 Annual Accounts 5.2 Audit Report, 2022-23 Accounts (Inc. Letter of Representation) 5.3 2022-23 Annual Report	 Endorse Discuss Endorse	 Navin Kalia Alison Butler Trish Mills	Paper	45 Mins
6.	Internal Audit Items 6.1 Head of Internal Audit Annual Report and Opinion – 2022-23 *Internal Audit Reports:* 6.2 Risk Management & Assurance 6.3 Savings and efficiencies 6.4 Trade Union Release Time 6.5 Pain Management 6.6 IM&T Infrastructure 6.7 Follow Up Action Tracker Review	Assurance	 Osian Lloyd Trish Mills Navin Kalia Angela Lewis Andy Swinburn Leanne Smith Trish Mills	Paper	60 Mins
COMFORT BREAK [10 mins] – 11:25					
7.	Audit Wales Reports 7.1 Audit Update 7.2 Final Audit Plan 2023 7.3 Work programme	Assurance	 Fflur Jones Alison Butler	Paper	30 Mins

No.	Agenda Item	Purpose	Lead	Format	Time
8.	Risk Management and Board Assurance Framework	Assurance	Julie Boalch	Paper	15 Mins
9.	Audit Tracker Report	Assurance	Julie Boalch	Paper	5 Mins
10.	Policy Report	Assurance	Julie Boalch	Paper	10 Mins
11.	Standards of Business Conduct Policy	Endorse	Trish Mills	Paper	15 Mins
12.	Losses and Special Payments	Assurance	Navin Kalia	Paper	10 Mins
13.	QUEST Committee Report – Clinical Audit Plan 2022/23 Approval	Assurance	Trish Mills	Paper	5 Mins
14.	Audit Committee Cycle of Business	Approval	Trish Mills	Paper	5 Mins
CONSENT ITEMS **The items that follow are for information only. Should a member wish to discuss any of these items they are requested to notify the Chair so that time may be allocated to do so.**					
15.	Committee Priorities Report	Information	Trish Mills	Paper	5 Mins
16.	20 April 2023 AAA Report	Information	Trish Mills	Paper	
CLOSING ITEMS					
17.	Reflections & Summary of Decisions and Actions	Information	Martin Turner	Verbal	5 Mins
18.	Key Messages for Board	Information	Martin Turner	Verbal	
19.	Any Other Business	Discussion	Martin Turner	Verbal	
20.	Date and time of next meeting: 14 September – 09:30	Information	Martin Turner	Verbal	

Lead Presenters

Name of Lead	Position of Lead
Martin Turner	Non-Executive Director and Committee Chair
Alison Butler	Audit Wales
Julie Boalch	Head of Risk and Deputy Board Secretary
Fflur Jones	Audit Wales
Navin Kalia	Deputy Director of Finance and Corporate Resources
Angela Lewis	Director of People and Culture
Osian Lloyd	Head of Internal Audit
Trish Mills	Board Secretary
Leanne Smith	Interim Director of Digital Services
Andy Swinburn	Director of Paramedicine

WELSH AMBULANCE SERVICES NHS TRUST

UNCONFIRMED MINUTES OF THE OPEN MEETING OF THE AUDIT COMMITTEE OF THE WELSH AMBULANCE SERVICES NHS TRUST HELD ON THURSDAY 2 MARCH 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
Joga Singh	Non-Executive Director

IN ATTENDANCE :

Judith Bryce	Assistant Director of Operations
David Butler	Internal Audit (Left after Item 2/23)
Kevin Davies	Non-Executive Director and Vice Chair of the Board
Colin Dennis	Chair of the Board (Left after Item 2/23)
Andrew Doughton	Audit Wales
Estelle Hitchon	Director of Partnerships and Engagement
Fflur Jones	Audit Wales
Navin Kalia	Deputy Director of Finance and Corporate Resources
Jason Killens	Chief Executive Officer (Left after Item 2/23)
Angela Lewis	Director of Workforce and Organisational Development (Left after Item 2/23)
Martyn Lewis	Internal Audit
Osian Lloyd	Head of Internal Audit
Gareth Lucey	Audit Wales
Trish Mills	Board Secretary
Steve Owen	Corporate Governance Officer
Hugh Parry	Trade Union Partner
Alex Payne	Corporate Governance Manager
Jessica Price	Deputy Head of Financial Accounting
Felicity Quance	Internal Audit
Duncan Robertson	Interim Assistant Director of Audit, Research and Service Improvement
Leanne Smith	Interim Director of Digital Services (Left after Item 2/23)
Paul Seppman	Trade Union Partner
Chris Turley	Executive Director of Finance and Corporate Resources
Carl Window	Counter Fraud Manager

APOLOGIES:

Lee Brooks	Executive Director of Operations
Damon Turner	Trade Union Partner
Liam Williams	Executive Director of Quality and Nursing

01/23 PROCEDURAL MATTERS

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

The Minutes of the open session of the Audit Committee meeting held on 1 December 2022 were confirmed as a correct record.

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

RESOLVED: The Minutes of the meeting held on 1 December 2022 were confirmed as a correct record.

02/23 INTERNAL AUDIT (IA) REPORTS

Osian Lloyd in updating the Committee gave an overview of the progress report and the internal audit plan for 2023/24. In terms of progress, he advised that the team were on track to deliver the IA programme. In terms of developing the plan for 2023/23 he thanked the Trust for their cooperation and support.

There were three proposed changes to the current plan in which the Committee's approval was sought; two of which related to health and safety and clinical handover related requests, and the request was to defer these from Q4 to Q1. The third was to request that Strategy Development be included in next year's plan to allow time for processes to embed.

Osian Lloyd drew the Committee's attention to the fees outlined in the Draft Internal Audit Charter which were calculated based on an estimate of the NHS inflationary uplift figures for next year. The cost to the Trust for IA conducting their work next year had been calculated at £58,130.

Comments

In terms of the ICT contract management IA the Committee sought assurance on whether cyber security would be considered as part of the audit and also if value for money (VFM) was also considered, Osian Lloyd explained that VFM would be considered as part of the ICT contract management procurement. Leanne Smith added that cyber security would form part of the scope of the audit.

The Committee welcomed the IA plan and going forward requested that a Gantt chart be produced on Internal Audit reviews to illustrate work completed over a period of time in relation to the time planned for the work. Osian Lloyd agreed to provide this for the next meeting.

Clarity was sought on the Trust's Medical Director in terms of their input into any clinical audits. Osian Lloyd explained that the Director of Paramedicine was the point of contact for any clinical audits.

The Committee noted there was no plan to review staff sickness. Osian Lloyd explained there were other areas in the workforce which were being prioritised. Paul Hollard advised that the People and Culture Committee would monitor the evaluations from the wellbeing service as part of the audit plan. Jason Killens commented that staff sickness was on an improving trajectory which suggested that the new actions in place in dealing with short and long term sickness were having a positive effect.

Osian Lloyd then provided an overview on the following IA reviews that had been carried out by his Team:

Immediate Release Directions (IRD) – Reasonable Assurance

This audit considered the effectiveness of the measures in place to immediately release ambulances outside hospitals to respond to patients' needs in the community. It was noted there had been a significant volume of IRDs which reflected the pressure on the unscheduled care system at the time of the review.

The review was rated as reasonable which indicated a positive assessment of the arrangements in place. In terms of the findings, there were two high priority and three medium priority findings raised. The two high priority findings related to the escalation of decline direction to the operational delivery unit and the completion of Datix incidents which should be in a timely manner following each decline. The medium priority findings related to the need of allocators to review information prior to release of vehicles and analysing and capturing any themes and trends.

Judith Bryce added that compliance has improved, particularly with Red calls, noting there was variation across all Health Boards in Wales.

Comments:

Clarity was sought on the date for reviewing the IRD protocol. Judith Bryce explained that the protocol had been reviewed recently with very few changes.

Following a query on the variation across Health Board with decline rates, Judith Bryce added it was a continual work in progress to understand some of the patient flow issues at hospitals. The Trust would be conducting work to understand on more detail the reasons for refusals.

Members were keen to understand the process involved with the escalation of refusals from the Control Room to the Operational Delivery Unit. Judith Bryce advised that further work was underway to review and improve the current process.

Infection Prevention and Control (IPC) – Reasonable Assurance

The purpose of this audit was to assess the adherence to the organisational policies and the standards for health services in Wales and to consider progress in the recommendations raised in the 2019/20 limited assurance report on cleaning standards.

In terms of the findings, there was one high, five medium and one low priority findings. The high priority finding related to the IPC audit noting that the spot checks were not yet underway following the suspension during the pandemic. The medium priority findings related to the fact the other supporting policies and procedures to the overarching IPC policy should be more aligned; these should illustrate in more clarity IPC responsibilities, governance arrangements and ownership. Other medium priority findings included issues around operational membership of the IPC strategic group surrounding the membership which required formalisation. There were also issues in terms of the IPC action plan which required further clarity with regards to timelines and also clarity was required in respect of the ongoing performance and reporting arrangements.

Data Analysis – Reasonable Assurance

Martyn Lewis explained that the aim of the audit was to assess the processes in place for the use of data and the foundations for being a data led organisation.

The review confirmed that the Trust has the right tools and technology in place to ensure appropriate data governance and data quality.

An issue that had arisen was that Qlik sense software was out of date which may present a cyber risk if not resolved.

Comments

With regards to intelligence and internal data It was queried whether the audit took into account whether the Trust used any external intelligence. Martyn Lewis explained that the audit considered how the Trust used its own data and not external data. Leanne Smith added that the audit had focussed on the infrastructure and qualitative data; there were gaps in linking to external data sets which was being addressed. She added that the Trust was addressing the recommendations and actions and explained there were some challenges with capacity and resource particularly around the Qlik sense software. Members were advised that Qlik sense was an internal facing product and was not an entry point into the Trust.

Standards of Business Conduct: Declarations – Limited Assurance

Felicity Quance explained that the aim of the review was to review the compliance of standards of business conduct; this included the management arrangements around declarations of interest (D of I) and gifts and hospitality. The limited assurance was awarded based on two high priority findings and five medium findings.

The two high priority findings were; the absence of a centralised D of I register in line with other NHS bodies, it was however noted this was being developed and the requirement to strengthen the process surrounding the gifts and hospitality register.

Trish Mills assured the Committee that all the actions were being/have been addressed and gave an overview of the details which would be monitored through several for a including the Assistant Director Leadership Team. In terms of the D of I register; work was underway to improve the register. With regards to the gifts and hospitality register, all forms will be reviewed and enhanced to improve completion.

Carl Window asked, from a fraud perspective, whether there was scope for D of I to be included in the annual PADR activity and whether it could extend to secondary employment, which may not always be documented. Trish Mills added that an appropriate electronic solution was being considered to facilitate this.

Integrated Medium Term Plan (IMTP) – Delivery – Reasonable Assurance

Felicity Quance explained that the purpose of this review was to examine the governance framework and operations of the Strategic Transformation Board, and to assess the effectiveness in delivery of the change programme, as outlined in the IMTP.

The review included a sample of the transformational programmes which considered the EMS operational transformation, ambulance care transformation and gateway into care transformation programmes.

The review concluded there was a clear project methodology being applied for delivery and development of the programmes, also noting there were a number of projects and work streams in place to support this activity.

Going forward there was a need for the inclusion of programme quality management arrangements within the Project Initiation Documents (PID) and the roll out of programme level deliverable plans.

All Wales Decarbonisation

David Butler briefed the Committee that the review sought to review the progression of decarbonisation plans within the Trust, notably to achieve the Welsh Government target of achieving net zero by 2030.

The report had sought to identify best practice across Wales within an advisory report and therefore it was not necessary to provide an audit opinion; however, several recommendations have been provided.

A range of themes had been identified across Wales and included funding and resources. The Trust confirmed that adequate resource were in place and specific funding had been agreed for 2024 and 2025.

Chris Turley added that some of the recommendations were general and may apply to the Trust. In terms of resources (people) this had increased, and in respect of funding a confirmed level of capital funding had been agreed for the next two years.

Comments:

Members queried whether this work had been linked to the Audit Wales (AW) work. David Butler added that the findings from AW had been taken into account, and WAST would have been sighted on all the themes described in that report.

The Chair thanked the IA Team for all the reviews which provided the Committee with a better understanding from and external perspective.

RESOLVED: That

(1) the IA progress report was noted and the changes to the IA plan as described were approved;

(2) the Internal Audit Charter was approved noting the resource requirement figure of £58,130;and

(3) the Internal Audit reviews as presented were received.

03/23 AUDIT WALES REPORTS

Fflur Jones updated the Committee on the following which were outlined in the update report:

- Structured Assessment report (further details below)
- Ongoing progress with unscheduled review
- Upcoming work on workforce planning
- Information related to good practice exchange

Accounts Audit Update

Gareth Lucey updated the Committee on the following:

- Charitable Funds accounts were approved by the Board of Trustees on 16 February 2023 and certified by the auditor General on 17 February 2023.
- Initial planning work for the 2022/23 audit of the financial statements of the Trust was underway.

Structured Assessment (SA) 2022

Fflur Jones updated the Committee on the following:

- The SA reviewed the Trust's progress in four specific areas; Governance, Strategic planning, Finance, and the use of resources.
- Positive progress generally had been achieved within the four areas and six recommendations were made which were detailed further within the report; these were being addressed by the management.
- The Committee noted that the report had previously been presented to the Board at its January meeting.

Comments:

Committee Members discussed in detail the issue surrounding Non-Executive Director (NED) challenge and scrutiny at Board and Committee meetings which had been highlighted in the Structured Assessment. Trish Mills added that she had been in discussion with Audit Wales to consider resolving the issue by considering targeted methods for NEDs and other Board/Committee members to ask more probing questions. Members suggested that a wider debate with Board Members and Fflur Jones be held in order to discuss further, at an informal setting, to better understand the detail which led to highlight External Audits' view of NED scrutiny. Members recognised that the reports

clearly illustrated the level of scrutiny at Committee level, especially for the public to understand. Trish Mills advised it would be appropriate to conduct this at a Board development session and agreed to arrange it following agreement with Chair of the Trust Board.

Final Annual Audit Report 2022

Andrew Doughton presented the report as read noting it drew together the key recommendations from the Structured Assessment.

Comments:

Chris Turley asked the Committee to note that the Charity accounts for 2021/22 had been filed on 17 February 2023 after the required date of 31 January 2023, due to delays in the external audit.

Outline Audit Plan 2023

In introducing the report, Gareth Lucey explained it was in a slightly different format to previous years in that the outline plan was being presented for this meeting with the full audit plan being presented at the next Audit Committee meeting.

The reasons for this change were as follows:

- Introduction of a new auditing standard, International Standard for Auditing (ISA) 315 which has a demanded a much more detailed planning process with more focus on IT systems.
- There has also been a requirement for Welsh Government to introduce new Statutory Instruments with retrospective changes to the accounting framework. This has impacted on Audit Wales's work on local governments, thereby absorbing a great deal of resource.

In terms of the fees for Audit Wales these were set out in the report noting there would be an increase in the region of 5% plus an increase of around 10% in response to ISA 315.

In line with other NHS bodies it was intended that the Trust's accounts would be certified by 31 July 2023.

Comments:

Chris Turley explained the challenges involved in preparing the accounts on time and expressed his concern with the elongated timeline in submission of the accounts. He advised that once Welsh Government had finalised and published its manual for accounts this would detail the final timelines for submitting accounts.

Members recognised the challenges as described by Chris Turley in particular acknowledging the capacity of the finance team which was a concern.

The Committee were keen to understand whether there would be a risk based view about the level of detail required by the Trust. Gareth Lucey assured the Committee that there will be significant focus on the risk assessment work; ultimately, the risk assessment will be

driven by an assessment of understanding how the accounts were compiled. This will also include an assessment of the Trust's IT infrastructure.

Following a query in respect of the fees, Gareth Lucey explained that the fees were currently an estimate of what the work will cost.

RESOLVED: That the Committee noted and received the reports, noting the detailed audit plan will be received at the next meeting.

04/23 ANNUAL FILINGS SCHEDULE 2022/23

Trish Mills gave an overview of the report noting that the dates at paragraph 6 (audit certification deadline) were likely to change. Once the Manual for Accounts had been received, the date for the Audit Committee to review the accounts and recommend for Board approval will be confirmed.

RESOLVED: The Annual Filings 2022-23 schedule was received, acknowledging that there will likely be changes to the dates presented due to the submission deadlines not yet having been confirmed by Welsh Government was approved.

05/23 ANNUAL ACCOUNTS UPDATE 2022/23

Chris Turley presented the report as read and drew their attention to the following point:

Last year several NHS organisations had a technical qualification on their accounts which was linked to the scheme which related to impacts on clinicians' pensions for the 2019/20 financial year, based on a Ministerial Direction. The impact involved pension tax implications for employers. As yet no one from the Trust has applied for this however a provision has been made for an individual concerned who has since left the Trust, should there be a future liability.

He added that correspondence has been received from the Pension Service that an estimated provision be applied for the individual in the Trust's accounts. It is contended by the Trust that this should not be the case; however, as it is a Ministerial Direction it must be complied with. Gareth Lucey added that should the position be confirmed and the amount therefore shown on the Trust's accounts, the accounts will be qualified (a decision for the Auditor General).

RESOLVED: The report was noted.

06/23 RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK

Trish Mills gave an outline of the report and drew the Committee's attention to risks that had been added, increased/decreased in score, and risks that had been closed.

The Committee were also provided with an overview in terms of how the principal risks were processed and managed through several for a, culminating in oversight at Committee level with assurance on the higher rated risks being given to the Board.

Members were updated on the position of the Board Assurance Framework (BAF) which was currently in development, and was the tool which assisted in which the Board and Committees in their challenge and scrutiny of the risks.

The Committee were updated on the how the higher rated risks, which scored 20 and above, were escalated to the Board. Details of these risks were contained in the Committee highlight reports and also within the standalone risk report. Furthermore, Trish Mills proposed that the specific risk owners provide an update at Board on each of the higher rated risks in addition to the narrative as outlined in the Committee highlight reports.

In summary, Trish Mills concluded that the Structured Assessment had shown that generally, risk management was positive, acknowledging there was still further work to mature it further.

Comments:

A conversation ensued which considered at which forum scrutiny and oversight of the higher rated risks should be conducted. It was generally agreed that there was value at discussing the high-level risks at Board level. Members recognised that at each Board Committee meeting there was opportunity to scrutinise the higher rated risks, and to challenge Executive Leads where necessary. The Committees should conduct the detailed work, updating the Board through their highlight report and it was suggested that the principal risks were referenced throughout the Trust Board meeting as and when they emerged.

In terms of process, it was queried how principal risks were agreed. Trish Mills gave an overview of the process in which the levels of risk and scores were obtained. Further detail would be contained in the policy currently being developed which would outline what the various risks were, i.e., Directorate, Corporate or Strategic and how they would be managed.

Colin Dennis, Chair of the Board, advised the Committee that the Board delegated various tasks to Committees and agreed that the detailed scrutiny needs to be a Committee level. However, as a whole the Board had a responsibly to satisfy itself that the appropriate scrutiny of the principal risks was carried out; and by using the Committee highlight report and the Chairs of Committees' additional input, this should be adequate. Trish Mills reminded Members that currently the principal risks should drive the agenda of the Committees and be the main focus.

RESOLVED: The Committee discussed the content of the report and noted the proposed measures to strengthen the risk management framework.

07/23 AUDIT TRACKER

1. Trish Mills explained that the report provided an update in respect of audit recommendations resulting from Internal Audit and External Audit reviews; noting there was no audit tracker to support the report.

2. There were some proposed closure of audit actions which will be confirmed along with the updated tracker in preparation for the next meeting.

RESOLVED: The Committee noted the update.

08/23 LOSSES AND SPECIAL PAYMENTS – PAYMENTS FOR THE PERIOD 1 APRIL 2022 – 31 JANUARY 2023

The Committee were informed by Chris Turley that the total net losses and special payments made during this period amounted to £0.902m.

RESOLVED: That the losses and special payments report for the period 1 April 2022 – 31 January 2023 were noted.

09/23 CONSENT ITEMS

The following reports were presented for the Committee to note:

- Committee priorities report Quarter 4.
- December 2022 Committee Highlight Report.

RESOLVED: The Committee noted the reports.

10/23 SUMMARY OF ACTIONS AND DECISIONS AND KEY MESSAGES FOR BOARD

This would be drafted by Trish Mills.

Meeting concluded at: 12:09

Date of Next Meeting: 20 April 2023

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 20 APRIL 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
Joga Singh	Non-Executive Director

IN ATTENDANCE :

Julie Boalch	Head of Risk/Deputy Board Secretary
Lee Brooks	Executive Director of Operations
Colin Dennis	Chair of the Board
Estelle Hitchon	Director of Partnerships and Engagement
Fflur Jones	Audit Wales
Navin Kalia	Deputy Director of Finance and Corporate Resources
Jason Killens	Chief Executive Officer
Osian Lloyd	Head of Internal Audit
Trish Mills	Board Secretary
Steve Owen	Corporate Governance Officer
Alex Payne	Corporate Governance Manager
Duncan Robertson	Assistant Director of Clinical Development
Paul Seppman	Trade Union Partner
Chris Turley	Executive Director of Finance and Corporate Resources (Left after Item 14/23)
Damon Turner	Trade Union Partner
Carl Window	Counter Fraud Manager

APOLOGIES:

Fflur Jones	Audit Wales
Angela Lewis	Director of People and Culture
Liam Williams	Executive Director of Quality and Nursing

11/23 PROCEDURAL MATTERS

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

Declarations of Interest, other than those listed in the Declarations of Interest register, there were no further declarations. The apologies as described were noted.

RESOLVED: The apologies as described were noted.

12/23 ANNUAL BOARD AND COMMITTEE EFFECTIVENESS REVIEWS 2022/23

Trish Mills explained that The Trust's Standing Orders and Committee terms of reference require that Board Committees evaluate their effectiveness annually and prepare an annual report to the Trust Board. This report provides the evaluation of the Audit Committee's effectiveness during the 2022/23 year and makes proposals for changes to operating arrangements.

In terms of the Audit Committee effectiveness review, Trish Mills advised that the questionnaires sent were different to the other Committees as the ones used were from the National Audit Office. The results for the returned questionnaires (29% of questionnaires returned) indicated that the Committee was meeting the required standards.

Following the receipt of the questionnaires a meeting took place with the Chair and Executive Lead of the Audit Committee to focus on the questions where more than one respondent rated effectiveness as there being 'room for improvement'. This gave rise to several themes which were detailed within the report. Of particular note was to agree the reinstatement of the Audit Committee and auditors meeting in private without the presence of management. Furthermore there was a strong desire to develop a Committee induction programme which would assist new members and attendees who were unfamiliar with the operations of government and the public sector.

Another theme which came to light was the operating arrangements around whistleblowing. This work was now being implemented by the Director of People and Culture. It was noted that the Chair of the People and Culture Committee would provide an update to the Audit Committee on this work in due course.

The Committee's attention was drawn to the annual report and the terms of reference for the Audit Committee.

Following a discussion, the Committee agreed that the review of the Board Member Induction Programme and Annex was a Committee priority for 2023/24.

Trish Mills advised that effectiveness reviews had been undertaken for all other committees of the Board, with all committees having received and approved their respective annual reports and amended terms of reference. Proposed changes to operating arrangements and committee priorities for 2023/24 have also been agreed.

There had been varied responses which again like the Audit Committee were discussed at length with the respective Chairs and Committee leads.

Details of any changes to the terms of reference were outlined in the report.

Of note, the Charitable Funds Committee requested to change its name to the Charity Committee.

Trish Mills added that each Committee reports to the Board by way of an Alert, Advise, Assure (AAA) report which was circulated to the Board as soon as possible after the meeting and formed part of the next Board meeting pack of papers.

The Committee were advised that these reports and changes to committees' terms of reference would be presented to the Trust Board at its next meeting for approval.

Comments:

Clarity was sought on the definition of 'near misses' and it was agreed this would be considered through the Quest Committee as part of its normal business.

Paul Hollard, Chair of People and Culture Committee (PCC) expressed the importance of the cycles of business. He commented that the terms of reference were now accurate adding that holding the agenda setting meetings well in advance of the meeting were extremely beneficial in terms of planning ahead for PCC and all other Committees.

Ceri Jackson, Chair of the Charitable Funds Committee welcomed the in-depth review reiterating Paul Hollard's comments in respect of the improved overall process.

Joga Singh, Chair of the Finance and Performance Committee echoed the comments already made and agreed with the changes that had been implemented.

Colin Dennis, Chair of the Remuneration Committee commented there had been very minor amendments to the terms of reference and was content with the overall outcome of the review.

Paul Hollard, as a member of the Quality Patient Experience and Safety (Quest) Committee commented that the Committee had reflected on the terms of reference to see if they were still suited to the new legislation Duty of Candour and Duty of Quality.

Trish Mills added that the cycle of business for each Committee was still maturing and would be monitored at each meeting going forward.

Following a query in terms of Board effectiveness and when/where it will be discussed, Trish Mills advised that at the May Board meeting, the Board will receive a report following the Board effectiveness survey.

In terms of strategy and planning and how Non-Executive Directors (NED) contributed and what their role was, Trish Mills advised this would be drawn out and articulated more within the Trust's strategy frameworks. Colin Dennis outlined in terms of how NEDs were involved in supporting the Trust's strategy development going forward and also applying scrutiny and challenge to the strategy.

The Committee acknowledged and recognised the significant volume of work involved in producing the effectiveness reviews.

RESOLVED: **The Committee:**

(1) Reviewed and endorsed changes to Audit Committee's terms of reference and operating arrangements in response to issues raised in questionnaires, and given the small number of responses, propose any other changes;

(2) Agreed that the review of the Board Member Induction Programme and Annex was the Committee's priority for 2023/24;

(3) Approved the Audit Committee's annual report;

(4) Noted the changes to the operating arrangements and terms of reference for:

- **Academic Partnership Committee**
- **Charity Committee**
- **Finance and Performance Committee**
- **People and Culture Committee**
- **Quality, Patient Experience and Safety Committee**
- **Remuneration Committee; and endorsed these and the annual reports for onward approval by the Trust Board; and**

(5) Confirmed there were no further assurances sought on the effectiveness of the Trust's governance arrangements for its committees.

13/23 STANDING ORDERS, SCHEME OF RESERVATION AND DELEGATION OF POWERS, AND STANDING FINANCIAL INSTRUCTIONS AND GOVERNANCE PRACTICE NOTES

Trish Mills explained that the Trust's Standing Orders required an annual review to ensure they remained accurate and current. The Standing Orders (SO) included the Scheme of

Reservation and Delegation of Powers (SoRD), and the Standing Financial Instructions (SFI).

The Standing Orders underwent an extensive review by the Audit Committee in December 2021 and the Trust Board in January 2022, including a wholesale review of the SFIs and Tables A and B of the SoRD.

Whilst no changes can be made to the main body of the Model SOs until the Welsh Government review was completed, there were changes within the Trust's gift, and Trish Mills outlined these in more details.

Trish Mills reminded the Committee that governance practice notes had been developed in 2022 to aid in the interpretation and application of SOs. The practice notes were reviewed annually and Trish Mills made reference to the proposed changes as outlined in the report.

Trish Mills drew the Committee's attention to paragraph 7.4.3 in SOs which stated that Board members shall be sent an agenda and a complete set of supporting papers at least ten calendar days before a formal Board meeting. Historically, Board papers have been uploaded on the Friday before the meeting the following Thursday, therefore outside of the ten calendar days. Whilst this was a non-compliance with SOs, the requirement for papers to be uploaded to Ibabs ten calendar days before a meeting, reduced the currency of information and data available to the Board and the ability for reports to make their way through internal governance processes between bi-monthly Board meetings. This has been raised with Welsh Government by the Board Secretaries Network. All endeavours were being made to ensure Board and Committee papers are available no less than seven days before a meeting. A standard operating procedure for the Corporate Governance Team was in development, which included an annex setting out the timetable for Board and Committee papers.

RESOLVED: The Committee

(1) Endorsed the amendments to Schedule 3 of the SOs and Table A of the SoRD;

(2) Noted the non-compliance with paragraph 7.4.3 with regard to the availability of Board papers ten calendar days ahead of meetings; and

(3) Noted the review of the Governance Practice Notes and approved amendments to Note 002.

14/23 SELF ASSESSMENT AGAINST THE CORPORATE GOVERNANCE CODE FOR CENTRAL GOVERNMENT DEPARTMENTS 2017 AND THE GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY HEALTH AND CARE STANDARDS

Trish Mills explained that the self-assessment against the Corporate Governance Code for Central Government Departments (2017) had been completed and reviewed by the Executive Management Team. The Code operates on a 'comply or explain' basis whereby

any deviation from the Code's requirements must be explained within the Annual Governance Statement. The self-assessment showed that there were no areas of non-compliance.

A self-assessment had also been completed against the Governance, Leadership and Accountability domains in the Health and Care Standards 2015. There were some 'partially met' provisions concluded within the self-assessment which the Trust was aware of, which were detailed in the corresponding report. It was noted that the majority of the Health and Care Standards fall within the remit of the Quest Committee and that compliance was reviewed by Quest against the domains of safe care, effective care, dignified care, timely care, individual care, staff and resources and staying healthy, at its meeting in February 2023.

Comments:

The Committee were made aware of the risk around resourcing for the development and implementation of the Quality Strategy. 'Trish Mills advised there was a focus on this issue at the Quest Committee together with the new Quality Standards 2023 that replace the Health and Care Standards 2015'.

RESOLVED: The Committee reviewed and approved the self-assessment against the Corporate Governance Code for Central Government Departments 2017, in addition to confirming compliance with the Code when it receives the 2022-23 Accountability Report; and reviewed and approved the self-assessment against the Governance, Leadership and Accountability domains in the Health and Care Standards 2015.

15/23 REGISTERS: REGISTER OF INTERESTS AND REGISTER OF GIFTS, HOSPITALITY AND SPONSORSHIP

Trish Mills reminded the Committee that a limited assurance opinion had been received on internal audit for the Standards of Business Conduct within the Trust which the Committee reviewed at its March meeting. This audit included the Trust's approach to management of declarations of interests and gifts and hospitality. The register of interests of Board and Executive Management Team members was before the Committee at this meeting, together with the Gifts and Hospitality Register. Both had been revised in accordance with management responses to the audit recommendations.

The Gifts, Hospitality, Interests: Commercial Sponsorship and Fundraising Policy has undergone review following the recommendations as set out by internal audit. The revised Policy will be brought to the Audit Committee for endorsement at its July meeting. The Trust was also looking to facilitate electronic solutions for the register of interests.

RESOLVED: The Committee

(1) Confirmed receipt of the Board and Executive Management Team Register of Interests as at 31 March 2023; and

(2) Confirmed receipt of the Gifts, Hospitality, Sponsorship Register as at 31 March 2023.

16/23 2 MARCH 2023 COMMITTEE AAA REPORT

Trish Mills advised the report was presented for information.

RESOLVED: That the report was noted.

17/23 REFLECTION: SUMMARY OF DECISIONS & ACTIONS

The Chair expressed his thanks to Trish Mills and her team for the well-presented reports.

Members commented it was interesting to see other Committee reports and to be assured of the whole governance picture across the Committees.

Trish Mills added that over time the governance and assurance framework for the Trust would mature and be more robust, particularly with the re-development of the Board Assurance framework.

Meeting concluded at: 10:21

Date of Next Meeting: This is to be confirmed following confirmation of the submission schedule for the Annual Report and Accounts.

ACTION LOG

WELSH AMBULANCE SERVICES NHS TRUST - AUDIT COMMITTEE - December 2021

Ref	Date	Agenda Item	Action Note	Responsible	Due Date	Progress/Comment	Status
02/23	2 March 2023	Internal Audit Reviews	Produce a Gantt chart on Internal Audit reviews that illustrates work completed over a period of time in relation to the time planned for the work.	Osian Lloyd	25 July 2023	Update for 25 July 2023 This is included as an appendix to the audit tracker paper	Complete
03/23	2 March 2023	Audit Wales - Structured Assessment	To agree with Chair of the Board a suitable forum to discuss the area regarding NED's challenge	Trish Mills	25 July 2023	Update for 25 July 2023 Discussion took place in Board Development in April 2023 with Audit Wales in attendance	Complete

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

2022/23 ANNUAL ACCOUNTS

MEETING	Audit Committee
DATE	25 July 2023
EXECUTIVE	Director of Finance & Corporate Resources
AUTHOR	Olaide Kazeem, Financial Services Project Accountant
CONTACT	Chris Turley chris.turley2@wales.nhs.uk

EXECUTIVE SUMMARY

The Trust submitted its unaudited Draft Annual Accounts for 2022/23 to the Welsh Government, on 5th May 2023, in line with the agreed timetable.

The accounts for the year ended 31st March 2023 have been prepared to comply with International Financial Reporting Standards (IFRS) adopted by the European Union, in accordance with HM Treasury's FReM by the Welsh Ambulance Services NHS Trust under schedule 9 section 178 Para 3 (1) of the National Health Service (Wales) Act 2006 (c.42) in the form in which the Welsh Ministers, with the approval of the Treasury, directed.

RECOMMENDED: That the Trust's Annual Accounts for 2022/23 be recommended for formal approval by the Trust Board.

KEY ISSUES/IMPLICATIONS

The final audited accounts (***Appendix 1***) as presented demonstrate that the Trust has:

a) Reported a retained surplus of £0.062 million for the year being reported as the financial duty;
b) Met its financial duty to break even over the 3 years 2020/2021 to 2022/2023.
c) Expended Capital Investment funds of £28.795 million, thereby utilising 100% of the Trust's Capital Expenditure Limit;
d) Achieved Public Sector Payments Policy (PSPP) of 97.4% within 30 days against the 95% target.

The requirement to achieve the administrative External Financing Target was again suspended for 2022/23.

REPORT APPROVAL ROUTE
An update on the financial performance of the Trust as at Month 12 2022/23 and therefore the draft 2022/23 year end position (subject to audit) was provided to both the Finance & Performance Committee on 15th May 2023 and Trust Board on 25th May 2023. The audited Annual Accounts are to be presented to Trust Board for their approval on 27th July 2023. The final approved and audited Annual Accounts are due to be submitted to Welsh Government by 31st July 2023 together with the Trust's Annual Report, as a single unified document in line with the agreed timetable.

REPORT APPENDICES
Appendix 1 – Annual Accounts 2022/23

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

WELSH AMBULANCE SERVICES NHS TRUST

AUDIT COMMITTEE

2022/23 ANNUAL ACCOUNTS REPORT

SITUATION

1. The Trust submitted its unaudited 2022/23 Draft Accounts on 5th May 2023 to the Welsh Government, in line with the agreed timetable.

BACKGROUND

2. The accounts for the year ended 31st March 2023 have been prepared to comply with International Financial Reporting Standards (IFRS) adopted by the *European Union, in accordance with HM Treasury's FReM by the Welsh Ambulance Services NHS Trust under schedule 9 section 178 Para 3 (1) of the National Health Service (Wales) Act 2006 (c.42) in the form in which the Welsh Ministers, with the approval of the Treasury, directed.

**Please note that following the withdrawal of the UK from the European Union this position is unchanged.*

ASSESSMENT

3. The Final Audited Accounts (**Appendix 1**) as presented demonstrate that the Trust has:

   a) As per the draft accounts, continued to report a retained surplus of £0.062 million for the year;

   b)

   - Under the National Health Services (Wales) Act 2006 the financial obligations of the NHS Trust are contained within Schedules 4 2(1) and 4(2).

   - The Trust is required to achieve financial breakeven over a rolling 3 year period.

   - Welsh Health Circular WHC/2016/054 replaced WHC/2015/014 'Statutory and Financial Duties of Local Health Boards and NHS Trusts' and further clarifies the statutory financial duties of NHS Wales bodies.

- The Trust is therefore deemed to have met its financial duty to break even over the 3 years 2020/21 to 2022/23 as shown below.

Annual Financial Performance	2020-21 £000	2021-22 £000	2022-23 £000	**2020-21 to 2022-23 Financial Duty £000**
Retained Surplus	70	260	62	**392**
Less Donated Asset/Grant Funded Revenue Adjustment	0	(185)	0	**(185)**
Adjusted Surplus/(Deficit)	**70**	**75**	**62**	**207**

c) External Financing Limit (EFL); the requirement to achieve the administrative External Financing Target has again been suspended for 2022/23.

d) Expended Capital Investment funds of £28.795 million, thereby utilising 100% of the Trust's Welsh Government set Capital Expenditure Limit; and

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

4. To aid discussion and understanding, it is also planned that some of the key financial values within the accounts will be presented to Audit Committee, along with explanations for any of the key movements from the previous financial year.

5. The draft accounts have subsequently been audited by the Audit Wales (AW) team and, where required, amended by the Trust. Adjustments between draft and final accounts were largely minimal and / or presentational in nature or impacted only on a small number of the disclosures or notes to the accounts and did not result in a change to the retained surplus position.

6. The financial statements are free of material misstatements and there are no uncorrected misstatements, there are a few corrected misstatements that have already been reflected in the accounts and none of these corrected misstatements affect the disclosed surplus of £62,000.

- Revenue (Notes 3 & 4) – £2.5m PIBS income reflected as other income instead of Welsh Government Income.
- Employee Costs (Note 10.1) – 6.3% pension support from Welsh Government reflected in Employer Pension Contribution line instead of Salaries and wages line in the note. The figures are £8.4m and £7.8m for 2022/23 and 2021/22 respectively.
- Events After Reporting Period (Note 32) – NHS Wales Recovery payment to be funded by Welsh Government is disclosed in this note. Though the amount of £4.2m relates to 2022/23 financial year, the arrangement was not confirmed until after year end and as such does not affect the 2022/23 financial year performance.
- Related Party Transactions (Note 33) – Removal of transactions with universities as the Welsh Government is not their parent body.

7. AW have therefore provided a report (ISA 260) that indicates that it is the intention of the Auditor General for Wales to issue an unqualified certificate and report on the 2022/23 financial statements, citing that they provide a true and fair view of the Trust's finances in the 2022/23 financial year.

8. The audited accounts are due to be presented to Trust Board for their approval on 27th July 2023.

9. The final approved and audited annual accounts and accountability report are then due to be submitted to Welsh Government by 31st July 2023 as one single unified document in line with the agreed timetable.

RECOMMENDED: That the Trust's Annual Accounts for 2022/23 be recommended for formal approval by the Trust Board.

Welsh Ambulance Services NHS Trust

Foreword

These accounts for the period ended 31 March 2023 have been prepared to comply with International Financial Reporting Standards (IFRS) adopted by the European Union, in accordance with HM Treasury's FReM by Public Health Wales NHS Trust under schedule 9 section 178 Para 3 (1) of the National Health Service (Wales) Act 2006 (c.42) in the form in which the Welsh Ministers, with the approval of the Treasury, directed.

Statutory background

The Trust was established in 1998. Spread over an area of almost 8000 square miles and serving a population of over 3 million, our diverse area encompasses tranquil rural retreats, busy seaside resorts and large urban boroughs.

Our varied and modern services are tailor-made for each community's differing environmental and medical needs, from cycles to fast response cars, frontline ambulances and nurses in our control centres.

We attend more than 250,000 emergency calls a year, over 50,000 urgent calls and transport over 1.3 million non-emergency patients to over 200 treatment centres throughout England and Wales.

Our dedicated staff are our biggest asset, and we employ in the region of 4,000 people. Approximately 70% of our workforce is within our emergency medical services which include our Clinical Contact Centres, and around 640 staff work in our Non-Emergency Patient Transport Service (NEPTS). Our patient facing services are also supported by colleagues working within our corporate and support functions (approximately 500 staff) and our valued extended volunteer workforce, including over 1,000 Community First Responders (CFRs) and circa 300 Volunteer Car Drivers.

We operate from over 90 buildings including ambulance stations, three control centres, three regional offices and five vehicle workshops.

We also have our own National Training College to ensure our staff remain at the top of their game and receive regular professional development.

We provide access to high quality, on-going training, regular continuous professional development opportunities and personal annual development reviews.

We are also the host for the 111 service, a 24 hour health advice and information service for the public and the front end call handling and clinical triage elements of the GP out-of-hours services.

Performance Management and Financial Results

This Welsh Health Circular WHC/2016/054 replaces WHC/2015/014 'Statutory and Administrative Financial Duties of NHS Trusts and Local Health Boards' and further clarifies the statutory financial duties of NHS Wales bodies and is effective for 2020-2021 onwards. The annual financial duty has been revoked and the statutory breakeven duty has reverted to a three year duty, with the first assessment of this duty in 2016-2017.

Under the National Health Services (Wales) Act 2006 the financial obligations of the NHS Trust are contained within Schedules 4 2(1) and 4 2(2). Each NHS trust must ensure that its revenue is not less than sufficient, taking one financial year with another, to meet outgoings properly chargeable to the revenue account. The first assessment of performance against the 3-year statutory duty under Schedules 4 2(1) and 4 2(2) was at the end of 2016-2017, being the first three year period of assessment.

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2023

	Note	2022-23 £000	2021-22 £000
Revenue from patient care activities	3	283,196	261,570
Other operating revenue	4	12,489	14,889
Operating expenses	5.1	(296,341)	(276,398)
Operating (deficit)/surplus		(656)	61
Investment revenue	6	432	14
Other gains and losses	7	279	129
Finance costs	8	7	56
Retained surplus	2.1.1	62	260
Other Comprehensive Income			
Items that will not be reclassified to net operating costs:			
Net gain/(loss) on revaluation of property, plant and equipment		3,071	1,016
Net gain / (loss) on revaluation of right of use assets		0	
Net gain/(loss) on revaluation of intangible assets		0	0
Movements in other reserves		0	0
Net gain/(loss) on revaluation of PPE and Intangible assets held for sale		220	0
Net gain/(loss) on revaluation of financial assets		0	0
Impairments and reversals		(318)	(96)
Transfers between reserves		0	0
Reclassification adjustment on disposal of available for sale financial assets		0	0
Sub total		2,973	920
Items that may be reclassified subsequently to net operating costs			
Net gain/(loss) on revaluation of financial assets held for sale		0	0
Sub total		0	0
Total other comprehensive income for the year		2,973	920
Total comprehensive income for the year		3,035	1,180

The notes on pages 6 to 76 form part of these accounts.

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

2022-23	Public Dividend Capital £000	Retained earnings £000	Revaluation reserve £000	Total £000
Changes in taxpayers' equity for 2022-23				
Balance as at 31 March 2022	**81,219**	**(5,701)**	**10,333**	**85,851**
NHS Wales Transfer	**0**	**0**	**0**	**0**
RoU Asset Transitioning Adjustment	**0**	**1,337**	**0**	**1,337**
Balance at 1 April 2022	81,219	(4,364)	10,333	**87,188**
Retained surplus/(deficit) for the year		**62**		**62**
Net gain/(loss) on revaluation of property, plant and equipment		**0**	**3,071**	**3,071**
Net gain/(loss) on revaluation of right of use assets		**0**	**0**	**0**
Net gain/(loss) on revaluation of intangible assets		**0**	**0**	**0**
Net gain/(loss) on revaluation of financial assets		**0**	**0**	**0**
Net gain/(loss) on revaluation of assets held for sale		**0**	**220**	**220**
Net gain/(loss) on revaluation of financial assets held for sale		**0**	**0**	**0**
Impairments and reversals		**0**	**(318)**	**(318)**
Other reserve movement		**0**	**0**	**0**
Transfers between reserves		**295**	**(295)**	**0**
Reclassification adjustment on disposal of available for sale financial assets		**0**	**0**	**0**
Reserves eliminated on dissolution	**0**			**0**
Total in year movement	**0**	**357**	**2,678**	**3,035**
New Public Dividend Capital received	**0**			**0**
Public Dividend Capital repaid in year	**(297)**			**(297)**
Public Dividend Capital extinguished/written off	**0**			**0**
PDC Cash Due but not issued	**0**			**0**
Other movements in PDC in year	**0**			**0**
Balance at 31 March 2023	**80,922**	**(4,007)**	**13,011**	**89,926**

The notes on pages 6 to 76 form part of these accounts.

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

2021-22	Public Dividend Capital	Retained earnings	Revaluation reserve	Total
	£000	£000	£000	£000
Changes in taxpayers' equity for 2021-22				
Balance at 31 March 2021	76,354	(5,961)	9,413	79,806
NHS Wales Transfer	0	0	0	0
RoU Asset Transitioning Adjustment				
Balance at 1 April 2021	76,354	(5,961)	9,413	79,806
Retained surplus/(deficit) for the year		260		260
Net gain/(loss) on revaluation of property, plant and equipment		0	1,016	1,016
Net gain/(loss) on revaluation of right of use assets				
Net gain/(loss) on revaluation of intangible assets		0	0	0
Net gain/(loss) on revaluation of financial assets		0	0	0
Net gain/(loss) on revaluation of assets held for sale		0	0	0
Net gain/(loss) on revaluation of financial assets held for sale		0	0	0
Impairments and reversals		0	(96)	(96)
Other reserve movement		0	0	0
Transfers between reserves		0	0	0
Reclassification adjustment on disposal of available for sale financial assets		0	0	0
Reserves eliminated on dissolution	0			0
Total in year movement	0	260	920	1,180
New Public Dividend Capital received	9,530			9,530
Public Dividend Capital repaid in year	(4,665)			(4,665)
Public Dividend Capital extinguished/written off	0			0
PDC Cash Due but not issued				
Other movements in PDC in year	0			0
Balance at 31 March 2022	81,219	(5,701)	10,333	85,851

The notes on pages 6 to 76 form part of these accounts.

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2023

		Note	31 March 2023	31 March 2022
			£000	£000
Non-current assets	Property, plant and equipment	**13**	**98,617**	95,594
	Right of Use Assets	**13.3**	**12,735**	
	Intangible assets	**14**	**1,349**	3,231
	Trade and other receivables	**17.1**	**380**	790
	Other financial assets	**18**	**0**	0
	Total non-current assets		**113,081**	99,615
Current assets	Inventories	**16.1**	**2,032**	1,826
	Trade and other receivables	**17.1**	**18,939**	17,148
	Other financial assets	**18**	**0**	0
	Cash and cash equivalents	**19**	**19,192**	18,708
			40,163	37,682
	Non-current assets held for sale	**13.2**	**0**	130
	Total current assets		**40,163**	37,812
Total assets			**153,244**	137,427
Current liabilities	Trade and other payables	**20**	**(39,859)**	(35,752)
	Borrowings	**21**	**(2,999)**	(1,364)
	Other financial liabilities	**22**	**0**	0
	Provisions	**23**	**(5,104)**	(4,402)
	Total current liabilities		**(47,962)**	(41,518)
Net current assets/(liabilities)			**(7,799)**	(3,706)
Total assets less current liabilities			**105,282**	95,909
Non-current liabilities	Trade and other payables	**20**	**0**	0
	Borrowings	**21**	**(8,400)**	0
	Other financial liabilities	**22**	**0**	0
	Provisions	**23**	**(6,956)**	(10,058)
	Total non-current liabilities		**(15,356)**	(10,058)
Total assets employed			**89,926**	85,851
Financed by Taxpayers' equity:				
	Public dividend capital		**80,922**	81,219
	Retained earnings		**(4,007)**	(5,701)
	Revaluation reserve		**13,011**	10,333
	Other reserves		**0**	0
	Total taxpayers' equity		**89,926**	85,851

The financial statements were approved by the Board on 27th July 2023 and signed on behalf of the Board by:

Chief Executive: Jason Killens .....

Date: 27th July 2023

The notes on pages 6 to 76 form part of these accounts.

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2023

	Note	2022-23 £000	2021-22 £000
Operating surplus/(deficit)	SOCI	(656)	61
Movements in working capital	30	6,809	(593)
Other cash flow adjustments	31	29,050	25,662
Provisions utilised		(3,021)	(6,963)
Interest paid		(123)	(44)
Net cash inflow (outflow) from operating activities		**32,059**	18,123
Cash flows from investing activities			
Interest received		432	14
(Payments) for property, plant and equipment		(28,277)	(21,339)
Proceeds from disposal of property, plant and equipment		279	158
(Payments) for intangible assets		(121)	(270)
Proceeds from disposal of intangible assets		0	0
Payments for investments with Welsh Government		0	0
Proceeds from disposals with Welsh Government		0	0
(Payments) for financial assets.		0	0
Proceeds from disposal of financial assets.		0	0
Net cash inflow (outflow) from investing activities		**(27,687)**	(21,437)
Net cash inflow (outflow) before financing		**4,372**	(3,314)
Cash flows from financing activities			
Public Dividend Capital received		**0**	9,530
Public Dividend Capital repaid		**(297)**	(4,665)
Loans received from Welsh Government		**0**	0
Loans repaid to Welsh Government		**0**	0
Other loans received		**0**	0
Other loans repaid		**0**	0
Other capital receipts		**0**	0
Capital elements of finance leases and on-SOFP PFI		**0**	(1,311)
Capital element of payments in respect of on-SoFP PFI		**0**	0
Capital element of payments in respect of Right of Use Assets		**(3,591)**	
Cash transferred (to)/from other NHS Wales bodies		**0**	0
Net cash inflow (outflow) from financing activities		**(3,888)**	3,554
Net increase (decrease) in cash and cash equivalents		**484**	240
Cash [and] cash equivalents at the beginning of the financial year	**19**	**18,708**	18,468
Cash [and] cash equivalents at the end of the financial year	**19**	**19,192**	18,708

The notes on pages 6 to 76 form part of these accounts.

Notes to the Accounts

1. Accounting policies

The Minister for Health and Social Services has directed that the financial statements of NHS Trusts (NHST) in Wales shall meet the accounting requirements of the NHS Wales Manual for Accounts. Consequently, the following financial statements have been prepared in accordance with the 2022-2023 Manual for Accounts. The accounting policies contained in that manual follow the 2022-2023 Financial Reporting Manual (FReM), in accordance with international accounting standards in conformity with the requirements of the Companies Act 2006, to the extent that they are meaningful and appropriate to the NHS in Wales.

Where the NHST Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the NHST for the purpose of giving a true and fair view has been selected. The particular policies adopted by the NHST are described below. They have been applied consistently in dealing with items considered material in relation to the accounts*.*

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets and inventories.

1.2 Acquisitions and discontinued operations

Activities are considered to be ‘acquired’ only if they are taken on from outside the public sector. Activities are considered to be ‘discontinued’ only if they cease entirely. They are not considered to be ‘discontinued’ if they transfer from one public sector body to another.

1.3 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.

From 2018-2019, IFRS 15 Revenue from Contracts with Customers has been applied, as interpreted and adapted for the public sector, in the FReM. It replaces the previous standards IAS 11 Construction Contracts and IAS 18 Revenue and related IFRIC and SIC interpretations. The potential amendments identified as a result of the adoption of IFRS 15 are significantly below materiality levels.

Income is accounted for applying the accruals convention. Income is recognised in the period in which services are provided. Where income is received from third parties for a specific activity to be delivered in the following financial year, that income will be deferred.

Only non-NHS income may be deferred.

1.4 Employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

The latest NHS Pension Scheme valuation results indicated that an increase in benefit required a 6.3% increase (14.38% to 20.68%) which was implemented from 1 April 2019.

As an organisation within the full funding scope, the joint (in NHS England and NHS Wales) transitional arrangement operated from 2019-2020 where employers in the Scheme would continue to pay 14.38% employer contributions under their normal monthly payment process, and in Wales the additional 6.3% would be funded by Welsh Government directly to the Pension Scheme administrator, the NHS Business Services Authority (BSA, the NHS Pensions Agency).

However, NHS Wales organisations are required to account for **their staff** employer contributions of 20.68% in full and on a gross basis, in their annual accounts. Payments made on their behalf by Welsh Government are accounted for on a notional basis. For detailed information see Other Note within these accounts.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the NHS Wales organisation commits itself to the retirement, regardless of the method of payment.

Where employees are members of the Local Government Superannuation Scheme, which is a defined benefit pension scheme this is disclosed. The scheme assets and liabilities attributable to those employees can be identified and are recognised in the NHS Wales organisation's accounts. The assets are measured at fair value and the liabilities at the present value of the future obligations. The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The expected gain during the year from scheme assets is recognised within finance income. The interest cost during the year arising from the unwinding of the discount on the scheme liabilities is recognised within finance costs.

NEST Pension Scheme

An alternative pensions scheme for employees not eligible to join the NHS Pensions scheme has to be offered. The NEST (National Employment Savings Trust) Pension scheme is a defined contribution scheme and therefore the cost to the NHS body of participating in the scheme is equal to the contributions payable to the scheme for the accounting period.

1.5 Other expenses

Other operating expenses for goods or services are recognised when, and to the extent that, they have been received. They are measured at the fair value of the consideration payable.

1.6 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

● it is held for use in delivering services or for administrative purposes;

● it is probable that future economic benefits will flow to, or service potential will be supplied to, the NHS Wales organisation;

● it is expected to be used for more than one financial year;

● the cost of the item can be measured reliably; and

● the item has cost of at least £5,000; or

● collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or

● items form part of the initial equipping and setting-up cost of a new building, vehicle or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Land and buildings used for services or for administrative purposes are stated in the Statement of Financial Position (SoFP) at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. NHS Wales' organisations have applied these new valuation requirements from 1 April 2009.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

In 2022-23 a formal revaluation exercise was applied to land and properties. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure.

References in IAS 36 to the recognition of an impairment loss of a revalued asset being treated as a revaluation decrease to the extent that the impairment does not exceed the amount in the revaluation surplus for the same asset, are adapted such that only those impairment losses that do not result from a clear consumption of economic benefit or reduction of service potential (including as a result of loss or damage resulting from normal business operations) should be taken to the revaluation reserve. Impairment losses that arise from a clear consumption of economic benefit should be taken to the Statement of Comprehensive Income (SoCI).

From 2015-2016, IFRS 13 Fair Value Measurement must be complied with in full. However IAS 16 and IAS 38 have been adapted for the public sector context which limits the circumstances under which a valuation is prepared under IFRS 13. Assets which are held for their service potential and are in use should be measured at their current value in existing use. For specialised assets current value in existing use should be interpreted as the present value of the assets remaining service potential, which can be assumed to be at least equal to the cost of replacing that service potential. Where there is no single class of asset that falls within IFRS 13, disclosures should be for material items only.

In accordance with the adaptation of IAS 16 in table 6.2 of the FReM, for non-specialised assets in operational use, current value in existing use is interpreted as market value for existing use which is defined in the RICS Red Book as Existing Use Value (EUV).

Assets which were most recently held for their service potential but are surplus should be valued at current value in existing use, if there are restrictions on the NHS organisation or the asset which would prevent access to the market at the reporting date. If the NHS organisation could access the market then the surplus asset should be used at fair value using IFRS 13. In determining whether such an asset which is not in use is surplus, an assessment should be made on whether there is a clear plan to bring the asset back into use as an operational asset. Where there is a clear plan, the asset is not surplus and the current value in existing use should be maintained. Otherwise the asset should be assessed as being surplus and valued under IFRS13.

Assets which are not held for their service potential should be valued in accordance with IFRS 5 or IAS 40 depending on whether the asset is actively held for sale. Where an asset is not being used to deliver services and there is no plan to bring it back into use, with no restrictions on sale, and it does not meet the IAS 40 and IFRS 5 criteria, these assets are surplus and are valued at fair value using IFRS 13.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any carrying value of the item replaced is written-out and charged to the SoCI. As highlighted in previous years the NHS in Wales does not have systems in place to ensure that all items being "replaced" can be identified and hence the cost involved to be quantified. The NHS in Wales has thus established a national protocol to ensure it complies with the standard as far as it is able to which is outlined in the capital accounting chapter of the Manual For Accounts. This ensures that asset carrying values are not materially overstated.

For All Wales Capital Schemes that are completed in a financial year, NHS Wales organisations are required to obtain a revaluation during that year (prior to them being brought into use) and also similar revaluations are needed for all Discretionary Building Schemes completed which have a spend greater than £0.5m. The write downs so identified are then charged to operating expenses.

1.7 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the NHS Wales organisation; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

● the technical feasibility of completing the intangible asset so that it will be available for use

● the intention to complete the intangible asset and use it

● the ability to use the intangible asset

● how the intangible asset will generate probable future economic benefits

● the availability of adequate technical, financial and other resources to complete the intangible asset and use it

● the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Measurement

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.8 Depreciation, amortisation and impairments

Freehold land, assets under construction and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the NHS Wales organisation expects to obtain economic benefits or service potential from the asset. This is specific to NHS Wales organisation and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and estimated useful lives.

At each reporting period end, the NHS Wales organisation checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

Impairment losses that do not result from a loss of economic value or service potential are taken to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to the SoCI. Impairment losses that arise from a clear consumption of economic benefit are taken to the SoCI. The balance on any revaluation reserve (up to the level of the impairment) to which the impairment would have been charged under IAS 36 are transferred to retained earnings.

1.9 Research and Development

Research and development expenditure is charged to operating costs in the year in which it is incurred, except insofar as it relates to a clearly defined project, which can be separated from patient care activity and benefits there from can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the SoCI on a systematic basis over the period expected to benefit from the project.

1.10 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the SoCI. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead it is retained as an operational asset and its economic life adjusted. The asset is derecognised when it is scrapped or demolished.

1.11 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration.

IFRS 16 leases is effective across public sector from 1 April 2022. The transition to IFRS 16 has been completed in accordance with paragraph C5 (b) of the Standard, applying IFRS 16 requirements retrospectively recognising the cumulative effects at the date of initial application.

In the transition to IFRS 16 a number of elections and practical expedients offered in the standard have been employed. These are as follows: The entity has applied the practical expedient offered in the standard per paragraph C3 to apply IFRS 16 to contracts or arrangements previously identified as containing a lease under the previous leasing standards IAS 17 leases and IFRIC 4 determining whether an arrangement contains a lease and not to those that were identified as not containing a lease under previous leasing standards.

On initial application, Welsh Ambulance Services NHS Trust has measured the right of use assets for leases previously classified as operating leases per IFRS 16 C8 (b)(ii), at an amount equal to the lease liability adjusted for accrued or prepaid lease payments.

No adjustments have been made for operating leases in which the underlying asset is of low value per paragraph C9 (a) of the standard.
The transitional provisions have not been applied to operating leases whose terms end within 12 months of the date of initial application has been employed per paragraph C10 (c) of IFRS 16.
Hindsight is used to determine the lease term when contracts or arrangements contain options to extend or terminate the lease in accordance with C10 (e) of IFRS 16.

Due to transitional provisions employed the requirements for identifying a lease within paragraphs 9 to 11 of IFRS 16 are not employed for leases in existence at the initial date of application. Leases entered into on or after the 1st April 2022 will be assessed under the requirements of IFRS 16.
There are further expedients or election that have been employed by Welsh Ambulance Services NHS Trust in applying IFRS 16.

These include:

- the measurement requirements under IFRS 16 are not applied to leases with a term of 12 months or less under paragraph 5 (a) of IFRS 16
- the measurement requirements under IFRS 16 are not applied to leases where the underlying asset is of a low value which are identified as those assets of a value of less than £5,000, excluding any irrecoverable VAT, under paragraph 5 (b) of IFRS 16

The entity will not apply IFRS 16 to any new leases of in tangible assets applying the treatment described in section 1.14 instead.

- Welsh Ambulance Services NHS Trust is required to apply IFRS 16 to lease like arrangements entered into with other public sector entities that are in substance akin to an enforceable contract, that in their formal legal form may not be enforceable. Prior to accounting for such arrangements under IFRS 16, Welsh Ambulance Services NHS Trust has assessed that in all other respects these arrangements meet the definition of a lease under the standard.

  Welsh Ambulance Services NHS Trust is required to apply IFRS 16 to lease like arrangements entered into in which consideration exchanged is nil or nominal, therefore significantly below market value. These arrangements are described as peppercorn leases. Such arrangements are again required to meet the definition of a lease in every other respect prior to inclusion in the scope of IFRS 16. The accounting for peppercorn arrangements aligns to that identified for donated assets. Peppercorn leases are different in substance to arrangements in which consideration is below market value but not significantly below market value.

  The nature of the accounting policy change for the lessee is more significant than for the lessor under IFRS 16. IFRS 16 introduces a singular lessee approach to measurement and classification in which lessees recognise a right of use asset.

  For the lessor leases remain classified as finance leases when substantially all the risks and rewards incidental to ownership of an underlying asset are transferred to the lessee. When this transfer does not occur, leases are classified as operating leases.

  1.11.1 The Welsh Ambulance Services NHS Trust (the entity) as lessee

  At the commencement date for the leasing arrangement a lessee shall recognise a right of use asset and corresponding lease liability. The entity employs a revaluation model for the subsequent measurement of its right of use assets unless cost is considered to be an appropriate proxy for current value in existing use or fair value in line with the accounting policy for owned assets. Where consideration exchanged is identified as below market value, cost is not considered to be an appropriate proxy to value the right of use asset.

  Irrecoverable VAT is expensed in the period to which it relates and therefore not included in the measurement of the lease liability and consequently the value of the right of use asset.

  The incremental borrowing rate of 0.95% has been applied to the lease liabilities recognised at the date of initial application of IFRS 16.

  Where changes in future lease payments result from a change in an index or rate or rent review, the lease liabilities are remeasured using an unchanged discount rate.

  Where there is a change in a lease term or an option to purchase the underlying asset the entity applies a revised rate to the remaining lease liability.

  Where existing leases are modified the entity must determine whether the arrangement constitutes a separate lease and apply the standard accordingly.

  Lease payments are recognised as an expense on a straight-line or another systematic basis over the lease term, where the lease term is in substance 12 months or less, or is elected as a lease containing low value underlying asset by the entity.

1.12 Inventories

Whilst it is accounting convention for inventories to be valued at the lower of cost and net realisable value using the weighted average or "first-in first-out" cost formula, it should be recognised that the NHS is a special case in that inventories are not generally held for the intention of resale and indeed there is no market readily available where such items could be sold. Inventories are valued at cost and this is considered to be a reasonable approximation to fair value due to the high turnover of stocks. Work-in-progress comprises goods in intermediate stages of production. Partially completed contracts for patient services are not accounted for as work-in-progress.

1.13 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value. In the Statement of Cash flows (SoCF), cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the cash management.

1.14 Provisions

Provisions are recognised when the NHS Wales organisation has a present legal or constructive obligation as a result of a past event, it is probable that the NHS Wales organisation will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using the discount rate supplied by HM Treasury.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the NHS Wales organisation has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the NHS Wales organisation has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.14.1 Clinical negligence and personal injury costs

The Welsh Risk Pool Services (WRPS) operate a risk pooling scheme which is co-funded by the Welsh Government with the option to access a risk sharing agreement funded by the participating NHS Wales bodies. The risk sharing option was implemented in both 2022-23 and 2021-22. The WRPS is hosted by Velindre NHS University Trust.

1.14.2 Future Liability Scheme (FLS)

General Medical Practice Indemnity (GMPI)

The FLS is a state backed scheme to provide clinical negligence General Medical Practice Indemnity (GMPI) for providers of GP services in Wales.

In March 2019, the Minister issued a Direction to Velindre University NHS Trust to enable Legal and Risk Services to operate the Scheme. The GMPI is underpinned by new secondary legislation, The NHS (Clinical Negligence Scheme) (Wales) Regulations 2019 which came into force on 1 April 2019.

1.15 Financial Instruments

From 2018-2019 IFRS 9 Financial Instruments is applied, as interpreted and adapted for the public sector, in the FReM. The principal impact of IFRS 9 adoption by Public Health Wales NHS Trust is a change to the calculation basis for bad debt provisions: changing from an incurred loss basis to a lifetime expected credit loss (ECL) basis.

1.16 Financial assets

Financial assets are recognised on the SoFP when the NHS Wales organisation becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

The accounting policy choice allowed under IFRS 9 for long term trade receivables, contract assets which do contain a significant financing component (in accordance with IFRS 15), and lease receivables within the scope of IAS 17 has been withdrawn and entities should always recognise a loss allowance at an amount equal to lifetime Expected Credit Losses.

All entities applying the FReM should utilise IFRS 9's simplified approach to impairment for relevant assets.

IFRS 9 requirements required a revised approach for the calculation of the bad debt provision, applying the principles of expected credit loss, using the practical expedients within IFRS 9 to construct a provision matrix.

1.16.1 Financial assets are initially recognised at fair value

Financial assets are classified into the following categories: financial assets ‘at fair value' through SoCI; ‘held to maturity investments’; ‘available for sale’ financial assets, and ‘loans and receivables’. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

1.16.2 Financial assets at fair value through SoCI

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through SoCI. They are held at fair value, with any resultant gain or loss recognised in the SoCI. The net gain or loss incorporates any interest earned on the financial asset.

1.16.3 Held to maturity investments

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

1.16.4 Available for sale financial assets

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to the SoCI on de-recognition.

1.16.5 Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the net carrying amount of the financial asset.

At the SOFP date, the NHS Wales organisation assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the expenditure and the carrying amount of the asset is reduced directly, or through a provision of impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through the expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.16.6 Other financial assets

Listed investments are stated at market value. Unlisted investments are included at cost as an approximation to market value. Quoted stocks are included in the balance sheet at mid-market price, and where holdings are subject to bid / offer pricing their valuations are shown on a bid price. The shares are not held for trading and accordingly are classified as available for sale. Other financial assets are classified as available for sale investments carried at fair value within the financial statements.

1.17 Financial liabilities

Financial liabilities are recognised on the SOFP when the NHS Wales organisation becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired. Loans from Welsh Government are recognised at historical cost.

1.17.1 Financial liabilities are initially recognised at fair value through SoCI

Financial liabilities are classified as either financial liabilities at fair value through the SoCI or other financial liabilities.

1.17.2 Financial liabilities at fair value through the SoCI

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the SoCI. The net gain or loss incorporates any interest earned on the financial asset.

1.17.3 Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.18 Value Added Tax (VAT)

Most of the activities of the NHS Wales organisation are outside the scope of VAT and, in general, output VAT does not apply and input VAT on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output VAT is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.19 Foreign currencies

Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. Resulting exchange gains and losses are taken to the SoCI. At the SoFP date, monetary items denominated in foreign currencies are retranslated at the rates prevailing at the reporting date.

1.20 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS Wales organisation has no beneficial interest in them. Details of third party assets are given in the Notes to the accounts.

1.21 Losses and Special Payments

Losses and special payments are items that the Welsh Government would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings in the SoCI on an accruals basis, including losses which would have been made good through insurance cover had the NHS organisation not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments is compiled directly from the losses register which is prepared on a cash basis.

The NHS Wales organisations accounts for all losses and special payments gross (including assistance from the WRPS).

The NHS Wales organisation accrues or provides for the best estimate of future payouts for certain liabilities and discloses all other potential payments as contingent liabilities, unless the probability of the liabilities becoming payable is remote.

All claims for losses and special payments are provided for, where the probability of settlement of an individual claim is over 50%. Where reliable estimates can be made, incidents of clinical negligence against which a claim has not, as yet, been received are provided in the same way. Expected reimbursements from the WRP are included in debtors. For those claims where the probability of settlement is between 5-50%, the liability is disclosed as a contingent liability.

1.22 Pooled budget

The NHS Wales organisation has/has not entered into pooled budgets with Local Authorities. Under the arrangements funds are pooled in accordance with section 33 of the NHS (Wales) Act 2006 for specific activities defined in the Pooled budget Note.

The pool budget is hosted by one NHS Wales's organisation. Payments for services provided are accounted for as miscellaneous income. The NHS Wales organisation accounts for its share of the assets, liabilities, income and expenditure from the activities of the pooled budget, in accordance with the pooled budget arrangement.

1.23 Critical Accounting Judgements and key sources of estimation uncertainty

In the application of the accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources.

The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates. The estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or the period of the revision and future periods if the revision affects both current and future periods.

1.24 Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the SoFP date, that have a significant risk of causing material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Significant estimations are made in relation to on-going clinical negligence and personal injury claims. Assumptions as to the likely outcome, the potential liabilities and the timings of these litigation claims are provided by independent legal advisors. Any material changes in liabilities associated with these claims would be recoverable through the WRPS.

1.25 Provisions for legal or constructive obligations for clinical negligence, personal injury & defence costs

The NHS Wales organisation provides for legal or constructive obligations for clinical negligence, personal injury and defence costs that are of uncertain timing or amount at the balance sheet date on the basis of the best estimate of the expenditure required to settle the obligation.

Claims are funded via the WRPS which receives an annual allocation from Welsh Government to cover the cost of reimbursement requests submitted to the bi-monthly WRPS Committee. Following settlement to individual claimants by the NHS Wales organisation, the full cost is recognised in year and matched to income (less a £25K excess) via a WRPS debtor, until reimbursement has been received from the WRPS Committee.

Probable & Certain Cases – Accounting Treatment

A provision for these cases is calculated in accordance with IAS 37. Cases are assessed and divided into four categories according to their probability of settlement:

Remote	Probability of Settlement	0 – 5%
	Accounting Treatment	Remote Contingent Liability
Possible	Probability of Settlement	6% - 49%
	Accounting Treatment	Defence Fee - Provision*
		Contingent Liability for all other estimated expenditure
Probable	Probability of Settlement	50% - 94%
	Accounting Treatment	Full Provision
Certain	Probability of Settlement	95% - 100%
	Accounting Treatment	Full Provision

** Defence fee costs are provided for at 25%.*

The provision for probable and certain cases is based on case estimates of individual reported claims received by Legal & Risk Services within NHS Wales Shared Services Partnership.

The solicitor will estimate the case value including defence fees, using professional judgement and from obtaining counsel advice. Valuations are then discounted for the future loss elements using individual life expectancies and the Government Actuary's Department actuarial tables (Ogden tables) and Personal Injury Discount Rate of -0.25%.

Future liabilities for certain & probable cases with a probability of 95%-100% and 50%-94% respectively are held as a provision on the Trust's balance sheet. Cases typically take a number of years to settle, particularly for high value cases where a period of development is necessary to establish the full extent of the injury caused.

1.26 Discount Rates

Where discount is applied, a disclosure detailing the impact of the discounting on liabilities to be included for the relevant notes. The disclosure should include where possible undiscounted values to demonstrate the impact. An explanation of the source of the discount rate or how the discount rate has been determined to be included.

1.27 Private Finance Initiative (PFI) transactions

The Trust has no PFI arrangements.

1.28 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS Wales organisation, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS Wales organisation. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

Remote contingent liabilities are those that are disclosed under Parliamentary reporting requirements and not under IAS 37 and, where practical, an estimate of their financial effect is required.

1.29 Absorption accounting

Transfers of function are accounted for as either by merger or by absorption accounting, dependent upon the treatment prescribed in the FReM. Absorption accounting requires that entities account for their transactions in the period in which they took place with no restatement of performance required.

For transfers of functions involving NHS Wales Trusts in receipt of PDC the double entry for the fixed asset NBV value and the net movement in assets is PDC.

1.30 Accounting standards that have been issued but not yet been adopted

The following accounting standards have been issued and or amended by the IASB and IFRIC but have not been adopted because they are not yet required to be adopted by the FReM:

IFRS14 Regulatory Deferral Accounts - Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable.

IFRS 17 Insurance Contracts, Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.

1.31 Accounting standards issued that have been adopted early

During 2022-2023 there have been no accounting standards that have been adopted early. All early adoption of accounting standards will be led by HM Treasury.

1.32 Charities

Following Treasury's agreement to apply IAS 27 to NHS Charities from 1 April 2013, the Trust has established that as it is not the corporate trustee of Charitable Funds, it is considered for accounting standards compliance to not have control any Charitable Funds as a subsidiary, and therefore is not required to consolidate the results of any Charitables Funds within the statutory accounts of the Trust.

1.33 Subsidiaries

Material entities over which the NHS Wales organisation has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries and are consolidated. Their income and expenses; gains and losses; assets, liabilities and reserves; and cash flows are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the NHS Wales organisation or where the subsidiary's accounting date is before 1 January or after 30 June.

Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.34 Borrowing costs

Borrowing costs are recognised as expenses as they are incurred.

1.35 Public Dividend Capital (PDC) and PDC dividend

PDC represents taxpayers' equity in the NHS Wales organisation. At any time the Minister for Health and Social Services with the approval of HM Treasury can issue new PDC to, and require repayments of, PDC from the NHS Wales organisation. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

From 1 April 2010 the requirement to pay a public dividend over to the Welsh Government ceased.

2. Financial Performance

2.1 STATUTORY FINANCIAL DUTIES

Under the National Health Services (Wales) Act 2006 the financial obligations of the NHS Trust are contained within Schedules 4 2(1) and 4(2).

The Trust is required to achieve financial breakeven over a rolling 3 year period.

Welsh Health Circular WHC/2016/054 replaced WHC/2015/014 'Statutory and Financial Duties of Local Health Boards and NHS Trusts' and further clarifies the statutory financial duties of NHS Wales bodies.

2.1.1 Financial Duty

	Annual financial performance			**2020-21 to 2022-23 Financial duty £000**
	2020-21 £000	2021-22 £000	2022-23 £000	
Retained surplus	70	260	62	**392**
Less Donated asset / grant funded revenue adjustment	0	(185)	0	**(185)**
Adjusted surplus/ (Deficit)	70	75	62	**207**

The Welsh Ambulance Services NHS Trust has met its financial duty to break even over the 3 years 2020-2021 to 2022-2023.

2.1.2 Integrated Medium Term Plan (IMTP)

The NHS Wales Planning Framework for the period 2022-2025 issued to Trusts placed a requirement upon them to prepare and submit Integrated Medium Term Plans to the Welsh Government.

The Trust submitted an Integrated Medium Term Plan for the period 2022-2025 in accordance with NHS Wales Planning Framework.

The Minister for Health and Social Services extant approval.

Status

Date 13/07/2022

The Welsh Ambulance Services NHS Trust has therefore met its statutory duty to have an approved financial plan.

2. Financial Performance (cont)

2.2 ADMINISTRATIVE REQUIREMENTS

2.2.1. External financing

The Trust is given an external financing limit which it is permitted to undershoot

The EFL target has been suspended for 2022-23, on the basis of value for money and the impracticality in relation to the length of deposit time required by the NLF to accept deposits.

2.3. Creditor payment

The Trust is required to pay 95% of the number of non-NHS bills within 30 days of receipt of goods or a valid invoice (whichever is the later). The Trust has achieved the following results:

	2022-23	2021-22
Total number of non-NHS bills paid	**51,541**	**49,800**
Total number of non-NHS bills paid within target	**50,195**	**48,400**
Percentage of non-NHS bills paid within target	**97.4%**	**97.2%**

The Trust has met the target.

3. Revenue from patient care activities	2022-23	2021-22
	£000	£000
Local health boards	16,569	41,034
Welsh Health Specialised & Emergency Ambulance Services Committees (WHSSC & EASC)	230,334	185,589
Welsh NHS Trusts	767	745
Welsh Special Health Authorities	0	0
Foundation Trusts	0	0
Other NHS England bodies	57	136
Other NHS Bodies	0	0
Local Authorities	0	0
Welsh Government	33,749	29,908
Welsh Government - Hosted Bodies	0	0
Non NHS:		
Private patient income	0	0
Overseas patients (non-reciprocal)	0	0
Injury Costs Recovery (ICR) Scheme	132	193
Other revenue from activities	1,588	3,965
Total	**283,196**	261,570

Injury Cost Recovery (ICR) Scheme income:

	2022-23	2021-22
	%	%
To reflect expected rates of collection ICR income is subject to a provision for impairment of:	23.76	23.76

4. Other operating revenue	2022-23	2021-22
	£000	£000
Income generation	0	0
Patient transport services	0	0
Education, training and research	1,554	1,329
Charitable and other contributions to expenditure	0	0
Receipt of Covid Items free of charge from other NHS Wales Organisations	0	0
Receipt of Covid Items free of charge from other organisations	0	0
Receipt of donations for capital acquisitions	0	185
Receipt of government grants for capital acquisitions	0	0
Right of Use Grant (Peppercorn Lease)	0	
Non-patient care services to other bodies	0	0
Right of Use Asset Sub-leasing rental income	0	
Rental revenue from finance leases	0	0
Rental revenue from operating leases	149	141
Other revenue:		
Provision of pathology/microbiology services	0	0
Accommodation and catering charges	0	0
Mortuary fees	0	0
Staff payments for use of cars	71	79
Business unit	0	0
Scheme Pays Reimbursement Notional	0	0
Other	10,715	13,155
Total	**12,489**	14,889
Total Patient Care and Operating Revenue	**295,685**	**276,459**

Other revenue comprises:		
Personal injury benefit scheme (PIBS)	(2,460)	132
Air Ambulance paramedic funding	0	0
Hazardous Area Response Team (HART)	2,615	2,570
Other minor services income	1,208	4,317
Funding for impairments (as funds flow monies)	9,352	6,136
Total	**10,715**	13,155

The 'Other' revenue includes -£2,460k in relation to a return of income relating to the Personal Injury Benefit Scheme (PIBS) which has resulted in a repayment of income to WG.

5. Operating expenses	2022-23	2021-22
5.1 Operating expenses	**£000**	£000
Local Health Boards	**112**	131
Welsh NHS Trusts	**958**	914
Welsh Special Health Authorities	**0**	0
Goods and services from other non Welsh NHS bodies	**0**	0
WHSSC/EASC	**0**	0
Local Authorities	**0**	0
Purchase of healthcare from non-NHS bodies	**12,541**	12,599
Welsh Government	**466**	374
Other NHS Trusts	**0**	0
Directors' costs	**1,780**	1,835
Operational Staff costs	**204,480**	189,878
Single lead employer Staff Trainee Cost	**0**	0
Collaborative Bank Staff Cost	**0**	0
Supplies and services - clinical	**5,874**	6,801
Supplies and services - general	**2,282**	2,336
Consultancy Services	**612**	878
Establishment	**5,465**	4,373
Transport	**17,470**	16,995
Premises	**11,447**	12,216
Impairments and Reversals of Receivables	**0**	0
Depreciation	**13,414**	15,190
Depreciation (RoU Asset)	**3,715**	
Amortisation	**1,948**	1,750
Impairments and reversals of property, plant and equipment	**9,352**	6,135
Fixed asset impairments and reversals (RoU Assets)	**0**	
Impairments and reversals of intangible assets	**0**	0
Impairments and reversals of financial assets	**0**	0
Impairments and reversals of non current assets held for sale	**0**	0
Audit fees	**167**	163
Other auditors' remuneration	**0**	0
Losses, special payments and irrecoverable debts	**(1,820)**	843
Research and development	**0**	0
Expense related to short-term leases	**0**	
Expense related to low-value asset leases (excluding short-term leases)	**0**	
Other operating expenses	**6,078**	2,987
Total	**296,341**	276,398

The 'Losses, special payment and irrecoverable debts' expenditure includes -£2,460k in relation to the Personal Injury Benefit Scheme (PIBS), this is due to a change in discount rate from -1.3% to +1.7%.

5. Operating expenses (continued)

5.2 Losses, special payments and irrecoverable debts:

Charges to operating expenses Increase/(decrease) in provision for future payments:	2022-23 £000	2021-22 £000
Clinical negligence;-		
Secondary care	1,931	310
Primary care	0	0
Redress Secondary Care	464	262
Redress Primary Care	0	0
Personal injury	(1,571)	(688)
All other losses and special payments	0	0
Defence legal fees and other administrative costs	324	171
Structured Settlements Welsh Risk Pool	0	0
Gross increase/(decrease) in provision for future payments	1,148	55
Contribution to Welsh Risk Pool	0	0
Premium for other insurance arrangements	0	0
Irrecoverable debts	28	37
Less: income received/ due from Welsh Risk Pool	(2,996)	751
Total charge	(1,820)	843

Personal injury includes -£2.460m in respect of Permanent Injury Benefit Scheme (PIBS) (2021-22 £0.126m), the large movement is due to a change in discount rate to +1.7% (2021-22 -1.3%). This expenditure includes a charge of £0.130m relating to the change in the rate at which the provision for future payments is calculated.

The Contribution to Welsh Risk Pool is disclosed in Note 5.1 for 2022-23.

	2022-23 £	2021-22 £
Permanent injury included within personal injury:	-2,461,950	125,783

6. Investment revenue	2022-23	2021-22
Rental revenue :	**£000**	£000
PFI finance lease revenue:		
Planned	**0**	0
Contingent	**0**	0
Other finance lease revenue	**0**	0
Interest revenue:		
Bank accounts	**432**	14
Other loans and receivables	**0**	0
Impaired financial assets	**0**	0
Other financial assets	**0**	0
Total	**432**	14

The increase in the interest revenue is due to the increase in interest rates during 22/23, from 0.75% at March 2022 to 4.25% at March 2023.

7. Other gains and losses	2022-23	2021-22
	£000	£000
Gain/(loss) on disposal of property, plant and equipment	**0**	0
Gain/(loss) on disposal of intangible assets	**0**	0
Gain/(loss) on disposal of assets held for sale	**279**	129
Gain/(loss) on disposal of financial assets	**0**	0
Gains/(loss) on foreign exchange	**0**	0
Change in fair value of financial assets at fair value through income statement	**0**	0
Change in fair value of financial liabilities at fair value through income statement	**0**	0
Recycling of gain/(loss) from equity on disposal of financial assets held for sale	**0**	0
Total	**279**	129

8. Finance costs	2022-23	2021-22
	£000	£000
Interest on loans and overdrafts	**0**	0
Interest on obligations under finance leases	**123**	44
Interest on obligations under Right of Use Leases	**0**	
Interest on obligations under PFI contracts:		
Main finance cost	**0**	0
Contingent finance cost	**0**	0
Interest on late payment of commercial debt	**0**	0
Other interest expense	**0**	0
Total interest expense	**123**	44
Provisions unwinding of discount	**(130)**	(100)
Periodical Payment Order unwinding of discount	**0**	0
Other finance costs	**0**	0
Total	**(7)**	**(56)**

9. Future change to SoCI/Operating Leases

9.1 Trust as lessee

Operating lease payments represent rentals payable by Welsh Ambulance Services NHS Trust for properties and equipment.

	Post Implementation of IFRS 16		Pre implementation of IFRS 16
	Low Value & Short Term	Other	
Payments recognised as an expense	**2022-23**	**2022-23**	2021-22
	£000	**£000**	£000
Minimum lease payments	**158**	**818**	2,027
Contingent rents	**0**	**0**	0
Sub-lease payments	**0**	**0**	0
Total	**158**	**818**	2,027

Total future minimum lease payments	**2022-23**	**2022-23**	2021-22
Payable:	**£000**	**£000**	£000
Not later than one year	**90**	**731**	1,842
Between one and five years	**0**	**1,440**	4,167
After 5 years	**0**	**588**	1,798
Total	**90**	**2,759**	7,807
Total future sublease payments expected to be received	**0**	**0**	0

As a result of the implementation of IFRS 16 the current year operating lease figures relate to low value and short term leases only. Previously reported Minimum lease payments of £1,188,813 transitioned to the balance sheet as Right of Use (RoU) assets.

The amounts disclosed within 'Other' relate to the VAT and Service Charges in relation to RoU assets and lease cars which include a private element and are therefore outside the scope of IFRS 16.

9. Future change to SoCI/Operating Leases (continued)

9.2 Trust as lessor

The Trust leases part of Vantage Point House to Aneurin Bevan NHS Trust in respect of their GP Out of Hours service.

Rental Revenue	**Post Implementation of IFRS 16**	Pre implementation of IFRS 16
Receipts recognised as income	**2022-23**	2021-22
	£000	£000
Rent	**0**	0
Contingent rent	**0**	0
Other	**150**	143
Total rental revenue	**150**	143

Total future minimum lease payments Receivable:	**2022-23**	2021-22
	£000	£000
Not later than one year	**0**	0
Between one and five years	**0**	0
After 5 years	**1**	1
Total	**1**	1

10. Employee costs and numbers

10.1 Employee costs

Operational Staff	Permanently employed staff	Staff on Inward Secondment	Agency Staff	Specialist Trainee (SLE)	Other Staff	2022-23 £000	2021-22 £000
	£000	£000	£000	£000	£000	£000	£000
Salaries and wages	160,812	324	1,845	0	0	162,981	151,409
Social security costs	16,609	0	0	0	0	16,609	15,091
Employer contributions to NHS Pensions Scheme	27,592	0	0	0	0	27,592	25,744
Other pension costs	7	0	0	0	0	7	6
Other post-employment benefits	0	0	0	0	0	0	0
Termination benefits	171	0	0	0	0	171	292
Total	205,191	324	1,845	0	0	207,360	192,542

Of the total above:	2022-23	2021-22
Charged to capital	1,056	956
Charged to revenue	206,304	191,586
Total	207,360	192,542

Net movement in accrued employee benefits (untaken staff leave)	1,145	673
Covid 19 - Net movement in accrued employee benefits (untaken staff leave)		673
Non Covid 19 - Net movement in accrued employee benefits (untaken staff leave)		0

10.2 Average number of employees

	Permanently Employed	Staff on Inward Secondment	Agency Staff	Specialist Trainee (SLE)	Other Staff	2022-23 Total	2021-22 Total
	Number	Number	Number	Number	Number	Number	Number
Administrative, clerical and board members	598	6	14	0	0	618	581
Medical and dental	1	0	0	0	0	1	1
Nursing, midwifery registered	196	0	0	0	0	196	207
Professional, scientific and technical staff	4	0	0	0	0	4	2
Additional Clinical Services	2,067	0	11	0	0	2,078	2,064
Allied Health Professions	1,091	0	1	0	0	1,092	1,052
Healthcare scientists	0	0	0	0	0	0	0
Estates and Ancillary	62	0	2	0	0	64	62
Students	0	0	0	0	0	0	0
Total	4,019	6	28	0	0	4,053	3,969

The average number is calculated using the full time equivalent (FTE) of employees

10.3. Retirements due to ill-health

	2022-23	2021-22
Number	9	5
Estimated additional pension costs £	324,957	348,066

The estimated additional pension costs of these ill-health retirements have been calculated on an average basis and are borne by the NHS Pension Scheme.

10.4 Employee benefits

Employee benefits refer to non-pay benefits which are not attributable to individual employees, for example group membership of a club. The trust does not operate any employee benefit schemes.

10.5 Reporting of other compensation schemes - exit packages

Exit packages cost band (including any special payment element)	2022-23 Number of compulsory redundancies Whole numbers only	2022-23 Number of other departures Whole numbers only	2022-23 Total number of exit packages Whole numbers only	2022-23 Number of departures where special payments have been made Whole numbers only	2021-22 Total number of exit packages Whole numbers only
less than £10,000	0	1	1	1	0
£10,000 to £25,000	0	3	3	0	1
£25,000 to £50,000	0	1	1	1	3
£50,000 to £100,000	0	1	1	1	2
£100,000 to £150,000	0	0	0	0	0
£150,000 to £200,000	0	0	0	0	0
more than £200,000	0	0	0	0	0
Total	0	6	6	3	6

Exit packages cost band (including any special payment element)	2022-23 Cost of compulsory redundancies £	2022-23 Cost of other departures £	2022-23 Total cost of exit packages £	2022-23 Cost of special element included in exit packages £	2021-22 Total cost of exit packages £
less than £10,000	0	7,000	7,000	7,000	0
£10,000 to £25,000	0	46,776	46,776	0	22,191
£25,000 to £50,000	0	42,573	42,573	42,573	131,053
£50,000 to £100,000	0	74,617	74,617	74,617	138,628
£100,000 to £150,000	0	0	0	0	0
£150,000 to £200,000	0	0	0	0	0
more than £200,000	0	0	0	0	0
Total	0	170,966	170,966	124,190	291,872

Exit costs paid in year of departure	Total paid in year 2022-23 £	Total paid in year 2021-22 £
Exit costs paid in year	303,842	171,637
Total	303,842	171,637

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Voluntary Early Release Scheme (VERS). Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

10.6 Fair Pay disclosures

10.6.1 Remuneration Relationship

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director /employee in their organisation and the 25th percentile, median and 75th percentile remuneration of the organisation's workforce.

Total pay and benefits	2022-23 £000 Chief Executive	2022-23 £000 Employee	2022-23 £000 Ratio	2021-22 £000 Chief Executive	2021-22 £000 Employee	2021-22 £000 Ratio
25th percentile pay ratio	**167,500**	**26,462**	**6.33:1**	162,500	24,565	6.62:1
Median pay	**167,500**	**34,225**	**4.89:1**	162,500	31,805	5.11:1
75th percentile pay ratio	**167,500**	**46,920**	**3.57:1**	162,500	44,814	3.63:1
Salary component of total pay and benefits						
25th percentile pay ratio	**172,500**	**23,525**		167,500	21,777	
Median pay	**172,500**	**26,676**		167,500	24,882	
75th percentile pay ratio	**172,500**	**41,197**		167,500	39,027	

Total pay and benefits	Highest Paid Director	Employee	Ratio	Highest Paid Director	Employee	Ratio
25th percentile pay ratio	**167,500**	**26,462**	**6.33:1**	162,500	24,565	6.62:1
Median pay	**167,500**	**34,225**	**4.89:1**	162,500	31,806	5.11:1
75th percentile pay ratio	**167,500**	**46,920**	**3.57:1**	162,500	44,814	3.63:1
Salary component of total pay and benefits						
25th percentile pay ratio	**172,500**	**23,525**		167,500	21,777	
Median pay	**172,500**	**26,676**		167,500	24,882	
75th percentile pay ratio	**172,500**	**41,197**		167,500	39,027	

In 2022-23, 1 (2021-22, 0) employee received remuneration in excess of the highest-paid director.

Remuneration for all staff ranged from £21,069 to £172,500 (2021-22, £18,576 to £167,500).

The all staff range includes directors (including the highest paid director) and excludes pension benefits of all employees.

*In terms of these disclosures, the Chief Executive is also the highest paid director.

Financial year summary

The total pay and benefits figure for the Chief Executive/Highest Paid Director is lower than the salary component due to a salary sacrifice scheme.

The employee who received remuneration in excess of the Chief Executive is a temporary agency worker who was in post as at the 31st of March and is not a Director.

In keeping with the Welsh Government circulars on pay, included in the calculations are a £1,400 consolidated increase and a one-off non-consolidated payment of 1.5%, along with an accrual for the consolidated 1.5% which was payable in 2022-2023 and will be paid in May 2023.

10.6.2 Percentage Changes	2021-22 to 2022-23 %	2020-21 to 2021-22 %
% Change from previous financial year in respect of Chief Executive		
Salary and allowances	**3.1**	-3
Performance pay and bonuses	**0**	0
% Change from previous financial year in respect of highest paid director		
Salary and allowances	**3.1**	-3
Performance pay and bonuses	**0**	0
Average % Change from previous financial year in respect of employees takes as a whole		
Salary and allowances	**6.1**	3.6
Performance pay and bonuses	**0**	0

The reduction of -3% reported in 21/22 notes was in relation to a salary sacrifice scheme entered into by the Chief Executive which reduces the salary banding. The 3% shown in 22/23 is in relation to the pay award received and accrued for during 22/23.

The 3.6% reported in 21/22 notes in terms of the average pay per FTE related to the agreed A4C pay increases across the organisation. The 6.1% in 22/23 notes is related to the pay award receive and accrued for during 22/23.

11. Pensions

PENSION COSTS

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2023, is based on valuation data as 31 March 2022, updated to 31 March 2023 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The actuarial valuation as at 31 March 2020 is currently underway and will set the new employer contribution rate due to be implemented from April 2024.

c) National Employment Savings Trust (NEST)

NEST is a workplace pension scheme, which was set up by legislation and is treated as a trust-based scheme. The Trustee responsible for running the scheme is NEST Corporation. It's a non-departmental public body (NDPB) that operates at arm's length from government and is accountable to Parliament through the Department for Work and Pensions (DWP).

NEST Corporation has agreed a loan with the Department for Work and Pensions (DWP). This has paid for the scheme to be set up and will cover expected shortfalls in scheme costs during the earlier years while membership is growing.

NEST Corporation aims for the scheme to become self-financing while providing consistently low charges to members.

Using qualifying earnings to calculate contributions, currently the legal minimum level of contributions is 8% of a jobholder's qualifying earnings, for employers whose legal duties have started. The employer must pay at least 3% of this.

The earnings band used to calculate minimum contributions under existing legislation is called qualifying earnings. Qualifying earnings are currently those between £6,240 and £50,270 for the 2022-2023 tax year (2021-2022 £6,240 and £50,000).

Restrictions on the annual contribution limits were removed on 1st April 2017.

12. Public Sector Payment Policy

12.1 Prompt payment code - measure of compliance

The Welsh Government requires that trusts pay all their trade creditors in accordance with the CBI prompt payment code and Government Accounting rules. The Welsh Government has set as part of the trust financial targets a requirement to pay 95% of the number of non-NHS creditors within 30 days of delivery or receipt of a valid invoice, whichever is the later.

	2022-23 Number	**2022-23 £000**	2021-22 Number	2021-22 £000
NHS				
Total bills paid in year	**1,160**	**9,147**	995	7,609
Total bills paid within target	**1,103**	**8,771**	923	6,848
Percentage of bills paid within target	**95.1%**	**95.9%**	92.8%	90.0%
Non-NHS				
Total bills paid in year	**51,541**	**137,279**	49,800	124,384
Total bills paid within target	**50,195**	**134,198**	48,400	122,353
Percentage of bills paid within target	**97.4%**	**97.8%**	97.2%	98.4%
Total				
Total bills paid in year	**52,701**	**146,426**	50,795	131,993
Total bills paid within target	**51,298**	**142,969**	49,323	129,201
Percentage of bills paid within target	**97.3%**	**97.6%**	97.1%	97.9%

12.2 The Late Payment of Commercial Debts (Interest) Act 1998

	2022-23 £	2021-22 £
Amounts included within finance costs from claims made under legislation	**0**	0
Compensation paid to cover debt recovery costs under legislation	**0**	0
Total	**0**	0

13. Property, plant and equipment :

2022-23	Land	Buildings, excluding dwellings	Dwellings	Assets under construction and payments on account	Plant & machinery	Transport Equipment	Information Technology	Furniture and fittings	Total
Cost or valuation	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost at 31 March bf	9,043	28,879	0	23,262	19,068	76,044	38,234	1,831	196,361
NHS Wales Transfers	0	0	0	0	0	0	0	0	0
Prepayments	0	0	0	0	0	0	0	0	0
Transfer of Finance Leases to ROU Asset Note	0	0	0	0	0	0	(20,030)	0	(20,030)
At 1 April 2022	9,043	28,879	0	23,262	19,068	76,044	18,204	1,831	176,331
Indexation	(269)	1,010	0	0	0	0	0	0	741
Additions - purchased	0	1,214	0	20,503	2	1,125	1,489	299	24,632
Additions - donated	0	0	0	0	0	0	0	0	0
Additions - government granted	0	0	0	0	0	0	0	0	0
Transfers from/(into) other NHS bodies	0	0	0	0	0	0	0	0	0
Reclassifications	0	6,393	0	(18,274)	507	10,433	845	87	(9)
Revaluation	577	(1,422)	0	0	0	0	0	0	(845)
Reversal of impairments	0	500	0	0	0	0	0	0	500
Impairments	(96)	(9,904)	0	0	0	(679)	4	0	(10,675)
Reclassified as held for sale	0	0	0	0	(695)	(7,529)	0	0	(8,224)
Disposals other than by sale	0	0	0	0	(211)	(242)	(2,655)	(771)	(3,879)
At 31 March 2023	9,255	26,670	0	25,491	18,671	79,152	17,887	1,446	178,572
Depreciation									
Depreciation at 31 March bf	0	4,181	0	0	13,104	51,227	30,838	1,417	100,767
NHS Wales Transfers	0	0	0	0	0	0	0	0	0
Transfer of Finance Leases to ROU Asset Note	0	0	0	0	0	0	(18,443)	0	(18,443)
At 1 April 2022	0	4,181	0	0	13,104	51,227	12,395	1,417	82,324
Indexation	0	45	0	0	0	0	0	0	45
Transfers from/(into) other NHS bodies	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluation	0	(2,902)	0	0	0	0	0	0	(2,902)
Reversal of impairments	0	0	0	0	0	0	0	0	0
Impairments	0	(329)	0	0	0	(494)	0	0	(823)
Reclassified as held for sale	0	0	0	0	(695)	(7,529)	0	0	(8,224)
Disposals other than by sale	0	0	0	0	(211)	(242)	(2,655)	(771)	(3,879)
Charged during the year	0	1,042	0	0	1,982	8,252	1,980	158	13,414
At 31 March 2023	0	2,037	0	0	14,180	51,214	11,720	804	79,955
Net book value									
At 1 April 2022	9,043	24,698	0	23,262	5,964	24,817	5,809	414	94,007
Net book value									
At 31 March 2023	9,255	24,633	0	25,491	4,491	27,938	6,167	642	98,617
Net book value at 31 March 2023 comprises :									
Purchased	9,255	24,633	0	25,491	4,474	27,810	6,167	642	98,472
Donated	0	0	0	0	17	128	0	0	145
Government Granted	0	0	0	0	0	0	0	0	0
At 31 March 2023	9,255	24,633	0	25,491	4,491	27,938	6,167	642	98,617
Asset Financing:									
Owned	9,255	24,633	0	25,491	4,491	27,938	6,167	642	98,617
Held on finance lease	0	0	0	0	0	0	0	0	0
On-SoFP PFI contract	0	0	0	0	0	0	0	0	0
PFI residual interest	0	0	0	0	0	0	0	0	0
At 31 March 2023	9,255	24,633	0	25,491	4,491	27,938	6,167	642	98,617

The net book value of land, buildings and dwellings at 31 March 2023 comprises :

	£000
Freehold	32,136
Long Leasehold	1,752
Short Leasehold	0
Total	33,888

The land and buildings were revalued by the Valuation Office Agency with an effective date of 1st April 2022. The valuation has been prepared in accordance with the terms of the latest version of the Royal Institute of Chartered Surveyors' Valuation Standards. NHSTs are required to apply the revaluation model set out in IAS 16 and value its capital assets to fair value. Fair value is defined by IAS 16 as the amount for which an asset could be exchanged between knowledgeable, willing parties in an arms length transaction. This has been undertaken on the assumption that the property is sold as part of the continuing enterprise in occupation.

The land and buildings have also been indexed as at 1st May 2022 based on the percentages provided by the Valuation Office Agency.

13. Property, plant and equipment :

2021-22	Land	Buildings, excluding dwellings	Dwellings	Assets under construttion and payments on account	Plant & machinery	Transport Equipment	Information Technology	Furniture and fittings	Total
Cost or valuation	£000	£000	£000	£000	£000	£000	£000	£000	£000
At 1 April 2021	8,598	21,069	0	17,182	22,597	78,399	35,731	1,848	185,424
Indexation	174	988	0	0	0	0	0	0	1,162
Additions - purchased	0	344	0	26,071	2	461	965	0	27,843
Additions - donated	0	0	0	185	0	0	0	0	185
Additions - government granted	0	0	0	0	0	0	0	0	0
Transfers from/(into) other NHS bodies	(29)	0	0	0	0	0	0	0	(29)
Reclassifications	300	12,710	0	(20,176)	1,901	1,863	1,980	32	(1,390)
Revaluation	0	(96)	0	0	0	0	0	0	(96)
Reversal of impairments	0	0	0	0	0	0	0	0	0
Impairments	0	(6,136)	0	0	0	0	0	0	(6,136)
Reclassified as held for sale	0	0	0	0	(118)	(4,227)	0	0	(4,345)
Disposals other than by sale	0	0	0	0	(5,314)	(452)	(442)	(49)	(6,257)
At 31 March 2022	9,043	28,879	0	23,262	19,068	76,044	38,234	1,831	196,361
Depreciation									
At 1 April 2021	0	3,105	0	0	16,203	47,335	28,113	1,278	96,034
Indexation	0	146	0	0	0	0	0	0	146
Transfers from/(into) other NHS bodies	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluation	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Impairments	0	(1)	0	0	0	0	0	0	(1)
Reclassified as held for sale	0	0	0	0	(118)	(4,227)	0	0	(4,345)
Disposals other than by sale	0	0	0	0	(5,314)	(452)	(442)	(49)	(6,257)
Charged during the year	0	931	0	0	2,333	8,571	3,167	188	15,190
At 31 March 2022	0	4,181	0	0	13,104	51,227	30,838	1,417	100,767
Net book value									
At 1 April 2021	8,598	17,964	0	17,182	6,394	31,064	7,618	570	89,390
Net book value									
At 31 March 2022	9,043	24,698	0	23,262	5,964	24,817	7,396	414	95,594
Net book value at 31 March 2022 comprises :									
Purchased	9,043	24,698	0	23,262	5,944	24,662	7,396	414	95,419
Donated	0	0	0	0	20	155	0	0	175
Government Granted	0	0	0	0	0	0	0	0	0
At 31 March 2022	9,043	24,698	0	23,262	5,964	24,817	7,396	414	95,594
Asset Financing:									
Owned	9,043	24,698	0	23,262	5,964	24,817	5,809	414	94,007
Held on finance lease	0	0	0	0	0	0	1,587	0	1,587
On-SoFP PFI contract	0	0	0	0	0	0	0	0	0
PFI residual interest	0	0	0	0	0	0	0	0	0
At 31 March 2022	9,043	24,698	0	23,262	5,964	24,817	7,396	414	95,594

The net book value of land, buildings and dwellings at 31 March 2022 comprises :

	£000
Freehold	30,806
Long Leasehold	2,935
Short Leasehold	0
Total	33,741

Valuers 'material uncertainty', in valuation. 0
The disclosure relates to the materiality in the valuation report not that of the underlying account.

The land and buildings were revalued by the Valuation Office Agency with an effective date of 1st April 2017. The valuation has been prepared in accordance with the terms of the latest version of the Royal Institute of Chartered Surveyors' Valuation Standards. LHBs are required to apply the revaluation model set out in IAS 16 and value its capital assets to fair value. Fair value is defined by IAS 16 as the amount for which an asset could be exchanged between knowledgeable, willing parties in an arms length transaction. This has been undertaken on the assumption that the property is sold as part of the continuing enterprise in occupation.

13. Property, plant and equipment :

Disclosures:

i) Donated Assets
The Welsh Ambulance Services NHST has not received donated assets during the year.

ii) Valuations
The NHST Land and Buildings were revalued by the Valuation Office Agency with an effective date of 1st April 2022. The valuation has been prepared in accordance with the terms of the latest version of the Royal Institute of Chartered Surveyors' Valuation Standards.

The NHST is required to apply the revaluation model set out in IAS 16 and value its capital assets to fair value. Fair value is defined by IAS 16 as the amount for which an asset could be exchanged between knowledgeable, willing parties in an arms length transaction. This has been undertaken on the assumption that the property is sold as part of the continuing enterprise in operation.

iii) Asset Lives
Tangible fixed assets are depreciated at rates calculated to write them down to estimated residual value on a straight line basis over their estimated useful lives. No depreciation is provided on freehold land, assets in the course of construction and assets surplus to requirements.

Equipment lives range from three and a half to eight years.
Buildings are depreciated on useful lives as determined by the Valuation Office Agency.

iv) Compensation
£9.352 million was received from the Welsh Assembly Government in respect of compensation for assets impaired during the year, of which £4.533m related to the impairment of a building brought into use in March 2023. The compensation received is included in the income statement.

v) Write Downs
There have been no write downs for this financial year.

vi) The NHST does not hold any property where the value is materially different from its open market value.

vii) Assets Held for Sale or sold in the period.
There are assets held for sale or sold in the period. As shown within Note 13.2, a brought forward asset held for sale has been disposed of in the period.

Gain/(Loss) on Sale

		Gain/(Loss) on sale
Asset description	**Reason for sale**	**£000**
Vehicles	No longer servicable	**259**
Equipment	No longer servicable	**25**
Land	Surplus to requirements	**(5)**
		279

13.2 Non-current assets held for sale

	Land	Buildings, including dwellings	Other property plant and equipment	Intangible assets	Other assets	Total
	£000	£000	£000	£000	£000	£000
Balance b/f 1 April 2022	**130**	**0**	**0**	**0**	**0**	**130**
Plus assets classified as held for sale in year	**0**	**0**	**0**	**0**	**0**	**0**
Revaluation	**220**	**0**	**0**	**0**	**0**	**220**
Less assets sold in year	**(350)**	**0**	**0**	**0**	**0**	**(350)**
Plus reversal of impairments	**0**	**0**	**0**	**0**	**0**	**0**
Less impairment for assets held for sale	**0**	**0**	**0**	**0**	**0**	**0**
Less assets no longer classified as held for sale for reasons other than disposal by sale	**0**	**0**	**0**	**0**	**0**	**0**
Balance c/f 31 March 2023	**0**	**0**	**0**	**0**	**0**	**0**
Balance b/f 1 April 2021	130	0	0	0	0	130
Plus assets classified as held for sale in year	0	0	0	0	0	0
Revaluation	0	0	0	0	0	0
Less assets sold in year	0	0	0	0	0	0
Plus reversal of impairments	0	0	0	0	0	0
Less impairment for assets held for sale	0	0	0	0	0	0
Less assets no longer classified as held for sale for reasons other than disposal by sale	0	0	0	0	0	0
Balance c/f 31 March 2022	130	0	0	0	0	130

As at 1st April 2022, one property is included within this category and was sold during the period.

The property included became surplus to requirement following the relocation of staff to new office accommodation during the latter part of the 2018/19 financial year. The sale of the property was orginally anticipated to take place during the financial year 2021/22 but as a result of delays caused by events outside of the Trust's control, the sale took place during the financial year 2022/23.

Within Note 13 there is £7.529m of Transport equipment and £0.695m of Plant & Machinery that is reclassified as held for sale. These relate wholly to fully depreciated vehicles and equipment which have been decommissioned and sold.

13.3 Right of Use Assets

The organisation's right of use asset leases are disclosed across the relevant headings below. Most are individually insignificant, however, 3 are significant in their own right:
VPH HQ & Control held under land and buildings nbv at 31 March 2023 £2,846k
Beacons House held under land and buildings nbv at 31 March 2023 £1,081k
Airwave under information technology nbv at 31 March 2023 £1,891k

2022-23	Land £000	Land & buildings £000	Buildings £000	Dwellings £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 31 March	0	0	0	0	0	0	0	0	0
Lease prepayments in relation to RoU Assets	0	0	0	0	0	0	0	0	0
Transfer of Finance Leases from PPE Note	0	0	0	0	0	0	20,030	0	20,030
Operating Leases Transitioning	0	10,336	0	0	0	71	0	0	10,407
Cost or valuation at 1 April	0	10,336	0	0	0	71	20,030	0	30,437
Additions	0	1,934	0	0	0	0	2,522	0	4,456
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluations	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
De-recognition	0	0	0	0	0	0	0	0	0
At 31 March	0	12,270	0	0	0	71	22,552	0	34,893
Depreciation at 31 March	0	0	0	0	0	0	0	0	0
Transfer of Finance Leases from PPE Note	0	0	0	0	0	0	18,443	0	18,443
Operating Leases Transitioning	0	0	0	0	0	0	0	0	0
Depreciation at 1 April	0	0	0	0	0	0	18,443	0	18,443
Recognition	0	0	0	0	0	0	0	0	0
Transfers from/into other NHS bodies	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluations	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
De-recognition	0	0	0	0	0	0	0	0	0
Provided during the year	0	1,465	0	0	0	32	2,218	0	3,715
At 31 March	0	1,465	0	0	0	32	20,661	0	22,158
Net book value at 1 April	0	10,336	0	0	0	71	1,587	0	11,994
Net book value at 31 March	0	10,805	0	0	0	39	1,891	0	12,735

RoU Asset Total Value Split by Lessor	Land £000	Land & buildings £000	Buildings £000	Dwellings £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
NHS Wales Peppercorn Leases	0	668	0	0	0	0	0	0	668
NHS Wales Market Value Leases	0	472	0	0	0	0	0	0	472
Other Public Sector Peppercorn Leases	0	503	0	0	0	0	0	0	503
Other Public Sector Market Value Leases	0	1,852	0	0	0	0	0	0	1,852
Private Sector Peppercorn Leases	0	0	0	0	0	0	0	0	0
Private Sector Market Value Leases	0	7,310	0	0	0	39	1,891	0	9,240
Total	0	10,805	0	0	0	39	1,891	0	12,735

13.3 Right of Use Assets continued
Quantitative disclosures

Maturity analysis Contractual undiscounted cash flows relating to lease liabilities	£000
Less than 1 year	2,999
2-5 years	4,715
> 5 years	3,685
Total	11,399

Lease Liabilities (net of irrecoverable VAT)	£000
Current	2,999
Non-Current	8,400
Total	11,399

Amounts Recognised in Statement of Comprehensive Net Expenditure	£000
Depreciation	3,715
Impairment	0
Variable lease payments not included in lease liabilities - Interest expense	0
Sub-leasing income	0
Expense related to short-term leases	158
Expense related to low-value asset leases (excluding short-term leases)	0

Amounts Recognised in Statement of Cashflows (net of irrecoverable VAT)	£000
Interest expense	123
Repayments of principal on leases	3,591
Total	3,714

The nature of the Trust's leasing activities relates mainly to properties which are utilised as operational sites/stations and office accommodation. The Trust also leases pool vehicles.

The Trust is not committed to any leases which have not yet commenced.

14. Intangible assets

	Computer software purchased	Computer software internally developed	Licenses and trade-marks	Patents	Development expenditure internally generated	Assets under Construction	Total
Cost or valuation	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
At 1 April 2022	**11,273**	**0**	**4,512**	**0**	**0**	**0**	**15,785**
Revaluation		**0**			**0**	**0**	**0**
Reclassifications	**0**	**0**	**9**	**0**	**0**	**0**	**9**
Reversal of impairments	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Impairments	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Additions							
- purchased	**57**	**0**	**0**	**0**	**0**	**0**	**57**
- internally generated	**0**	**0**	**0**	**0**	**0**	**0**	**0**
- donated	**0**	**0**	**0**	**0**	**0**	**0**	**0**
- government granted	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reclassified as held for sale	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Transfers from/(into) other NHS bodies	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Disposals other than by sale	**(1,035)**	**0**	**(996)**	**0**	**0**	**0**	**(2,031)**
At 31 March 2023	**10,295**	**0**	**3,525**	**0**	**0**	**0**	**13,820**
Amortisation							
At 1 April 2022	**9,271**	**0**	**3,283**	**0**	**0**	**0**	**12,554**
Revaluation		**0**			**0**	**0**	**0**
Reclassifications	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reversal of impairments	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Impairments	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Charged during the year	**1,185**	**0**	**763**	**0**	**0**	**0**	**1,948**
Reclassified as held for sale	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Transfers from/(into) other NHS bodies	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Disposals other than by sale	**(1,035)**	**0**	**(996)**	**0**	**0**	**0**	**(2,031)**
Accumulated amortisation at 31 March 2023	**9,421**	**0**	**3,050**	**0**	**0**	**0**	**12,471**
Net book value At 1 April 2022	**2,002**	**0**	**1,229**	**0**	**0**	**0**	**3,231**
Net book value At 31 March 2023	**874**	**0**	**475**	**0**	**0**	**0**	**1,349**
Net book value							
Purchased	**874**	**0**	**475**	**0**	**0**	**0**	**1,349**
Donated	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Government granted	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Internally Generated	**0**	**0**	**0**	**0**	**0**	**0**	**0**
At 31 March 2023	**874**	**0**	**475**	**0**	**0**	**0**	**1,349**

14. Intangible assets

	Computer software purchased	Computer software internally developed	Licenses and trade-marks	Patents	Development expenditure internally generated	Assets under Construction	Total
Cost or valuation	£000	£000	£000	£000	£000	£000	£000
At 1 April 2021	11,570	0	4,589	0	0	0	16,159
Revaluation		0			0	0	0
Reclassifications	788	0	602	0	0	0	1,390
Reversal of impairments	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0
Additions							
- purchased	128	0	0	0	0	0	128
- internally generated	0	0	0	0	0	0	0
- donated	0	0	0	0	0	0	0
- government granted	0	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0	0
Transfers from/(into) other NHS bodies	0	0	0	0	0	0	0
Disposals other than by sale	(1,213)	0	(679)	0	0	0	(1,892)
At 31 March 2022	11,273	0	4,512	0	0	0	15,785
Amortisation							
At 1 April 2021	9,448	0	3,248	0	0	0	12,696
Revaluation		0			0	0	0
Reclassifications	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0
Charged during the year	1,036	0	714	0	0	0	1,750
Reclassified as held for sale	0	0	0	0	0	0	0
Transfers from/(into) other NHS bodies	0	0	0	0	0	0	0
Disposals other than by sale	(1,213)	0	(679)	0	0	0	(1,892)
Accumulated amortisation at 31 March 2022	9,271	0	3,283	0	0	0	12,554
Net book value At 1 April 2021	2,122	0	1,341	0	0	0	3,463
Net book value At 31 March 2022	2,002	0	1,229	0	0	0	3,231
Net book value							
Purchased	2,002	0	1,229	0	0	0	3,231
Donated	0	0	0	0	0	0	0
Government granted	0	0	0	0	0	0	0
Internally Generated	0	0	0	0	0	0	0
At 31 March 2022	2,002	0	1,229	0	0	0	3,231

14. Intangible assets

Disclosures:

i) Donated Assets
Welsh Ambulance Services NHS Trust has not received any donated intangible assets during the year.

ii) Recognition
Intangible assets acquired separately are initially recognised at fair value. The amount recognised for internally-generated intangible assets is the sum of the expenditure incurred to date when the criteria for recognising internally generated assets has been met (see accounting policy 1.7 for criteria).

iii) Asset Lives
The useful economic lives of all intangible fixed assets held are finite and where applicable are in line with the terms of the individual license.

iv) Additions during the period
There have been additions to purchased software during the period.

v) Disposals during the period
The disposals made during the period as shown within Note 14 relate to nil net book value intangible assets that have been identified as no longer in use and have been written off.

15. Impairments

Impairments in the period arose from:	2022-23 Property, plant & equipment £000	2022-23 Right of Use Assets £000	2022-23 Intangible assets £000	2021-22 Property, plant & equipment £000	2021-22 Right of Use Assets £000	2021-22 Intangible assets £000
Loss or damage from normal operations	0	0	0	0		0
Abandonment of assets in the course of construction	0	0	0	0		0
Over specification of assets (Gold Plating)	0	0	0	0		0
Loss as a result of a catastrophe	0	0	0	0		0
Unforeseen obsolescence	0	0	0	0		0
Changes in market price	0	0	0	0		0
Other	9,852	0	0	6,135		0
Reversal of impairment	(500)	0	0	0		0
Impairments charged to operating expenses	**9,352**	**0**	**0**	6,135		0
Analysis of impairments :						
Operating expenses in Statement of Comprehensive Income	9,352	0	0	6,135		0
Revaluation reserve	318	0	0	96		0
Total	**9,670**	**0**	**0**	6,231		0

Included within the above total of £9.670m are the following items:-

- a review undertaken in connection with expenditure incurred on Trust buildings identified that a total impairment of £4.269m was required as there were instances where the value of the buildings had not been enhanced. Of this amount, £3.976m was charged to operating expenses.

- an amount of £0.687m was impaired in relation to the quinquennial revaluations and negative land indexation. Of this amount, £0.661m was charged to operating expenses.

- an amount of £0.181m was impaired in relation to damaged vehicles, all of this amount was charged to operating expenses.

- the remaining £4.533m relates to the amount spent on the Phone First call centre over and above the valuation received once the works to the property were complete and property brought into use during March 2023. All of this amount was charged to operating expenses.

16. Inventories

16.1 Inventories

	31 March 2023 £000	31 March 2022 £000
Drugs	122	120
Consumables	1,655	1,439
Energy	0	0
Work in progress	0	0
Other	255	267
Total	**2,032**	1,826
Of which held at net realisable value:	0	0

16.2 Inventories recognised in expenses

	31 March 2023 £000	31 March 2022 £000
Inventories recognised as an expense in the period	0	0
Write-down of inventories (including losses)	0	0
Reversal of write-downs that reduced the expense	0	0
Total	**0**	0

17. Trade and other receivables

17.1 Trade and other receivables

	31 March 2023	31 March 2022
Current	**£000**	£000
Welsh Government	**4,003**	2,437
WHSSC & EASC	**34**	2,509
Welsh Health Boards	**4,242**	2,077
Welsh NHS Trusts	**132**	192
Welsh Special Health Authorities	**140**	8
Non - Welsh Trusts	**60**	15
Other NHS	**27**	24
2019-20 Scheme Pays - Welsh Government Reimbursement	**0**	0
Welsh Risk Pool Claim reimbursement:-		
NHS Wales Secondary Health Sector	**5,605**	4,198
NHS Wales Primary Sector FLS Reimbursement	**0**	0
NHS Wales Redress	**0**	0
Other	**0**	0
Local Authorities	**151**	1
Capital debtors- Tangible	**0**	0
Capital debtors- Intangible	**0**	0
Other debtors	**3,105**	4,560
Provision for impairment of trade receivables	**(319)**	(291)
Pension Prepayments		
NHS Pensions Agency	**0**	0
NEST	**0**	0
Other prepayments	**1,759**	1,418
Accrued income	**0**	0
Sub-total	**18,939**	17,148
Non-current		
Welsh Government	**0**	0
WHSSC & EASC	**0**	0
Welsh Health Boards	**0**	0
Welsh NHS Trusts	**0**	0
Welsh Special Health Authorities	**0**	0
Non - Welsh Trusts	**0**	0
Other NHS	**0**	0
2019-20 Scheme Pays - Welsh Government Reimbursement	**0**	0
Welsh Risk Pool Claim reimbursement		
NHS Wales Secondary Health Sector	**0**	406
NHS Wales Primary Sector FLS Reimbursement	**0**	0
NHS Wales Redress	**0**	0
Other	**0**	0
Local Authorities	**0**	0
Capital debtors- Tangible	**0**	0
Capital debtors- Intangible	**0**	0
Other debtors	**380**	384
Provision for impairment of trade receivables	**0**	0
Pension Prepayments		
NHS Pensions Agency	**0**	0
NEST	**0**	0
Other prepayments	**0**	0
Accrued income	**0**	0
Sub-total	**380**	790
Total trade and other receivables	**19,319**	17,938

The great majority of trade is with other NHS bodies. As NHS bodies are funded by Welsh Government, no credit scoring of them is considered necessary.

Other debtors includes £0.585m re Compensation Recovery Unit (2021/22 £0.669m).

17.2 Receivables past their due date but not impaired

	31 March 2023 £000	31 March 2022 £000
By up to 3 months	427	1,342
By 3 to 6 months	0	1
By more than 6 months	0	0
Balance at end of financial year	**427**	1,343

17.3 Expected Credit Losses (ECL) Allowance for bad and doubtful debts

	31 March 2023 £000	31 March 2022 £000
Balance at 1 April	(291)	(259)
Transfer to other NHS Wales body	0	0
Provision utilised (Amount written off during the year)	1	5
Provision written back during the year no longer required	0	0
(Increase)/Decrease in provision during year	(28)	(37)
ECL/Bad debts recovered during year	0	0
Balance at end of financial year	**(318)**	(291)

17.4 Receivables VAT

	31 March 2023 £000	31 March 2022 £000
Trade receivables	40	38
Other	0	0
Total	**40**	**38**

18. Other financial assets

	31 March 2023 £000	31 March 2022 £000
Current		
Shares and equity type investments		
Held to maturity investments at amortised costs	0	0
At fair value through SOCI	0	0
Available for sale at FV	0	0
Deposits	0	0
Loans	0	0
Derivatives	0	0
Other (Specify)		
Right of Use Asset Finance Sublease	0	
Held to maturity investments at amortised costs	0	0
At fair value through SOCI	0	0
Available for sale at FV	0	0
Total	**0**	**0**
Non-Current		
Shares and equity type investments		
Held to maturity investments at amortised costs	0	0
At fair value through SOCI	0	0
Available for sale at FV	0	0
Deposits	0	0
Loans	0	0
Derivatives	0	0
Other (Specify)		
Right of Use Asset Finance Sublease	0	
Held to maturity investments at amortised costs	0	0
At fair value through SOCI	0	0
Available for sale at FV	0	0
Total	**0**	**0**

19. Cash and cash equivalents

	31 March 2023 £000	31 March 2022 £000
Opening Balance	**18,708**	18,468
Net change in year	**484**	240
Closing Balance	**19,192**	18,708
Made up of:		
Cash with Government Banking Service (GBS)	**15,127**	18,644
Cash with Commercial banks	**64**	60
Cash in hand	**1**	4
Total cash	**15,192**	18,708
Current investments	**4,000**	0
Cash and cash equivalents as in SoFP	**19,192**	18,708
Bank overdraft - GBS	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash & cash equivalents as in Statement of Cash Flows	**19,192**	18,708

20. Trade and other payables at the SoFP Date	31 March 2023	31 March 2022
Current	**£000**	£000
Welsh Government	**1,133**	0
WHSSC & EASC	**709**	442
Welsh Health Boards	**213**	248
Welsh NHS Trusts	**697**	219
Welsh Special Health Authorities	**0**	35
Other NHS	**50**	95
Taxation and social security payable / refunds:		
Refunds of taxation by HMRC	**0**	0
VAT payable to HMRC	**0**	0
Other taxes payable to HMRC	**2,233**	1,589
National Insurance contributions payable to HMRC	**2,622**	2,192
Non-NHS trade payables - revenue	**6,705**	3,883
Local Authorities	**2**	8
Capital payables-Tangible	**6,418**	10,063
Capital payables- Intangible	**40**	104
Overdraft	**0**	0
Rentals due under operating leases	**0**	0
RoU Lease Liability	**26**	
Obligations due under finance leases and HP contracts		0
Imputed finance lease element of on SoFP PFI contracts	**0**	0
Pensions: staff	**2,642**	2,450
Non NHS Accruals	**16,136**	13,931
Deferred Income:		
Deferred income brought forward	**493**	230
Deferred income additions	**199**	263
Transfer to/from current/non current deferred income	**0**	0
Released to the Income Statement	**(459)**	0
Other liabilities - all other payables	**0**	0
PFI assets – deferred credits	**0**	0
PFI - Payments on account	**0**	0
Sub-total	**39,859**	35,752

The Trust aims to pay all invoices within the 30 day period directed by the Welsh Government.

In respect of the Pensions figure shown above, £2.618m relates to the NHS Pension scheme (2021/22 £2.429m) and £0.024m to the NEST pension scheme (2021/22 £0.021m).

20. Trade and other payables at the SoFP Date (cont)

Non-current	31 March 2023 £000	31 March 2022 £000
Welsh Government	0	0
WHSSC & EASC	0	0
Welsh Health Boards	0	0
Welsh NHS Trusts	0	0
Welsh Special Health Authorities	0	0
Other NHS	0	0
Taxation and social security payable / refunds:		
Refunds of taxation by HMRC	0	0
VAT payable to HMRC	0	0
Other taxes payable to HMRC	0	0
National Insurance contributions payable to HMRC	0	0
Non-NHS trade payables - revenue	0	0
Local Authorities	0	0
Capital payables- Tangible	0	0
Capital payables- Intangible	0	0
Overdraft	0	0
Rentals due under operating leases	0	0
RoU Lease Liability	0	
Obligations due under finance leases and HP contracts		0
Imputed finance lease element of on SoFP PFI contracts	0	0
Pensions: staff	0	0
Non NHS Accruals	0	0
Deferred Income:		
Deferred income brought forward	0	0
Deferred income additions	0	0
Transfer to/from current/non current deferred income	0	0
Released to the Income Statement	0	0
Other liabilities - all other payables	0	0
PFI assets –deferred credits	0	0
Payments on account	0	0
Sub-total	0	0
Total	**39,859**	35,752

21. Borrowings	31 March 2023	31 March 2022
Current	**£000**	£000
Bank overdraft - Government Banking Service (GBS)	**0**	0
Bank overdraft - Commercial bank	**0**	0
Loans from:		
Welsh Government	**0**	0
Other entities	**0**	0
PFI liabilities:		
Main liability	**0**	0
Lifecycle replacement received in advance	**0**	0
Finance lease liabilities		1,364
RoU Lease Liability	**2,999**	
Other	**0**	0
Total	**2,999**	1,364

Non-current		
Bank overdraft - GBS	**0**	0
Bank overdraft - Commercial bank	**0**	0
Loans from:		
Welsh Government	**0**	0
Other entities	**0**	0
PFI liabilities:		
Main liability	**0**	0
Lifecycle replacement received in advance	**0**	0
Finance lease liabilities		0
RoU Lease Liability	**8,400**	
Other	**0**	0
Total	**8,400**	0

21.2 Loan advance/strategic assistance funding

	31 March 2023	31 March 2022
Amounts falling due:	**£000**	£000
In one year or less	**0**	0
Between one and two years	**0**	0
Between two and five years	**0**	0
In five years or more	**0**	0
Sub-total	**0**	0
Wholly repayable within five years	**0**	0
Wholly repayable after five years, not by instalments	**0**	0
Wholly or partially repayable after five years by instalments	**0**	0
Sub-total	**0**	0
Total repayable after five years by instalments	**0**	0

The Trust has not received a loan advance or strategic funding from the Welsh Government.

RoU Lease Liability Transitioning & Transferring	**£'000**	**£'000**
RoU Liability as at 31 March 2020	0	0
Transfer of Finance Leases from PPE Note	1,587	0
Operating Leases Transitioning	10,409	0
RoU Lease Liability as at 01 April 2022	**11,996**	**0**

22. Other financial liabilities

Current	31 March 2023 £000	31 March 2022 £000
Financial Guarantees		
At amortised cost	0	0
At fair value through SoCI	0	0
Derivatives at fair value through SoCI	0	0
Other		
At amortised cost	0	0
At fair value through SoCI	0	0
Total	**0**	0

Non-current	31 March 2023 £000	31 March 2022 £000
Financial Guarantees		
At amortised cost	0	0
At fair value through SoCI	0	0
Derivatives at fair value through SoCI	0	0
Other		
At amortised cost	0	0
At fair value through SoCI	0	0
Total	**0**	0

23. Provisions

2022-23

Current	At 1 April 2022	Structured settlement cases transferr-ed to Risk Pool	Transfers to creditors	Transfers between current and non current	Transfers (to)/from other NHS body	Arising during the year	Utilised during the year	Reversed unused	Unwinding of discount	At 31 March 2023
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Clinical negligence:-										
Secondary Care	1,350	0	(438)	248	0	2,105	(1,081)	(324)	0	1,860
Primary Care	0	0	0	0	0	0	0	0	0	0
Redress Secondary Care	194	0	(3)	12	0	617	(219)	(154)	0	447
Redress Primary Care	0	0	0	0	0	0	0	0	0	0
Personal injury	1,560	0	0	0	0	1,620	2,024	(3,191)	(130)	1,883
All other losses and special payments	0	0	0	0	0	0	0	0	0	0
Defence legal fees and other administration	298	0	0	71	0	419	(181)	(95)	0	512
Structured Settlements - WRPS	0	0	0	0	0	0	0	0	0	0
Pensions relating to: former directors	0		0	0	0	0	0	0	0	0
Pensions relating to: other staff	15		0	0	0	12	(6)	(4)	(1)	16
2019-20 Scheme Pays - Reimbursement	0		0	0	0	0	0	0	0	0
Restructurings	0		0	0	0	0	0	0		0
RoU Asset Dilapidations CAME	0		0	0	0	0	0	0		0
Other Capital Provisions	0		0	0	0	0	0	0		0
Other	985		0	0	0	0	(599)	0		386
Total	4,402	0	(441)	331	0	4,773	(62)	(3,768)	(131)	5,104
Non Current										
Clinical negligence:-										
Secondary Care	348	0	0	(248)	0	150	0	0	0	250
Primary Care	0	0	0	0	0	0	0	0	0	0
Redress Secondary Care	12	0	0	(12)	0	1	0	0	0	1
Redress Primary Care	0	0	0	0	0	0	0	0	0	0
Personal injury	9,571	0	0	0	0	0	(2,952)	0	0	6,619
All other losses and special payments	0	0	0	0	0	0	0	0	0	0
Defence legal fees and other administration	71	0	0	(71)	0	0	0	0	0	0
Structured Settlements - WRPS	0	0	0	0	0	0	0	0	0	0
Pensions relating to: former directors	0		0	0	0	0	0	0	0	0
Pensions relating to: other staff	56		0	0	0	0	(7)	0	0	49
2019-20 Scheme Pays - Reimbursement	0		0	0	0	37	0	0	0	37
Restructurings	0		0	0	0	0	0	0		0
RoU Asset Dilapidations CAME	0		0	0	0	0	0	0		0
Other Capital Provisions	0		0	0	0	0	0	0		0
Other	0		0	0	0	0	0	0		0
Total	10,058	0	0	(331)	0	188	(2,959)	0	0	6,956
TOTAL										
Clinical negligence:-										
Secondary Care	1,698	0	(438)	0	0	2,255	(1,081)	(324)	0	2,110
Primary Care	0	0	0	0	0	0	0	0	0	0
Redress Secondary Care	206	0	(3)	0	0	618	(219)	(154)	0	448
Redress Primary Care	0	0	0	0	0	0	0	0	0	0
Personal injury	11,131	0	0	0	0	1,620	(928)	(3,191)	(130)	8,502
All other losses and special payments	0	0	0	0	0	0	0	0	0	0
Defence legal fees and other administration	369	0	0	0	0	419	(181)	(95)	0	512
Structured Settlements - WRPS	0	0	0	0	0	0	0	0	0	0
Pensions relating to: former directors	0		0	0	0	0	0	0	0	0
Pensions relating to: other staff	71		0	0	0	12	(13)	(4)	(1)	65
2019-20 Scheme Pays - Reimbursement	0		0	0	0	37	0	0	0	37
Restructurings	0		0	0	0	0	0	0		0
RoU Asset Dilapidations CAME	0		0	0	0	0	0	0		0
Other Capital Provisions	0		0	0	0	0	0	0		0
Other	985		0	0	0	0	(599)	0		386
Total	14,460	0	(441)	0	0	4,961	(3,021)	(3,768)	(131)	12,060

Expected timing of cash flows:

	In year to 31 March 2024	Between 01-Apr-24 to 31 March 2028	Thereafter	Totals
	£000	£000	£000	£000
Clinical negligence:-				
Secondary Care	1,860	250	0	2,110
Primary Care	0	0	0	0
Redress Secondary Care	447	1	0	448
Redress Primary Care	0	0	0	0
Personal injury	1,883	1,828	4,791	8,502
All other losses and special payments	0	0	0	0
Defence legal fees and other administration	512	0	0	512
Structured Settlements - WRPS	0	0	0	0
Pensions - former directors	0	0	0	0
Pensions - other staff	16	46	3	65
2019-20 Scheme Pays - Reimbursement	0	37	0	37
Restructuring	0	0	0	0
RoU Asset Dilapidations CAME	0	0	0	0
Other Capital Provisions	0	0	0	0
Other	386	0	0	386
Total	5,104	2,162	4,794	12,060

"Other" provisions of £0.386m is in relation to the dilapidation of leasehold premises.

23. Provisions (continued)

2021-22

	At 1 April 2021	Structured settlement cases transferred to Risk Pool	Transfers to creditors	Transfers between current and non current	Transfers (to)/from other NHS body	Arising during the year	Utilised during the year	Reversed unused	Unwinding of discount	At 31 March 2022
Current										
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Clinical negligence:-										
Secondary Care	2,711	0	0	640	0	1,432	(1,963)	(1,470)	0	1,350
Primary Care	0	0	0	0	0	0	0	0	0	0
Redress Secondary Care	158	0	0	(14)	0	472	(212)	(210)	0	194
Redress Primary Care	0	0	0	0	0	0	0	0	0	0
Personal injury	1,521	0	0	1,201	0	3,656	(375)	(4,344)	(99)	1,560
All other losses and special payments	0	0	0	0	0	0	0	0	0	0
Defence legal fees and other administration	313	0	0	91	0	470	(206)	(370)	0	298
Structured Settlements - WRPS	0	0	0	0	0	0	0	0	0	0
Pensions relating to: former directors	0		0	0	0	0	0	0	0	0
Pensions relating to: other staff	18		0	0	0	18	(9)	(11)	(1)	15
2019-20 Scheme Pays - Reimbursement	0		0	0	0	0	0	0	0	0
Restructurings	0		0	0	0	0	0	0		0
Other	2,228		0	0	0	2,759	(3,868)	(134)		985
Total	6,949	0	0	1,918	0	8,807	(6,633)	(6,539)	(100)	4,402
Non Current										
Clinical negligence:-										
Secondary Care	640	0	0	(640)	0	348	0	0	0	348
Primary Care	0	0	0	0	0	0	0	0	0	0
Redress Secondary Care	0	0	0	14	0	10	(2)	(10)	0	12
Redress Primary Care	0	0	0	0	0	0	0	0	0	0
Personal injury	11,096	0	0	(1,201)	0	0	(324)	0	0	9,571
All other losses and special payments	0	0	0	0	0	0	0	0	0	0
Defence legal fees and other administration	91	0	0	(91)	0	71	0	0	0	71
Structured Settlements - WRPS	0	0	0	0	0	0	0	0	0	0
Pensions relating to: former directors	0		0	0	0	0	0	0	0	0
Pensions relating to: other staff	60		0	0	0	0	(4)	0	0	56
2019-20 Scheme Pays - Reimbursement	0		0	0	0	0	0	0	0	0
Restructurings	0		0	0	0	0	0	0		0
Other	0		0	0	0	0	0	0		0
Total	11,887	0	0	(1,918)	0	429	(330)	(10)	0	10,058
TOTAL										
Clinical negligence:-										
Secondary Care	3,351	0	0	0	0	1,780	(1,963)	(1,470)	0	1,698
Primary Care	0	0	0	0	0	0	0	0	0	0
Redress Secondary Care	158	0	0	0	0	482	(214)	(220)	0	206
Redress Primary Care	0	0	0	0	0	0	0	0	0	0
Personal injury	12,617	0	0	0	0	3,656	(699)	(4,344)	(99)	11,131
All other losses and special payments	0	0	0	0	0	0	0	0	0	0
Defence legal fees and other administration	404	0	0	0	0	541	(206)	(370)	0	369
Structured Settlements - WRPS	0	0	0	0	0	0	0	0	0	0
Pensions relating to: former directors	0		0	0	0	0	0	0	0	0
Pensions relating to: other staff	78		0	0	0	18	(13)	(11)	(1)	71
2019-20 Scheme Pays - Reimbursement	0		0	0	0	0	0	0	0	0
Restructurings	0		0	0	0	0	0	0		0
Other	2,228		0	0	0	2,759	(3,868)	(134)		985
Total	18,836	0	0	0	0	9,236	(6,963)	(6,549)	(100)	14,460

24 Contingencies

24.1 Contingent liabilities

Provision has not been made in these accounts for the following amounts:	31 March 2023 £000	31 March 2022 0 £000
Legal claims for alleged medical or employer negligence;		
Secondary care	13,818	9,193
Primary Care	0	0
Secondary care - Redress	0	0
Primary Care - Redress	0	0
Doubtful debts	0	0
Equal pay cases	0	0
Defence costs	376	316
Other	0	0
Total value of disputed claims	**14,194**	9,509
Amount recovered under insurance arrangements in the event of these claims being successful	(12,757)	(8,290)
Net contingent liability	**1,437**	1,219

Other litigation claims could arise in the future due to known incidents. The expenditure which may arise from such claims cannot be determined and no provision has been made for them.

Liability for Permanent Injury Benefit under the NHS Injury Benefit Scheme lies with the employer. Individual claims to the NHS Pensions Agency could arise due to known incidents.

Contingent liabilities includes claims relating to alleged clinical negligence, personal injury and permanent injury benefits under the NHS Injury Benefits Scheme. The above figures include contingent liabilities for all Health Bodies in Wales.

24.2. Remote contingent liabilities

	31 March 2023 £000	31 March 2022 0 £000
Guarantees	0	0
Indemnities	0	0
Letters of comfort	0	0
Total	**0**	0

24.3 Contingent assets

	31 March 2023 £000	31 March 2022 0 £000
	0	0
	0	0
	0	0
	0	**0**

The Trust has no contingent assets.

25. Capital commitments

Commitments under capital expenditure contracts at the statement of financial position sheet date :

The disclosure of future capital commitments not already disclosed as liabilities in the accounts.

	31 March 2023	31 March 2022
	£000	£000
Property, plant and equipment	**3,764**	12,914
Right of Use Assets	**0**	
Intangible assets	**62**	86
Total	**3,826**	13,000

The decreases in capital commitments is due to an in-depth review of all open purchase orders being carried out during the year and closed where no longer required.

26. Losses and special payments

Losses and special payments are charged to the Income statement in accordance with IFRS but are recorded in the losses and special payments register when payment is made. Therefore this note is prepared on a cash basis.

Gross loss to the Exchequer

Number of cases and associated amounts paid out during the financial year

	Amounts paid out during year to 31 March 2023	
	Number	£
Clinical negligence	9	1,518,617
Personal injury	66	904,258
All other losses and special payments	123	245,501
Total	**198**	**2,668,376**

Analysis of cases in excess of £300,000

	Case Type	In year claims in excess of £300,000		Cumulative claims in excess of £300,000	
		Number	£	Number	£
Cases in excess of £300,000:					
	Personal injury	1	18774	1	306,764
	Personal injury	1	18,517	1	302,716
	Clinical negligence			1	704,493
	Personal injury			1	378,967
	Clinical negligence			1	632,585
	Personal injury			1	4,314,610
	Clinical negligence	1	150,000	1	858,810
	Clinical negligence	1	68,000	1	591,880
	Clinical negligence	1	105,620	1	531,400
	Clinical negligence	1	863,750	1	863,822
Sub-total		**6**	**1,224,661**	**10**	**9,486,047**
All other cases		192	1,443,715	696	10,150,743
Total cases		**198**	**2,668,376**	**706**	**19,636,790**

27. Right of Use / Finance leases obligations

27.1 Obligations (as lessee)

A contract was entered into with Airwave during 2007-08 in respect of the National Ambulance Radio Re-procurement Project. This was transferred to Right of Use Assets as at 1st April 2022.

The Trust does not hold any Finance Leases. All information shown is in relation to Right of Use Assets.

Amounts payable under right of use asset / finance leases:		**Post Implementation of IFRS 16 (RoU)**	Pre implementation of IFRS 16 (FL)
LAND		**31 March 2023 £000**	31 March 2022 £000
Minimum lease payments			
Within one year		**0**	0
Between one and five years		**0**	0
After five years		**0**	0
Less finance charges allocated to future periods		**0**	0
Minimum lease payments		**0**	0
Included in:	Current borrowings	**0**	0
	Non-current borrowings	**0**	0
Total		**0**	0
Present value of minimum lease payments			
Within one year		**0**	0
Between one and five years		**0**	0
After five years		**0**	0
Total present value of minimum lease payments		**0**	0
Included in:	Current borrowings	**0**	0
	Non-current borrowings	**0**	0
Total		**0**	0

27. Right of Use / Finance leases obligations

27.1 Obligations (as lessee) continued

Amounts payable under right of use asset / finance leases:		Post Implementation of IFRS 16 (RoU)	Pre implementation of IFRS 16 (FL)
BUILDINGS		**31 March 2023**	31 March 2022
Minimum lease payments		**£000**	£000
Within one year		**1,385**	0
Between one and five years		**4,930**	0
After five years		**3,783**	0
Less finance charges allocated to future periods		**(408)**	0
Minimum lease payments		**9,690**	0
Included in:	Current borrowings	**1,300**	0
	Non-current borrowings	**8,390**	0
Total		**9,690**	0
Present value of minimum lease payments			
Within one year		**1,300**	0
Between one and five years		**4,706**	0
After five years		**3,684**	0
Total present value of minimum lease payments		**9,690**	0
Included in:	Current borrowings	**1,300**	0
	Non-current borrowings	**8,390**	0
Total		**9,690**	0

		Post Implementation of IFRS 16 (RoU)	Pre implementation of IFRS 16 (FL)
OTHER - Non Property		**31 March 2023**	31 March 2022
Minimum lease payments		**£000**	£000
Within one year		**1,706**	1,373
Between one and five years		**10**	0
After five years		**0**	0
Less finance charges allocated to future periods		**(7)**	(9)
Minimum lease payments		**1,709**	1,364
Included in:	Current borrowings	**1,699**	1,364
	Non-current borrowings	**10**	0
Total		**1,709**	1,364
Present value of minimum lease payments			
Within one year		**1,699**	1,364
Between one and five years		**10**	0
After five years		**0**	0
Total present value of minimum lease payments		**1,709**	1,364
Included in:	Current borrowings	**1,699**	1,364
	Non-current borrowings	**10**	0
Total		**1,709**	1,364

27.2 Right of Use Assets / Finance lease receivables (as lessor)

The Trust has no amounts receivable under right of use asset or finance leases as lessor.

Amounts receivable under right of use assets / finance leases:		Post Implementation of IFRS 16 (RoU)	Pre implementation of IFRS 16 (FL)
		31 March 2023	31 March 2022
Gross investment in leases		**£000**	£000
Within one year		**0**	0
Between one and five years		**0**	0
After five years		**0**	0
Less finance charges allocated to future periods		**0**	0
Present value of minimum lease payments		**0**	0
Included in:	Current borrowings	**0**	0
	Non-current borrowings	**0**	0
Total		**0**	0
Present value of minimum lease payments			
Within one year		**0**	0
Between one and five years		**0**	0
After five years		**0**	0
Less finance charges allocated to future periods		**0**	0
Total present value of minimum lease payments		**0**	0
Included in:	Current borrowings	**0**	0
	Non-current borrowings	**0**	0
Total		**0**	0

27.3 Finance Lease Commitment

The Trust does not have any commitments becoming operational in a future period.

28. Private finance transactions

Private Finance Initiatives (PFI) / Public Private Partnerships (PPP)

The Trust has no PFI or PPP Schemes.

29. Financial Risk Management

IFRS 7, Derivatives and Other Financial Instruments, requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities.

NHS Trusts are not exposed to the degree of financial risk faced by business entities. Financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which IFRS 7 mainly applies. NHS Trusts have limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day to day operational activities rather than being held to change the risks facing NHS Trusts in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. The Trust treasury activity is subject to review by the Trust's internal auditors.

Liquidity risk
The Trust's net operating costs are incurred under annual service agreements with various Health bodies, which are financed from resources voted annually by parliament. NHS Trusts also largely finance their capital expenditure from funds made available from the Welsh Government under agreed borrowing limits. NHS Trusts are not, therefore, exposed to significant liquidity risks.

Interest-rate risks
The great majority of NHS Trust's financial assets and financial liabilities carry nil or fixed rates of interest. NHS Trusts are not, therefore, exposed to significant interest-rate risk.

Foreign currency risk
NHS Trusts have no or negligible foreign currency income or expenditure and therefore are not exposed to significant foreign currency risk.

Credit Risk
Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures are in receivables from customers as disclosed in the trade and other receivables note.

General
The powers of the Trust to invest and borrow are limited. The Board has determined that in order to maximise income from cash balances held, any balance of cash which is not required will be invested. The Trust does not borrow from the private sector. All other financial instruments are held for the sole purpose of managing the cash flow of the Trust on a day to day basis or arise from the operating activities of the Trust. The management of risks around these financial instruments therefore relates primarily to the Trust's overall arrangements for managing risks to their financial position, rather than the Trust's treasury management procedures.

30. Movements in working capital

	31 March 2023	31 March 2022
	£000	£000
(Increase) / decrease in inventories	(206)	(198)
(Increase) / decrease in trade and other receivables - non-current	410	1,488
(Increase) / decrease in trade and other receivables - current	(1,791)	(2,667)
Increase / (decrease) in trade and other payables - non-current	0	0
Increase / (decrease) in trade and other payables - current	4,107	7,231
Total	2,520	5,854
Adjustment for accrual movements in fixed assets - creditors	3,709	(6,547)
Adjustment for accrual movements in fixed assets - debtors	0	0
Other adjustments	580	100
Total	6,809	(593)

31. Other cash flow adjustments

Other cash flow adjustments	31 March 2023 £000	31 March 2022 £000
Depreciation	17,129	15,190
Amortisation	1,948	1,750
(Gains)/Loss on Disposal	0	0
Impairments and reversals	9,352	6,135
Release of PFI deferred credits	0	0
NWSSP Covid assets issued debited to expenditure but non-cash	0	0
NWSSP Covid assets received credited to revenue but non-cash	0	0
Donated assets received credited to revenue but non-cash	0	0
Government Grant assets received credited to revenue but non-cash	0	0
Right of Use Grant (Peppercorn Lease) credited to revenue but non cas	0	
Non-cash movements in provisions	621	2,587
Total	29,050	25,662

32. Events after reporting period

NHS Wales Recovery payment 2022-23
NHS Wales bodies were notified in a pay circular letter issued on 25th May 2023 by the Welsh Government, of the additional pay arrangements for employees covered by the Agenda for Change terms and conditions in Wales for 2022-23, which will be funded by the Welsh Government.

NHS Wales bodies will make a one off non-consolidated, prorated “recovery payment” for staff employed on the Agenda for Change terms and conditions (this includes most NHS staff including nursing staff but excludes medical staff).

These costs have not been recognised in the 2022-23 financial statements because the obligating event was the publication of the offer agreed with the Minister on 20 April 2023 and therefore post 31st March 2023. The costs will be accounted for in the 2023-24 Annual Accounts of NHS Wales bodies.

The estimated cost is £4,248,602.58

These financial statements were authorised for issue by the Chief Executive and Accountable Officer on 27/07/2023; post the date the financial statements were certified by the Auditor General for Wales.

33. Related Party transactions

The Trust is a body corporate established by order of the Welsh Minister for Health and Social Services.

The Welsh Government is regarded as a related party. During the year, the Trust has had a significant number of material transactior with the Welsh Government and with other entities for which the Welsh Government is regarded as the parent body, namely:

Related Party	Expenditure to related party £000	Income from related party £000	Amounts owed to related party £000	Amounts due from related party £000
Welsh Government	4,371	38,020	1,133	4,004
WHSSC/EASC	15	230,371	693	34
Aneurin Bevan University Health Board	241	10,837	34	2,865
Betsi Cadwaladr University Health Board	496	1,893	96	562
Cardiff & Vale University Health Board	106	216	24	118
Cwm Taf Morgannwg University Health Board	85	764	11	521
Hywel Dda University Health Board	96	1,745	9	37
Powys Teaching Health Board	45	21	18	12
Swansea Bay University Health Board	140	1,214	23	128
Public Health Wales NHS Trust	34	49	7	0
Velindre University NHS Trust	2,275	1,080	689	132
Health Education and Improvement Wales (HEIW)	31	372	0	15
Digital Health & Care Wales (DHCW)	1,028	149	0	125
Welsh Local Authorities	1,843	332	2	150
	10,806	**287,063**	**2,739**	**8,703**

The Trust Board is the Corporate Trustee of the Welsh Ambulance Services NHS Trust Charity. All voting members of the Trust (marked with an asterisk in the table overleaf) can act as a corporate trustee of the charity. During the year receipts from the Charity amounted to £0.010m (2021/22 £0.010m) with no other transactions being made. Net assets of the charity amount to £0.398m.

The Welsh Government income shown above includes £9.352m relating to impairment funding.

Lee Brooks, Executive Director of Operation, is also a Member of the Order of St John

Kevin Davies, Vice Chair & Non Executive Director, is both a Charity Trustee and Company Director of St John's Ambulance Cyrmu

Jason Killens, Chief Executive, is both a Member of the Order St John and Honorary Professor at Swansea University

33. Related Party transactions (continued)

A number of the Trust's members have declared interests in related parties.
The register of Declarations of Interest for the Trust's members can be found on the Trust website:
Board Member Register of Interests, March 2023 - Live.xlsx (nhs.wales)

No other Trust members provided declarations of interest in related parties during the period.

Material transactions between the Trust and related parties disclosed on the register of Declarations of Interest for 2022-23 were as follows (unless already reported on page 70):

	Payments to related party £000	Receipts from related party £000	Amounts owed to related party £000	Amounts due from related party £000
St John Ambulance	4,301	0	323	0
Swansea University	19	256	12	0
TOTAL	**4,320**	**256**	**335**	**0**

34. Third party assets

The Trust has no third party assets.

35. Pooled budgets

The Welsh Ambulance Services NHS Trust has no pooled budgets.

36. Operating Segments

IFRS 8 requires organisations to report information about each of its operating segments.

The Trust's primary remit is the provision of Ambulance and Unscheduled Care services throughout Wales and this is viewed as the only segment that is recognisable under this legislation.

The Chief Operating Decision Maker (CODM) is considered to be the Trust Board. The CODM receives a variety of information in a variety of formats dealing with various aspects of ambulance service and NHS Direct Wales performance. The Trust however considers the provision of services to be ultimately generic, in terms of geography and service.

The Trust therefore is deemed to operate as one segment.

37. Other Information

37.1. 6.3% Staff Employer Pension Contributions - Notional Element

The value of notional transactions is based on estimated costs for the twelve month period 1 April 2022 to 31 March 2023. This has been calculated from actual Welsh Government expenditure for the 6.3% staff employer pension contributions between April 2022 and February 2023 alongside Trust data for March 2022.

Transactions include notional expenditure in relation to the 6.3% paid to NHS BSA by Welsh Government and notional funding to cover that expenditure as follows:

	2022-23	2021-22
STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2023	**£000**	**£000**
Revenue from patient care activities	8,402	7,841
Operating expenses	8,402	7,841
3. Analysis of gross operating costs		
3. Revenue from patient care activities		
Welsh Government	8,402	7,841
Welsh Government - Hosted Bodies	0	0
5.1 Operating expenses		
Directors' costs	66	76
Staff costs	8,336	7,765

37. Other Information (continued)

37.2 Other (continued)

Welsh Government Covid 19 Funding

Details of Covid 19 Pandemic Welsh Government funding amounts provided to NHS Wales

	Total 2022-23 £000	Total 2021-22 £000
Capital		
Capital Funding Field Hospitals		0
Capital Funding Equipment & Works		200
Capital Funding other (Specify)		0
Welsh Government Covid 19 Capital Funding	**-**	**200**
Revenue		
Stability Funding	**0**	5368
Covid Recovery	**0**	0
Cleaning Standards	**400**	400
PPE (including All Wales Equipment via NWSSP)	**388**	966
Testing / TTP- Testing & Sampling - Pay & Non Pay	**709**	0
Tracing / TTP - NHS & LA Tracing - Pay & Non Pay	**0**	0
Extended Flu Vaccination / Vaccination - Extended Flu Programme	**-**	0
Mass Covid-19 Vaccination / Vaccination - COVID-19	**0**	0
Annual Leave Accrual - Increase due to Covid		0
Urgent & Emergency Care		6076
Private Providers Adult Care / Support for Adult Social Care Providers		0
Hospices		0
Other Mental Health / Mental Health		0
Other Primary Care	**0**	0
Social care		0
Other	**0**	0
Welsh Government Covid 19 Revenue Funding	**1,497**	**12,810**

THE NATIONAL HEALTH SERVICE IN WALES ACCOUNTS DIRECTION GIVEN BY WELSH MINISTERS IN ACCORDANCE WITH SCHEDULE 9 SECTION 178 PARA 3(1) OF THE NATIONAL HEALTH SERVICE (WALES) ACT 2006 (C.42) AND WITH THE APPROVAL OF TREASURY

NHS TRUSTS

1. Welsh Ministers direct that an account shall be prepared for the financial year ended 31 March 2010 and subsequent financial years in respect of the NHS Wales Trusts in the form specified in paragraphs [2] to [7] below.

BASIS OF PREPARATION

2. The account of the NHS Wales Trusts shall comply with:

(a) the accounting guidance of the Government Financial Reporting Manual (FReM), which is in force for the financial year for which the accounts are being prepared, as detailed in the NHS Wales Trust Manual for Accounts;

(b) any other specific guidance or disclosures required by the Welsh Government.

FORM AND CONTENT

3. The account of the Trust for the year ended 31 March 2010 and subsequent years shall comprise a foreword, an income statement, a statement of financial position, a statement of cash flows and a statement of changes in taxpayers' equity as long as these statements are required by the FReM and applied to the NHS Wales Manual for Accounts, including such notes as are necessary to ensure a proper understanding of the accounts.

4. For the financial year ended 31 March 2010 and subsequent years, the account of the Trust shall give a true and fair view of the state of affairs as at the end of the financial year and the operating costs, changes in taxpayers' equity and cash flows during the year.

5. The account shall be signed and dated by the Chief Executive.

MISCELLANEOUS

6. The direction shall be reproduced as an appendix to the published accounts.

7. The notes to the accounts shall, inter alia, include details of the accounting policies adopted.

Signed by the authority of Welsh Ministers

Signed : Chris Hurst Dated : 17.06.2010

1 Please see regulation 3 of the 2009 No 1558(W.153); NATIONAL HEALTH SERVICE, WALES; The National Health Service Trusts (Transfer of Staff, Property Rights and Liabilities) (Wales)

Archwilio Cymru
Audit Wales

Audit of Accounts Report – Welsh Ambulance Services NHS Trust

Audit year: 2022-23

Date issued: July 2023

Document reference: 3686A2023

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 the Wales Audit Office are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to the Wales Audit Office 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.

Contents

We intend to issue an unqualified audit report on your accounts. There are some matters to report to you prior to their approval.

Audit of Accounts Report

Appendices

Audit of Accounts Report

Introduction

1 We summarise the main findings from our audit of your 2022-23 annual report and accounts in this report.

2 We have already discussed these issues with the Director of Finance.

3 Auditors can never give complete assurance that accounts are correctly stated. Instead, we work to a level of 'materiality'. This level of materiality is set to try to identify and correct misstatements that might otherwise cause a user of the accounts into being misled.

4 We set this level at £3.0 million for this year's audit.

5 There are some areas of the accounts that may be of more importance to the reader and we have set lower materiality levels for these, as follows:

- Executive Directors' and independent members' remuneration; and
- Executive Directors' and independent members' related party interests.

6 We have now substantially completed this year's audit.

7 In our professional view, we have complied with the ethical standards that apply to our work; remain independent of yourselves; and our objectivity has not been compromised in any way. There are no relationships between ourselves and yourselves that we believe could undermine our objectivity and independence.

8 In our Audit Plan we explained that the Financial Audit Manager's husband is the Director of Finance and Corporate Services at NHS Wales Shared Services Partnership. We confirm that the planned safeguards set out in our Audit Plan to ensure the independence of our work have operated as intended.

Proposed audit opinion

9 We intend to issue an unqualified audit opinion on this year's accounts once you have provided us with a Letter of Representation based on that set out in **Appendix 1**.

10 We issue a 'qualified' audit opinion where we have material concerns about some aspects of your accounts; otherwise we issue an unqualified opinion.

11 The Letter of Representation contains certain confirmations we are required to obtain from you under auditing standards along with confirmation of other specific information you have provided to us during our audit.

12 Our proposed audit report is set out in **Appendix 2**.

Significant issues arising from the audit

Uncorrected misstatements

13 There are no misstatements identified in the accounts which remain uncorrected.

Corrected misstatements

14 There were initially misstatements in the accounts that have now been corrected by management. However, we believe that these should be drawn to your attention and they are set out with explanations in **Appendix 3**.

Other significant issues arising from the audit

15 In the course of the audit, we consider a number of matters relating to the accounts and report any significant issues arising to you. Any such issues arising in these areas this year are shown in **Exhibit 1**.

Exhibit 1 – significant issues arising from the audit

Ministerial direction relating to senior NHS staff's pension tax liabilities	In prior years, the Trust has disclosed a contingent liability resulting from a Ministerial Direction to NHS bodies to fund certain pensions tax liabilities above the pension savings annual allowance threshold in 2019-20. For the first time, expenditure of £37,000 has been recognised in the Trust's 2022-23 accounts in relation to this matter. A number of NHS bodies received qualified audit opinions for their 2021-22 accounts when such expenditure was recognised for the first time. While the Auditor General still views such expenditure as irregular, he does not propose to classify it as material by its nature and qualify his 2022-23 audit opinions for this matter, given the recent abolition of some pensions tax allowance limits by the UK Government.	For information only

Recognition of expenditure in the 2022-23 accounts	Our audit testing of post year-end payments identified two transactions totalling £110,000 which were incorrectly recorded as 2022-23 transactions, when they should have been recorded in the 2023-24 accounts. We have performed further audit procedures to provide assurance that there are no further material amounts of expenditure relating to 2023-24 currently accounted for in the 2022-23 financial ledger, and we are satisfied this is the case. However, a risk remains that a material issue could arise in future years. As such we have raised this matter as a recommendation in this report.	See recommendation 1

Recommendations

16 The one recommendation arising from our audit is set out in **Appendix 4**. Management has responded to it and we will follow up progress against it during next year's audit. Where any actions are outstanding, we will continue to monitor progress and report it to you in next year's report.

Appendix 1

Final Letter of Representation

[Audited body's letterhead]

Auditor General for Wales
Wales Audit Office
1 Capital Quarter
Tyndall Street
Cardiff
CF10 4BZ

27 July 2023

Representations regarding the 2022-23 financial statements

This letter is provided in connection with your audit of the financial statements (including that part of the Remuneration Report that is subject to audit) of the Welsh Ambulance Services NHS Trust for the year ended 31 March 2023 for the purpose of expressing an opinion on their truth and fairness, their proper preparation and the regularity of income and expenditure.

We confirm that to the best of our knowledge and belief, having made enquiries as we consider sufficient, we can make the following representations to you.

Management representations

Responsibilities

As Chief Executive and Accountable Officer I have fulfilled my responsibility for:

- preparing the financial statements in accordance with legislative requirements and the Treasury's Financial Reporting Manual. In preparing the financial statements, I am required to:
  - observe the accounts directions issued by Welsh Ministers, including the relevant accounting and disclosure requirements and apply appropriate accounting policies on a consistent basis;
  - make judgements and estimates on a reasonable basis;
  - state whether applicable accounting standards have been followed and disclosed and explain any material departures from them; and
  - prepare them on a going concern basis on the presumption that the services of Welsh Ambulance Services NHS Trust will continue in operation;
- ensuring the regularity of any expenditure and other transactions incurred;

- the design, implementation and maintenance of internal control to prevent and detect error.

Information provided

We have provided you with:

- full access to:
  - all information of which we are aware that is relevant to the preparation of the financial statements such as books of account and supporting documentation, minutes of meetings and other matters;
  - additional information that you have requested from us for the purpose of the audit; and
  - unrestricted access to staff from whom you determined it necessary to obtain audit evidence;
- the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud;
- our knowledge of fraud or suspected fraud that we are aware of and that affects the Welsh Ambulance Services NHS Trust and involves:
  - management;
  - employees who have significant roles in internal control; or
  - others where the fraud could have a material effect on the financial statements;
- our knowledge of any allegations of fraud, or suspected fraud, affecting the financial statements communicated by employees, former employees, regulators or others;
- our knowledge of all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing the financial statements;
- the identity of all related parties and all the related party relationships and transactions of which we are aware; and
- our knowledge of all possible and actual instances of irregular transactions.

Financial statement representations

All transactions, assets and liabilities have been recorded in the accounting records and are reflected in the financial statements.

The methods, the data and the significant assumptions used in making accounting estimates, and their related disclosures are appropriate to achieve recognition, measurement or disclosure that is reasonable in the context of the applicable financial reporting framework.

Related party relationships and transactions have been appropriately accounted for and disclosed.

All events occurring subsequent to the reporting date which require adjustment or disclosure have been adjusted for or disclosed.

All known actual or possible litigation and claims whose effects should be considered when preparing the financial statements have been disclosed to the auditor and accounted for and disclosed in accordance with the applicable financial reporting framework.

The financial statements are free of material misstatements, including omissions. The effects of uncorrected misstatements identified during the audit are immaterial, both individually and in the aggregate, to the financial statements taken as a whole.

Representations by the Board

We acknowledge that the representations made by management, above, have been discussed with us.

We acknowledge our responsibility for the preparation of true and fair financial statements in accordance with the applicable financial reporting framework. The financial statements were approved by the Board on 27 July 2023.

We confirm that we have taken all the steps that we ought to have taken in order to make ourselves aware of any relevant audit information and to establish that it has been communicated to you. We confirm that, as far as we are aware, there is no relevant audit information of which you are unaware.

Signed by:	Signed by:
Jason Killens	Colin Dennis
Chief Executive	Board Chair
Date: 27 July 2023	Date: 27 July 2023

Appendix 2

Proposed Audit Report

The Certificate and report of the Auditor General for Wales to the Senedd

Opinion on financial statements

I certify that I have audited the financial statements of the Welsh Ambulance Services NHR Trust for the year ended 31 March 2023 under Section 61 of the Public Audit (Wales) Act 2004.

These comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Cash Flow Statement and the Statement of Changes in Taxpayers' Equity and related notes, including a summary of significant accounting policies.

The financial reporting framework that has been applied in their preparation is applicable law and UK adopted international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual.

In my opinion, in all material respects, the financial statements:

- give a true and fair view of the state of affairs of the Welsh Ambulance Services NHS Trust as at 31 March 2023 and of its surplus for the year then ended;
- have been properly prepared in accordance with UK adopted international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual; and
- have been properly prepared in accordance with the National Health Service (Wales) Act 2006 and directions made there under by Welsh Ministers.

Opinion on regularity

In my opinion, in all material respects, the expenditure and income in the financial statements have been applied to the purposes intended by the Senedd and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Basis for opinions

I conducted my audit in accordance with applicable law and International Standards on Auditing in the UK (ISAs (UK)) and Practice Note 10 'Audit of Financial Statements of Public Sector Entities in the United Kingdom'. My responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of my certificate.

My staff and I are independent of the Trust in accordance with the ethical requirements that are relevant to my audit of the financial statements in the UK including the Financial

Reporting Council's Ethical Standard, and I have fulfilled my other ethical responsibilities in accordance with these requirements. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinions.

Conclusions relating to going concern

In auditing the financial statements, I have concluded that the use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work I have performed, I have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the body's ability to continue to adopt the going concern basis of accounting for a period of at least 12 months from when the financial statements are authorised for issue.

My responsibilities and the responsibilities of the directors with respect to going concern are described in the relevant sections of this certificate.

The going concern basis of accounting for the Welsh Ambulance Services NHS Trust is adopted in consideration of the requirements set out in HM Treasury's Government Financial Reporting Manual, which require entities to adopt the going concern basis of accounting in the preparation of the financial statements where it anticipated that the services which they provide will continue into the future.

Other information

The other information comprises the information included in the annual report other than the financial statements and my auditor's report thereon. The Chief Executive is responsible for the other information contained within the annual report. My opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in my report, I do not express any form of assurance conclusion thereon. My responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or knowledge obtained in the course of the audit, or otherwise appears to be materially misstated. If I identify such material inconsistencies or apparent material misstatements, I am required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact.

I have nothing to report in this regard.

Opinion on other matters

In my opinion, the part of the remuneration report to be audited has been properly prepared in accordance with the National Health Service (Wales) Act 2006 and directions made there under by Welsh Ministers.

In my opinion, based on the work undertaken in the course of my audit:

- the parts of the Accountability Report subject to audit have been properly prepared in accordance with the National Health Service (Wales) Act 2006 and directions made there under by Welsh Minsters' directions; and
- the information given in the Performance Report and Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements and in accordance with Welsh Ministers' guidance.

Matters on which I report by exception

In the light of the knowledge and understanding of the Trust and its environment obtained in the course of the audit, I have not identified material misstatements in the Performance Report and Accountability Report.

I have nothing to report in respect of the following matters, which I report to you, if, in my opinion:

- I have not received all the information and explanations I require for my audit;
- adequate accounting records have not been kept, or returns adequate for my audit have not been received from branches not visited by my team;
- the financial statements and the audited part of the Accountability Report are not in agreement with the accounting records and returns;
- information specified by HM Treasury or Welsh Ministers regarding remuneration and other transactions is not disclosed;
- certain disclosures of remuneration specified by HM Treasury's Government Financial Reporting Manual are not made or parts of the Accountability Report to be audited are not in agreement with the accounting records and returns; or
- the Governance Statement does not reflect compliance with HM Treasury's guidance.

Responsibilities of Directors and the Chief Executive for the financial statements

As explained more fully in the Statements of Directors' and Chief Executive's Responsibilities, the Directors and the Chief Executive are responsible for:

- maintaining adequate accounting records;
- the preparation of financial statements and annual report in accordance with the applicable financial reporting framework and for being satisfied that they give a true and fair view;
- ensuring that the annual report and financial statements as a whole are fair, balanced and understandable;
- ensuring the regularity of financial transactions;
- internal controls as the Directors and Chief Executive determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; and

- assessing the Trust's ability to continue as a going concern, disclosing as applicable, matters related to going concern and using the going concern basis of accounting unless the Directors and Chief Executive anticipate that the services provided by the Trust will not continue to be provided in the future.

Auditor's responsibilities for the audit of the financial statements

My responsibility is to audit, certify and report on the financial statements in accordance with the National Health Service (Wales) Act 2006.

My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue a certificate that includes my opinion.

Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. I design procedures in line with my responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud.

My procedures included the following:

- enquiring of management, internal audit and those charged with governance, including obtaining and reviewing supporting documentation relating to the Welsh Ambulance Services NHS Trust's policies and procedures concerned with:
  - identifying, evaluating and complying with laws and regulations and whether they were aware of any instances of non-compliance;
  - detecting and responding to the risks of fraud and whether they have knowledge of any actual, suspected or alleged fraud; and
  - the internal controls established to mitigate risks related to fraud or non-compliance with laws and regulations.
- considering as an audit team how and where fraud might occur in the financial statements and any potential indicators of fraud. As part of this discussion, I identified potential for fraud in expenditure recognition, and management override.
- obtaining an understanding of the Welsh Ambulance Services NHS Trust's framework of authority as well as other legal and regulatory frameworks that the Welsh Ambulance Services NHS Trust operates in, focusing on those laws and regulations that had a direct effect on the financial statements or that had a fundamental effect on the operations of the Welsh Ambulance Services NHS Trust.
- obtaining an understanding of related party relationships.

In addition to the above, my procedures to respond to identified risks included the following:

- reviewing the financial statement disclosures and testing to supporting documentation to assess compliance with relevant laws and regulations discussed above;
- enquiring of management and the Audit Committee about actual and potential litigation and claims;
- reading minutes of meetings of the Audit Committee and the Board; and
- in addressing the risk of fraud through management override of controls, testing the appropriateness of journal entries and other adjustments; assessing whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluating the business rationale of any significant transactions that are unusual or outside the normal course of business.

I also communicated relevant identified laws and regulations and potential fraud risks to all audit team members and remained alert to any indications of fraud or non-compliance with laws and regulations throughout the audit.

The extent to which my procedures are capable of detecting irregularities, including fraud, is affected by the inherent difficulty in detecting irregularities, the effectiveness of the Welsh Ambulance Services NHS Trust's controls, and the nature, timing and extent of the audit procedures performed.

A further description of the auditor's responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website www.frc.org.uk/auditorsresponsibilities. This description forms part of my auditor's report.

Other auditor's responsibilities

I am also required to obtain evidence sufficient to give reasonable assurance that the expenditure and income recorded in the financial statements have been applied to the purposes intended by the Senedd and the financial transactions recorded in the financial statements conform to the authorities which govern them.

I communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

Report

I have no observations to make on these financial statements.

Adrian Crompton
Auditor General for Wales
28 July 2023

1 Capital Quarter
Tyndall Street
Cardiff
CF10 4BZ

Appendix 3

Summary of Corrections Made

During our audit, we identified the following misstatements that have been corrected by management, but which we consider should be drawn to your attention due to their relevance to your responsibilities over the financial reporting process.

None of the corrections below affect the Trust's disclosed surplus of £62,000 for 2022-23.

Exhibit 2: summary of corrections made

Area of correction	Nature of correction	Reason for correction
Revenue (Notes 3 and 4)	To ensure that funding is correctly classified within these notes.	Our audit identified that a £2.5 million transaction relating to Permanent Injury Benefits had been incorrectly netted off 'Welsh Government income' in Note 3, while 'other minor service income' in Note 4 had been increased by the same amount. 'Welsh Government income' has now been increased by £2.5 million while 'other minor service income' has been reduced by the same amount. Total revenue is unaffected by this amendment.
Employee Costs (Note 10.1)	To ensure that all pension contributions are correctly reflected in this disclosure for both 2022-23 and 2021-22.	Our audit identified that 6.3% of employer pension contributions (paid by the Welsh Government on the Trust's behalf, as agreed with the NHS Business Services Authority) were incorrectly reflected within 'salaries and wages' rather than 'employer pension contributions' for the current and prior financial year. These amounts (£8.4 million for 2022-23 and £7.8 million for 2021-22) have now been correctly classified within this disclosure for both financial years.
Property, Plant and Equipment (Note 13)	To ensure that the note is correctly disclosed and reflects current practice.	Our audit identified that the note for 2022-23 included reference to a 'material valuation uncertainty' raised by the District Valuer who values the Trust's assets. Such uncertainties were reported by valuers during the COVID-19 pandemic given their impact on valuation work at the time. However, no such uncertainty has been reported by the valuer for 2022-23, so this narrative has been removed from the final accounts.

Area of correction	Nature of correction	Reason for correction
Events After Reporting Period (Note 32)	To ensure that all relevant matters are presented in this disclosure note.	During the audit, NHS bodies were notified of the 'NHS Wales Recovery Payment' – additional Agenda for Change pay arrangements relevant to the 2022-23 financial year, to be funded by the Welsh Government. As the arrangements were not confirmed until after year-end, they do not affect these accounts even though the pay arrangements relate to 2022-23. However, the Trust has appropriately disclosed the arrangements and their future impact within Note 32.
Related Party Transactions (Note 33)	To ensure that the note is correctly disclosed in line with the Financial Reporting Manual (FReM).	Our audit identified required amendments to the disclosure in the draft accounts, including: • removal of transactions with universities as the Welsh Government is not their parent body (except for one instance where a personal relationship exists with Swansea University). • disclosure of other transactions with related parties where personal interests have been identified.
Various	To make other required minor amendments to the accounts.	A number of other narrative, presentational and minor amendments were made to supporting notes throughout the final financial statements.

Appendix 4

Recommendations

We set out the one recommendation arising from our audit with management's response to it. We will follow this up next year and include any outstanding issues in next year's audit report.

Exhibit 3: matter arising 1

Matter arising 1 – expenditure cut-off	
Findings	Our audit testing of post year-end payments identified two transactions totalling £110,000 which were incorrectly recorded as 2022-23 transactions, when they should have been recorded in the 2023-24 accounts. The transactions have therefore been accounted for in the wrong financial year. Both transactions were recorded by the same individual. These transactions are not material in value, individually or in aggregate. We have performed further audit procedures to provide assurance that there are no material amounts of expenditure relating to 2023-24 accounted for in the 2022-23 financial ledger, and we are satisfied that is the case. However, there remains a risk that the Trust could record a material amount of expenditure in the incorrect financial year for future accounts.
Priority	Medium
Recommendation	The Trust should ensure that all individuals are aware of the requirements and processes in place to accurately record income and expenditure in the appropriate financial year.
Benefits of implementing the recommendation	Enhancing awareness of these requirements should reduce the risk of future transactions being accounted for in the incorrect financial year, and therefore of potential material issues arising in future.
Accepted in full by management	Accepted by management.

Matter arising 1 – expenditure cut-off	
Management response	As explained during the audit and confirmed through additional samples successfully tested by the auditors, this was a one-off incident and is not pervasive in the system as we continue to ensure the already existing process is adhered to in order to prevent any future occurrence.
Implementation date	This will be an ongoing matter and will be internally monitored by the relevant process owner(s) to ensure process compliance.

Audit Wales

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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.

Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services
NHS Trust

Cadeirydd
Chair: Colin Dennis

Prif Weithredwr
Chief Executive: Jason Killens

Swyddfa'r Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services Office

Auditor General for Wales
Wales Audit Office
1 Capital Quarter
Tyndall Street
Cardiff
CF10 4BZ

27 July 2023

Representations regarding the 2022-23 financial statements

This letter is provided in connection with your audit of the financial statements (including that part of the Remuneration Report that is subject to audit) of the Welsh Ambulance Services NHS Trust for the year ended 31 March 2023 for the purpose of expressing an opinion on their truth and fairness, their proper preparation and the regularity of income and expenditure.

We confirm that to the best of our knowledge and belief, having made enquiries as we consider sufficient, we can make the following representations to you.

Management representations

Responsibilities

As Chief Executive and Accountable Officer I have fulfilled my responsibility for:

- preparing the financial statements in accordance with legislative requirements and the Treasury's Financial Reporting Manual. In preparing the financial statements, I am required to:
  - observe the accounts directions issued by Welsh Ministers, including the relevant accounting and disclosure requirements and apply appropriate accounting policies on a consistent basis;
  - make judgements and estimates on a reasonable basis;
  - state whether applicable accounting standards have been followed and disclosed and explain any material departures from them; and
  - prepare them on a going concern basis on the presumption that the services of Welsh Ambulance Services NHS Trust will continue in operation;
- ensuring the regularity of any expenditure and other transactions incurred;
- the design, implementation and maintenance of internal control to prevent and detect error.

Information provided

We have provided you with:

- full access to:
  - all information of which we are aware that is relevant to the preparation of the financial statements such as books of account and supporting documentation, minutes of meetings and other matters;
  - additional information that you have requested from us for the purpose of the audit; and
  - unrestricted access to staff from whom you determined it necessary to obtain audit evidence;
- the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud;
- our knowledge of fraud or suspected fraud that we are aware of and that affects the Welsh Ambulance Services NHS Trust and involves:
  - management;
  - employees who have significant roles in internal control; or
  - others where the fraud could have a material effect on the financial statements;
- our knowledge of any allegations of fraud, or suspected fraud, affecting the financial statements communicated by employees, former employees, regulators or others;
- our knowledge of all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing the financial statements;
- the identity of all related parties and all the related party relationships and transactions of which we are aware;
- our knowledge of all possible and actual instances of irregular transactions.

Financial statement representations

All transactions, assets and liabilities have been recorded in the accounting records and are reflected in the financial statements.

The methods, the data and the significant assumptions used in making accounting estimates, and their related disclosures are appropriate to achieve recognition, measurement or disclosure that is reasonable in the context of the applicable financial reporting framework.

Related party relationships and transactions have been appropriately accounted for and disclosed.

All events occurring subsequent to the reporting date which require adjustment or disclosure have been adjusted for or disclosed.

All known actual or possible litigation and claims whose effects should be considered when preparing the financial statements have been disclosed to the auditor and accounted for and disclosed in accordance with the applicable financial reporting framework.

The financial statements are free of material misstatements, including omissions. The effects of uncorrected misstatements identified during the audit are immaterial, both individually and in the aggregate, to the financial statements taken as a whole.

Representations by the Board

We acknowledge that the representations made by management, above, have been discussed with us.

We acknowledge our responsibility for the preparation of true and fair financial statements in accordance with the applicable financial reporting framework. The financial statements were approved by the Board on 27 July 2023.

We confirm that we have taken all the steps that we ought to have taken in order to make ourselves aware of any relevant audit information and to establish that it has been communicated to you. We confirm that, as far as we are aware, there is no relevant audit information of which you are unaware.

Signed by: Signed by:

Jason Killens
Chief Executive
Date: 27 July 2023

Colin Dennis
Board Chair
Date: 27 July 2023

AGENDA ITEM No	**5.3**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**1**

ANNUAL REPORT 2022/23

MEETING	Audit Committee
DATE	25 July 2023
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Trish Mills, Board Secretary
CONTACT	trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. The Trust submitted its draft Annual Report 2022/23 on 12 May 2023 to Audit Wales and Welsh Government in line with the agreed timetable.

2. Comments from both Audit Wales and Welsh Government have been incorporated into the final Annual Report which is attached for review and endorsement by the Audit Committee.

RECOMMENDATION:

3. That the 2022/23 Annual Report be recommended for formal approval by the Trust Board.

KEY ISSUES/IMPLICATIONS

4. The Annual Report includes the Performance Report and the Accountability Report. Both have been developed in accordance with the NHS Wales 2022-23 Manual for Accounts**.**

5. The Accountability Report includes the Statement of Directors' responsibilities in respect of the Accounts (page 100) which will be signed by order of the Board by the Chair, Chief Executive and Director of Finance and Corporate Resources.

6. Welsh language translation of the Annual Report and the Accounts foreword will be completed throughout August, once the Annual Report and Accounts have been approved by the Board.

REPORT APPROVAL ROUTE

- The draft annual report was considered by the Executive Management Team on 27 April and circulated to the Audit Committee on 28 April. The Remuneration Committee received the Remuneration Table on 21 April. A further review of the annual report was undertaken by the Executive Management Team on 12 July 2023.

- Welsh Government and Audit Wales have received and commented on the draft Annual Report and their comments have been addressed and closed off.

REPORT ANNEXES

1. Annual Report 2022/23

REPORT CHECKLIST

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

ANNUAL REPORT 2022/23

SITUATION

7. The Trust submitted its Draft Annual Report 2022/23 on 12 May 2023 to Audit Wales and Welsh Government in line with the agreed timetable. Comments from both Audit Wales and Welsh Government have been incorporated into the final Annual Report which is attached for review and endorsement by the Audit Committee.

BACKGROUND

8. The Annual Report, which consists of Part 1 - Performance Report and Part 2 – Accountability Report, have been prepared in accordance with the NHS Wales 2022-23 Manual for Accounts Chapter 3.

9. A Task and Finish Group was established for the development of the Annual Report. The Group coordinated contributions to the Annual Report from across the Trust and will submit its closing report to the Executive Management Team for receipt in August. It is anticipated that the Group will be re-established for the 2023/24 Annual Report production.

10. The timetable for the production of the Annual Report that was agreed by the Audit Committee in March 2023 has been complied with; however, the dates presented to the Committee in March were in draft because the final timeline had not been confirmed at that time.

ASSESSMENT

11. Following submission of the draft Annual Report to Audit Wales and Welsh Government on 12 May 2023 comments were provided relating to both the Performance Report and Accountability Report which have been addressed. These largely related to cross-referencing, charity accounts, confirmation of appointments, internal governance arrangements, Welsh Government circulars; carbon reduction plans, and capacity to handle risk – in particular, governance arrangements; stakeholder involvement; and how identified weaknesses are addressed.

12. This Annual Report is part of a suite of documents that provides information about the Trust. In accordance with the NHS Wales 2022/23 Manual for Accounts and HM Treasury's Financial Reporting Manual, the Annual Report for 2022/23 includes:

    - **Part 1: Performance Report** which details how the Trust performed in the year. For 2022/23 there was no requirement to prepare a separate Annual Quality Statement, however, key quality themes are captured within the Performance Report.

- The other significant changes in the Performance Report from the disclosure requirements for 2021/22 include the restructuring of the report in to two overarching sections – the 'Performance Overview' and the 'Delivery and Performance Analysis'; inclusion of narrative regarding the Six Goals for Urgent and Emergency Care, and the reintroduction of the requirement to prepare a separate organistional Sustainability Report (which will be published separately to the Annual Report later in the year).

- **Part 2: Accountability Report** which details the key accountability requirements and our Governance Statement provides information about how the Trust manages and controls resources and risks and complies with governance arrangements. It includes the Corporate Governance Report (including the Governance Statement), the Remuneration and Staff Report, and the Parliamentary Accountability and Audit Report.

13. The Accountability Report includes the Statement of Directors' responsibilities in respect of the Accounts (page 100) which will be signed by order of the Board by the Chair, Chief Executive and director of Finance and Corporate Resources.

14. The Remuneration Table (pages 170-171) has been reviewed by Remuneration Committee members and the Executive Management Team.

15. The Annual Report and 'foreword' section of the Financial Accounts will be submitted for translation after approval of the Annual Report and Accounts by the Trust Board. The translation will be completed throughout August in readiness for the Annual General Meeting in September. The full financial accounts have not been translated. This is due to the complexity of the document where translation of complex excel workbooks poses risk of errors and a significant workload from the finance and audit teams.

16. The Welsh Government Manual for Accounts 2022-23 requires the Trust to submit as a single PDF document a three-part Annual Report and Financial Accounts. For this submission, the document attached will be entitled Annual Report and Financial Accounts 2022/23 and include the Financial Statements as 'Part 3'. This is required to be submitted to Welsh Government by 31 July 2023.

RECOMMENDATION

17. That the 2022/23 Annual Report be recommended for formal approval by the Trust Board.

Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services
NHS Trust

Welsh Ambulance Services NHS Trust

Annual Report and Accounts 2022/23

INTRODUCTION

This Annual Report is part of a suite of documents that provides information about the Welsh Ambulance Services NHS Trust (the Trust). It will provide the reader with information on our services, the care we provide and what we do to plan, deliver, and improve those services. It will provide the reader with detail on the Trust's performance and how we responded to changing demands and challenges in 2022/23.

In accordance with the NHS Wales 2022/23 Manual for Accounts and HM Treasury's Financial Reporting Manual, our Annual Report for 2022/23 includes: -
Part 1: Performance Report which details how the Trust performed in the year and how we adapted and responded to the system pressures currently impacting our patients and our people.

Part 2: Accountability Report which details the key accountability requirements and our Governance Statement, which provides information about how the Trust manages and controls resources and risks and complies with governance arrangements.

Part 3 Financial Statements which detail how the Trust has spent its money and met its obligations. These accounts for the period ended 31 March 2023 have been prepared to comply with International Financial Reporting Standards (IFRS) adopted by the European Union, in accordance with HM Treasury's FReM by the Welsh Ambulances Services NHS Trust under schedule 9 section 178 Para 3 (1) of the National Health Service (Wales) Act 2006 (c.42) in the form in which the Welsh Ministers, with the approval of the Treasury, directed.

For 2022/23, there was no requirement to prepare a separate Annual Quality Statement or Annual Putting Things Right Report; however, key quality themes are captured within the Performance Report. Whilst acronyms are explained in full when they are first used, a glossary is included for ease of reference. If you require a version of the Annual Report in printed or alternative formats or languages, please contact the Board Secretary on trish.mills@wales.nhs.uk.

WELCOME MESSAGE FROM THE CHAIR AND CHIEF EXECUTIVE OFFICER

Thank you for reading the Welsh Ambulance Services NHS Trust Annual Report for 2022/23. Over the last two years, we have set out in our Annual Report the challenges we have faced during, and as we emerged from, the pandemic. The challenge throughout 2022/23, however, has continued to grow.

Our people continue to work in a health and care system which at times has been overwhelmed by pressures in our hospitals, the community and, for us, the number of calls to our 999 and 111 services. In our Emergency Medical Services (EMS), demand for the most serious of 999 calls increased again whilst delays at hospital peaked at their highest ever level in December 2022, equating to over one third of our ambulances being unable to respond to calls. This has meant that we do not always reach patients in a timely way, some come to avoidable harm, and it is not the safe, high-quality service that any of us want to provide.

Our 111 service also came under severe pressure at times, particularly as we saw a rise in seasonal infections such as influenza, Respiratory Syncytial Virus (RSV) and Strep A that had been tempered during the pandemic meaning we were sometimes unable to answer calls in a timely way either. Our Non-Emergency Patient Transport Service (NEPTS) continued to deliver a consistently good quality service, although we know we can still make improvements, particularly for our oncology patients. We are also working hard to improve transfers between hospitals where we have also seen some delays causing avoidable patient harm during the year.

Over the winter, our people made the difficult decision to take industrial action and whilst the principal reason was pay, we had the chance to talk to those on picket lines who raised issues including work life balance being compromised, often because of unpredictable shift end times, and many other day to day issues. The public responded well during industrial action and on some days, we saw a reduction in the number of people calling 999. However, hospitals still saw pressure at the front door and compounding issues such as seasonal infection and the inability to maintain flow out of hospitals means the system is still under severe pressure.

Despite the challenges, our achievements during this last year have been impressive. Our people have come together at all levels of the organisation not only to respond to the challenges they face on a daily basis but also to make service improvements, without which the situation we faced would have been much worse.

We continued to grow our EMS, recruiting an additional 90 Full Time Equivalent (FTE) front line staff as well as re-rostering across the whole of Wales to better meet demand. We implemented a new remote triage system (ECNS) enabling our Clinical Support Desk to increase the number of people whose needs can be met remotely. Our 111-service responded amazingly to a system outage across GP out of hours, developing new ways of working at pace. Our NEPTS service completed a procurement exercise which has improved the efficiency of the service and allowed us to put new quality standards in place with external providers. We also saw new stations opening, new carbon efficient vehicles being deployed and strides forward in our digital capability.

We are pleased to say that the Trust achieved financial balance in 2022/23, with a small revenue surplus of £62k and met its statutory duty to breakeven during this financial year. Gross savings of £4.392m were achieved against a target of £4.300m.

Following a sustained pandemic response and rising inflation, the financial outlook for 2023/24 and beyond is challenging and this, and continued improvements in performance will need to be closely monitored. This will be supported by strengthened monitoring and oversight by Board Committees and revised escalation and reporting arrangements to the Board.

We want to provide the right care and advice, in the right place, every time by delivering quality driven, clinically led and value focussed services. This was the commitment we set out in our long-term strategy 'Delivering Excellence' and it remains our commitment now. However, the operating and financial environment that we face means we need to balance our ambition to make improvements in the quality of care for our patients with the need to look after our people and at the same time provide efficiencies and savings that will help us to deliver financial balance. However, we are motivated by a greater sense of direction having agreed our organisational purpose: 'To Support. To Serve. To Save.'

Finally, we would like to thank all of our staff and volunteers, Armed Forces, blue light partners, commissioners, the private sector, and the voluntary sector for their continued support. We look forward to working with colleagues, patients, and partners as we continue to deliver the improvements to our services that will benefit the population of Wales.

Colin Dennis

Chair of the Trust Board

Jason Killens

Chief Executive Officer

REPORT CONTENTS

GLOSSARY OF TERMS	
Abbreviation	**Term**
ACAS	Advisory Conciliation and Arbitration Service
ADLT	Assistant Directors' Leadership Team
AfC	Agenda for Change
AGM	Annual General Meeting
AMR	Antimicrobial Resistance
APPs	Advanced Paramedic Practitioners
AQIs	Ambulance Quality Indicators
BAF	Board Assurance Framework
CASC	Chief Ambulance Services Commissioner
CFRs	Community First Responders
CHARU	Cymru High Acuity Response Unit
CIAT	Clinical Intelligence and Assurance Team
COPI	Control of Patient Information Regulations
CPD	Continual Professional Development
CPR	Cardiopulmonary Resuscitation
CSD	Clinical Support Desk
DAP	Decarbonisation Action Plan
EASC	Emergency Ambulance Services Committee
EDs	Emergency Departments
EMS	Emergency Medical Service
EMT	Executive Management Team
ePCR	Electronic Patient Care Record
EPRR	Emergency Preparedness Resilience and Response
ESR	Electronic Staff Record
HART	Hazardous Area Response Team
FPC	Finance and Performance Committee
FReM	Government Financial Reporting Manual
HSE	Health and Safety Executive
ICAP	Integrated Commissioning Action Plan
ICO	Information Commissioner's Office
IMTP	Integrated Medium-Term Plan
IPC	Infection Prevention Control
JIF	Joint Investigations Framework
JOL	Joint Organisational Learning
LCFS	Local Counter Fraud Service
MACA	Military Aid to Civil Authorities
MDS	Minimum Data Set

GLOSSARY OF TERMS	
Abbreviation	**Term**
MIQPR	Monthly Integrated Quality and Performance Report
NEPTS	Non-Emergency Patient Transport Service
NHSDW	NHS Direct Wales
NRIs	National Reportable Incidents
NWSSP	NHS Wales Shared Services Partnership
PADRs	Performance and Development Reviews
PCC	People and Culture Committee
PECI	Patient Experience and Community Involvement
PLICS	Patient Level Costing System
PPE	Personal Protective Equipment
PSOW	Public Service Ombudsman for Wales
QuEST	Quality, Patient Experience and Safety Committee
REAP	Resource Escalation Action Plan
RBPs	Regional Partnership Boards
ROSC	Return of spontaneous circulation from cardiac arrest
SDECs	Same Day Emergency Care Centres
SI	Statutory Instrument
SORT	Specialist Operational Response Team
STB	Strategic Transformation Board
STEMI	ST segment elevation myocardial infarction
The Trust	Welsh Ambulance Services NHS Trust
TRiM	Trauma and Risk Management
WASPT	Welsh Ambulance Services Partnership Team
WHSCC	Welsh Health Specialised Services Committee
WTEs	Whole-time equivalents

PART 1: – PERFORMANCE REPORT

PERFORMANCE OVERVIEW

1.1. Introduction

This Performance Overview aims to provide an integrated quality, patient safety, patient experience, and performance narrative on the Welsh Ambulance Services NHS Trust (the Trust) for the period 01 April 2022 to 31 March 2023. The Performance Report is produced in line with the requirements of the NHS Wales 2022/23 Manual for Accounts, in particular, Chapter three and Annex seven.

1.2. Statement from the Chief Executive Officer

The challenges throughout 2022/23 have once again been significant, as the Trust has had to respond to the unprecedented pressures across the system in the aftermath of the Covid-19 pandemic, as well as managing three months of industrial action across the NHS.

Whilst staff and volunteers have continued to step up to the challenge, we have not been able to respond to patients as quickly as we would want. For 999 callers, our headline target is to respond to 65% of Red calls in eight minutes. We did not achieve the target for any month in 2022/23 with performance declining to below 40% for the first time in December 2022. Patients in the Amber category (serious, but not immediately life threatening) also waited far too long for a response, and we know that avoidable harm occurred as a result. The call abandonment rate in the 111 service, particularly on the weekends, is another area of concern.

Over the winter, our people made the difficult decision to take industrial action and whilst the principal reason was pay, staff have told the Trust that working conditions within such a pressurised system were also a factor.

Despite these pressures, our people have continued to deliver, taking action to improve services for patients and for staff and volunteers. The Trust increased its front-line ambulance workforce by 90 whole time equivalents (WTEs), almost delivered its ambition to increase its telephone triage target to 15% and reduced its sickness absence rate to its 8% interim ambition. The Non-Emergency Patient Transport Service (NEPTS) achieved its headline renal appointments time for every month in 2022/23.

The Trust is open and transparent in its monthly reporting of patient experience, patient safety, and performance. The annual Performance Report provides a fair and balanced assessment of how the Trust is doing. Finally, I thank all of our staff and volunteers, Armed Forces, blue light partners, commissioners, the private sector, and the voluntary sector for their continued support.

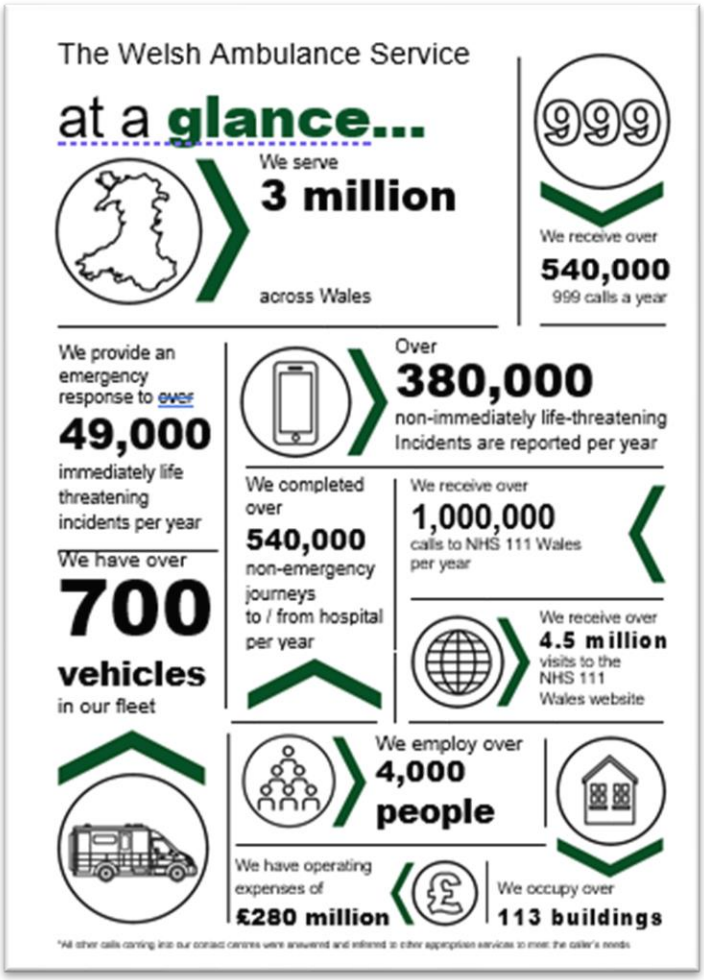
SIGN

Jason Killens
Welsh Ambulance Services NHS Trust Chief Executive Officer

DATE

1.3. Areas of Responsibility

The Trust provides health care services for people across the whole of Wales, delivering high quality and patient-led clinical care wherever and whenever needed. Services include: -



- The blue light emergency ambulance services: including call taking, remote clinical consultation, see and treat and if necessary, conveyance to an appropriate hospital or appropriate treating facility.
- Non-Emergency Patient Transport Service (NEPTS): including call taking, journey planning, service commissioning, taking patients to and from hospital appointments and transferring them between hospitals and treating facilities.
- The 111 service: website and a free-to-call service, acts as a first line gateway to a patient's journey within the health and care system providing them with the right advice or referral every time.
- The Trust also supports volunteers: Community First Responders (CFRs), Co-Responders and Uniformed Responders to provide additional response resource to emergency calls and a volunteer car service to aid patient transport to planned appointments.

The Trust is a commissioned service for Emergency Medical Service (EMS) and NEPTS. The commissioning is undertaken by the Emergency Ambulance Services Committee (EASC), on behalf of Health Boards, who are also supported by the Chief Ambulance Service Commissioner (CASC). The Trust has engaged constructively with EASC and its governance structures, and has received financial support during 2022/23, in particular for the recruitment of an additional 90 WTEs for front line Emergency Medical Service. EASC set out a range of commissioning intentions each year, with good progress made through 2022/23 on delivery.

1.4. Our Purpose and Long-Term Strategy

Our Long-Term Strategic Framework for 2030, 'Delivering Excellence' was agreed in 2019. It set out an ambition to move from being a traditional ambulance and transport service to being a trusted provider of out-of-hospital high quality care, ensuring that patients receive the 'right advice and care, in the right place, every time', with a greater emphasis on providing care closer to home.

The strategy is not only concerned with service models, but also with how staff and volunteers are supported and enabled to be the best that they can be. The strategy also commits the Trust to being an organisation that collaborates with its partners, stays at the forefront of innovation and technology, remains focussed on being quality driven and clinically led, and delivers exceptional value.

The Trust has progressed work with colleagues over the last year to help frame its organisational 'purpose' which sets out 'why' the organisation exists. This is different from an organisational vision or mission statement which set out 'where' an organisation wants to go and 'how' it will get there. A purpose statement is something that can bind and unite people across the organisation towards a common goal. Our new purpose statement, '**To Support. To Serve. To Save'** will anchor us as we continue to transform and grow.

1.5. Integrated Medium-Term Plan

At an organisational level, the Integrated Medium-Term Plan (IMTP) sets out, on a three-year rolling basis, the prioritised actions that the Trust will take to move it towards its strategic objectives. The IMTP considers the national planning guidance issued by Welsh Government, the external environment in which the Trust operates including statutory requirements and commissioning intentions, the risks it is managing, as well as intelligence gathered from patients, staff, and volunteers.

In particular the Trust was required to articulate through the IMTP how it planned to deliver on the priorities set by the Minister for Health and Social Services in Wales and to contribute to the aims of the Six Goals Programme for Urgent and Emergency Care.

The Trust Board approved the IMTP for 2022/23 and submitted it to Welsh Government at the end of March 2022 and it was formally approved in July 2022. The Trust reviews its performance against the commitments within the IMTP both through tracking of actions and deliverables at the Strategic Transformation Board and analysis of key metrics within the Monthly Integrated Quality and Performance Report (MIQPR).

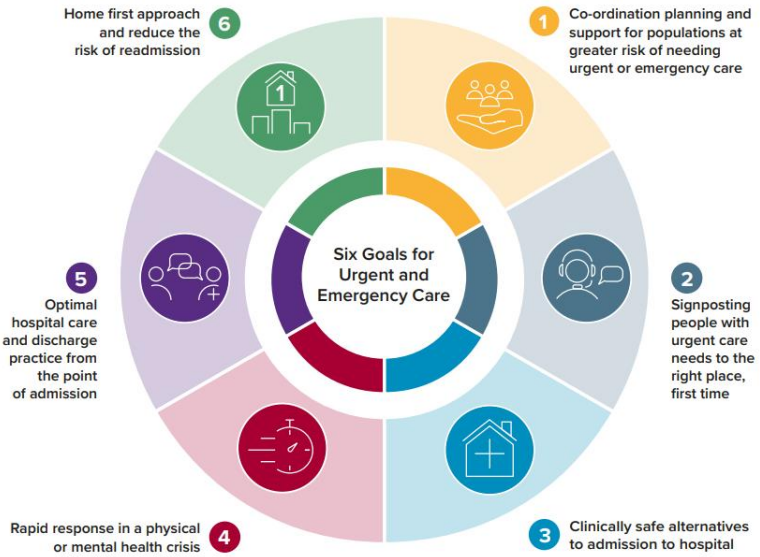
1.6. Performance Summary

The Trust has a Quality & Performance Management Framework, approved by its Board. A requirement of the Framework is to look at quality and performance in a balanced and consistent way. The Trust uses four lenses to do so: -

- Our Patients;
- Our People;
- Finance and Value; and
- Partnerships and System Contribution.

These four headings are used in the following sections to review the Trust's performance in 2022/23 and were based on Welsh Government's 'quadruple aims' for health and social care. The Trust Board receives an in-year Monthly Integrated Quality and Performance Report (MIQPR) every two months which provides the latest position on key performance indicators against these four headings. This top-level report is supported by a comprehensive range of more specific reports to each Board Committee and management teams.

A subsequent key development has been the publication of the Ministerial Six Goals for Urgent and Emergency Care, which sets out expectations for health, social care, independent and third sector partners for the delivery of the right care, in the right place first time for physical and mental health.

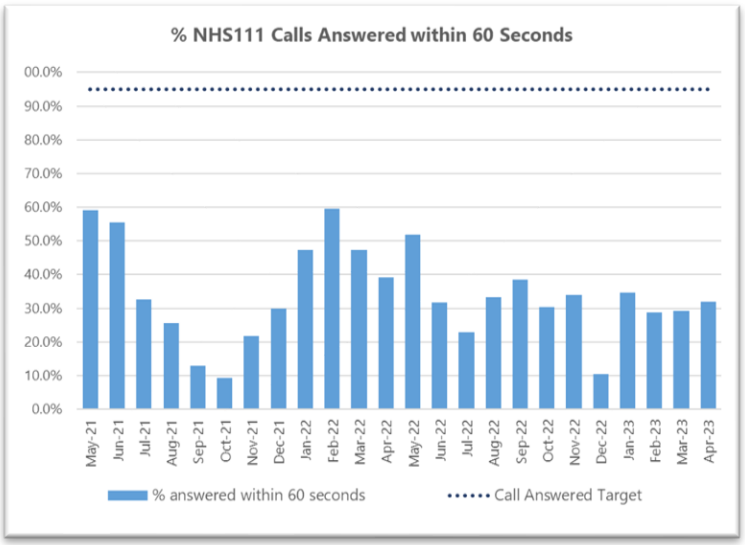


The following sections also denote which quality and performance indicators the Trust considers relevant to the Six Goals illustrated above.

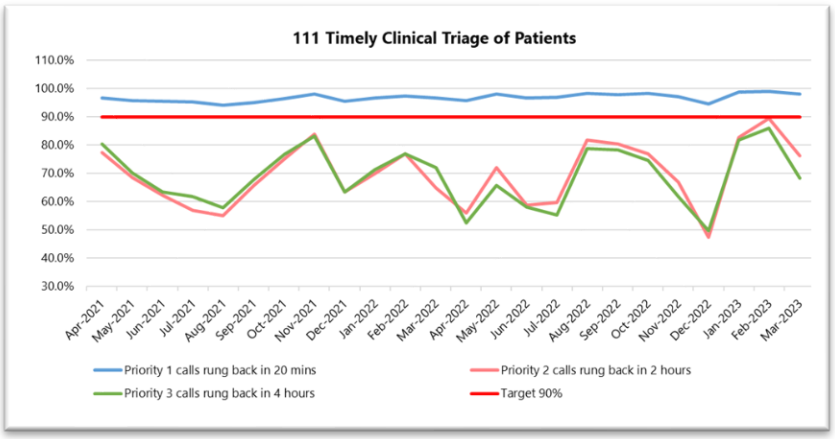
1.6.1 Our Patients – Quality, Safety and Patient Experience

NHS111 Wales Service

For many of the Trust's patients, the first point of contact with the Trust is the **111 service**, which is now live across every part of Wales. The total number of 111 calls offered in 2022/23 was just over one million compared to 890,000 in 2021/22. The Trust measures the quality of the service it provides through call answering times and clinical ring back times. Call answering times have been significantly below target throughout the year, with only 32% of calls answered within 60 seconds.



Significant spikes in demand through winter contributed to this position, and deeper analysis also shows that call answering times are worse at weekends, with insufficient staff available to meet the higher demand at these times. Commissioners agreed an uplift of call handler numbers in-year, and looking forward to 2023/24, a priority will be the re-rostering of available staff to align capacity with demand through the week.



In relation to clinical ring back for triage, the Trust consistently achieved the ring back target for the highest priority patients, but many other patients waited too long for a clinical ring back and assessment.

Note: contribution to Goal 2 (see page 6).

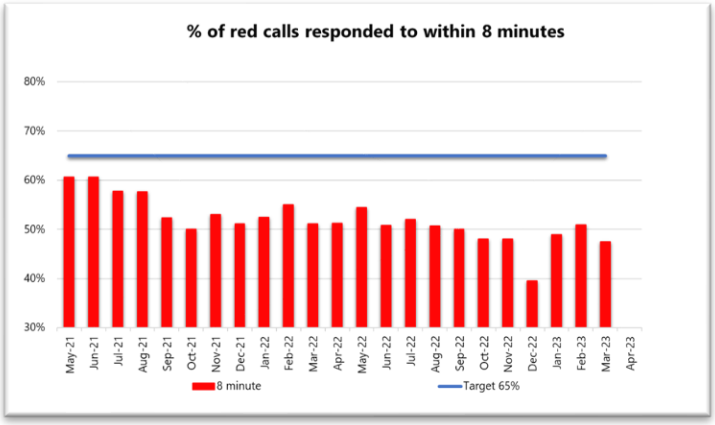
Actions through the year to improve this position included a focus on recruiting and retaining clinicians by supporting remote working and creating a new centre in Cardiff.

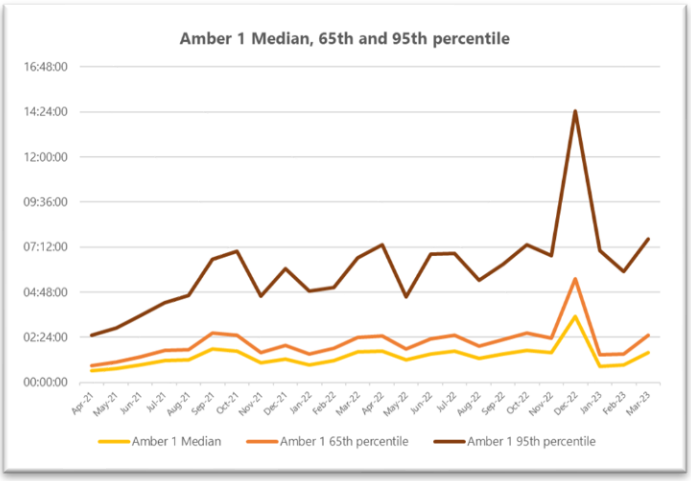
Emergency Medical Services (999 calls)

Within the Emergency Medical Service (EMS), despite the actions taken through the year, the ongoing system pressures and excessive hospital handover delays have led to extended call answering times and unacceptably long waiting times for an ambulance which in turn have contributed directly to avoidable patient harm.

Harm can occur to patients who have waited too long for a response in the community, to those who are waiting in the back of an ambulance waiting for offload into an emergency department, or to those who we cannot send an ambulance to at times of highest escalation. The Board received a detailed report at each of its meetings from July 2022 on actions being taken to reduce and mitigate this harm.

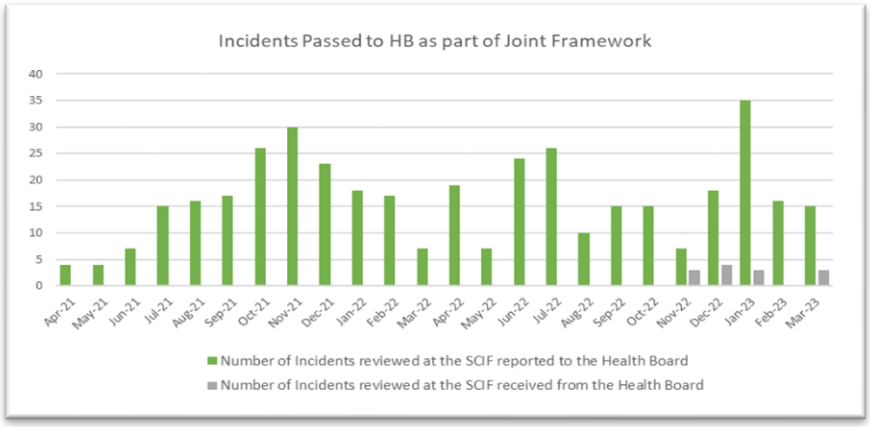
The Trust's target, as agreed with Welsh Government, is to respond to 65% of immediately life threatening 999 calls (Red calls) within eight minutes. The Trust has unfortunately seen no clear improvement in performance against this target.

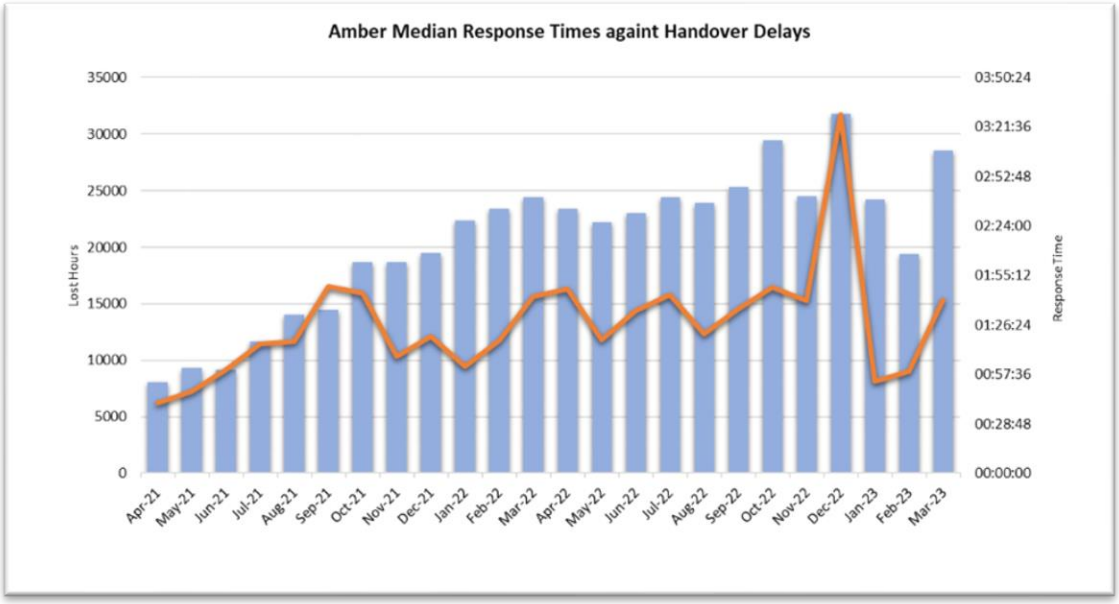




For patients in our Amber 1 category (serious but not immediately life threatening), there is no specific target set for response times, but with calls including those for stroke and cardiac arrest, the Trust would ideally want to respond on average within 18-20 minutes. The response times through this year have been far longer than this as the graph shows, with some patients waiting many hours and this directly impact on patient outcomes.

In relation to the most serious incidents, the Trust reported 66 patient National Reportable Incidents (NRIs) in 2022/23 compared with 65 in 2021/22. Most, but not all of these NRIs relate to the Trust's 999 service. Serious Incidents referred to Health Boards through the new Joint Investigation Framework increased slightly over the past year. These are often due to long waits in the community caused by handover delays at hospitals.

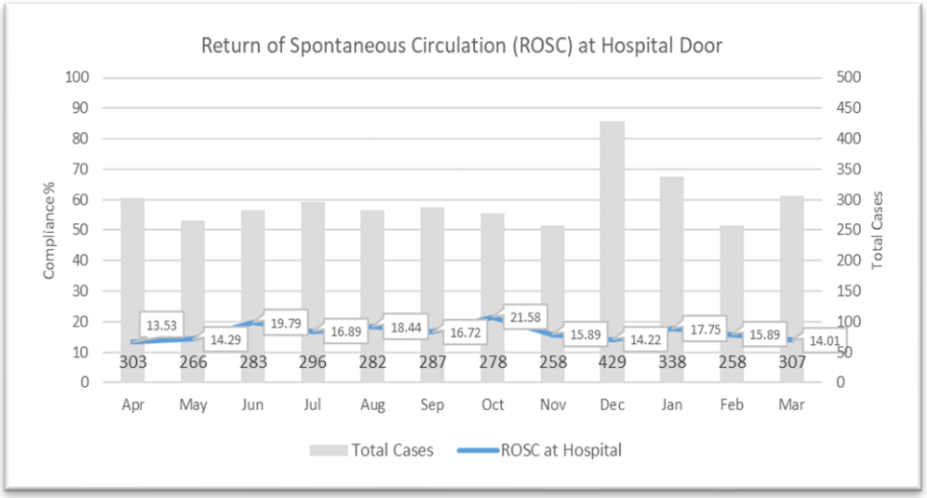




There are many reasons for longer response times, which include increases in Red call demand and overall acuity, as well as a loss of capacity through high levels of sickness absence and increased hospital handover delays. There is a clear correlation between the latter of these factors and higher response times.

Over the past year the Trust has undertaken a number of initiatives to positively impact upon response times and the quality of the service it provides, including recruiting 90 additional whole-time equivalent front-line staff; implementation of a new Cymru High Acuity Response Unit (CHARUs), re-rostering the whole service to better align capacity with demand and reducing hours lost to sickness through managing attendance programmes. Further actions are articulated through into 2023/24, but significantly improved performance will depend on handover delays reducing in line with ministerial expectations.

The Trust also measures and monitors five clinical indicators, these being Fractured Neck of Femur, Stroke, ST Elevation Myocardial Infarction (STEMI), Hypoglycaemia and Return of Spontaneous Circulation (ROSC). The introduction of the new Electronic Patient Care Record system (ePCR) towards the end of 2021/22 has meant that there are some issues with compliance in terms of completing clinical records and as a result, performance against the first four of these clinical indicators is showing a deterioration compared to previous years. Urgent improvement work and analysis is ongoing to allow the Trust to further develop and quality assure these key metrics.



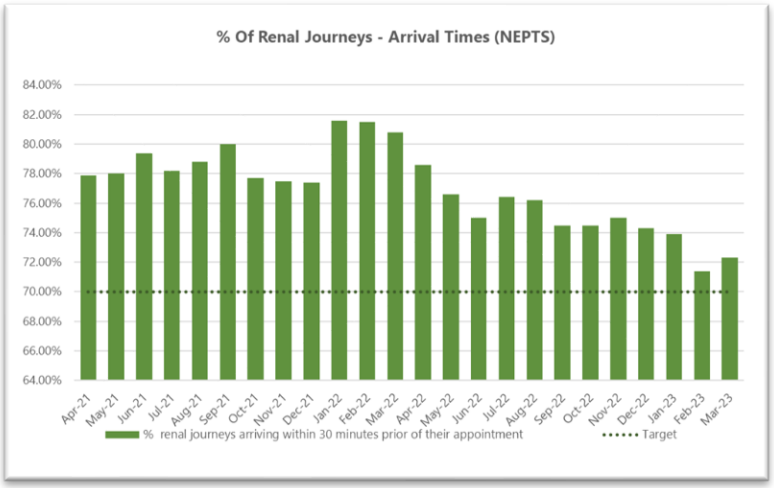
In relation to the percentage of patients who have return of spontaneous circulation, although performance in 2022/23 remains lower than the Trust would want at 16.58%, it is an improvement on the previous years.

Whilst there are many factors outside the Trust's direct control, the Cymru High Acuity Response Unit (CHARU) service has been introduced to directly impact on this metric. This service is aimed at providing a response to high acuity incidents by an experienced paramedic with additional medicines and training. They support clinical decision making, co-ordinate patient care and ensure clinical practice is in line with current best practice guidelines to improve overall outcomes.

Ambulance Care

In relation to the Trust's **Ambulance Care** service**,** which includes the Non-Emergency Transport Service, demand is still not quite back to pre-Covid-19 levels and uncertainty around demand remains as Health Boards move through system recovery following the pandemic. This is a high-volume service, with over 540,000 patient journeys across the year.

The quality of the service for patients is measured through metrics which consider whether patients are transported to and from their hospital appointments in a timely manner. Targets are met for most patients, although only 49% of oncology journeys are completed within the required timeframes. Patient survey data is positive.



Quality Management

The Trust has a 75% target for responding to patient concerns within 30 days. This has only been achieved once in the past two years and in 2022/23 the monthly average percentage was just 27%. Further review and improvement are planned into 2023/24 to provide patients with more timely responses.

The Trust received six Regulation 28 (Prevention of Future Deaths) reports during 2022/23. Five relate to timeliness of ambulance response, one relates to delay in transfer of patient from hospital to hospital for vascular surgery.

A multi-disciplinary panel meets regularly to review incidents to ensure appropriate investigations are undertaken. Joint investigations with health board colleagues are undertaken to ensure improvements cover the whole of the patient pathway. The Quality Governance arrangements are discussed in more detail in the Accountability Report, where the improvements that have been implemented following the Quality Governance Review are noted.

The Patient Experience and Community Involvement (PECI) team continues to engage with the public to listen, capture and report on their experiences of accessing and receiving care across all Trust services. The feedback captured and reported demonstrates how patient experience is a key indicator of the level of quality being provided and the need to improve patient experiences, patient safety, and patient outcomes.

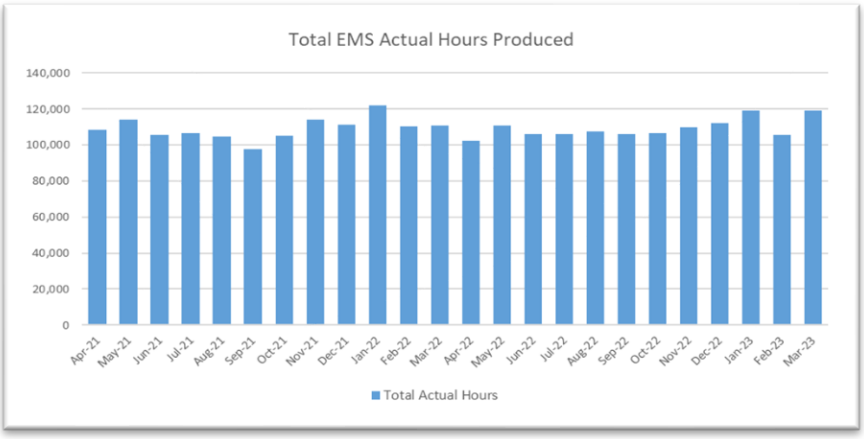
1.6.2 Our People

In relation to the Trust's workforce, the indicators reviewed at Board relate to whether the Trust has the right workforce capacity in place to meet demand, how the Trust is keeping staff safe and well, and how they are being developed. More detailed and numerous indicators are also considered at the People and Culture Committee.

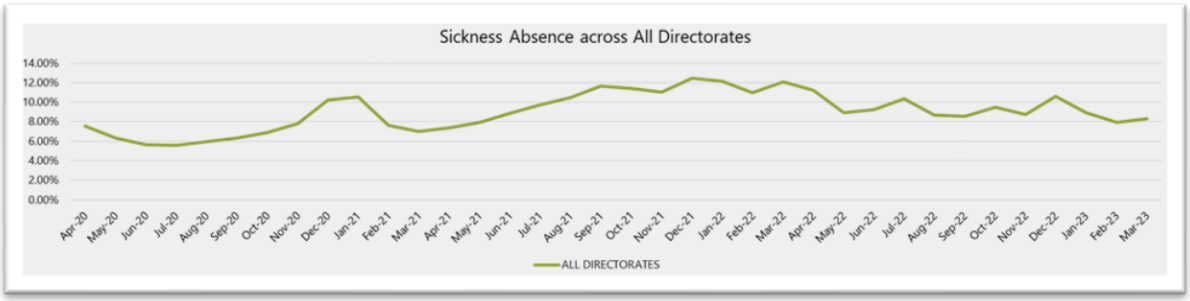
In relation to the Emergency Medical Service (EMS), additional funding provided by commissioners has allowed the Trust to significantly increase the number of front-line staff over the last 3 years. In 2022/23, funding for a further 100 WTE was secured, with 90 in post by the end of the year. The Trust is proud of its record on recruiting and training paramedics, technicians, and ambulance care assistants.

As part of its commitment to improving the efficiency of the service, the Trust undertook a major programme of re-rostering of its EMS staff, to align capacity with demand across the week. This programme completed in November 2022 and the performance improvement gained was equivalent to recruiting an additional 72 staff.

However, even with the additional staff in post, the total number of hours the Trust has been able to produce has not increased proportionately.



A key factor in the Trust's ability to ensure capacity to meet the demand is the impact of sickness absence. The significant impact of the last two years at all levels throughout the Trust cannot be underestimated. To support the workforce there has been an on-going focus on wellbeing activities across all areas of the Trust. Despite this, sickness has remained one of the key causes for rota abstraction, although the graph below shows that positive progress has been made over the last 12 months across the organisation as a result of a focused programme of work on managing attendance.

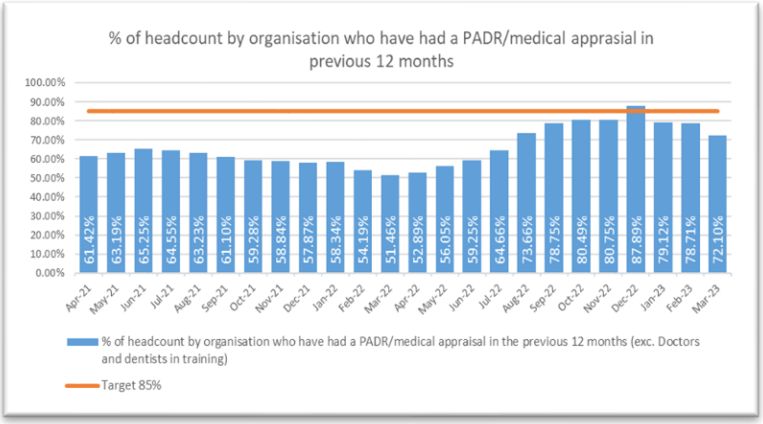


Similar pictures were also seen in 111 and Ambulance Care, and this will remain a major area of focus over the coming year in order to move towards a 6% sickness absence target in 2023/24.

Other indicators of how the Trust is keeping its staff safe and well include vaccination rates and statutory/mandatory training levels. We saw that 94% of frontline staff received a Covid-19 booster vaccine; 94% are double jabbed, and 35% have received the SPIKEVAX booster. The flu vaccination level was 44.5%, this surpassed the 38.5% figure seen the previous year.

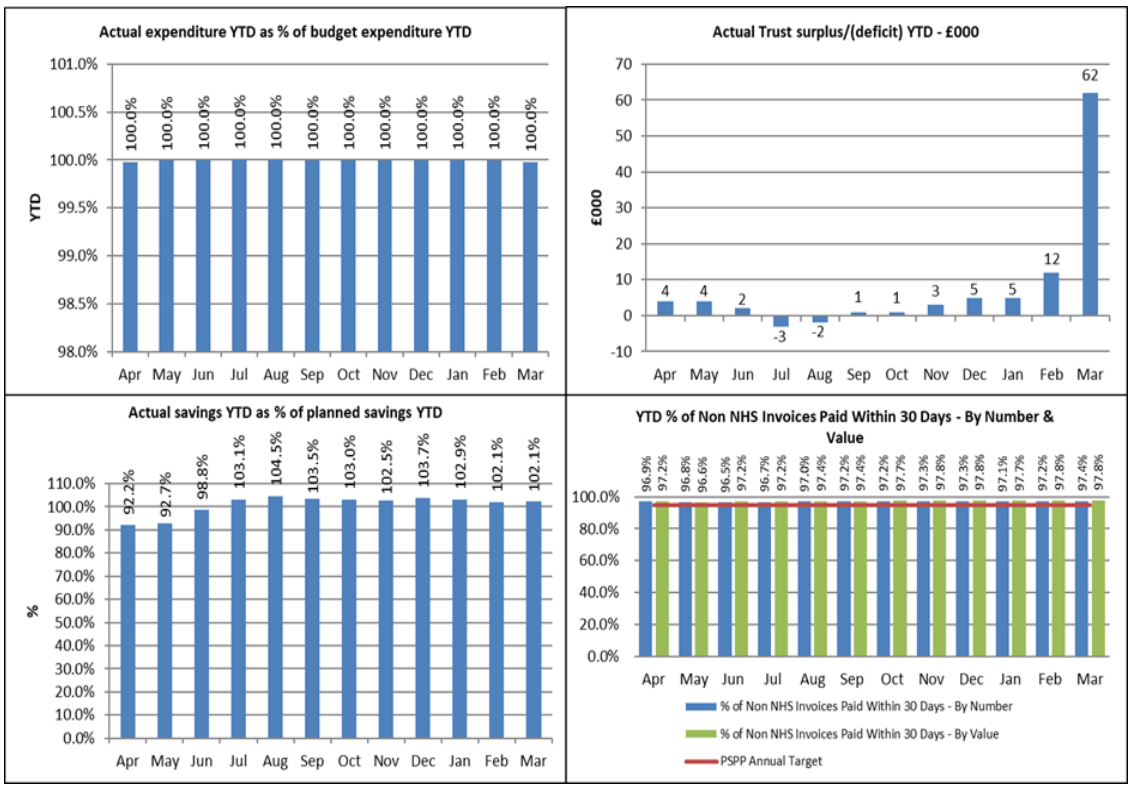
Statutory & Mandatory Training rates during 2022/23 did not achieve the 85% target overall, with the completed level at 80.71% for the year. However, the 85% compliance rate was achieved between May and November 2022.

In terms of staff development, the Trust views levels of Personal Appraisal and Development Reviews (PADRs) as the best way of representing development at a high level. Compliance rates generally improved, with December 2022 seeing the compliance rate go above the 85% target for the first time.



1.6.3 Finance and Value

The Trust reviews a number of indicators which aim to demonstrate how it provides a service in line with statutory financial duties, and of high value and efficiency. The Trust met its statutory duty to breakeven with a small revenue surplus of £62k.



Gross savings of £4.392m were achieved against a target of £4.300m, thus a slight over achievement. Public Sector Payment Policy was on track with performance of 97.5% for the number, and 97.8% of the value of non-NHS invoices paid within 30 days (target 95%). Further information can be found in the Trust's annual accounts and financial statements, which have been prepared on a going concern basis.

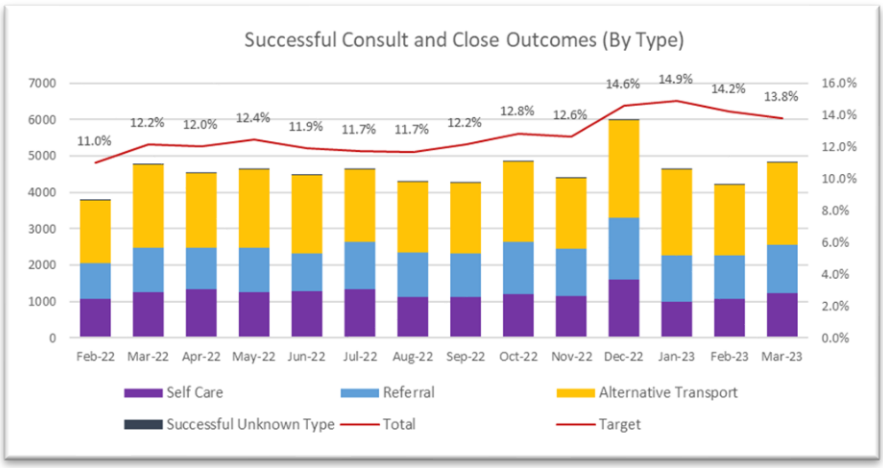
Following a sustained pandemic response and rising inflation, the financial outlook for 2023/24 and beyond is challenging. The Financial Sustainability Programme, which commenced in early 2022/23, is a key programme of work which will drive transformation to achieve cost efficiencies as well as exploring opportunities for income generation for 2023/24 and beyond.

1.6.4 Partnerships and Systems Contributions

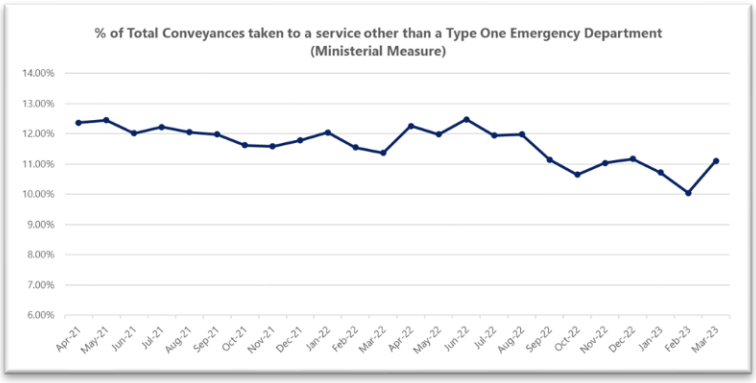
The Trust aims to consider both its impact on the wider system, but also the wider system's impact on its service.

Handover lost hours consistently increased throughout 2021 and 2022, reaching a peak in December 2022 of 32,000 hours lost. This equated to 64,000 people hours or just over 5,300 twelve-hour shifts, which meant the Trust could have responded to over 10,000 more patients during December if handovers were reduced.

There has been strong messaging from Welsh Government and the Minister for Health and Social Services that this issue must be tackled as a matter of priority. Integrated Commissioning Action Plan (ICAP) meetings were set up in 2022/23 for individual Health Boards and the Trust to work collaboratively to reduce handover hours, and these will continue throughout the coming year.

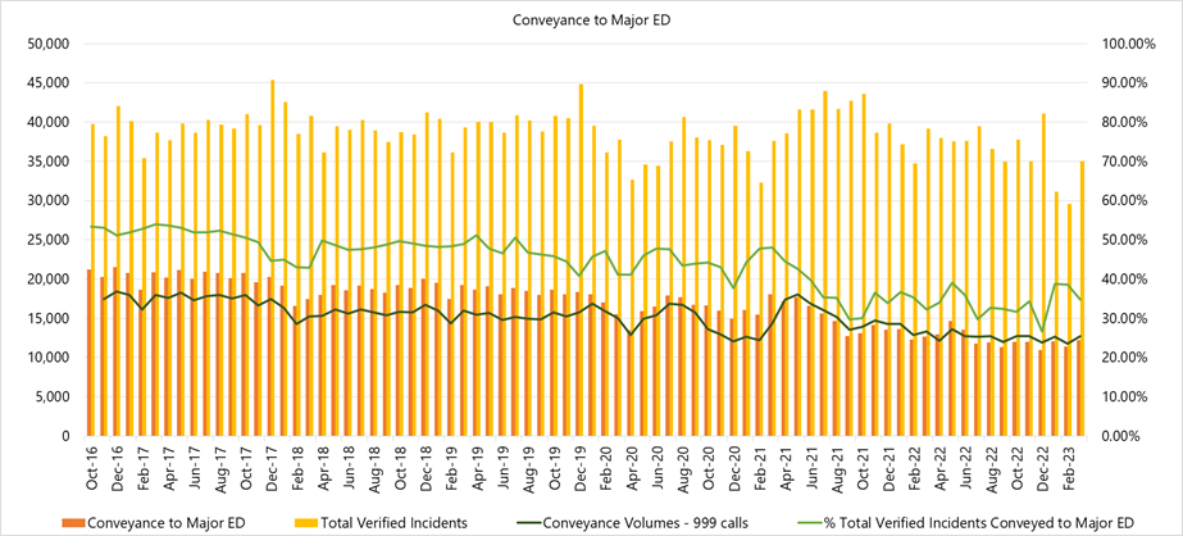


The Trust is committed to transforming its services, getting patients the right care, in the right place, every time, and to reduce the reliance on emergency departments as the default location. The Trust supports the system in reducing demand through the work of the remote clinicians in the Clinical Support Desk (CSD). Following an expansion of the CSD in 2021/22, the Trust set a target for 15% of 999 calls to be managed remotely without the need for an ambulance to be dispatched. This figure has yet to be achieved in any single month, although it did rise to 14.9% in January 2023. A target of 17% has been set for 2023/24.



The Trust is also looking to treat more patients on scene and to convey more patients to appropriate alternatives to emergency departments s. Performance in these areas has not improved, including against the Ministerial measure. The Trust worked hard with Health Board colleagues to agree a national paramedic referral protocol into the newly established Same Day Emergency Care centres; a priority for the national Six Goals programme. Modelling has been completed which shows that around 4% of activity could safely be conveyed to these services. To date, less than 1% has been referred and actions will continue into 2023/24 to maximise the potential of SDECs across Wales.

The overall impact of the Trust's focus on looking to treat patients through consult & close, see & treat and pathways where it is clinically safe and appropriate to do so, and avoid conveyance to emergency departments, is shown in the following graph. The Trust conveyed 34% of its verified patient demand.



Note: contribution to Goal 1, Goal 3, and Goal 4 (see page 6).

As another key component of its long-term strategy, more paramedics than ever before were supported in 2022/23 to undertake further education to become advanced paramedic practitioners (APPs), with evidence showing that the additional knowledge and skills reduce rates of conveyance to hospital. These additional APPs will become operational in 2023/24.

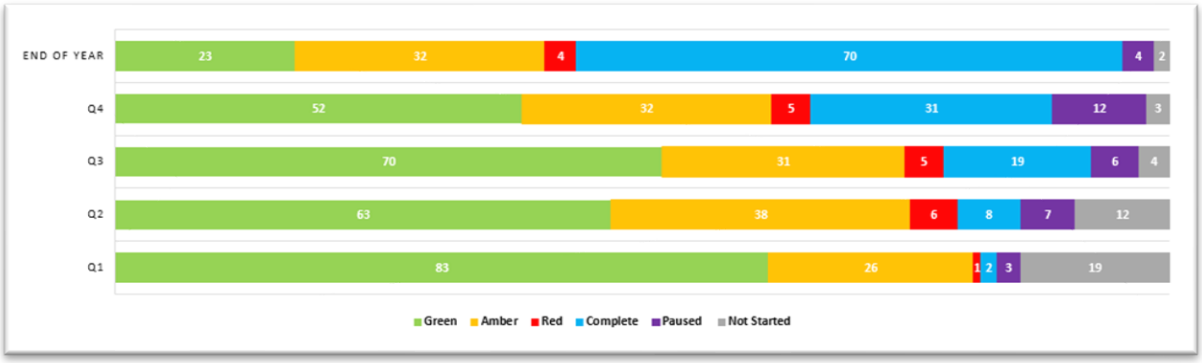
This year has seen a number of significant developments in the formal partnership landscape, which will have a bearing on the Trust as it moves forward. One of the most significant has been Welsh Government's consultation on plans for the Trust, along with a number of other additional bodies, to come under the auspices of the Well-being of Future Generations (Wales) Act 2015. This opportunity has been welcomed by the Trust and while the results of the consultation are not yet known, the Trust is working on the basis that, in future, it will be covered by the legislation.

Over the last seven years, the Trust has worked hard to secure representation on four of the seven Regional Partnership Boards (RPB). The RPBs have evolved over the years and are now seen as a key delivery vehicle for the integration of health and care services, with access to funding to support this important work from Regional Investment Funds. Welsh Government is likely to be consulting in 2023/24 on adding organisations, including the Trust, to the list of statutory partners entitled to sit on RPBs, which could result in future Trust representation on all seven Regional Partnership Boards in Wales.

The Trust has refreshed its engagement framework and delivery plan. The framework and plan focus on working with stakeholders and the public on new solutions for the Trust as an ambulance service, while making a positive impact on the wider health and care system. A programme of positive engagement with our stakeholders, patients and the public will commence in 2023/24 on how the Trust can ensure its services better meet the needs of the people it serves going forward.

1.6.5 Integrated Medium-Term Plan (IMTP) Delivery

The IMTP is delivered through its core services transformation programmes and enabling workstreams which report to the Strategic Transformation Board (STB).



Good progress was made in all areas, including in areas such as digital, estates and fleet. The graph above sets out the progress through the year in terms of completion of the deliverables in the IMTP, with over half of the actions completed and only four actions rated as red.

The infographic below gives some examples of work completed through the year.

1.6.6 Managing Risk

A number of risks to delivery were identified at the start of the year and were set out in the IMTP. The table below draws out how the Trust managed and mitigated these risks.

Risk	Mitigating actions
A confirmed commitment from EASC and / or Welsh Government is required in relation to funding for recurrent costs of Commissioning	Additional revenue funding was secured from commissioners for both 999 and 111 services as a result of cases being made. Capital resources remained lower than required
Maintaining effective and strong Trade Union Partnerships	New partnership working arrangements were agreed and implemented through the year. ACAS supported discussions at the start of the year.

Ongoing impacts of Covid-19 recovery both internally within WAST and as the Health Boards recover their activity (risk now closed);	Pandemic structures continued at the start of the year. These effectively managed the response and recovery phases of the pandemic and were stood down once a series of detailed criteria were met.
Prioritisation or availability of resources to deliver the Trust's IMTP	Capacity remained an issue through the year, particularly as a result of Industrial Action in Quarter four. The Trust undertook a prioritisation exercise in January and identified the most important areas of work, with other programmes paused or slowed down.
Significant handover delays outside emergency departments impacts on access to definitive care being delayed and affects the Trust's ability to provide a safe and effective service	Handover delays have increased. This has been discussed at every Board meeting and has been escalated to Commissioners, Welsh Government officials and the Minister. Targets have been set by the Minister for improvements, but improvements remain outside of the Trust's direct control.
Deterioration of staff health and wellbeing as a consequence of both internal and external system pressures	A range of actions have been taken through the Managing Attendance programme to support people to remain in work. Reports have been received fortnightly into the Executive Team and improvements have been made in performance.
Potential impact on services as a result of industrial action	Formal structures were put in place to manage and oversee the Trust's response to the Industrial Action. The Trust has ensured that it has respected the right of staff to take action whilst taking action to deliver a safe service for patients.

There is further narrative on the Trust's capacity to handle risk in Section D of the Annual Governance Statement where the Trust's risk profile, Corporate Risk Register as at the 31 March 2023, and other related narrative has been included.

DELIVERY AND PERFORMANCE ANALYSIS

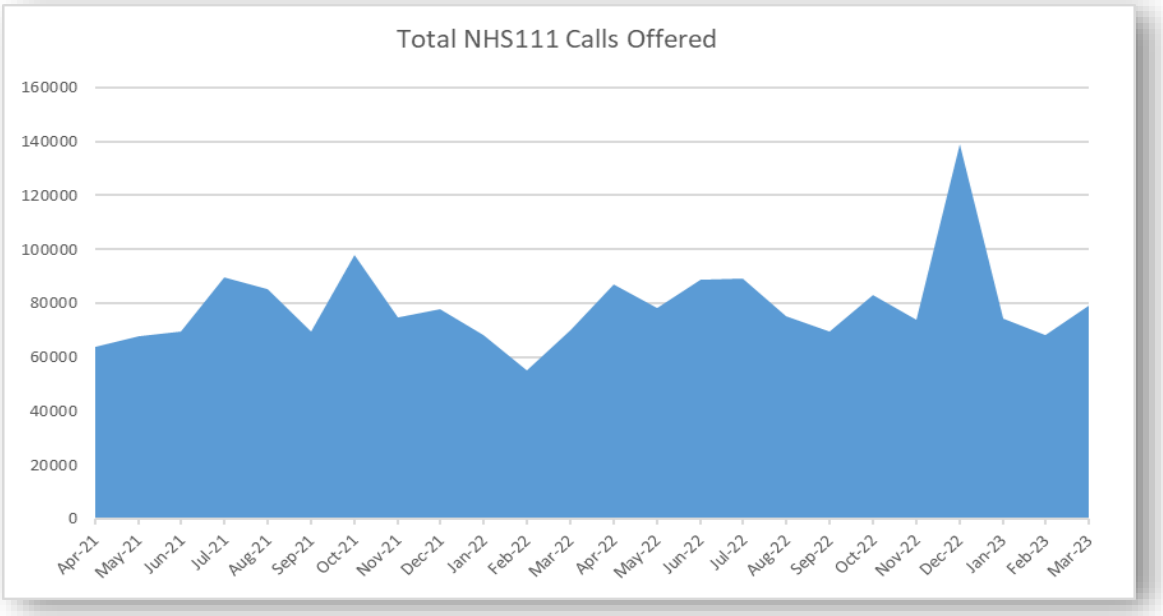
The Delivery and Performance Analysis section provides commentary on the Trust's key performance measures and a more detailed integrated performance analysis of the Trust's service delivery.

1.7. Our Patients (Quality, Safety and Patient Experience)

Call Answering

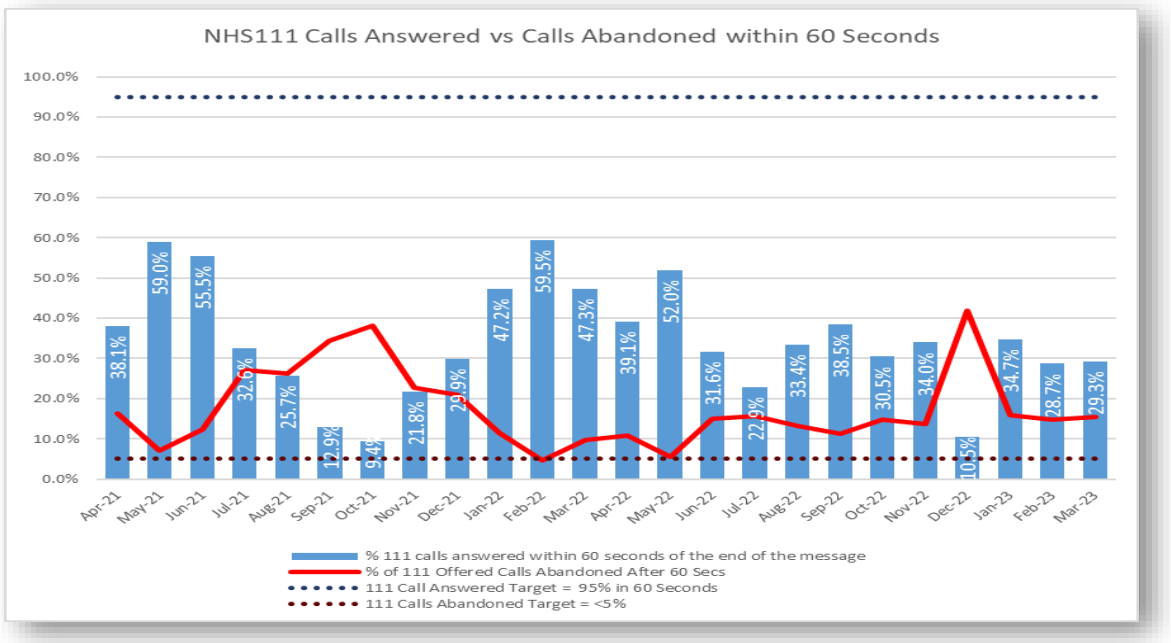
Patients have not been receiving the timeliness of service they require, and patient safety has been compromised by a difficult operating environment across the urgent and emergency care system in Wales, particularly throughout the latter part of 2022, culminating with unprecedented figures being experienced in December 2022.

For many of the Trust's patients, the first point of contact with the Trust is the **111 service**. The 111 number and the full 111 service is now live across every part of Wales and has been since early 2022, which has contributed to a continued increase in the number of calls received into the service. The total number of 111 calls offered in 2022/23 was 1,005,255 compared to 889,231 in 2021/22.

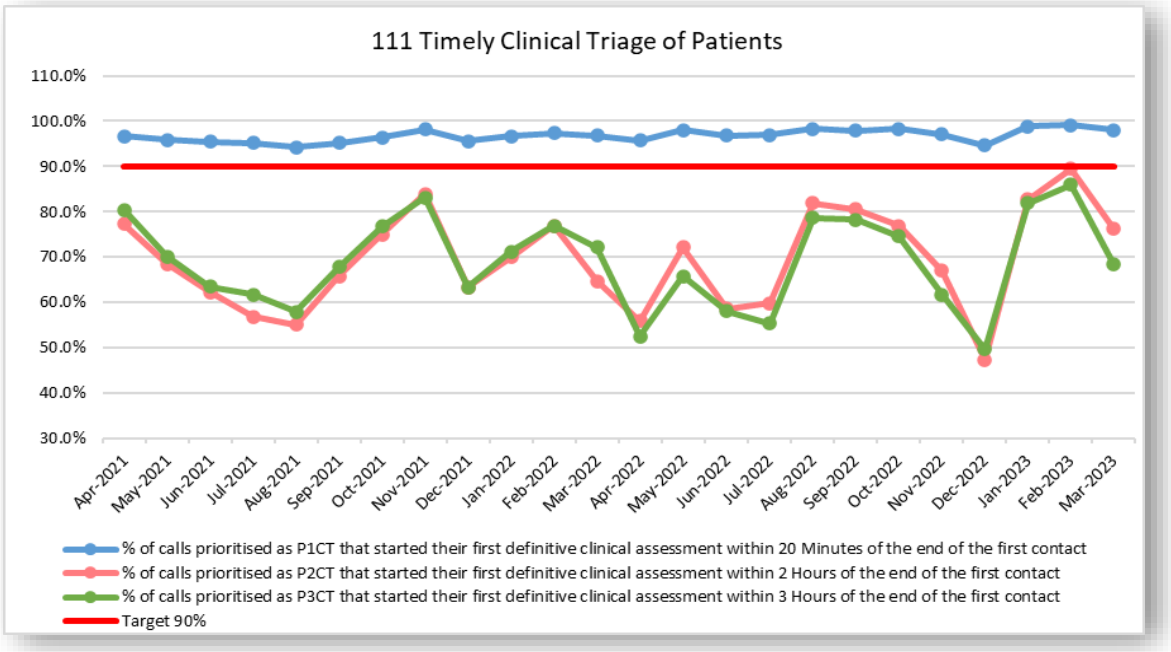


In the **111 service**, the Trust measures the quality of the service it provides through call answering times and clinical ring back times. The Trust aims to answer 95% of calls within 60 seconds and to have an abandonment rate of less than 5%, but the graph below demonstrates that the service has been significantly off target during 2022/23. Over the course of the year, an average of 32.1% of 111 calls were answered within 60 seconds and 15.7% of calls were abandoned after 60 seconds.

Although there has been an uplift in call handler numbers during 2022/23, the vacancy rate as of the end of February 2023 was still 12.5 WTEs below the commissioned level. However, it has been recognised that call answering times will only be improved through increased efficiency in other areas such as reducing sickness absence, re-rostering to ensure capacity is aligned to demand, and reducing the time required for the Clinical Advice Line.



In relation to clinical ring back for triage, the Trust consistently achieved the one-hour target of 90% for highest priority patients (Priority 1 Clinical Triage – P1CT), averaging 97.5% during 2022/23. However, it did not achieve the 90% target for either of the other patient acuity categories, with 70.7% of patients prioritised as Priority 2 Clinical Triage (P2CT) receiving a clinical ring back within two hours of the end of the first contact and 67.5% of patients prioritised as Priority 3 Clinical Triage (P3CT) receiving a clinical ring back within 3 hours of the end of the first contact.

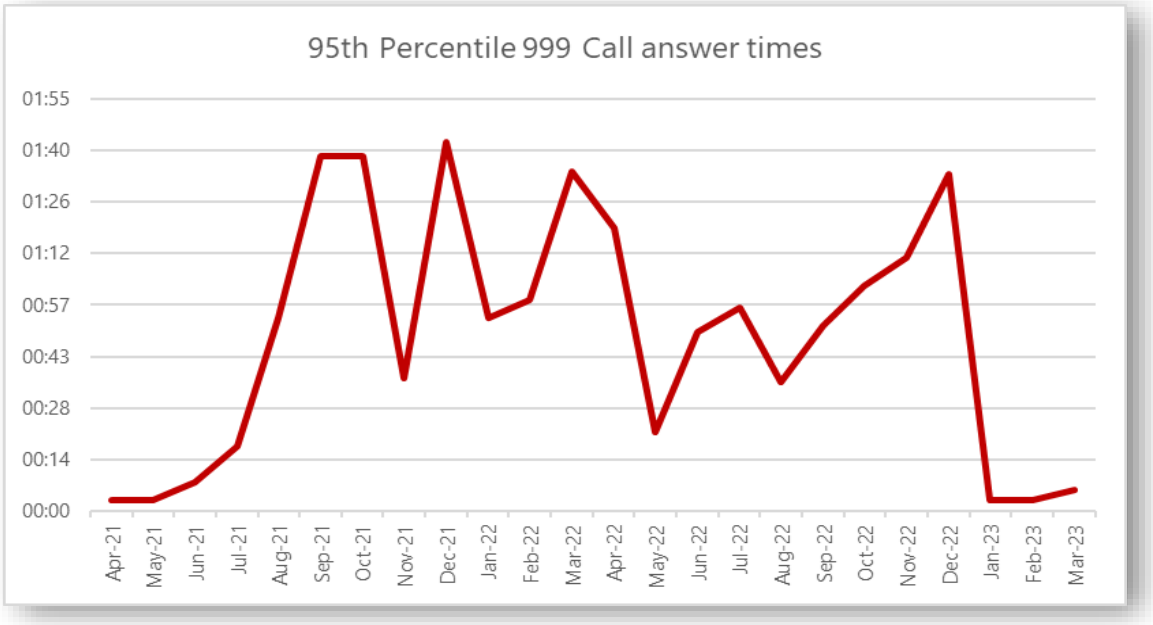


Note: contribution to Goal 2.

Patients have provided feedback on long wait times and there is potential for these waits to have a knock-on effect on both 999 and the rest of the urgent and emergency care system. The Trust is acutely aware that improved performance in this area is closely linked to having the correct number of clinicians in post to meet the current and expected demand. To this end urgent actions have been put in place towards the end of 2022/23 to increase the number of clinicians available, including a targeted recruitment drive and looking to maximise opportunities through remote or agile working.

One of the key factors influencing response times is demand. 111 demand has increased significantly over the past two years, which can be attributed to the service going live across Wales, alongside government announcements and media stories relating to the pandemic and other recognised illnesses, which have the effect of creating spikes in demand levels. There is also an increasing use of the service which is now seen as the 'Gateway to Care' across the system.

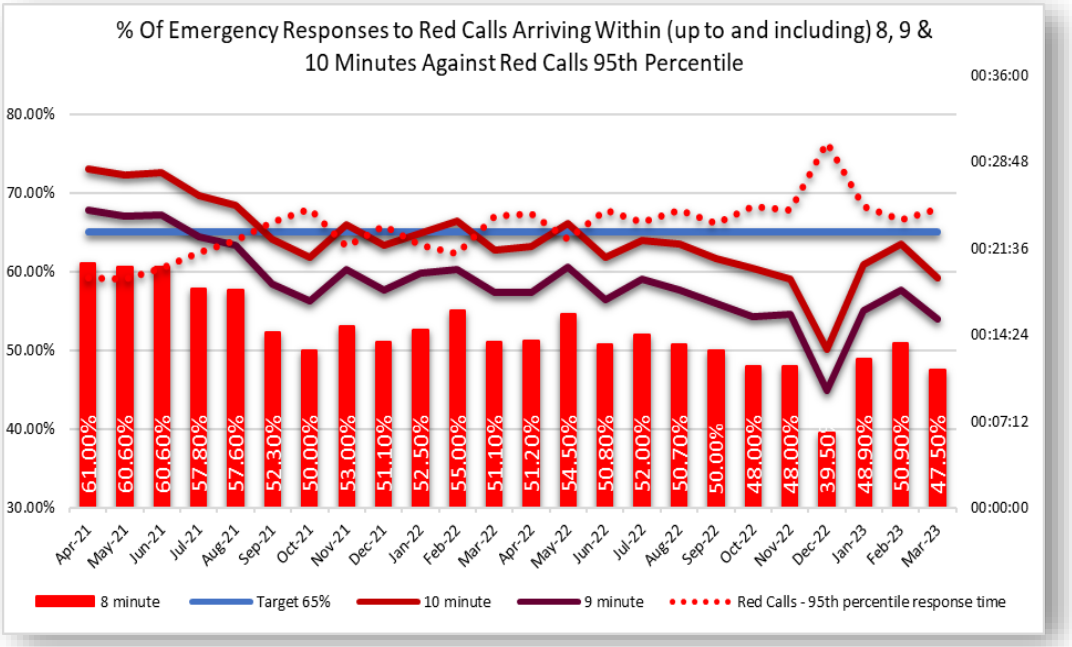
Within the 999 service, the Trust assesses the quality of the service it provides through a range of response time metrics, clinical indicators, and outcome measures. Call answering performance steadily worsened during the latter part of 2022, with the 95th percentile of calls increasing to one minute 34 seconds in December 2022 (which was exacerbated by the UK-wide Intelligent Routing Platform that saw additional demand answered in Wales originally destined for English ambulance services). However, since that time it has seen significant improvement, with the metric returning to just three seconds during the early months of 2023. No additional funding was available during the year to increase call handler numbers. Increased pressures and some high levels of 999 demand impacted upon staff attrition and wellbeing. The EMS Coordination team meet regularly to review demand and align staffing levels appropriately in order to alleviate pressure at times of high demand and provide the best possible service.



The NEPTS call taking function continues to improve and has been routinely operating at a high standard during the latter half of 2022/23. Some pressure points remain during certain times of the day, where demand can exceed capacity, however a roster review is due to be completed in first half of 2023/24 which is aimed at minimising this issue.

Response Times

The headline patient metric for the Trust is Red 8 performance; this is the percentage of Red – immediately life threatening – incidents responded to within eight minutes. The Trust has unfortunately seen no clear improvement in performance against the Red eight-minute target over the past year, with a further deterioration evident between October and December 2022; together with lengthening response times for its Amber calls, which includes strokes and heart attacks. The Trust knows that the bulk of patient safety incidents occur in the Amber category and that these long response times directly impact on patient outcomes.

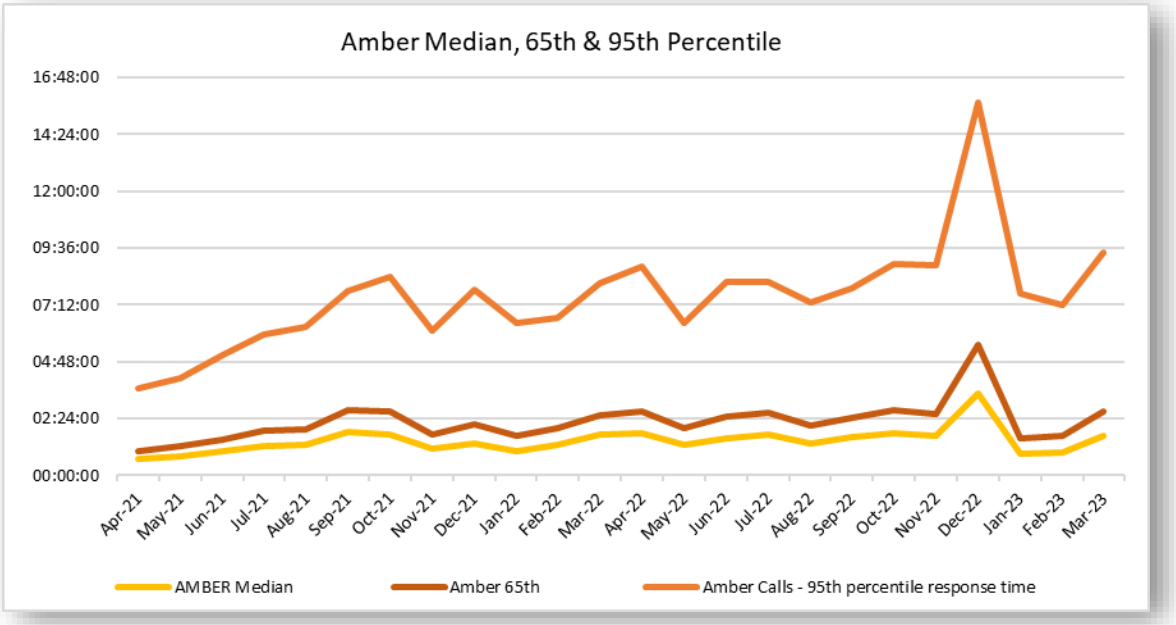


Note: contribution to Goal 4

The Trust believes strongly that this is one of the greatest clinical risks that the system faces, and that it needs to collaboratively and urgently address this so that patients are not left alone for hours in the community with no clinical assessment or treatment. Although resources have been increased alongside continuing initiatives to help mitigate these risks, potential gains have been offset by other factors, such as high levels of staff abstractions and increasing hours lost to hospital handovers.

The Trust did not achieve the Red 8-minute Welsh Government monthly target of 65%, throughout the whole of 2022/23, with the highest rate of 54.5% being achieved in May 2022. This was also the only month which saw over 65% of incidents being responded to in under 10 minutes.

During 2022/23, the Trust's median Amber performance was one hour and 38 minutes, an increase from the one hour and 16 minutes recorded the previous year. The year also saw the 65th percentile increase to two hours and 35 minutes and the 95th percentile to eight hours and 42 minutes.



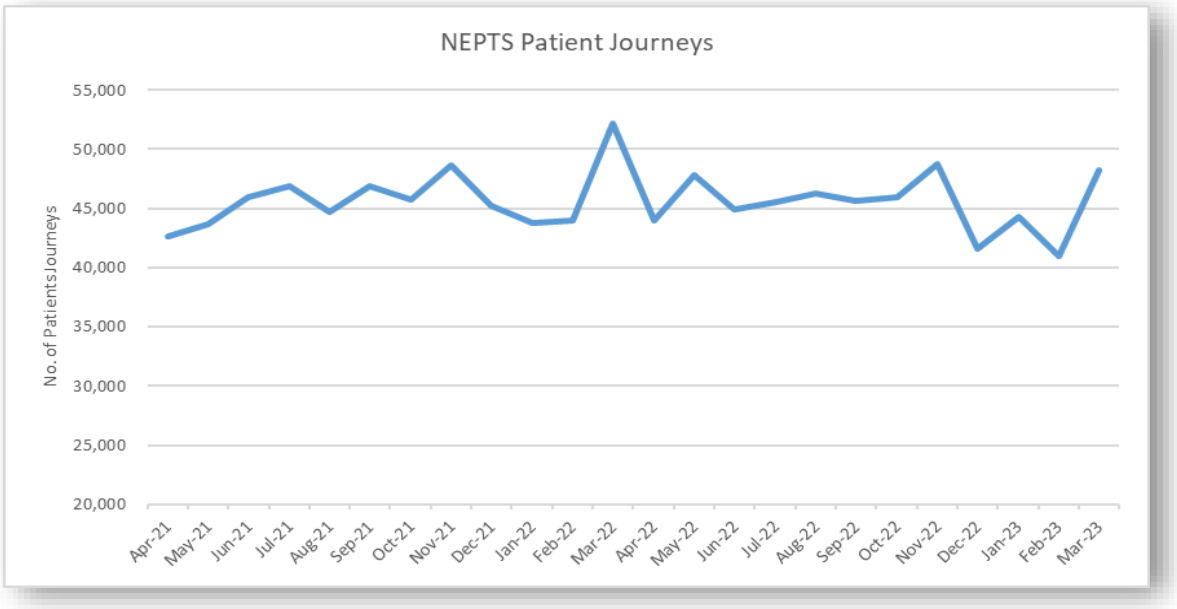
As alluded to there are many reasons for longer response times, which include increases in Red demand and overall acuity, as well as a loss of capacity through high levels of sickness absence and increased hospital handover delays. It has been identified there is a clear correlation between the latter of these factors and higher Red response times.

Over the past year the Trust has undertaken a number of initiatives to positively impact upon response times and the service it provides, including recruiting 90 WTE Emergency Medical Technicians and Ambulance Care Assistant 2s (with a budget for an extra 100 i.e., 10 more); the full roll out of the Cymru High Acuity Response Unit and reducing hours lost to sickness through managing attendance programmes.

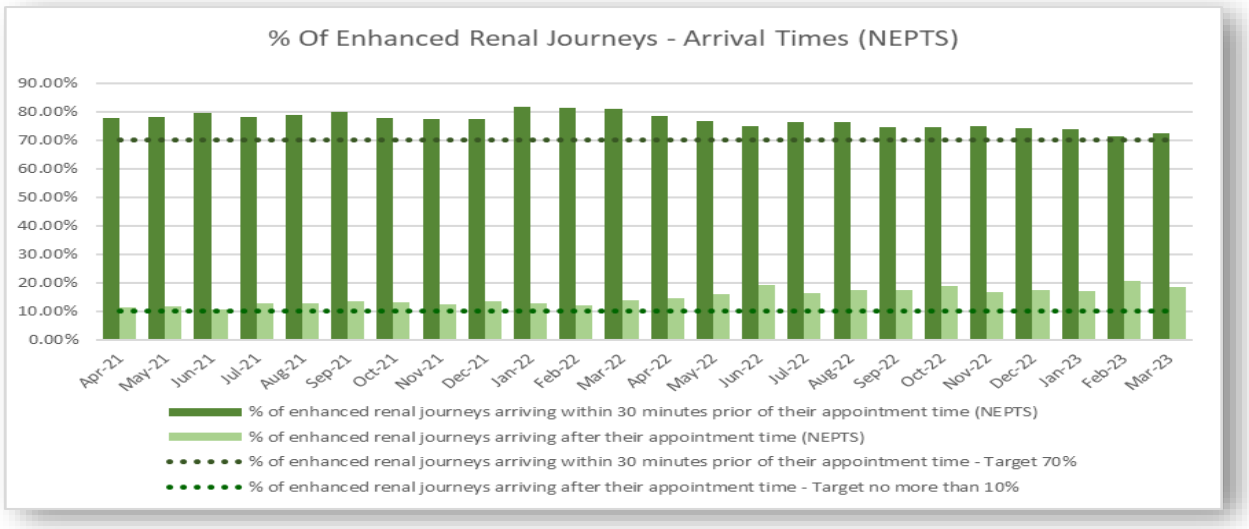
In relation to the Trust's **Ambulance Care**, demand has been increasing throughout the year, but overall is still not quite back to pre-Covid levels, and uncertainty around demand remains as Health Boards move through system recovery following the pandemic. With the addition of austerity, it means performance in this area is difficult to forecast. Whilst renal and oncology demand has been relatively stable, outpatient demand is down, and discharge and transfer variable.

The Trust continues to work closely with the Health Boards through the commissioning Delivery Assurance Group to deliver the best possible performance for the patient; however, it is likely the service will experience on-going fluctuations in performance until activity begins to normalise once again, at which point the Trust anticipates that further increases in demand could be experienced. Although this could cause issues in capacity, this has been modelled and mitigations have been put in place.

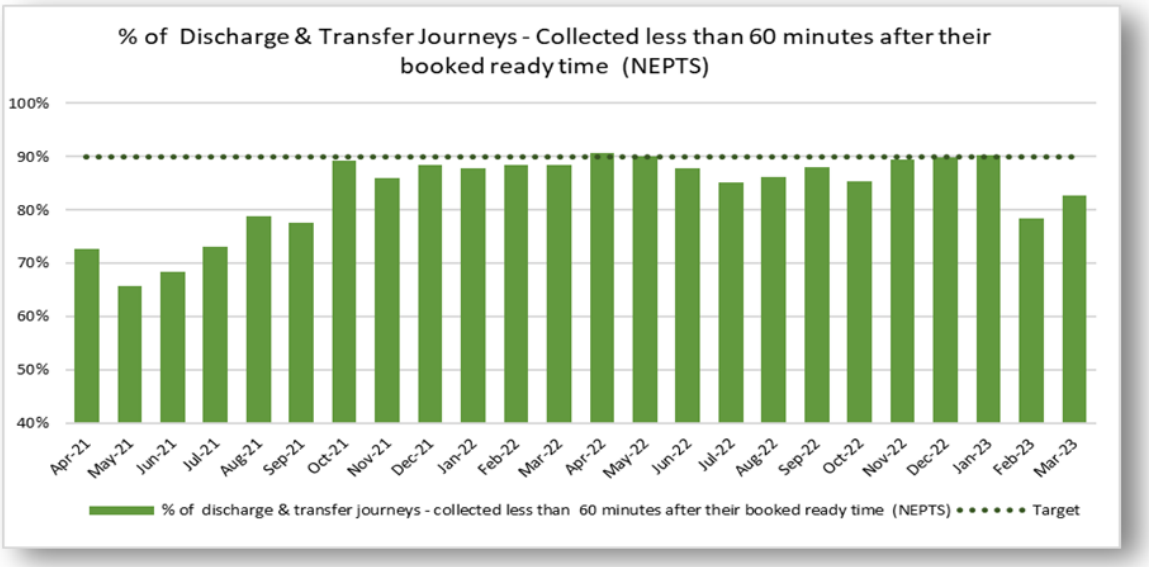
The total number of non-emergency patient journeys undertaken in 2022/23 was 543,840, which while being a further increase on the 497,570 seen in 2021/22, is still significantly below the 670,353 recorded for 2019/20.



The quality of the service is measured through the various arrival/collection time indicators and has been more stable in some areas, with in-bound renal patients arriving within 30 minutes prior of their appointment being 74.9% for 2022/23 and achieving the 70% target in every month. Renal journeys arriving after their appointment time did slip slightly to 17.5% for the year, compared to 12.6% in 2021/22, with the target for this indicator being not greater than 10%. However, this performance was particularly affected towards the end of 2022/23 when other factors influenced capacity and the ability to meet demand, such as the numerous days of industrial action that took place and the updating of the NEPTS Computer Aided Dispatch system.



Discharge and transfer journeys also failed to achieve the 90% target of journeys collected less than 60 minutes after their booked ready time, with the figure for the year being 87%. However, the target was achieved in five of the 12 months with others being affected by the same reasons mentioned above, such as industrial action days.



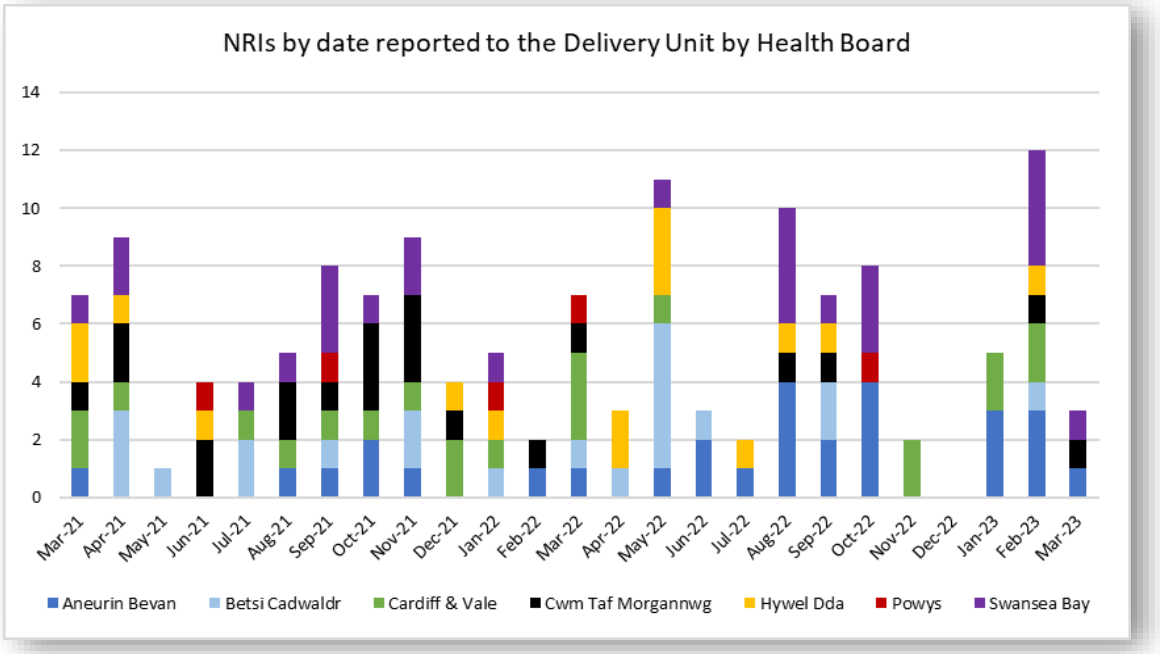
Note: contribution to Goal 5

Oncology performance remains off target with 49.1% of inbound oncology journeys arriving within 30 minutes prior to their appointment time. This is recognised as an area of difficulty within the NEPTS Demand and Capacity Review, which has been considered by the Ambulance Care Transformation Programme. A revised metric is being introduced which provides improved information on the patient experience.

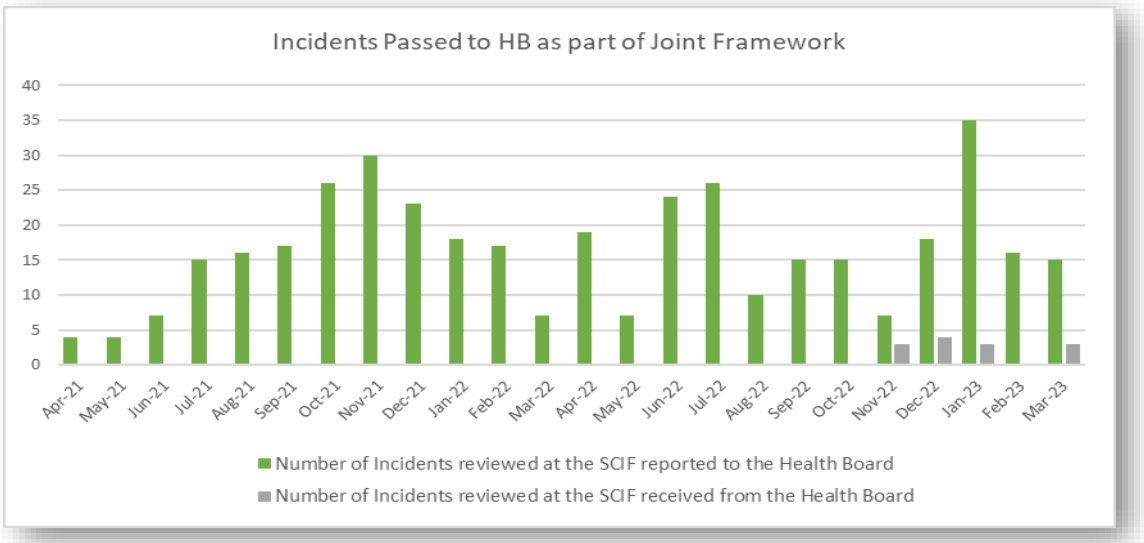
Safety

The Trust actively encourages a positive safety culture and sees all incidents/events as an opportunity for learning and improvement. There were 5,346 patient safety incidents, near misses and hazards reported in 2022/23, compared to 4,374 in 2021/22.

The Trust is seeing higher levels of National Reportable Incidents (NRIs); and of serious incidents referred to Health Boards for them to investigate. There were 66 patient NRIs in 2022/23 compared with 65 in 2021/22 and 56 in 2020/21. It is recognised this figure is too high, but that it reflects the pressures that are evident within the health care system. Most, but not all of these NRIs relate to the Trust's 999 service.



Incidents referred to Health Boards have increased slightly over the past year, rising from 184 in 2021/22 to 207 in 2022/23. These are often due to long waits in the community caused by handover delays at hospitals. The length of time patients were waiting in the community has increased over the past year. In 2022/23, there were 10,045 patient waits of 12 hours or over, compared to 5,939 in 2021/22, which in itself was a large increase from the 1,850 recorded in 2020/21.



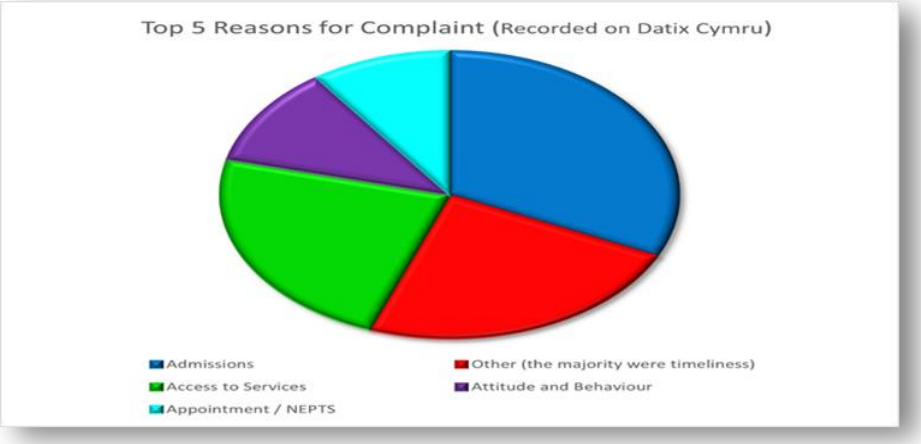
The Trust has a 75% target for responding to patient concerns within 30 days. This has only been achieved once in the past two years (76% in March 2022). In 2022/23 the monthly average percentage in this area was just 27%, although this is against a backdrop of the number of concerns being reported increasing. There were 1161 concerns received in 2022/23 compared to 983 in 2021/22, and 725 in 2020/21.

The Trust moved to the Once for Wales Concerns Management System in May 2022. Nationally a suite of feedback codes has been developed which have recently been implemented pan NHS Wales, enabling improved analysis of concerns at organisation level and nationally.

A number of the concerns received during 2022/23 have been categorised under the 'other' code. On review the majority of these relate to our timeliness to respond to patients in the community. The Trust continues to work with its commissioners and system partners to improve our response times.

A breakdown is provided below of the top five concerns: - 57 cases were referred to the Public Service Ombudsman Wales (PSOW) during 2022/2023 and 15 cases remain currently open as follows. The majority of the issues raised with the PSOW relate to timeliness of ambulance response.

- Fourteen cases are with the PSOW's office for consideration and/or investigation;
- One case the Final Report has been received providing recommendations.



The Trust received six Regulation 28 (Prevention of Future Deaths) reports during 2022/23. Five relate to timeliness of ambulance response, one relates to delay in transfer of patient from hospital to hospital for vascular surgery.

A multi-disciplinary panel is in place that meets on a twice weekly basis to review and discuss incidents to ensure appropriate investigations are undertaken. The Trust frequently undertakes joint investigations with health board colleagues to ensure the investigation and subsequent learning and improvements cover the whole of the patient pathway.

Learning and improving from incidents/events is discussed in the Patient Safety and Experience Monitoring and Learning Group with oversight from the Quality, Patient Experience and Safety Committee, which is a Committee of the Trust Board. Some examples of learning and improvements include:

- Sharing of clinical practice notices;
- Updates to education and training programmes;
- Improvements in clinical pathways;
- Improve conveyance communication around pre-alert; and
- Improvements to clinical documentation and roll out of an electronic patient care record (ePCR).

The PECI Team continues to engage with the public to listen, capture and report on their experiences of accessing and receiving care across all Trust services. Through its continuous engagement model, the team are in an ongoing dialogue with the public on what they think are important developments the Trust could make to improve services they receive.

The feedback captured and reported demonstrates how patient experience is a key indicator of the level of quality being provided and the need to improve patient experiences, patient safety, and patient outcomes.

This work is supporting the Trust's principles of providing the highest quality of care and service user experience as a driver for change and, delivering services which meet the differing needs of each of our communities, without prejudice or discrimination.

The Safeguarding Team continues to provide assurances that the Trust fulfils its legislative and statutory responsibilities in relation to safeguarding children and adults, ensuring that the well-being of children and adults are at the heart of everything it does. During 2022/23 the Safeguarding Team have: -

- Docworks continues to gain momentum across the Trust gaining both internal recognition from our staff and external recognition by our partner agencies - received commendation at National Safeguarding conference;
- The team have successfully contributed to the NATC CPD Clinical skills sessions with the inclusion of safeguarding based scenarios - all have received positive feedback from staff;
- Received an innovation award from Cardiff and Vale Safeguarding Board and shortlisted for an award by Cwm Taf Morgannwg Safeguarding Board for our Docworks initiative.

Engagement

Outcomes of our engagement with people and communities across Wales remain consistent with people continuing to tell the Trust that long waits and delays remain their primary concern – though the transport, care, or treatment they ultimately receive is good.

This theme is repeated across all services delivered by the Trust; 999 emergency care, Non-Emergency Patient Transport, and NHS 111 Wales.

The Trust has shared a clear theme around long waits for an emergency ambulance and the associated poor experiences, trauma, bereavement, and impact on families. These experiences are well documented with plans already underway to increase capacity within the Emergency Medical Service.

The Trust has also consistently heard about poor experiences of long waits on the NHS 111 Wales number. This is also exacerbated by frustrations in navigating the NHS 111 Wales website and looking for appropriate service and health information.

The PECI Team regularly hears from people talking about concerns they have about potential ambulance delays. Sometimes, these concerns relate to an experience, while other people tell us about things they have heard through friends, family, or the media. It was clear there was concern for community safety with people wondering "Will there be an ambulance available for me if I need one?". These concerns are echoed in some of the feedback received through the 999 Patient Experience Survey.

Where these concerns are raised, the team are able to explain how 999 calls are categorised, reassure that we are doing all we can to get help to the people who need it the most and provide information about other avenues that might be more appropriate than calling 999.

In Wales, 80% of cardiac arrests occur in the home, so knowing what to do and being familiar with Cardiopulmonary Resuscitation (CPR), and how to use a defibrillator can improve the chances of survival for a loved one.

Throughout 2022, the campaign aimed to familiarise people with the symptoms of a heart attack and cardiac arrest, know how to treat these two different emergencies by equipping people with skills and confidence through a specially developed Welsh Ambulance Service video demonstrating how to perform effective CPR and use a defibrillator. The video was shared extensively through the Trust's social media platforms and was viewed over 3,500 times.

The Trust's continued engagement with the public is important to ensure ongoing conversations on what it is doing and why, especially during this continued period when the Trust is experiencing increased demand and is at high levels of escalation.

The Trust's understanding learning disability e-Learning module went live in early 2023. It has amassed over 480 participants and participation is steadily increasing, with discussions ongoing to ensure it is included in CPD days across all areas of the service. This comes alongside developments to the ePCR system which can guide crews through a series of hints, tips, and questions to help improve the quality of care, experiences, and outcomes for people with a learning disability, and also allow the Trust to capture more information on the reasonable adjustments that have been made for people with a learning disability. This development will help to better inform future recommendations and highlight further training needs.

In 2021, as a result of our engagement and activities with children and young people across Wales, The Trust developed, and launched the Blue Light Hub gaming app. In 2022 a formal evaluation of the effectiveness of the app was undertaken. The final evidence report was received in early 2023 and results suggested that even brief use of the Blue Light Hub gaming app had a positive impact on children's understanding and awareness of emergency services.

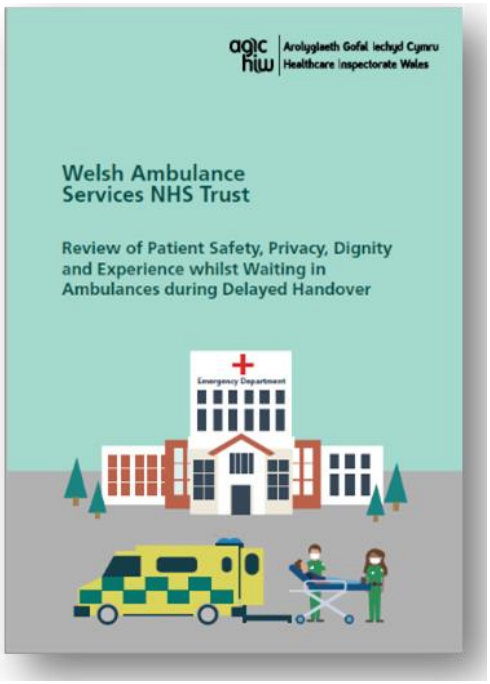
The app has four lightly challenging games to teach users about what happens when they call 999, the appropriate use of 999, how ambulance resources are dispatched and managed, and the different uniforms they might encounter on their NHS journey. Players are encouraged to return to the hub frequently, developing a familiarity with the theme, further encouraging them to make better choices about how to treat the emergency services, and what to do in difficult situations.

The Trust has taken on board the feedback received from the schools during the evaluation and are now looking ahead at further improvements that can be made to the app. The app can be downloaded via the links below: -

Google:
https://play.google.com/store/apps/details?id=com.WelshAmbulance.BlueLightHub

Apple:
https://apps.apple.com/us/app/blue-light-hub/id1575745545

Healthcare Inspectorate Wales is the independent inspectorate and regulator of healthcare in Wales. An inspection of the Trust was undertaken in 2021. The report 'Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover' was subsequently published in 2022. The report includes all emergency departments (EDs) across Wales and includes a number of recommendations. These recommendations will now need to be considered and incorporated where possible more than ever, as waiting times outside of EDs has increased further during 2022 and into early 2023.



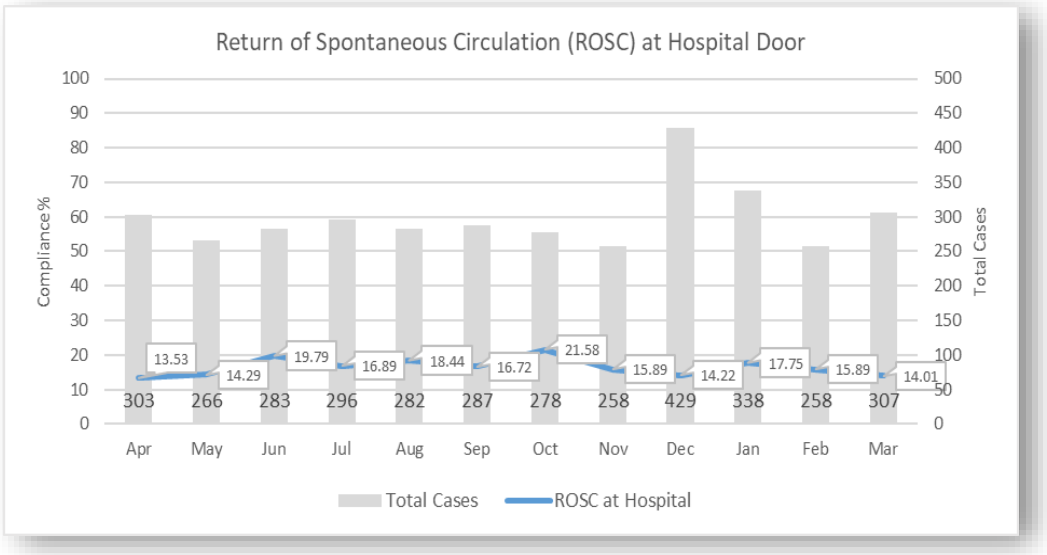
Following publication of the report the Emergency Ambulance Services Committee recently set up a task and finish group chaired by the Deputy Chief Ambulance Services Commissioner to respond to the recommendations. The membership of the group includes clinical and operational representatives from each of the seven Health Boards, and representatives from the Trust and Welsh Government.

Clinical Outcomes

The introduction of the Electronic Patient Care Record (ePCR) enables the collection and sharing of information in a more timely and accurate manner. The Trust currently uses ePCR to report on five key clinical indicators to the Emergency Ambulance Services Committee, these being Fractured Neck of Femur, Stroke, ST Elevation Myocardial Infarction (STEMI), Hypoglycaemia and Return Of Spontaneous Circulation (ROSC).

It is likely that as the system continues to embed within clinical practice, that users are still getting used to an adjusted workflow and data points might be missed. Therefore, an improvement approach has been taken and a series of 'Top Tips' posters have been circulated and specifically shared with senior Paramedics. This is based on deep dive quality assurance audits conducted for each of the clinical indicators and reported through the Clinical Intelligence Assurance Group. The deep dive quality assurance audits are also contributing to recommending additional improvements that can be made to the ePCR user interface to enable better data capture in future versions of the application, allowing the Trust to further develop and quality assure these key metrics.

One of the clinical indicators the Trust currently measures is the percentage of patients who have ROSC. Although for the year 2022/23 this remains lower than the Trust would want at 16.58%, it is an improvement on the 12.9% recorded in the period April to November 2021, at which point data stopped being reported temporarily due to the roll out of ePCR.



Of the other key clinical indicators the Trust measures, none of them achieved the 95% target during 2022/23. The percentage of older people with suspected hip fracture who are documented as receiving the appropriate care bundle (including analgesia) was at 65.02% for the year; the percentage of STEMI patients who are documented as receiving the appropriate care bundle was at 39.45%; the percentage of hypoglycaemic patients who are documented as receiving the appropriate care bundle was at 44.08%, and the percentage of suspected stroke patients who are documented as receiving the appropriate care bundle was at 77.51%.

Whilst there are many factors outside of the Trust's direct control it has developed a new service, the Cymru High Acuity Response Unit (CHARU), which was introduced during the latter half of 2022/23. Although still some way short of the fully modelled position of 153 WTEs, as currently at 83, with a further 20 in training as of 20 April 2023 (103), the Trust is currently working to close this gap. This service is aimed at providing a response to a dedicated code set of high acuity incidents by an experienced paramedic with additional medicines and training. They will support clinical decision making, co-ordinate patient care and ensure clinical practice is in line with current best practice guidelines to improve overall outcomes in several of the areas highlighted above, such as successfully increasing ROSC rates. It is hoped that following recruitment adverts and application reviews in late 2022/23, the remaining posts will be filled in the first half of 2023/24.

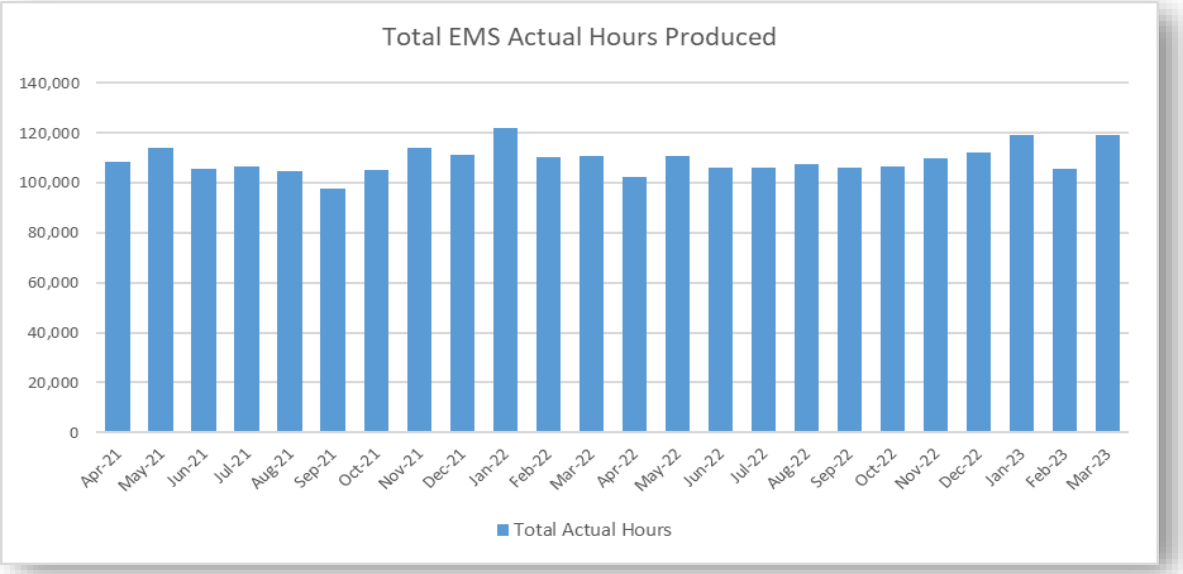
1.8. Our People

In relation to the Trust's workforce, the indicators reviewed at Board relate to whether the Trust has the right workforce capacity in place to meet demand, how the Trust is keeping staff safe and well, and how they are being developed. More detailed and numerous indicators are also considered at the People and Culture Committee.

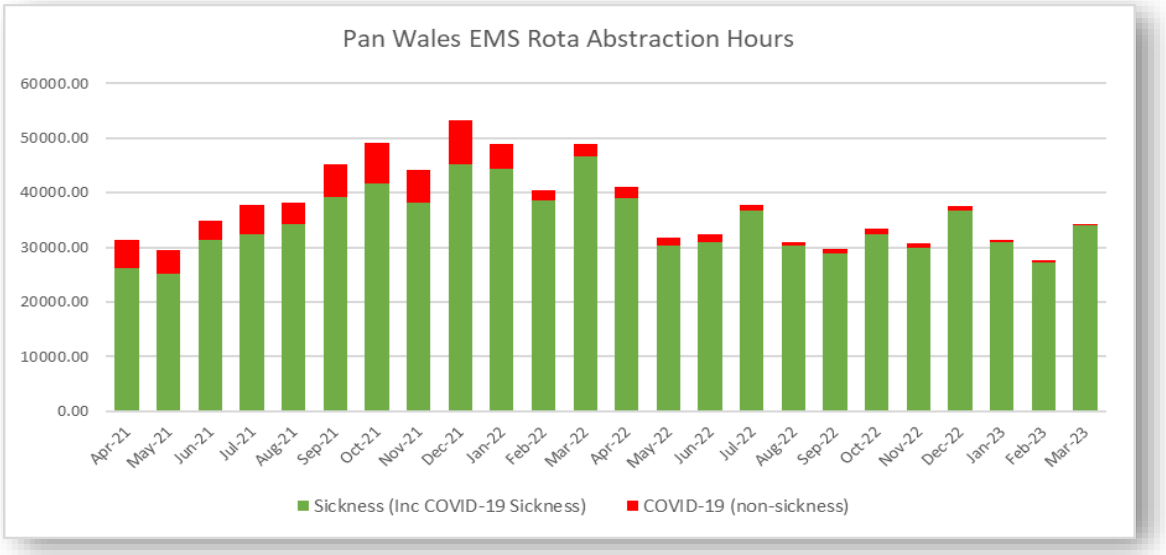
In relation to the Emergency Medical Service (EMS), the EMS Demand and Capacity review in 2019 determined that the required capacity to respond to demand should be based on a 30% abstraction assumption (including sickness absence, training etc), with levels of investment provided by EASC to increase WTEs by 263 over two years.

The Trust had a budgeted EMS establishment of 1,661 WTEs for 2022/23, but through the EMS Operational Transformation Programme the funded plan was to add an additional 100 WTEs during the course of the year comprising of 90 Emergency Medical Technicians and 10 Ambulance Care Assistants. Although these posts had not been filled by the January 2023 deadline, as of the 31 March 2023 the Trust had achieved an uplift of 90 WTEs and is budgeting on the basis of 100 WTEs for 2023/24.

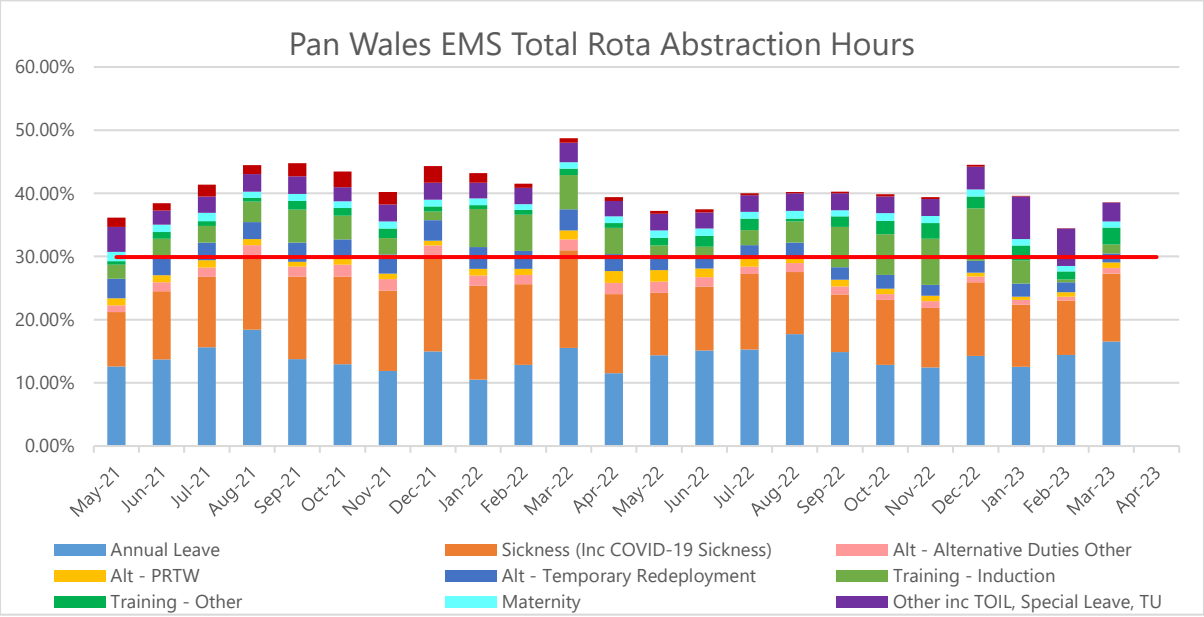
With the new EMS response rosters going fully live by the end of 2022, following a two-and half-year project, it was hoped that together, these would have provided a significantly positive impact for patients. However, as the graph below demonstrates, despite having more staff in post the Trust has not been able to produce additional hours compared to the previous year. In 2022/23, 1,311,430 actual hours were produced compared to 1,309,433 hours in 2021/22. The 2021/22 figures were inflated slightly through the use of military aid, while 2022/23 has been affected by numerous days of industrial action during quarter four.



A key factor in the Trust's ability to ensure capacity to meet the demand is the impact of abstractions, and this also provides an indicator of our people's well-being. The significant impact of the last two years at all levels throughout the Trust cannot be underestimated. To support the workforce there has been an on-going focus on well-being activities across all areas of the Trust, including those in both frontline and support roles. Despite this, sickness has remained one of the key causes for rota abstraction.



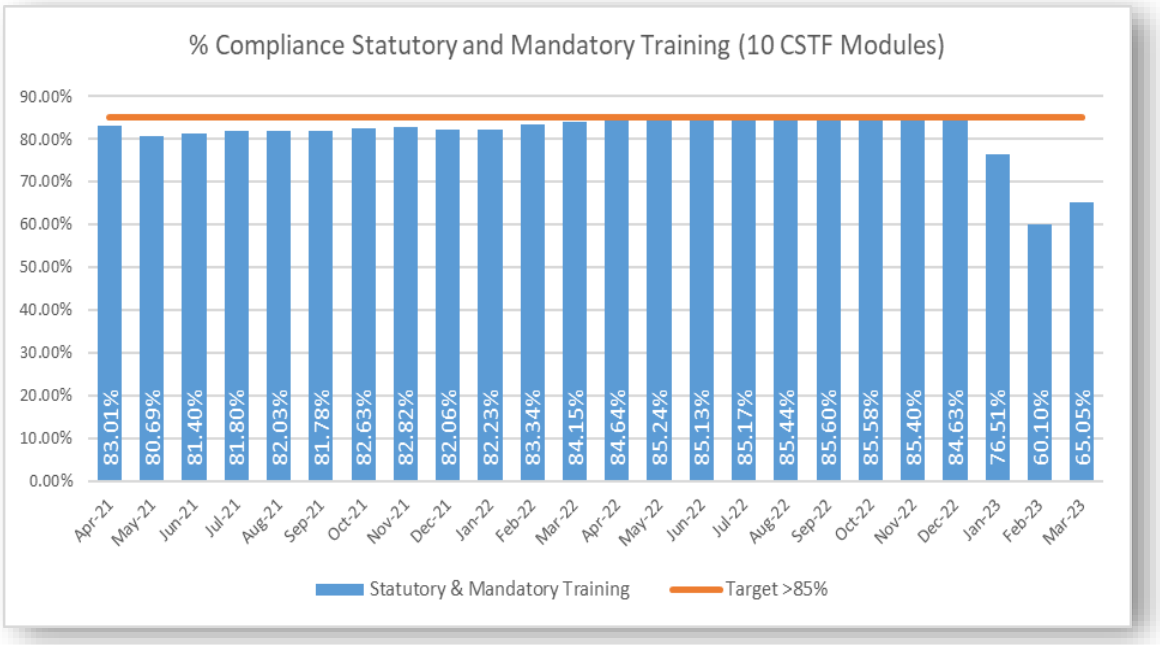
The graph above shows the level of abstractions due to sickness and Covid-19 factors over the past two years for EMS staff. In 2021/22, 12.43% of abstractions were due to sickness and 1.64% were due to Covid-19 (non-sickness). Although these figures have reduced during 2022/23 to 10.33% for sickness and 0.29% for Covid-19 (non-sickness) they still remain high, and above the Trust's year-end sickness target of 8%. However, across the organisation the Trust did achieve this 8% target in February 2023. The below graph also highlights how this has contributed to total EMS abstractions remaining above the 30% target throughout the whole of the year.



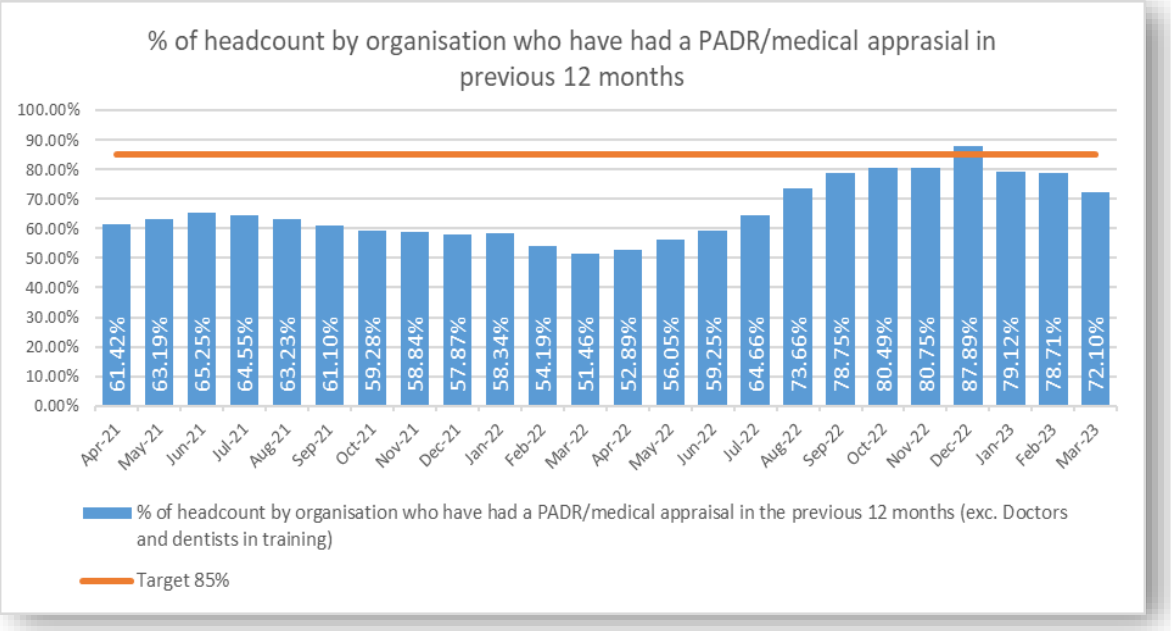
Similar pictures were also seen in 111 and Ambulance Care, with a 10.79% abstraction rate due to sickness in the 111 service and a 10.68% rate in Ambulance Care. However, there has been a steady reduction in long-term absence rates, with short term absence spikes being directly related to Covid-19 increases, mirroring the wider community. The Trust is fully aware that sickness absence needs to remain a major area of focus over the coming year in order to ensure that sickness reduction targets are met and is fully committed to a number of initiatives including training for managers and wellbeing sessions for staff. The full sickness rates can be found within the Accountability Report.

Other indicators of how the Trust is keeping its staff safe and well include vaccination rates and statutory/mandatory training levels. As of 28 February 2023, 94% of frontline staff had received a Covid-19 booster vaccine, 94% were double jabbed and 35% had received the SPIKEVAX booster. The flu vaccination level for the Trust for 2022/23 was 44.5%; this surpassed the 38.5% figure seen the previous year.

Statutory and Mandatory Training rates during 2022/23 did not achieve the 85% target overall, with the completed level at 80.71% for the year. However, the 85% compliance rate was achieved between May and November 2022, with levels only dropping off in early 2023. Further analysis was undertaken, and it was found that industrial action days, coupled with the introduction of a new statutory training module, both had an impact on compliance rates in early 2023.

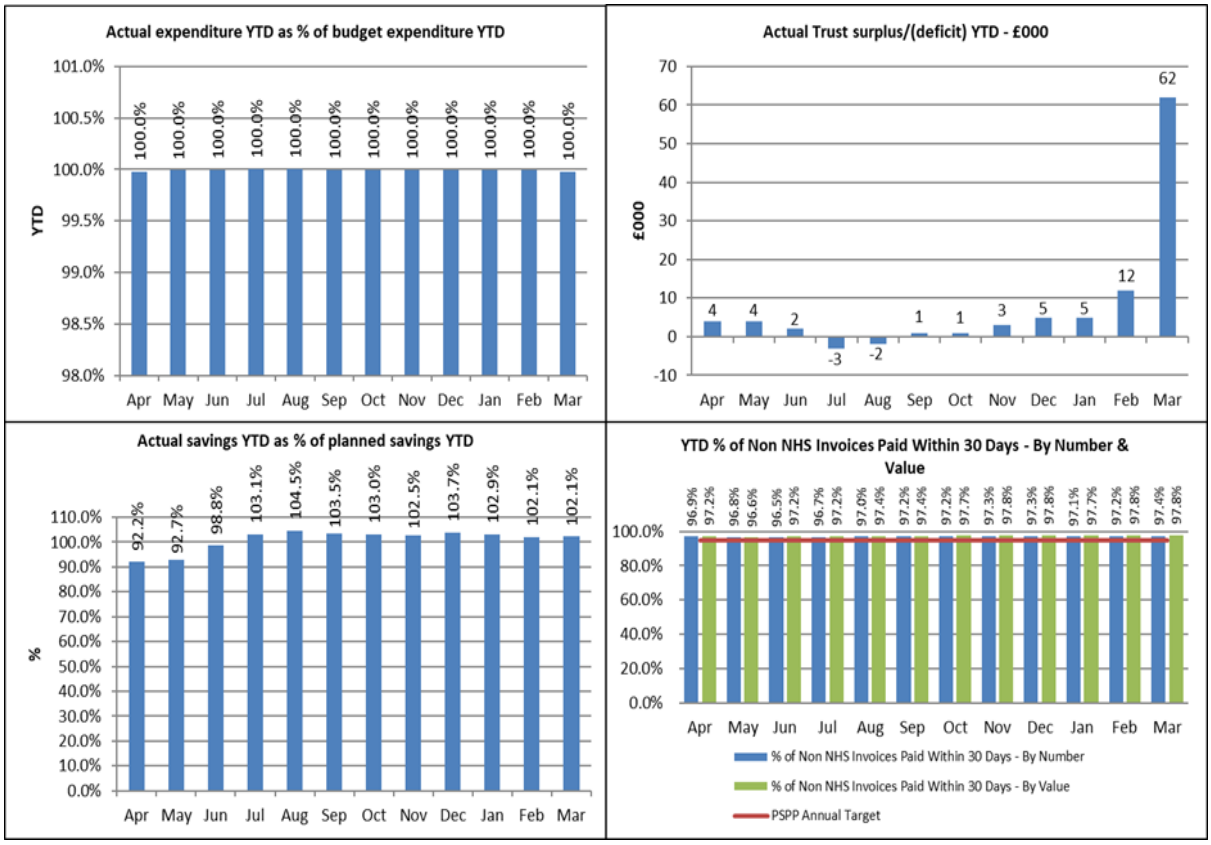


In terms of staff development, the Trust views levels of Personal Appraisal and Development Reviews as the best way of representing development at a high level. Although the figure for 2022/23 of 72.03% failed to achieve the 85% target, it was a significant improvement on the 51.5% compliance rate recorded for 2021/22. December 2022 also saw the compliance rate go above the 85% target for the first time.



1.9. Finance and Value

The Trust reviews a number of indicators which aim to demonstrate how it provides a service in line with statutory financial duties, and of high value and efficiency. This area of the Performance Report will be strengthened over time as the value-based health care programme continues. The Trust achieved financial balance in 2022/23, with a small revenue surplus of £62k and met its statutory duty to breakeven during this financial year.



Gross savings of £4.392m were achieved against a target of £4.300m, thus a slight over achievement. Public Sector Payment Policy was on track with performance of 97.5% for the number, and 97.8% of the value of non-NHS invoices paid within 30 days (target 95%). Further information can be found in the Trust's annual accounts and financial statements, which have been prepared on a going concern basis.

Following a sustained pandemic response and rising inflation, the financial outlook for 2023/24 and beyond is challenging. The Financial Sustainability Programme, which commenced in early 2022/23, is a key programme of work which will drive transformation to achieve cost efficiencies as well as exploring opportunities for income generation for 2023/24 and beyond.

As part of the Trust's ongoing work around Value it is introducing a Patient Level Costing system (PLICS) to allow the establishment of detailed costing analysis. This combines both financial data, along with activity data collected from multiple Trust systems, which will allow for both internal and external benchmarking.

The Trust has also implemented a Financial Sustainability Programme following a sustained pandemic response, and with the impact of inflation and the costs of living as they relate to the Trust and the wider public sector, the financial outlook for 2023/24 and beyond is understandably challenging.

This environment has led the Trust to develop a plan which has more focus on value and financial sustainability as well as the impact on our people, whilst maintaining ambitions to improve the quality of service provided to our patients. The Financial Sustainability Programme, which started to be put in place in early 2022/23, is a key pillar which will drive transformation to achieve cost efficiencies as well as exploring opportunities for income generation for 2023/24 and beyond.

1.10. Non-Financial Performance Information

Human Rights, Diversity and Equality

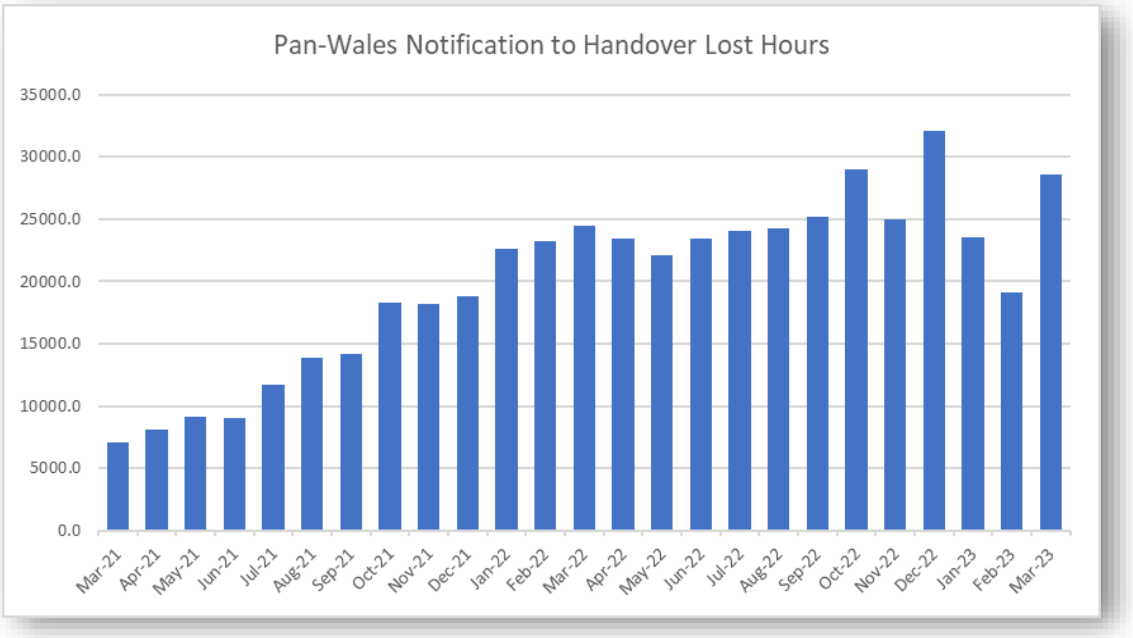
The Annual Governance Statement in the Accountability Report discloses how the Trust meets its obligations under equality, diversity, and human rights legislation. Refer to the Disclosure Statements and the Modern Slavery Act 2015 statement for further information. There is also additional commentary regarding 'Other Employee Matters' in the Remuneration and Staff Report, within the Accountability Report.

Anti-corruption and Anti-bribery

The Annual Governance Statement also includes narrative regarding the Trust's counter fraud arrangements, and the Local Counter Fraud Specialist's relationship with the Audit Committee. This narrative can be found in the 'The Control Framework' section of the Accountability Report.

1.11. Partnerships and System Contribution

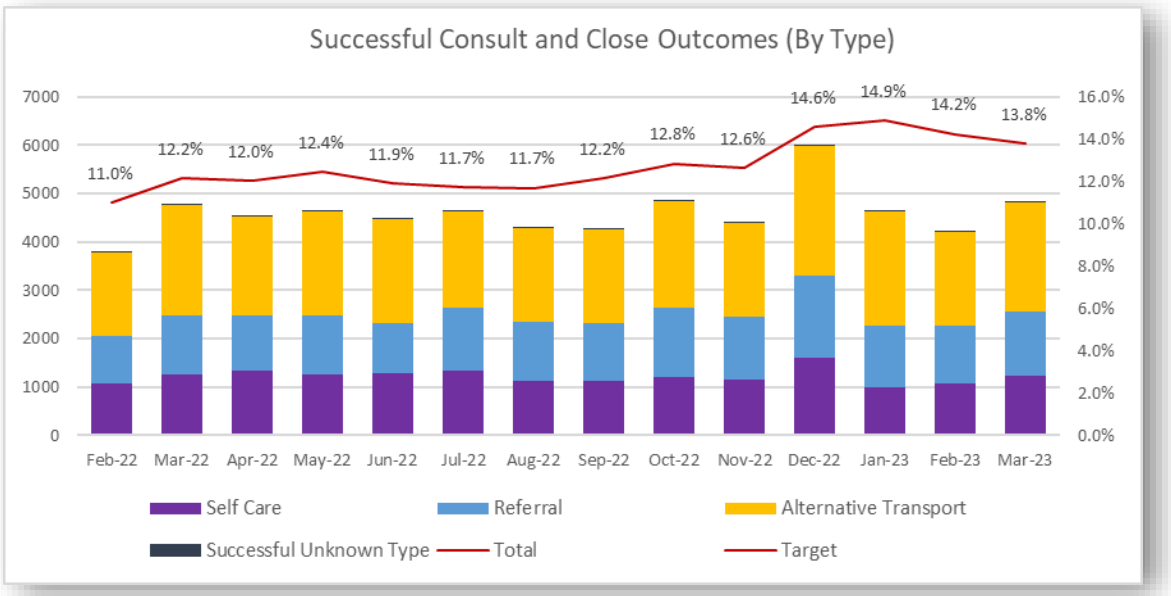
The Trust aims to consider both its impact on the wider system, but also the wider system's impact on its service. Handover lost hours were already extremely high within Wales even before the pandemic, but levels consistently increased throughout 2021 and 2022, reaching a peak in December 2022 of 32,000 hours being lost to hospital handovers. This equated to 64,000 people hours or just over 5,300 twelve-hour shifts, which meant the Trust could have responded to over 10,000 more patients during December if handovers were reduced. This meant that 299,636 ambulance hours were lost during 2022/23 compared to 191,461 in 2021/22.



The Trust is aware that Health Boards are introducing urgent and emergency care escalation frameworks, and that there has been strong messaging from Welsh Government and the Minister for Health and Social Services that this issue must be tackled as a matter of priority. A series of Integrated Commissioning Action Plan meetings have also been set up by the National Collaborative Commissioning Unit, designed for individual Health Boards and the Trust to work collaboratively in order to look at reducing handover hours, and these will continue throughout the coming year.

Following the December peak, early quarter four of 2022/23 did see a slight reduction in lost hours, albeit to levels that are still unacceptably high. Some caution is required on this trend as there were industrial action days within these months on which lost hours were contained by Health Boards. It was not a signal of broad improvement. However, given the scale of the challenge and its links to wider system pressures, the Trust is having to plan on the basis that lost hours will remain high for the foreseeable future and acknowledge they will continue to cause significant patient harm. The Six Goals policy handbook sets out an expectation of no handover being longer than an hour by 2025.

The Trust is committed to transforming its services to become more sustainable, to get patients to the right service, in the right place, every time, and to reduce the reliance on emergency departments as the default location for definitive urgent and emergency care. One of the areas where the Trust already supports the system in reducing demand is 'Consult and Close' through the work of the Clinical Support Desk (CSD) and 111. The 2019 EMS Demand and Capacity review benchmarked a 'Consult and Close' rate for the Trust of 10.2%, which was achieved in 2021/22, and following the expansion of the team by 36 WTE paramedics in 2021/22, the Trust reset a trajectory to 15% for 2022/23. This figure has yet to be achieved in any single month, with the 'Consult and Close' figure for the year being 12.91%, although it did rise to 14.9% in January 2023.

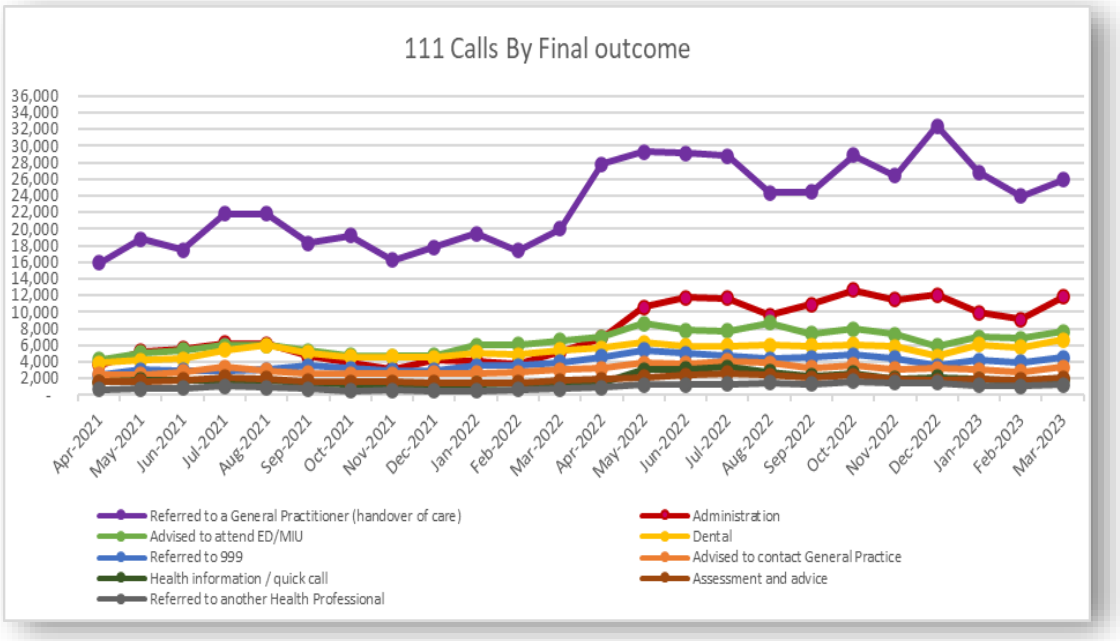


The revised establishment of the CSD now stands at 96 WTEs, which includes five Mental Health Practitioners, of which 90 are currently in post. The team are undertaking detailed process maps of the work that they do in order to identify where further improvements can be made.

The Trust also monitors its 'See and Treat' rates and those treated at scene, which have declined slightly throughout 2022/23. It is thought this has been due to a number of reasons including slight changes in the way Advanced Paramedic Practitioners are tasked, along with an increase in respiratory patients (of all ages) during quarter four who were very poorly and required hospital admission.

However, the Trust's ambition remains, as articulated through the 'Inverting the Triangle' work, to increase this shift left activity and reduce the number of patients that need to be conveyed to emergency departments.

In relation to the Trust's 111 service, one of the success factors for NHS 111 Wales is getting the patient to the right service, first time. At the moment, the Trust measure outcomes in terms of where patients are directed, but further work is currently being undertaken to improve 111 data metrics, allowing more meaningful data to be reported and identifying whether these outcomes are the best and most appropriate.



The graph above highlights where callers to the 111 service are currently directed, with those being referred to a General Practitioner making up the biggest percentage for the year (40%).

1.12. Infection Prevention and Control

Infection Prevention and Control (IPC) continued to be a critical component of healthcare in 2022, as the World continued to grapple with the ongoing Covid-19 pandemic and other emerging infectious diseases with the potential to cause harm.

The Trust continued to promote strict infection prevention guidance, hand hygiene, personal protective equipment (PPE) and enhanced cleaning regimes to prevent the spread of infectious diseases among staff and patients.

Overall IPC will remain a priority for healthcare providers and policy makers in 2023 as the Trust continues to face ongoing challenges from infectious diseases.

Healthcare-associated infections (HAIs) can have severe consequences, especially for vulnerable populations such as the elderly, immunocompromised individuals, and those with chronic illnesses, therefore it is imperative to continue to strengthen healthcare-associated infection prevention strategies and implement evidence-based practices. These include: -

- The continuation of Covid-19 prevention measures, as whilst Covid-19 is no longer classed as "a public health emergency of international concern" by the World Health Organisation, it continues in our communities. It is therefore essential to continue implementing where necessary measures such as wearing masks, maintaining physical distance, and practicing good hand hygiene. These simple steps are basic and effective preventative measures to reduce the spread of infections.

- Preparing for emerging infectious diseases. Emerging infectious diseases pose a significant threat to public health, e.g., Monkeypox. It is important that as part of our practices we detect and respond to emerging infectious diseases promptly in particular those that are categorised as High Consequence Infectious Diseases.

- The current PPE provision is under review with the long-term vision being for this to be easily accessible, appropriate, and sustainable for at least the near future.

- Education and awareness campaigns will continue, as they are known to play a crucial role in preventing infectious diseases. The IPC Team are working closely with the National Training College to ensure that the education provided for 2023/24 is relevant, easily accessible, up to date and can be monitored for compliance and effectiveness.

- The Trust continues to look for, and test, new and innovative technologies, and strategies to help prevent the spread of infectious diseases. It has already embraced the use of the rapid sanitisation process of cleaning vehicles and must continue to be open minded and motivated to continue to seek ways in which it can reduce healthcare associated infectious diseases.

- There is an expectation that National Ambulance cleaning guidelines will be available in 2023, and that standards and processes will be reviewed with national recommendations.

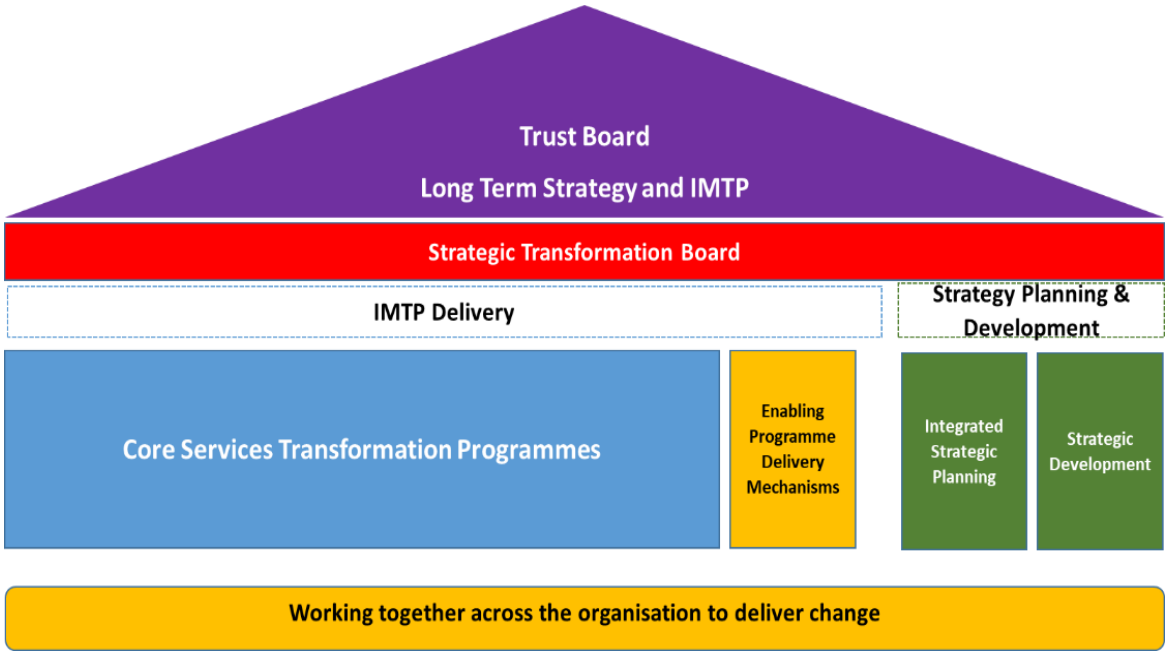
- Encouraging and promoting vaccination of healthcare staff against vaccine-preventable diseases including Influenza and Covid-19. As of March 2023, 94% of frontline staff had received the second dose of the Covid-19 vaccine and 44.5% had received the vaccination against flu.

- Antimicrobial resistance (AMR) is a global public health threat. Antimicrobial stewardship programmes and infection prevention and control measures can help prevent the spread of resistant organisms and reduce the use of antibiotics, thereby reducing the risk of AMR.

It is essential to regularly review and update IPC policies and procedures to align with the latest guidelines and recommendations from relevant authorities and to ensure that this reaches frontline practitioners.

1.13. Integrated Medium Term Plan

The Integrated Medium-Term Plan (IMTP) is delivered through its core services transformation programmes and enabling workstreams which report to the Strategic Transformation Board (STB). STB continued to meet regularly (every six weeks) during the pandemic response and recovery, delivering significant transformation despite the increased pressure across the urgent and emergency care system. The infographic overleaf shows some of the delivery across the planned and emergent projects throughout 2022/23.



IMTP Delivery

1.14. Delivering in Partnership

Society may have emerged from the worst of the Covid-19 pandemic, but that does not mean that the increasingly strong working relationships with partners, including those forged in more recent years, have diminished in importance.

While partnership and collaboration had been at the heart of the Trust's mission for a number of years, the pandemic brought home both the importance of relationships within and beyond the organisation. It also sowed the seeds of a new era of less linear and more dynamic relationships, where the concept of shared benefit, both for organisations and, importantly, for patients and staff, would need to be at the heart of the Trust's future approach to partnership and engagement.

In 2022/23, the Trust spent time reflecting on the lessons of the pandemic and how the positive aspects of partnership can be sustained as it enters a new environment of post-pandemic healthcare. Given the challenges and opportunities of the post-pandemic environment, 2022/23 was a year in which strong and effective partnerships were more important than ever.

This year has seen a number of significant developments in the formal partnership landscape, which will have a bearing on the Trust as it moves forward. One of the most significant has been Welsh Government's consultation on plans for the Trust, along with a number of other additional bodies, to come under the auspices of the Well-being of Future Generations (Wales) Act 2015.

The Trust was not one of the 44 public service organisations originally covered by the Act. At the time, the Trust committed to working within the spirit of the Act and has continued to do so. The opportunity for that omission to be rectified has been welcomed by the Trust and while the results of the consultation are not yet known, we are working on the basis that, in future, the Trust will be covered by the legislation, with all that it entails.

Over the last seven years, the Trust has worked hard to secure representation on four of the seven Regional Partnership Boards (RPB), with representation also on the Gwent Adult Services Partnership which is a subset of the Gwent RPB. The RPBs have evolved over the years and are now seen as a key delivery vehicle for the integration of health and care services, with access to funding to support this important work from Regional Investment Funds.

The Trust were delighted to hear at the end of the year that Welsh Government is likely to be consulting in 2023/24 on adding organisations, including the Trust, to the list of statutory partners entitled to sit on RPBs, which could result in future Trust representation on all seven Regional Partnership Boards in Wales.

While both these developments may not come to fruition until 2023/24, it is gratifying to note that there is growing and important recognition of the Trust's contribution in the partnership arena.

Understanding our collective challenges, working with partners to deliver different solutions to both new and established problems and, ultimately, better services for our patients and a more fulfilling working life for our people, are now at the heart of our refreshed engagement framework and delivery plan.

The framework and plan focus on working with stakeholders and the public on new solutions for us as an ambulance service, while making a positive impact on the wider health and care system.

Both these documents were approved by our Board this year, paving the way for positive engagement with our stakeholders, patients, and the public on how we can ensure our services better meet the needs of the people we serve going forward.

In 2022, the Trust conducted a reputation audit to understand the starting point for our dialogue with partners, receiving responses from almost 50 key stakeholders. Feedback was varied and highly insightful. Moving forward, that feedback will form the basis of a refreshed approach and help inform our thinking.

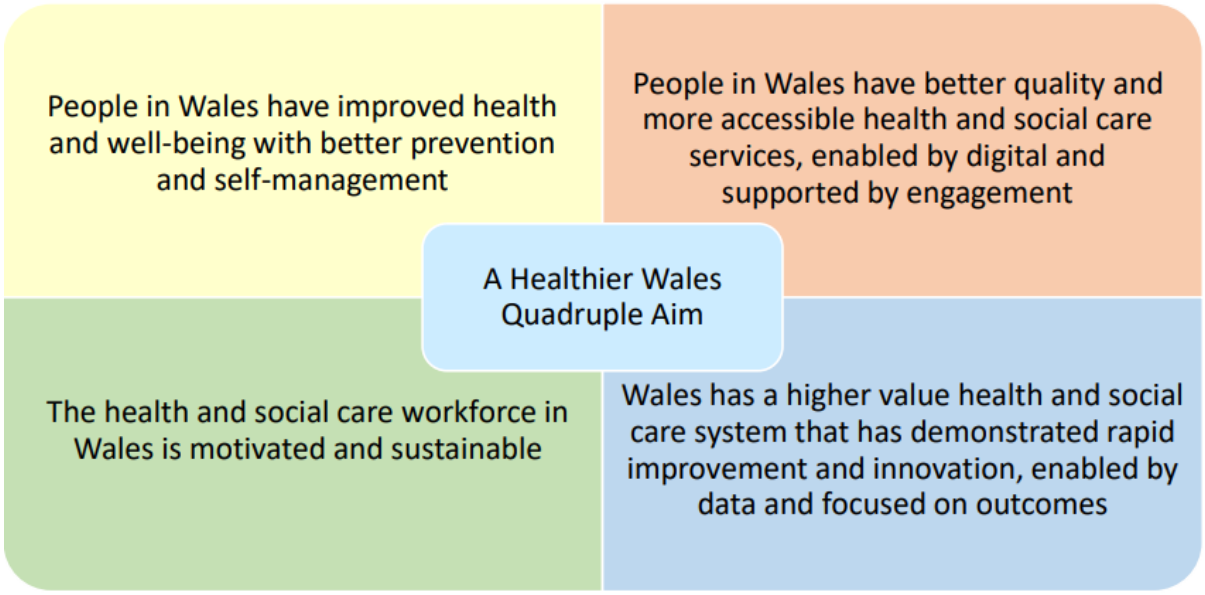
1.15. Ministerial Priorities and NHS Wales

NHS Wales were set a range of 'Ministerial Priorities' in 2022/2023. The Trust's progress against each priority is detailed in the following section.

Ministerial Priorities

A Healthier Wales – As an Overarching Policy Context

A healthier Wales: Long Term Plan for Health and Social A healthier Wales: long term plan for health and social care | GOV.WALES, sets out a "quadruple aim" for NHS Wales organisations of:-



The Trust has interpreted the "quadruple aim" into four themes: Our Patients, Our People, Finance & Value and Partnerships & System Contribution, through which it reviews its quality and performance. Both the Overview and the Delivery and Performance Analysis report the Trust's 2022/23 progress against these four headings. In year, the Trust uses these four headings to report quality performance; and the Trust's Quality and Performance Management Framework is based on a 'balanced scorecard' approach around these four themes.

Population Health

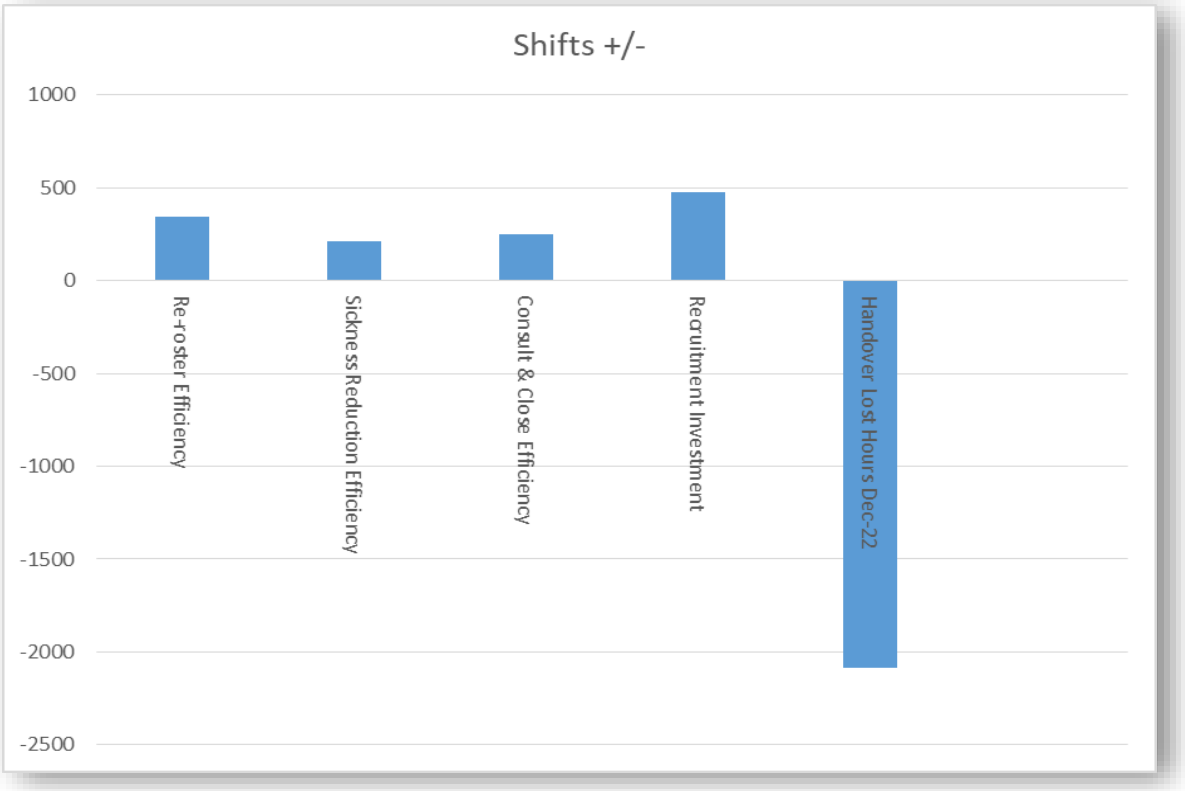
Health Boards have a statutory responsibility for their population's health. Health Boards commission ambulance services for their geographic areas through the Emergency Ambulance Services Committee (EASC), with 111 currently being a Programme, which will be commissioned by Health Boards with the Trust as the provider, from 2023/24.

The Trust's contribution to population health is therefore defined by the commissioning process, in particular, any Welsh Government targets that apply, for example Red eight-minute performance, and other metrics as directed by EASC, for example, renal performance. Invariably these metrics are time bound, however, the Trust implemented the new ePCR in 2022/23, which will start to give the Trust improved clinical information. A key area of development is data linking so that the Trust can track its patients into the wider health care system, in particular, the outcomes for patients it has had contact with.

Covid-19 Response

The Trust originally triggered its Pandemic Influenza Plan on 04 March 2020. The Trust monitored a key set of indicators, both performance, forecasting & modelling signals, to determine how close it was to being able to declare the Pandemic Plan as being no longer required. Following a sufficient improvement in the indicators and a closure of actions required to move the Trust out of its Pandemic Plan and into business as usual, the Executive Pandemic Team agreed to close down the Pandemic Plan structures on 20 July 2022.

NHS Recovery



For the Trust the key metric that indicates the pressure (and state of recovery) of the unscheduled care system in Wales is handover lost hours. The 2019 EMS Demand & Capacity Review was predicated on December 2018 handover lost hours, which were 6,038. In December 2022 the Trust lost 32,098 hours to hospital handover, which equated to 37% of emergency conveying ambulance production that month. The Trust cannot take actions that compensate for this level of loss. The above graph illustrates the positive impact (ambulance shifts gained) from actions within the Trust's control, which are offset by the level of handover in December 2022.

The Trust will continue to take actions, within its control, to improve its efficiency and "shift left" i.e., reduce the flow into hospitals, where it is clinically safe and appropriate to do so, but handover reduction to pre-pandemic levels remains critical to recovery and patient safety. Health Boards were given Ministerial direction to reduce handover lost hours in 2022/23, but these directions were not achieved.

Mental Health and Emotional Well-being

During 2022/23 the Trust rolled out the 111 press 2 service to ensure patients with urgent mental health needs get immediate access to 24/7 health services and received funding from EASC to employ five Mental Health Practitioners into the Clinical Support Desk to support telephone triage with a specific focus on mental health. These initiatives will be subject to evaluation in due course.

The Trust achieved a year end compliance rate of 89.71% for the Dementia NHS Wales eLearning module. The Trust also delivers role specific dementia awareness to a range of different staff groups, for example, half day sessions have been provided to Emergency Medical Technicians, and one full day session to BSc Paramedicine students as part of Year one Swansea University induction, during 2022/23.

The Trust has one of the most comprehensive mental health and wellbeing employee support offers across the sector. Refer to the 'Workforce Management and Well-being' section of the Performance Report for further narrative.

Supporting the Health and Care Workforce

As above, the Trust one of the most comprehensive mental health and wellbeing employee support offers across the sector. The Trust has also had a very strong focus on workforce planning and recently received positive feedback from a large international consultancy that its approach was comparatively advanced.

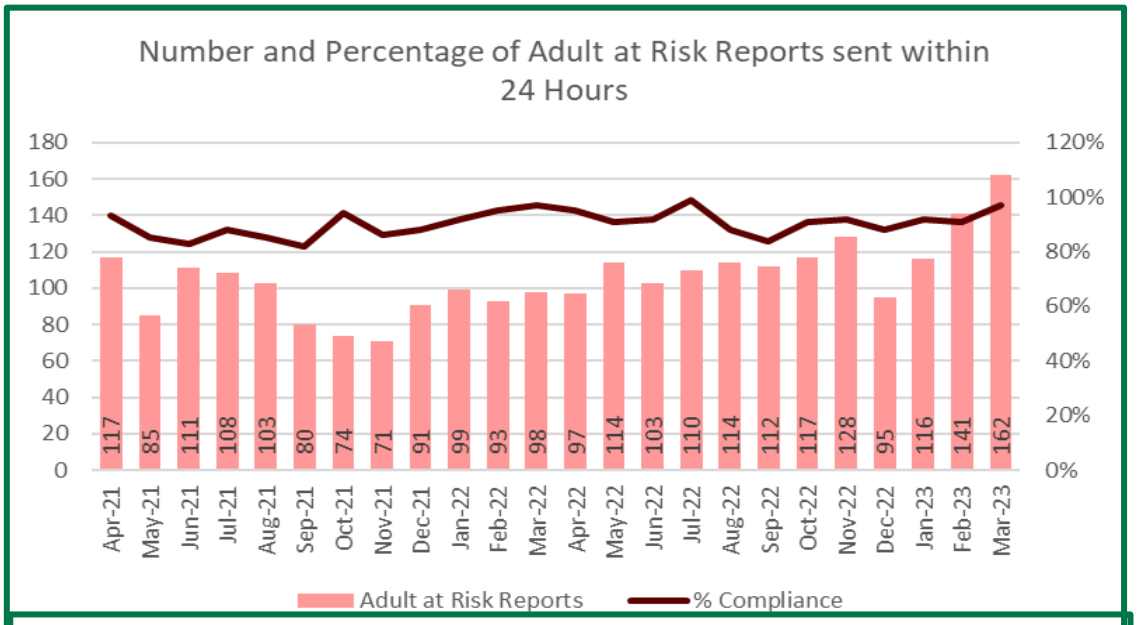
Clearly, 2022/23 has been a difficult year for industrial relations with strike action in the sector. All parties have conducted themselves professionally throughout, with strike action currently suspended with detailed negotiations on-going.

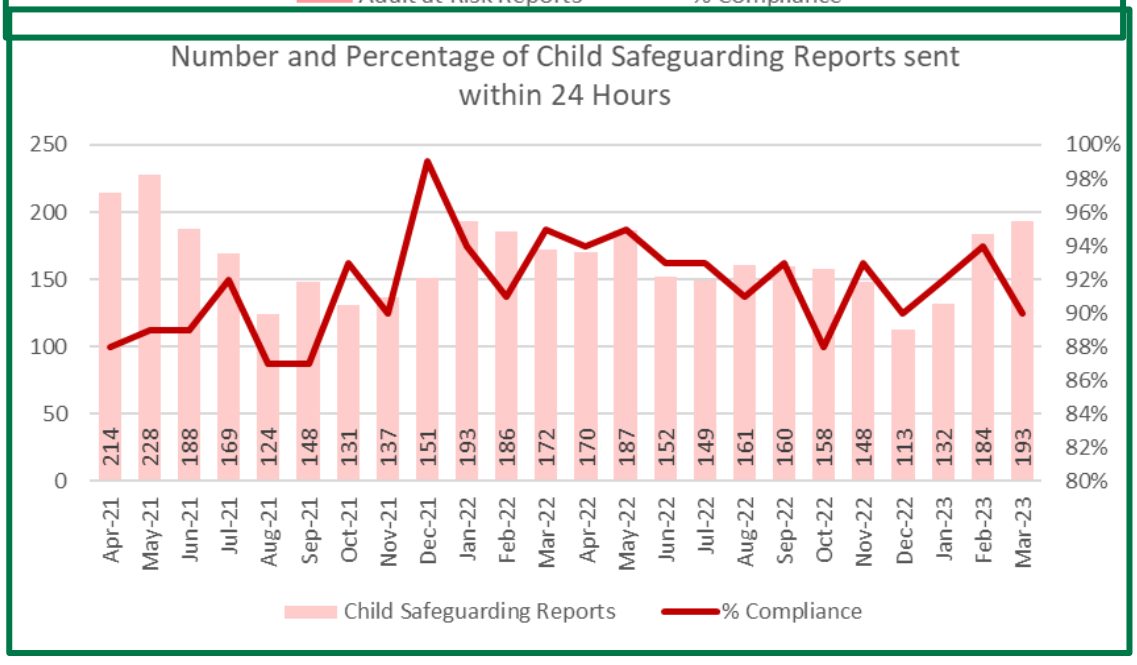
NHS Finance and Managing within Resources

The Trust achieved financial balance in 2022/23. Refer to the 'Finance and Value' section of the Performance Report for further narrative.

Working Alongside Social Care

The Trust has a significant amount of contact with the population in their home environments, which means the Trust's people can identify issues for social care. A key area is safeguarding reporting for adults and children. The Trust achieves a high level of reporting within 24 hours and these key metrics are reported to every committee and to every Trust Board: -





The Trust also operates a Falls Service and during 2022/23 agreed to launch a Connecting Care Cymru service in 2023/24, which will provide a sitting service combining St John's Ambulance and remote clinical support from the Trust.

Accountability Conditions

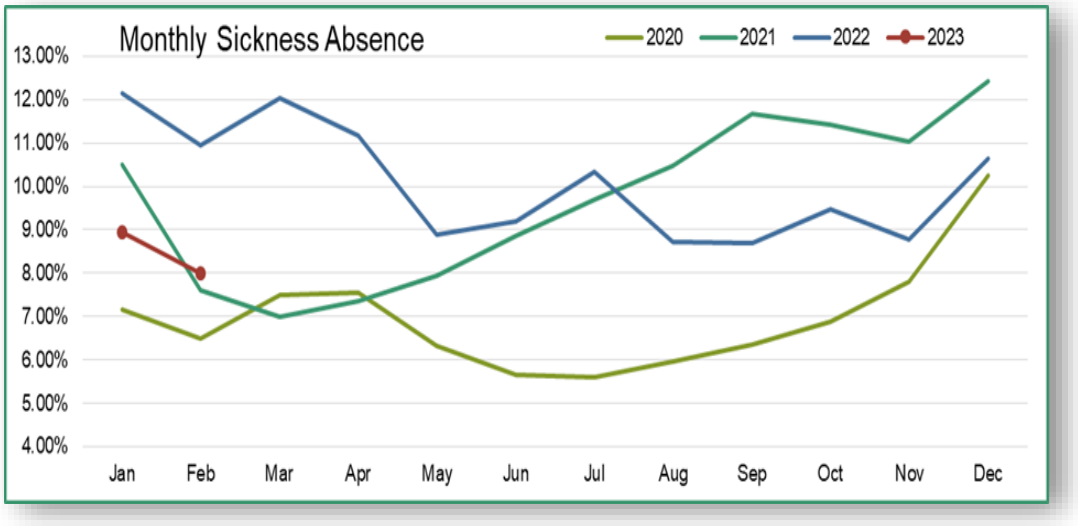
When the Minister approved the Trust's 2022/25 IMTP, approval came with a number of accountability conditions. This section details the conditions and the Trust's progress against each of them.

a. The Trust's contribution to the Six Goals for Urgent and Emergency Care is helpfully set out in the plan, however articulation of how this will translate to improved outcomes and performance needs to be clearly demonstrated. The Trust has provided a detailed response to Welsh Government as part of its 2023-26 IMTP submission Bundle Trust Board (Open Session) 30 March 2023 (nhs.wales).

b. The adoption of Value Based Healthcare needs to be strengthened and progress in reducing variation and removing harm demonstrated clearly. The Trust has set out its approach to Value Based Healthcare in its 2023/26 IMTP submission.

c. Further expansion and completion of the Minimum Data Set (MDS) in the quarter refresh exercises is required. The Trust reviewed the MDS in collaboration with Welsh Government in 2022/23 and agreed a revised set. The Trust submitted year end data and forecasts for the revised MDS as part of its 2023/26 IMTP submission.

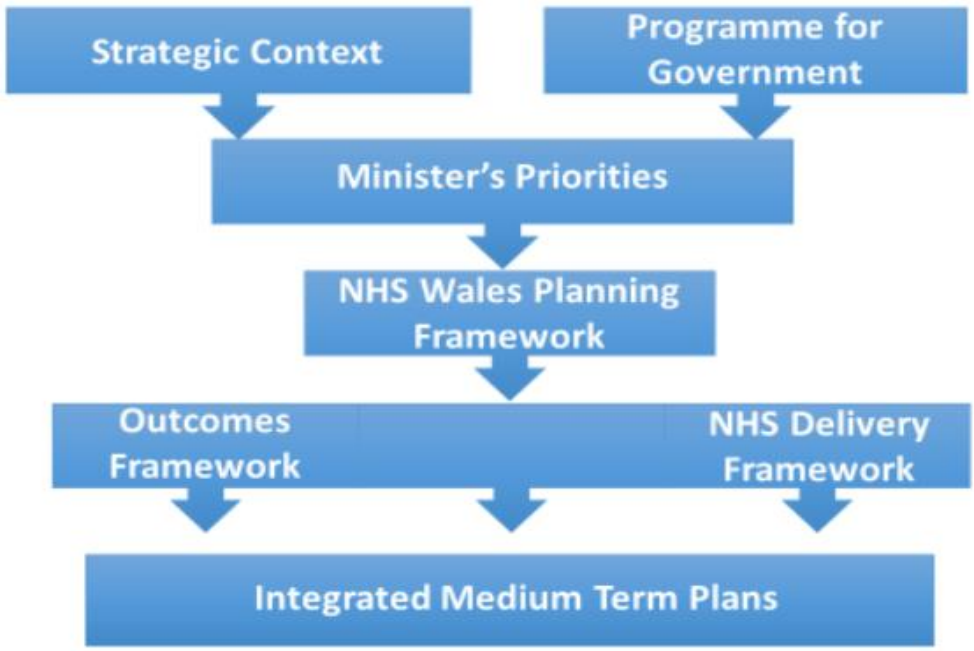
d. Improvement in sickness and absence rates across the Trust workforce needs to be demonstrated clearly. The Trust set itself an interim sickness absence target of 8% by 31 March 2023, and achieved 7.99% in February 2023. The Trust's final target is 6% by 31 March 2024.



e. Delivery of workforce efficiencies and the implementation of roster review by end of December 2022. The Trust successfully delivered the roster review by December 2022.

NHS Wales

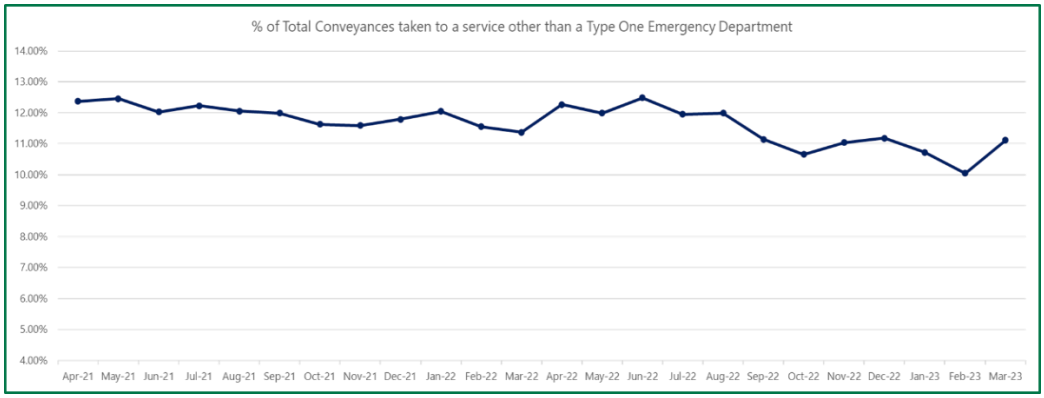
The Trust is subject to two key frameworks, the NHS Wales Planning Framework, and the NHS Wales Delivery Framework: -



The 'Ministerial Priorities' have been covered above. The IMTP is a separate document and is publicly available on the Trust's website via this link - Trust IMTP 2022/25. For the NHS Delivery Framework, the following measures apply to the Trust:

a. Percentage of 111 patients prioritised as P1CHC that started their definitive clinical assessment within one hour of their initial call being completed:
Refer to the Call Answering sub-section of the 'Our Patients (Quality, Safety and Patient Experience) section for further information.

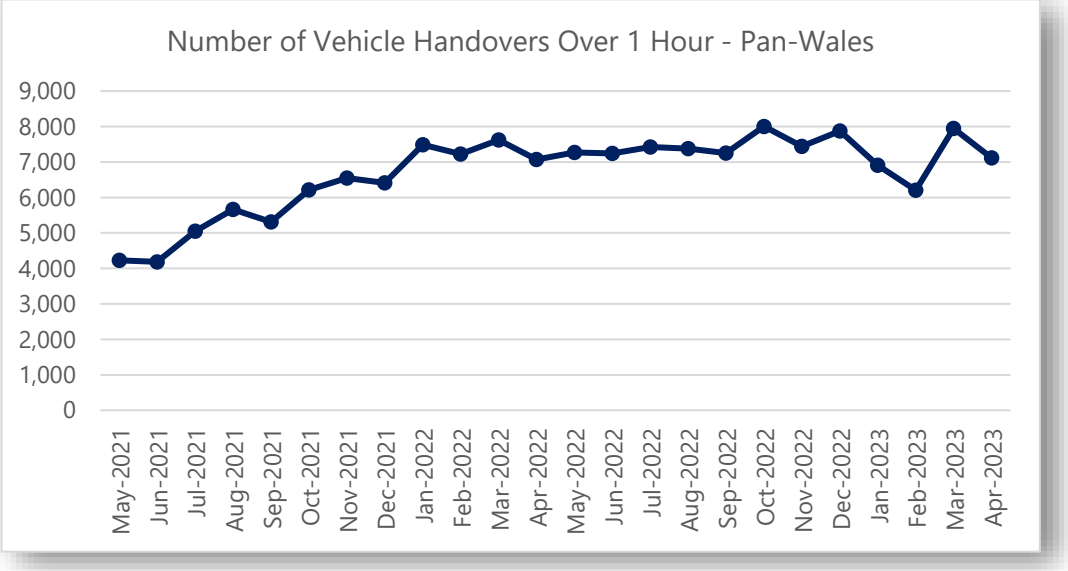
b. Percentage of total conveyances taken to a service other than a Type One emergency department:
The Trust's ability to convey is dependent on pathways being available to the Trust. A key area of development in 2022/23 were Same Day Emergency Care (SDEC) centres by Health Boards. The Trust has identified that less than 0.5% of its verified demand is going into SDECs, consequently there has been no impact on this indicator: -



The Trust estimates that 4% of its patient demand could be suitable for SDECs. Another reason for this indicator not improving is that the Trust has to operate its Clinical Safety Plan to higher levels than it would want, which means that more acute patients are prioritised, more of who will need to go to an emergency department.

c. Percentage of emergency responses to Red calls arriving within (up to and including) eight minutes: Refer to the Response Times sub-section of the 'Our Patients (Quality, Safety and Patient Experience) section for further information.

d. Number of ambulance patient handovers over one hour:
This is a health board responsibility but is relevant to the Trust's performance. There is an increasing trend, which is consistent with the extreme levels of handover lost hours that the Trust has had to work within during 2022/23.



e. Agency spend as a percentage of total pay bill:
Agency costs for 22/23 totalled £1.761m which was 0.9% of pay bill. The majority of this was due to the "co-horting" costs in the early part of the financial year. Patient "co-horting" i.e., the holding of patients in cohorts by the Trust outside emergency departments, in order to release emergency ambulances for other calls, was trialled in 2022/23, but not considered value for money and stopped. The Trust is anticipating a reduction of agency spend in 2023/24, in particular, because the "co-horting" has stopped.

f. Percentage of sickness absence rate of staff:
See section above on Accountability Conditions.

g. Percentage of staff who have recorded their Welsh language skills on ESR who have Welsh language listening/speaking skills level two (foundation level) and above:
89% of staff have recorded their Welsh Language skills on ESR (Welsh language listening/speaking); 25% Welsh language listening/speaking skills level two (foundation level) and above.

h. Percentage compliance for all completed level one competencies of the Core Skills and Training Framework by organisation:
Refer to the 'Our People' section for further information.

i. Percentage headcount by organisation who have had their Personal Appraisal & Development Review/medical appraisal in the previous 12 months:
Refer to the 'Our People' section for further information.

j. Overall engagement score:
NHS Wales has not run the staff survey, which includes this metric, through the pandemic period.

k. Percentage of staff who report that their line manager takes a positive interest in their health & well-being:
NHS Wales has not run the staff survey, which includes this metric, through the pandemic period.

l. Emissions reported in line with the Welsh Public Sector Net Zero Carbon Reporting Approach:
The Trust Decarbonisation Action Plan (DAP) is currently reporting internally as Amber. Estates and Facilities Advisory Board funding in 2023/24 and 2024/25 will allow for investment in further infrastructure and decarbonisation schemes across a range of sites. The Trust has completed a scoping exercise for electrical capacity requirements across the WAST estate and work is

ongoing with Welsh Government Energy Services on rapid electronic vehicle charging.
A governance system has been developed to monitor, report, update and support all required DAP actions. The Decarbonisation Programme Board, chaired by the Director of Partnership and Engagement, ensures a strategic overview is achieved, alongside continuing to develop a work programme and risk management approach with meetings every quarter.

Annual quantitative public sector carbon emission reporting will be available for review upon submission following public sector carbon reporting guidelines. This information will be published on the Trust's website.
Collation of this data from internal processes is complete, however scope three supply chain data provided by NWSSP has yet to be received.

m. Qualitative report detailing the progress of NHS Wales' contribution to decarbonisation as outlined in the organisation's plan:
The Trust submitted its report to Welsh Government which is available on request.

n. Qualitative report detailing evidence of NHS Wales advancing its understanding and role within the foundational economy via the delivery of the Foundation Economy in Health & Social Services 2021/22 Programme:
The Trust submitted its report to Welsh Government which is available on request.

o. Report detailing evidence of NHS Wales embedding Value Based Health & Care within the organisational strategic plans and decision-making processes:
The Trust has not submitted a report as such, but the Value Based Healthcare Working Group in the Trust continues to develop its work programme alongside the Financial Sustainability Programme. There has been some slippage in implementation of Patient Level Information and Costing (PLICs), with data quality issues pushing implementation back to Q3 or Q4 in 2023/24. The work to trial Patient Reported Experience Measures with Aneurin Bevan University Health Board has been live during quarter four and we expect the results in quarter one of 2023/24.

We will be holding a workshop facilitated by Value in Health Centre in May 2023 to further enhance our understanding of Value Based HealthCare and how we can apply it across pre-hospital urgent and emergency care. Following this workshop, we will establish a Value Based HealthCare steering group with Executive leadership to guide the organisation in embedding Value Based HealthCare across all of our activities. This is a commitment that has been made in our IMTP this year.

1.16. Workforce Management and Well-being

Staff Well-being

The Trust has one of the most comprehensive mental health and wellbeing employee support offers across the sector. This includes internal and external supports to ensure our people have a wide range of options, and not assuming that one size fits all. Within this is an internal wellbeing department, with three wellbeing practitioners, a Trauma Risk Intervention Management (TRiM) lead and an assistant psychologist and psychology placement student; an online portal that can be accessed from personal devices, as well as within the Trust,
called www.wastkeepingtalking.co.uk and 24 hour access to our Employee Assistance Programme – Health Assured, who were selected due to their trauma informed approach. All staff can access the Thrive App which includes live coaching, Cognitive Behaviour Therapy courses and this has been downloaded to all Trust issued iPads.

In terms of mental health, and in particular expertise in trauma, the Trust employs three clinical psychologists who all provide consultation to managers and teams, in addition to working directly with individuals with complex presentations including post-traumatic stress disorder and all are trained in multiple trauma approaches, including eye movement desensitization and reprocessing. Every new starter to the Trust, or those who change roles, are made aware of our comprehensive offer at our WASTWarmWelcome sessions. The Occupational Health and Wellbeing Teams have two mobile clinic vans and regularly visit emergency departments and stations to promote health and wellbeing, as well as being present at all Chief Executive Roadshows that occur over two separate weeks each year.

TRiM was introduced into the Trust in 2018 and there are currently 50 TRiM Practitioners across Wales. Road crews have personal issue iPads, and there is a TRiM button on each one to use to self-refer. Managers also can refer staff to our TRiM Lead who will then contact the member of staff. In addition, there is a Peer Support Network and an extended chaplaincy service throughout Wales. The Trust is actively offering REACT Mental Health training to all managers so that they are able to notice any signs in their staff relating to distress and become more adept at having supportive conversations them. So far 279 managers have undergone this training, and further training sessions are set to be delivered throughout the 2023/24.

The Trust also has good links with services that are available to all NHS staff including Canopi and Silvercloud. The Ambulance Services Charity is also an important support option for staff, and the Trust have worked closely with them around employee wellbeing and suicide prevention across the sector. They have recently extended their services to include a crisis line for staff at risk of suicide, and those concerned about them. Staff are also able to access charities such as MIND, Blue Light, and the Samaritans.

Our services are advertised regularly through many mediums, including posters, leaflets, outreach by the Occupational Health and Wellbeing Team, Yammer, Intranet, and information regularly passed to managers. There is also a dedicated Occupational Health and Wellbeing Intranet site with up-to-date information on all services available to our people, along with contact details.

The health and wellbeing of our people is a priority, and the Trust is constantly reviewing how best to support them at work. However, it cannot be ignored that much of the stress experienced by our people at the current time is as a result of system pressures and the Trust must be cautious to ensure it does not try to locate difficulties within individuals that are as a result of external factors. No amount of wellbeing support will mitigate against working conditions currently being experienced by many staff.

Health and Safety

2022/23 continued to be a challenging year for the Trust in regard to ensuring the health, safety, and welfare of its staff. Whilst there is a strong level of internal control with respect to metrics provided to the Health & Safety Executive, challenges around incident reporting times or handlers confirming staff sickness absence to the Health and Safety function continue to impact on the timeliness of Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDORS) to the Health and Safety Executive. Also, whilst some restrictions did ease, pressures surrounding Covid-19 continued to have an impact upon the service.

The health and safety corporate Risk 199, '*Failure to embed an interdependent and mature health and safety culture which could cause harm and a breach in compliance with Health & Safety statutory legislation*', was subject to review and subsequently reframed to incorporate the aspects to health and safety culture within the organisation that could present a risk to staff and patients. In May 2022, the risk was reduced from 20 to 16 due to several deliverables achieved which provided a greater level of confidence within the Trust.

Following significant investment to support the Workforce Transformation business case, the new model commenced in quarter three 2022 with the new structure embedding health and safety further into the organisation at all levels throughout the Trust.

The pump prime phase for the health and safety function was completed in September 2022, with 13 deliverables as had been identified within the Trust's Working Safely Action Plan. As the Working Safely Programme is a medium-term project, four key workstreams have been identified for further improvement for 2023/24 which will assist in a potential reduction in risk 199.

Other actions identified on the Working Safely Action Plan will be incorporated into business-as-usual activities via the Annual Safety Plan, which support the Trust's IMTP objectives.

Delays outside emergency departments heavily contributed to a volume of Datix incidents citing ill health effects from potential exposure to diesel fumes. Three environmental surveys were undertaken by an external provider in quarter four 2022 and found not to have exceeded the legislative Workplace Exposure Limit. Following this, working groups were established with associated Health Boards to identify and implement pragmatic solutions.

Further surveys have been repeated at seven priority sites during quarter four 2023. These reports are currently being subject to analysis. Work continues at strategic and local levels throughout the Trust in the reduction of fume exposure.

Workforce Planning

Workforce planning continues to play a key role in the Trust's ability to achieve its strategic objectives. The last few years have seen close working with its colleagues in education and planning, and with key stakeholders both within and outside the organisation to ensure availability of fully trained and capable staff working at their optimum to ensure positive patient experience.

The year 2022/23 saw the continuation of significant recruitment and training activities following the ask from Welsh Government for an additional 100 WTEs. This number incorporated an additional 90 Emergency Medical Technicians and 10 Ambulance Care Assistants over and above the funded establishment. This has resulted in the numbers below being added to the total workforce. Significant recruitment activity took place during 2022/2023 with almost 700 hires, including:

- Over 150 hires for Emergency Medical Service (152);
- Over 70 hires for Emergency Medical Service Coordination Service (77);
- Over 100 hires for the 111 service (106);
- Over 280 hires for Ambulance Care Directorate (includes Ambulance Care Contact Centre) (289).

The Trust also received the following support from its volunteers: -

- Five Volunteer Car Service Drivers;
- 90 new Community First Responders;
- Five Volunteer Chaplains.

The resultant change in workforce numbers is reflected in the Accountability Report.

1.17. Decision-making and Governance

Trust's Governance and Accountability Framework

The Trust Board is accountable for governance, risk management and internal control in the organisation. The board is supported by seven Committees, the detail of which is in the Accountability Report at Section B of the Annual Governance Statement.

The management governance structures consist of the Executive Management Team (EMT) which assists the Chief Executive in discharging his accountabilities and is comprised of the Directors. The EMT meets weekly for formative discussions, support and decision making. The EMT is supported by a series of sub-groups including the Assistant Director's Leadership Team, the Clinical Quality Governance Group, the Policy Group, and the Quality and Performance Management Steering Group. The Strategic Transformation Board is the executive group that oversees the development and delivery of the IMTP and is supported by a number of Programme Boards aligned to the IMTP.

Each Directorate has a governance structure relevant to the size and portfolio of its director. Further details on the Trust's governance and accountability arrangements, and audit and assurance arrangements are set out in the section H 'Review of Effectiveness' within the Annual Governance Statement.

Ambulance Commissioning

A key aspect of the Trust's accountability and governance framework is that the Trust is a commissioned service for Emergency Medical Service and NEPTS. The commissioning is undertaken by the Emergency Ambulance Services Committee (EASC), on behalf of Health Boards, who are also supported by the Chief Ambulance Service Commissioner (CASC) and the National Collaborative Commissioning Unit. EASC, and its supporting committees, have continued to meet, with one or two exceptions, during periods of maximum escalation. Similarly, the monthly CASC Assurance meeting has continued to function through 2022/23, again with one or two exceptions for maximum escalation periods. The Trust has maintained its weekly dialogue with the CASC on quality, performance, governance, and financial commitments.

The Trust has received financial support from EASC during 2022/23, in particular for the recruitment of an additional 90 WTEs for front line Emergency Medical Service.

The Trust was working on a 'payment by results' basis for the recruitment of this extra 90 WTEs. The Trust is currently awaiting confirmation from EASC that the funding for these additional 90 staff is recurrent.

EASC sets the Trust a range of 'commissioning intentions' linked to the funding package, what is referred to as the 'resource envelope'. The Trust provides a Provider Report to every EASC meeting and also more detailed information to its sub-committees. The Trust has made good progress on the 2022/23 commissioning intentions and reported its progress through the year to the EASC Management Group with the year-end position being reported to EASC Management Group on the 20 April 2023.

Further information on EASC and the Trust can be found at https://easc.nhs.wales/. The Trust continues to operate a collaborative and open style of working with the CASC and his team.

Well-being of Future Generations (Wales) Act 2015

Please refer to the 'Partnerships and System Contribution' and 'Delivering in Partnerships' sections of the Performance Report for the Trust's position and progress on the Well-Being of Future Generations (Wales) Act 2015.

Welsh Language

The Welsh Language Standards, effective from 30 May 2019, have given the organisation the opportunity to improve the level of Welsh language services we provide for our patients, services users, and the wider population. The Trust's compliance requirements can be accessed via the Welsh Language Standards section on our website.

The Trust continues to strive towards ensuring that the Standards are embedded within its processes and systems to ensure that the Welsh language is treated no less favourably than the English language in its services and operations and that members of the public, learners and staff are able to interact with the Trust in the language of their choice.

Within the Trust's Integrated Medium-Term Plan (IMTP) 2023/26 we have a Welsh language framework that incorporates a new policy and guidance, as well as an action plan to implement the Welsh Government Mwy na geiriau/More than just words strategy with a focus on an active offer of Welsh across our services.

The Trust reports progress on key actions to achieve its ambitions and statutory obligations for the Welsh language in its Annual Welsh Language Report, where a range of statistics such as Welsh Language complaints, staff numbers with Welsh Language skills and recruitment numbers requiring Welsh Language can be found. This is published on the Trust's website by the end of September each year, in accordance with Standard 120 of the Regulations.

Sustainability

The Trust is committed to reducing its impact on the environment and hold the Welsh Government's ambition for the public sector to be carbon neutral by 2030. Under the NHS Wales Decarbonisation Strategic Delivery Plan, The Trust is required to meet stringent environmental targets for all Trust functions, including decarbonising its estate and fleet for 2030. A Decarbonisation Action Plan (DAP) has been produced, detailing actions, action owners and timelines for completion. The DAP is submitted to Welsh Government and updated annually. It is also included as an appendix within the Trusts IMTP.

Following current guidance, a decarbonisation qualitative report is submitted bi-annually to the Welsh Government detailing carbon reduction progress, challenges, and risks. Further data is not available at this time, but Carbon reporting data for 2022/23 will be made available to view from September 2023, in-line with Welsh Government public sector carbon reporting guidance. The Trust's Sustainability Report will be published when available, after the publication of the Carbon reporting data.

1.18. Conclusions and Look Forward

2022/23 has been another extraordinary year for the Trust as it has continued to respond to a number of internal and external pressures. There is no doubt that the Trust's staff have stepped up to the challenge, as have the Trust's partners.

Whilst the Trust has stepped up to meet the challenge, patient experience and safety in 2022/23 were not at the levels the Trust, or its stakeholders, aspire to. The reasons are complex and multiple, with some directly, or indirectly, related to COVID-19 and others due to underlying fundamentals that were a problem pre-pandemic.

The Trust recognises that the organisational and broader health system landscape has changed over the past few years. This has placed even greater emphasis on the need for system wide collaboration, developing longer-term solutions that meet the needs of the people of Wales today, and of future generations, focussing on improving clinical outcomes, patient experience and being value driven.

The long-term Strategic Framework for 2030, 'Delivering Excellence', which was agreed in 2019, sets out the Trust's ambition to move from being a traditional ambulance and transport service, to being a trusted provider of out-of-hospital high quality care, ensuring that patients receive the right advice and care, in the right place, every time, with a greater emphasis on providing care closer to home. The Trust's IMTP 2023/26 provides further details on the Trust's strategic plans.

1.19. Links to Further Information

The Trust reports delivery against its IMTP throughout the year and reports on performance to every Trust Board meeting through the Integrated Quality & Performance Report. For further information and to view these reports please click on the following links: -

Board Date	Board Agenda Item	Link to Trust Board Papers (Public)
26 May 2022	9 and 13	Trust Board Papers - May 2022
28 July 2022	10 and 12	Trust Board Papers - July 2022
29 September 2022	11 and 13	Trust Board Papers - September 2022
24 November 2022	11 and 13	Trust Board Papers - November 2022
26 January 2023	11, 13 and 14	Trust Board Papers - January 2023
30 March 2023	12, 13 and 15	Trust Board Papers - March 2023

Ambulance Quality Indicators: Each Health Board receives a performance indicator dashboard, from Welsh Government, to ensure consistent reporting in their annual reports. The Trust is not a Health Board and is a commissioned service by EASC; consequently, Welsh Government do not issue a dashboard to the Trust. Whilst no dashboard exists, the Trust considers itself a very transparent ambulance service, with the publication of the monthly Ambulance Service Indicators by EASC and Welsh Government.

Performance Report Contact Details: Should you require any further information on this Performance Report, please contact Hugh Bennett, Assistant Director - Commissioning and Performance on hugh.bennett2@wales.nhs.uk.

PART 2: - ACCOUNTABILITY REPORT

The Accountability Report is intended to meet key accountability requirements to the Welsh Government. The requirements of the Accountability Report are based on the matters required to be dealt with in a Directors' Report, as set out in Chapter 5 of Part 15 of the Companies Act 2006 and Schedule 7 of Statutory Instrument 2008 No 410, and in a Remuneration Report, as set out in Chapter 6 of the Companies Act 2006 and Schedule 8 of SI 2008 No 410.

The requirements of the Companies Act 2006 have been adapted for the public sector context as set out in the Government Financial Reporting Manual (FReM). It will, therefore, cover such matters as directors' salaries and other payments, governance arrangements and the audit certificate and report. The Accountability Report will be signed and dated by the Accountable Officer. The Accountability Report consists of three main parts. These are:

The Corporate Governance Report: This Report explains the composition and organisation of the Trust's Board and governance structures and how they support the achievement of the Trust's objectives. The Corporate Governance Report itself is in three main parts; the Directors' Report, the Statement of Accounting Officer's Responsibilities, and the Governance Statement.

The Remuneration and Staff Report: The Remuneration and Staff Report contains information about senior managers' remuneration. It will detail salaries and other payments, the Trust's policy on senior managers' remuneration and whether there were any exit payments or other significant awards to current or former senior managers. In addition, the Remuneration and Staff Report sets out the membership of the Trust's Remuneration Committee, and staff information with regard to numbers, composition, and sickness absence, together with expenditure on consultancy and off payroll expenditure.

Parliamentary Accountability and Audit Report: The Parliamentary Accountability and Audit Report provides information on such matters as regularity of expenditure, fees and charges, and the audit certificate and report.

2.1 Corporate Governance Report

This Corporate Governance Report details the composition of the Trust's Board and governance structures and how they support the achievement of the Trust's objectives. The Report explains the management and control of resources and the extent to which the Trust complies with its own governance requirements, including how the Trust has monitored and evaluated the effectiveness of its governance arrangements. It is intended to bring together in one place matters relating to governance, risk, and control.

The Corporate Governance Report aims to provide the reader with a clear understanding of the organisation and its internal control structure, the stewardship of the organisation and an explanation of the risks the organisation is exposed to. Where there are weaknesses reported in the Report, an explanation is provided on how these are being addressed. The Corporate Governance Report consists of three main parts which are: -

The Directors' Report: This provides details of the Board and Executive Team who have authority or responsibility for directing and controlling the major activities of the Trust during the year. Where information which would normally be shown here is provided in other parts of the Annual Report and Accounts, this is signposted.

The Statement of Accounting Officer's Responsibilities and Statement of Directors' Responsibilities in Respect of the Accounts: This requires the Accountable Officer, Chair and Executive Director of Finance and Corporate Resources to confirm their responsibilities in preparing the financial statements and that the Annual Report and Accounts, as a whole, is fair, balanced, and understandable.

The Governance Statement: This is the main document in the Corporate Governance Report. It explains the governance arrangements and structures within the Trust and brings together how the organisation manages governance, risk, and control.

2.1.1 The Directors' Report

The Directors' Report provides details of the Board, Executive Team and any other individuals who were Directors of the Trust and have, or had, authority or responsibility for directing and controlling the major activities of the Trust at any point during the year.

Where information normally presented in this report is discussed elsewhere in the Annual Report and Accounts, this will be cross-referenced, and the corresponding citation provided.

a) Details of the Chair, Chief Executive and Other Directors

The details of the Chair, Chief Executive and any other individuals who were Directors of the Trust at any point during the financial year, and up to the date that the Annual Report and Accounts were approved, are provided in the Governance Statement which forms part of this Corporate Governance Report.

The composition of the Trust Board and the names of the Directors forming the Audit Committee are also provided in the Governance Statement. Board Members are listed below, together with in-year changes.

Voting Members of the Board 2022/23 as at 31 March 2023

Colin Dennis (From 01 October 2022) 	**Trust Board Chair** Remuneration Committee Chair	**Prof Kevin Davies** 	**Vice Chair** Chair of Charitable Funds (until 04 May2022), and Academic Partnerships (until 31 December2022) and Finance and Performance Committees (until 31 December2022) Champion for armed forces and veterans; mental health
Bethan Evans 	**Non-Executive Director** Chair of Quality, Patient Experience and Safety Committee Champion for Welsh Language	**Paul Hollard** 	**Non-Executive Director** Chair of People and Culture Committee, Champion for; children and young people; older persons; raising concerns
Ceri Jackson 	**Non-Executive Director** Chair of Charitable Funds Committee (from 05 May2022), Champion for digital and transformation	**Hannah Rowan (From 01 April 2022)** 	**Non-Executive Director** Chair of the Academic Partnerships Committee (From 01 January2023); Champion for infection prevention control; equality; Putting Things Right; research
Joga Singh 	**Non-Executive Director** Chair of the Finance and Performance Committee (from 01 January 2023) Champion for equality	**Martin Turner** 	**Non-Executive Director** Chair of Audit Committee
Jason Killens 	**Chief Executive Officer** Accountable Officer	**Lee Brooks** 	**Executive Director of Operations** Champion for emergency planning

Brendan Lloyd 	**Executive Medical Director**	**Rachel Marsh** 	**Executive Director of Strategy, Planning & Performance** **(Voting member of Board from 25 April 2022[1])** Joint Executive Lead for the Finance and Performance Committee
Chris Turley 	**Executive Director of Finance and Corporate Resources** Joint executive lead for Finance and Performance Committee; Executive lead for Charitable Funds and Audit Committees; Fire safety champion	**Liam Williams** 	**Executive Director of Quality & Nursing** **(From 01 August 2022)** Caldicott Guardian Executive lead for Quality, Patient Experience and Safety Committee Champion for children and young people and putting things right

[1] Refer to narrative under these tables for further explanation.

Non-Voting Members of the Board 2022/23 as at 31 March 2023			
Estelle Hitchon 	**Director of Partnerships & Engagement** Executive lead for Academic Partnerships Committee	**Angela Lewis** 	**Director of Workforce and Organisational Development (From 12 September 2022)** Executive lead for People and Culture Committee and Remuneration Committee Champion for violence and aggression
Trish Mills 	**Board Secretary** Champion for Welsh Language	**Hugh Parry**	**Trade Union Representative at Trust Board (From 30 June 2022)**
Leanne Smith 	**Interim Director of Digital Services (From 01 August 2022)** Senior Information Risk Officer	**Andy Swinburn** 	**Director of Paramedicine**
Damon Turner 	**Trade Union Representative at Board**		

Board Members who left Board positions in-year			
Voting Members		**Non-Voting Members**	
Martin Woodford 	**Trust Board Chair (Until 30 September 2022)** Remuneration Committee Chair	**Craig Brown** 	**Trade Union Representative at Board – RCN (Until 30 June 2022)**
Wendy Herbert 	**Interim Executive Director of Quality & Nursing (From 07 March 2022 to 31 July 2022)[2]**	**Catherine Goodwin** 	**Interim Director of Workforce & Organisational Development (From 22 April 2022 to the 11 September 2022)[3]**
Claire Vaughan 	**Executive Director of Workforce & Organisational Development (Until 22 April 2022)**	**Andy Haywood** 	**Director of Digital Services (Until 31 July 2022)**

Further to the changes reflected in the above tables, Board member changes made during 2022/23 are set out below. These changes had no detrimental impact on the balance of the Board or on collective decision- making; the Board had a full complement of voting members at all times.

- Professor Kevin Davies' tenure as Vice-Chair of the Trust Board was extended from the 01 January 2023 to the 31 August 2023.
- Bethan Evans was reappointed as a Non-Executive Director for a second term of four years effective from 12 December 2022.

[2] Interim Director of Quality and Nursing from 01 August 2022 – 31 August 2022
[3] Acting Executive Director of Workforce & Organisational Development from 11 – 21 April 2022

- Ceri Jackson was an interim appointment to the Trust Board and, following an open recruitment campaign, was appointed as a substantive Non-Executive Director, effective from 01 April 2022.
- Hannah Rowan was appointed as a Non-Executive Director for a first term of four years effective from 01 April 2022.

As a result of the introduction of the National Health Service Trusts (Membership and Procedure) (Amendment) (Wales) Regulations 2022, which came into effect from 01 April 2022, the Trust Board composition – with regard to the number of voting Executive Directors and non-voting Directors – changed. These Regulations permitted the Trust to appoint a sixth voting Executive Director and made the Vice-Chair of the Trust Board a statutory role.

As a result, the Director of Operations role was reassigned as an Executive Director of Operations, effective from 01 April 2022, in response to the ability to appoint an additional Executive Director. It was further agreed that the Executive Director attribution assigned to the Executive Director of Workforce and Organisational Development move to the Director of Strategy, Planning and Performance, effective from 25 April 2022 – with the latter therefore becoming an Executive Director.

The members of the Trust's Audit Committee as at 31 March 2023 were Martin Turner (Chair), Paul Hollard, Ceri Jackson, and Joga Singh.

b) Declarations of Interest

The Register of declarations of interest for Directors can be found on the Trust website, Board Member Register of Interests, March 2023 - Live.xlsx (nhs.wales). A revised Standards of Business Conduct Policy will be rolled out in 2023.

c) Personal Data Related Incidents

Information on personal data related incidents which have been formally reported to the Information Commissioner's Office and "serious untoward incidents" involving data loss or confidentiality breaches are detailed in the Governance Statement which forms part of this Corporate Governance Report.

d) Environmental, Social and Community Issues

The Trust is aware of the potential impact its operation has on the environment and it is committed to:

- ensuring compliance with all relevant legislation and Welsh Government Directives;
- sharing the Welsh Government's ambition for public bodies to be carbon neutral by 2030;
- working in a manner that protects the environment for future generations by ensuring that long-term and short-term environmental issues are considered;
- preventing pollution and reducing potential environmental impact; and
- maintaining for the foreseeable future its ISO 14001 environmental management accreditation.

The Performance Report provides further details of the Decarbonisation Action Plan, the work of the Patient Engagement Community Involvement Team and our volunteers during 2022/23. It also details the Trust's involvement in the Regional Partnership Boards and the likely formal inclusion of the Trust in the Well-being of Future Generations (Wales) Act 2015.

e) Cost Allocation and Charging Requirements

The Directors confirm that they have complied with the cost allocation and charging requirements set out in His Majesty's Treasury guidance.

2.1.2 Statement of Accountable Officer's Responsibilities

The Accountable Officer is required to confirm that, as far as they are aware, there is no relevant audit information of which the Trust's auditors are unaware, and the Accountable Officer has taken all the steps that they ought to have taken to make themselves aware of any relevant audit information and to establish that the Trust's auditors are aware of that information.

The Accountable Officer is also required to confirm that the Annual Report and Accounts as a whole, is fair, balanced, and understandable and that they take personal responsibility for the Annual Report and Accounts and the judgments required for determining that it is fair, balanced, and understandable.

Statement
The Welsh Ministers have directed that the Chief Executive should be the Accountable Officer to the Trust.

The relevant responsibilities of Accountable Officers, including their responsibility for the propriety and regularity of the public finances for which they are answerable, and for the keeping of proper records, are set out in the Accountable Officer's Memorandum issued by the Welsh Government.

As Accountable Officer, I can confirm that, as far as I am aware, there is no relevant audit information of which the Trust's auditors are unaware and that I have taken all the steps that I ought to have taken to ensure that I and the auditors are aware of relevant audit information.

I can confirm that the Annual Report, and Accounts as a whole, is fair, balanced, and understandable, that I take personal responsibility for the Annual Report and Accounts and the judgement required for determining that it is fair, balanced, and understandable.

I can confirm that I am responsible for authorising the issue of the financial statements on the date they were certified by the Auditor General for Wales.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

SIGN

Jason Killens

Chief Executive Officer

DATE

2.1.3 Statement of Directors' responsibilities in respect of the Accounts

The Directors are required under the National Health Service Act (Wales) 2006 to prepare accounts for each financial year. The Welsh Ministers, with the approval of the Treasury, direct that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure of the Trust for that period.
In preparing those accounts, the Directors are required to:

- apply on a consistent basis accounting principles laid down by the Welsh Ministers with the approval of the Treasury;
- make judgements and estimates which are responsible and prudent
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the account

The Directors confirm that they have complied with the above requirements in preparing the accounts.

The Directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the authority and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction by the Welsh Ministers.

By Order of the Board
Signed:

SIGN
Colin Dennis
Chair of the Trust Board
Dated: 28 July 2023

SIGN
Jason Killens
Chief Executive Officer
Dated: 28 July 2023

SIGNATURE

Chris Turley

Executive Director of Finance and Corporate Resources

Dated: 28 July 2023

2.1.4 The Governance Statement

This Governance Statement demonstrates how we managed and controlled resources in 2022/23 and the extent to which we complied with our own governance requirements, including how we have monitored and evaluated the effectiveness of these arrangements. In doing so, it brings together all disclosures relating to governance, risk, and control.

a) Scope of Responsibility

The Trust Board is accountable for governance, risk management and internal control in the organisation. The Chief Executive (and Accountable Officer) of the Trust has responsibility for maintaining appropriate governance structures and procedures. This includes ensuring that the Trust has a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives, whilst also safeguarding the public funds and the organisation's assets. For the year ended 31 March 2023, and through to the date of approval of the Annual Report and Accounts, these have been carried out in accordance with the responsibilities assigned by the Accountable Officer of NHS Wales.

The Executive Management Team assists the Chief Executive in discharging his accountabilities and it meets weekly for formative discussions, support and decision making. A similar structure is mirrored for Assistant Directors in the Assistant Directors' Leadership Team.

The Annual Report outlines the different ways the Trust has had to work, both internally and with partners, in response to the unprecedented pressure in planning and providing services. It explains arrangements for ensuring standards of governance are maintained, risks are identified and mitigated, and assurance has been sought and provided.

Where necessary, additional information is provided in the Governance Statement. However, the intention has been to reduce duplication where possible. It is therefore necessary to review other sections in the Annual Report alongside this Governance Statement.

b) Governance Framework

Governance describes the ways that organisations ensure they run themselves efficiently and effectively. It also describes the ways organisations are open and accountable to the people they serve for the work they do. For the Trust, good governance is about creating a framework within which we:

- Provide our patients with good quality healthcare services.
- Are transparent in the ways we are responsible and accountable for our work.
- Ensure we continually improve the ways we work.
- Adhere to principles of good governance and the Nolan Principles.

Good governance is maintained by the structures, systems, and processes we put in place to ensure the proper management of our work, and by the ways we expect our staff to work. It is also about how we scrutinise our performance and deal with poor practice, ensure quality is at the heart of everything we do, and how we identify and manage risks, whether in terms of patient care, to our staff, or to the organisation as a whole.

The Trust's governance framework houses the structures, systems, processes, and behaviours NHS Wales health bodies are required to establish for ensuring good governance, and they include but are not limited to:

- Standing Orders, which incorporates the Schedule of Matters Reserved to the Board and Delegated Matters, and the Standing Financial Instructions;
- The requirement for a unitary Board and the Committees that support the Board, together with their terms of reference;
- How line managers operate, including codes of conduct and accountability;
- Annual business planning;
- Quality and performance management frameworks;
- Procedural guidance for staff;
- Risk register and assurance frameworks;
- Internal audit; and
- Scrutiny by external assessors including Audit Wales, the Welsh Government, Health Inspectorate Wales, and other stakeholders.

The Trust has agreed Standing Orders for the regulation of proceedings and business. These are designed to translate the statutory requirements set out in the NHS (Wales) Act 2006 and the National Health Service Trusts (Membership and Procedure) Regulations 1990 (SI 1990 No. 2024) as amended, into day-to-day operating practice. The impact of the 2022 amendments to these Regulations on the composition of the Board has been explained in the Directors' Report. Together with the accompanying Scheme of Matters Reserved to the Board, Scheme of Delegation to Officers and Others, and Standing Financial Instructions (all referred to as the 'Standing Orders'), they provide the regulatory framework for the business conduct of the Trust and define its ways of working.

On the 20 April 2023 the Audit Committee was alerted to the non-compliance with paragraph 7.4.3 of the Standing Orders with regard to the availability of Board papers ten calendar days ahead of meetings. All endeavours are made to publish papers seven days before each meeting.

In May 2023 the Trust Board approved a temporary amendment to Standing Order 7.2.5 which requires the Trust to hold its Annual General Meeting (AGM) no later than the 31 July each year. The temporary amendment was in response to guidance from the Welsh Government which allows NHS bodies to hold their AGM no later than 28 September 2023.

Whilst no other changes were made to the Model Standing Orders, Standing Financial Instructions, or the Scheme of Matters Reserved to the Board in 2022/23, amendments to the Scheme of Delegation to Officers and Others were approved in May 2023, as were amendments to the Terms of Reference for Committees which form part of the Standing Orders. The Standing Orders and accompanying documents can be found in the publications section of our website.

Governance Practice Notes have been developed to aid in the interpretation of parts of the Standing Orders and to provide consistency of approach. These included matters related to the affixing of the Trust's common seal; procedure with respect to Chair's actions, and how we conduct Board and Committee business in private session. These Governance Practice Notes were approved by the Audit Committee in March 2022 and reviewed in April 2023.

Trust Board

The Board is accountable for governance, risk management and internal controls. It focuses on the following key areas:

- Strategy: Developing the strategy, vision, and purpose of the Trust. Identifying priorities, establishing goals and objectives, applying resources, and allocating funds to support the decisions that need to be made around strategic planning;
- Embedding Ethical Behaviour: The Board shapes the culture of the Trust in several ways, including by the way in which it engages with staff, the public and stakeholders, the way it manages its agenda, by the nature of the debate at the Board and the relative emphasis given to different performance criteria, by the visibility of its members in the organisation, and by where it chooses to invest time and resources. Board members must live up to the highest ethical standards of integrity and probity and abide by the Nolan Principles;
- Quality: Sets organisation wide expectations and accountability for high performance and compliance with the Duty of Quality and the Duty of Candour as set out in the Health and Care (Quality and Engagement) (Wales) Act 2022. Ensures that all staff understand their role in the effective and high-quality provision of care in a governance framework that ensures a balance between trust, constructive debate, and effective challenge in a culture of openness and learning;
- Managing Risk: The Board is responsible for ensuring there is a robust system of risk management and internal controls in place, and that they are sighted on the mitigations in place for the principal risks to the delivery of the strategy;
- Gaining Assurance on the Delivery of Strategy and Performance: Holding to account, and being held to account, for the delivery of the strategy in accordance with the strategic and performance frameworks developed by the Board, focusing on strategy, performance, culture, and behaviours. Board Members have responsibility for the strategic direction of the Trust, and provide leadership and direction, ensuring sound governance arrangements are in place.

The Board comprises the Chair, Vice Chair, six Non-Executive Directors and six Executive Directors. It holds scheduled meetings bi-monthly, with an additional meeting to approve the Annual Report and Accounts, and an Annual General Meeting. The Trust Board met in public seven times in 2022/23, and nine times in private session, where matters of confidentiality and/or commercial sensitivity were discussed. Decisions made in private session of the Board and Committees are reported in the public session of the Trust Board.

The Board is supported by the Board Secretary who acts as principal adviser on all aspects of corporate governance within the Trust, four further non-voting Directors and two Trade Union partner representatives.

Board and Committee meetings in 2022/23 were appropriately constituted and were quorate. The Trust did not stand down any of the scheduled Board or Board Committee meetings during 2022/23, other than the Advisory Group (Local Partnership Forum) which operated under the pandemic governance structure as the Trade Union Partnership Cell until November 2022, when it was reconstituted and is now known as the Welsh Ambulance Services Partnership Team (WASPT). The terms of reference for WASPT were approved by the Board on 30 March 2023.

In accordance with the Public Bodies (Admissions to Meetings) Act 1960, the Trust is required to meet in public and has done so for its 2022/23 Board meetings, with meetings held at venues in Cwmbran, Cardiff, Wrexham, and Llandudno. Committee meetings continue to take place virtually over Microsoft Teams and the public sessions of these meetings are open to the public, who are provided with a link to the meeting. This is effective given the national remit of the Trust and allows for greater participation from members and attendees located throughout Wales.

To ensure business is conducted in as open and transparent manner as possible, members of the public, staff and stakeholders are able to join the public Board and Committee meetings via Zoom and Teams and have the opportunity to send questions for the Board prior to those meetings. Board meetings are livestreamed on the Trust's Facebook page and retained on YouTube and the Trust website for future reference.

Details of meeting dates and member attendance can be found in Appendix 1 and Appendix 2. Agendas and papers for public sessions are published on the Trust's website and all endeavours are made to ensure that this is done seven days before a meeting. The Trust held its Annual General Meeting in Cardiff on 14 July 2022, and this too was livestreamed.

The key focus of the Board during the year was delivery of performance and quality assurance and improvement, in an environment where the Trust saw the longest handover delays in its history, coupled with a very challenging winter and prolonged periods of industrial action. Much time at the Board and its Committees was devoted to the harm which our patients and our people were, and continue to be, exposed to, and in ensuring the Trust was doing all it could to mitigate this. This continues to be the focus into 2023/24, whilst at the same time ensuring it maintains pace in terms of strategic transformation to reduce instances of harm.

Decisions and actions were recorded and maintained in the form of full meeting minutes and a supporting action log, both of which are reviewed at each meeting. Key decisions and significant matters of business which require escalation are made by each Committee to the Trust Board after each Committee meeting in a highlight report. Examples of the key governance and control matters addressed by the Board during 2022/23 were:

- Audit Wales Annual Report;
- Audit Wales Structured Assessment 2022
- Charitable Funds accounts and annual report;
- Integrated quality and performance reporting aligned to the balanced scorecard of patients, people, value, and partnerships;
- Integrated medium term plan delivery of the 2022/25 plan and approval of the 2023/26 plan;
- Incidents;
- Risk and Board Assurance Framework;
- Standing Orders, Scheme of Reservation and Delegation, Standing Financial Instructions;
- Annual effectiveness reviews and amendments to terms of reference for all Committees;

- Trust Annual Report, accounts, and governance statements; and
- Welsh language Annual Report.

Further details on the working of the Trust Board in 2022/23 can be found on our website here including the dates of meetings, papers, minutes and recordings of past meetings.

The **Board Development Programme** continued in 2022/23 with a focus on understanding, learning and reflection. The ten scheduled sessions were well attended and designed to stimulate discussion on strategic initiatives; shape culture and behaviours; strengthen system and partnership working; enhance knowledge of the regulatory environment and allow for more detailed briefing of complex issues ahead of formal meetings. Sessions included:

- Equality, diversity & inclusion workshop and allyship programme;
- Working Safely Programme: A health & safety awareness session;
- Effective Scrutiny session by Audit Wales;
- The Trust's organisational strategy;
- Developing the Trust's Strategic Engagement Framework;
- Board behaviours discussion and being 'Our Best';
- Going from good to great – Board maturity;
- Blue light collaboration;
- Learning from public inquiries and independent reviews in regard to patient safety;
- Organisational purpose;
- Institution of Occupational Safety and Health (IOSH) training;
- Compassionate Leadership;
- 2023/26 IMTP development & 2023/24 Financial Plan;
- Financial Sustainability;
- The Health & Social Care (Quality and Engagement) (Wales) Act 2020 – Duties of Quality & Candour, including preparedness for the Duty of Quality;
- Digital Vision & Inclusion;
- Anti-Racist Wales Action Plan;
- Charity strategy;
- Structured Assessment.

In their Structured Assessment 2022, Audit Wales noted that whilst Non-Executive Directors do not tolerate poor performance - challenge and scrutiny by the Non-Executive Directors should be strengthened, particularly as it relates to the impact of actions to mitigate risk and improvements to internal controls following the adoption and closure of audit recommendations. This was discussed at the Trust Board on 26 January 2023 and the Audit Committee on 02 March 2023. On 27 April 2023 Audit Wales attended the Board Development session to facilitate a discussion on this. The further maturation of the risk management framework in 2023 will naturally assist this and, in the interim, guidance on the component parts of the Board Assurance Framework has been developed to support scrutiny.

The **Welsh Ambulance Services NHS Trust Charity** (registration number 1050084) is registered as a charity with the Charity Commission for England and Wales. The Trust is a corporate body in its own right, and the Trust Board acts as the Corporate Trustee of the Charity.

The Corporate Trustee is responsible for the general control, management, and administration of its charity, as well as setting its strategic aims and objectives. Oversight of the Charity is carried out by the Charitable Funds Committee.

The Charity Annual Report and Accounts for 2021/22 have been published on the Trust website here. As a result of a delay in the final audit of the accounts, these were filed after the filing date of 31 January 2023, on the 17 February 2023. The Board of Trustees expressed their disappointment at the delay and resultant notification on the Charity Commission website, and a risk has been developed on the impact to the Charity's reputation as a result.

The audit opinion is one of technical qualification with regards to the 2015/16 Opening Balances. Due to the charitable funds accounts not having a full audit since 2014/15 (but having received independent examinations each year by Audit Wales), as part of the 2021/22 audit, Audit Wales were required to gain assurances over the opening balances meaning their audit work also covered transactional testing of the accounting periods from 01 April 2015 to 31 March 2021, leading to a lengthier and more time-consuming audit.

Given the significant length of time this covered, unfortunately the supporting evidence for the transactions of 2015/16 were no longer available. Due to this, Audit Wales have not been able to gain assurances over the movements seen in 2015/16 of £28k income and £29k expenditure. This has resulted in a technical qualification of the 2021/22 accounts related specifically to prior year carried forward balances.

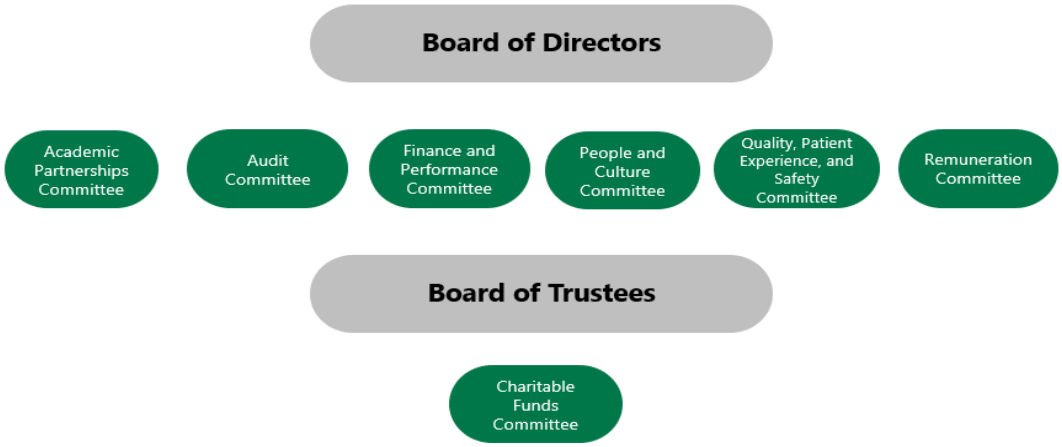
In summary, Audit Wales provided a technical qualification linked specifically to the 2015/16 opening balances and found no issue with subsequent financial years or directly in respect of the latest 2021/22 accounts.

Board Committees

The Board has seven standing Board Committees, each chaired by a Non-Executive Director. Committees play an important role in supporting the Board in fulfilling its responsibilities by:

- providing advice on strategic development and performance within the terms of reference;
- gaining assurance and providing oversight on key aspects of organisational performance, and supporting achievement of the Trust's strategic goals;
- carrying out specific responsibilities on the Board's behalf; and
- providing a forum where ideas can be explored in greater detail than Board meetings are able to allow, providing time and space to consider issues in greater depth.

Committee papers and minutes for each meeting are contained in the Committee section of the Trust's website. The Committee structure is as follows:



Committee Chairs prepare a highlight report for the Board which is based on an 'alert, advise, assure' (AAA) model. This is circulated to the Board following each meeting and discussed at the Board meeting following that Committee meeting. Minutes of Committee meetings are also presented to the Board once approved by the relevant Committee.

As well as reporting to the Board, Committees work together on behalf of the Board to ensure that cross-reporting and consideration takes place, and assurance and advice is provided to the Board and the wider organisation.

Each Board Committee has an Executive Director or Director lead who works closely with the Chair of that Committee and the Board Secretary in agenda setting, business cycle planning and to support good quality, timely information being relayed to the Committee.

The terms of reference for each of the Board Committees are set out in the Trust's Standing Orders and a summary of each of the Committee's responsibilities is given below. The Trust completed comprehensive effectiveness reviews and update of the terms of reference for each Board Committee during 2022/23; with the revised terms of reference approved by each Committee during January, February and March 2023 and approved by the Board in May 2023.

Each Committee has prepared an annual report of its business and effectiveness in 2022/23, with the annual reports and revised terms of reference for each Committee being accessed via this link Bundle Trust Board (Open Session) 25 May 2023 (nhs.wales).

The **Audit Committee** provides key sources of assurance to the Board that the organisation has effective controls in place to manage the risks to achieving its strategic objectives and reviewing governance and assurance processes. The Committee met four times during 2022/23 and considered the following key governance and control matters:

- Reviewed the Audit of Accounts Report (ISA260);
- Reviewed and endorsement for Board approval of the Annual Report and Accounts, and Governance Statement for 2021/22;
- Received the Head of Internal Audit Opinion for 2021/22;
- Agreed the internal and external audit plans for the year;
- Received internal and external audit reports and monitored progress against the audit recommendations tracker;
- Received the following reports from Audit Wales – Structured Assessment 2022, Quality Governance Report 2022, Emergency Services Joint Working Group Report;
- Reviewed the Risk Management Report and Board Assurance Framework, and considered adjustments to the Risk Management Framework and arrangements for reporting to the Board;
- Monitored arrangements for the preparation of the 2022/23 Annual Report and Accounts;
- Reviewed its effectiveness and agreed changes to its operating arrangements and terms of reference for 2022/23, and its cycle of business for 2022/23;
- Oversight and updates on the Covid-19 Public Inquiry;
- Reviewed losses and special payments, tender updates, and waiver reports.

Further details on the working of the Audit Committee in 2022/23 can be found here.

The **Remuneration Committee** provides advice and assurance to the Board in relation to the Trust's arrangements for the remuneration and terms of service for staff, in particular senior staff. The Committee meets in closed session only and met seven times during 2022/23. All of the non-executive directors are members of the Remuneration Committee, and the Chair is the Chair of the Trust Board.

The **Academic Partnerships Committee** is a fairly new Committee (established July 2020) to the Trust's corporate governance structure, and as such its purpose and role is still forming and will continue to do so over the next 12 months as the Trust pursues University Trust Status. Within year, the Chair of this Committee moved from Kevin Davies to Hannah Rowan (effective 01 January 2023). The Committee met four times in 2022/23 and the following key matters were discussed:

- The University Trust Status submission, and plan for there to be a member of the Board who represents academia, as a part of this process;
- Discussions on future income generation opportunities;
- Benefits and limitations of the apprenticeship landscape in relation to education and training;
- Mapping engagement interfaces to illustrate where and how the organisation connects with its academic and industry stakeholders;
- Discussion of institutions and the need to explore opportunities for innovation and improvement and connection with action research, which can be applied in practice;
- Reviewed its effectiveness and agreed changes to its operating arrangements and terms of reference for 2023/24 and approved its cycle of business for 2022/23.

Further details on the working of the Academic Partnerships Committee can be found here.

The purpose of the **Charitable Funds Committee** (whose name will change from May 2023 to the Charity Committee) is to make and monitor arrangements for the control and management of the Trust's charitable funds and its strategic direction. The Committee met six times during 2022/23 and the following key matters were discussed:

- Commissioned a strategic review of the charity to provide recommendations for its future direction, and received a presentation from Hywel Dda University Health Board's charity on their charity maturation journey;
- Agreed a full audit of the 2021/22 charity annual report and accounts, which would go on to be approved by the Board of Trustees;
- Received regular financial reporting on charitable funds and grant applications made by the charity;
- Received regular reports from the Bids Panel and Bursary Panel on bids approved under delegated authority;
- Approved amendments to the terms of reference for the Bursary Panel and agreed an appropriate delegated authority limit to the Panel regarding individual applications;
- Reviewed its effectiveness and agreed changes to its operating arrangements and terms of reference for 2023/24 and approved its cycle of business for 2022/23.

Further details on the working of the Charitable Funds Committee can be found here.

The **Finance and Performance Committee** supports the Board by providing assurance with regard to the Trust's statutory financial and planning responsibilities and has a monitoring role in the delivery and performance of business functions across the Trust. Within year, the Chair of the Committee moved from Kevin Davies to Joga Singh (effective from 01 January 2023). The Committee met six times during 2022/23 and the following key matters were considered:

- Received regular reports on performance and handover delays, escalating to the Trust Board the effect of avoidable harm and death to patients and poor experience for staff;
- Received a finance report at each meeting;
- Discussed the financial sustainability programme;
- Reviewed performance against the Monthly Integrated Quality and Performance Report at each meeting, with a deep dive on Ambulance Care in January 2023. The annual review of metrics for this report was reviewed in July 2022;
- Received and discussed progress on the Integrated Medium-Term Plan (IMTP) for 2022/2025, which was reviewed at each meeting;
- Received the outturn position against the 2021/24 IMTP, and received and endorsed the 2023/2026 IMTP and financial plan;
- Regular discussion throughout the year on progress against the Decarbonisation Action Plan, which was approved by the Committee in March 2022;
- Received a six-monthly update on the Quality and Performance Management Framework was received in November 2022;
- Received an operational update at each meeting;
- Received internal audits within the Committee's remit, and the audit tracker to monitor progress against recommendations;
- Received the Risk Management Report and Board Assurance Framework at each meeting. The Committee agendas were built around the highest rated risks for the Committee;
- Reviewed its effectiveness and agreed changes to its operating arrangements and terms of reference for 2023/24 and approved its cycle of business for 2022/23.
- In private session the Committee discussed the Integrated Information System (Salus), NHS Wales Microsoft Enterprise Agreement, Decommissioning of Digipen, the 2023/24 fleet replacement business case justification case, and the Trust's position in relation to the findings of Audit Wales reports on cyber-attacks and cyber-resilience.

Further details on the working of the Finance and Performance Committee in 2022/23 can be found here.

The **People and Culture Committee** supports the Board by providing assurance with regard to all matters pertaining to its workforce, both paid and volunteer. The Committee provides assurance to the Board of its leadership arrangements, behaviours and culture, training, education and development, equality, diversity and inclusion agenda, and Welsh Language. The Committee met four times during 2022/23 and the following key matters were considered:

- Received regular reports on the challenging staff experience, escalating this to the Trust Board, and received updates at each meeting from the Director of Workforce and Organisational Development and Executive Director of Operations;
- Monitoring sickness absence rates, in relation to the discussions regarding the monitoring of the related corporate risk, and received reports on the Improving Attendance Programme;
- Received the Welsh Language report;
- Received regular staff experience presentations, together with learning and improvements made as a result of the issues raised;
- Received regular updates on partnership working with Trade Union colleagues including receipt of the Trade Union Annual Report, and updates in regard to the re-establishment of the Welsh Ambulance Services Partnership Team, approving this group's terms of reference;
- The Committee reviewed the proactive well-being offer in place and the increased profile of the occupational health team and peer support networks;
- Received and discussed the areas of focus for the Integrated Medium-Term Plan for 2023/26 in relation to people and culture, which was aligned to the development of the 2023/26 People and Culture Plan;
- Oversight of health and safety matters was transferred to the Committee from the Quality, Patient Experience and Safety Committee from 01 April 2022, and the Committee received an overview of the transformational efforts underway with the Working Safely Programme;
- The actions to address the Wales Anti-Racist Action Plan were discussed which will inform the people and culture plan, and the Annual Equality Report was received in November 2022;

- Received regular updates from the Speaking Up Safely Task & Finish Group on the development of the new framework, and received results from the Sexism and Sexual Safety at Work survey;
- Received internal audits within the Committee's remit, in addition to the audit tracker, to monitor progress against recommendations;
- Received the Risk Management Report and Board Assurance Framework at each meeting. The Committee agendas were built around the highest rated risks for the Committee;
- Reviewed its effectiveness and agreed changes to its operating arrangements and terms of reference for 2023/24 and approved its cycle of business for 2022/23.

Further details on the working of the People and Culture Committee in 2022/23 can be found here.

The **Quality, Patient Experience and Safety Committee** supports the Trust Board by providing assurance with regard to the Trust's clinical governance arrangements, in particular those for safeguarding and improving the quality and safety of patient centred healthcare. The Committee met four times during 2022/23 and the following key matters were considered:

- Received regular reports on patient safety, escalating to the Trust Board the volume of serious incidents and nationally reportable incidents causing avoidable harm and death to patients;
- Received the Health Inspectorate Wales Annual Review 2021/22 at its meeting in November 2022, which was subsequently received by the Trust Board;
- Reviewed remedial plans in place and escalated to the Trust Board of timeliness of response for Putting Things Right Regulations;
- Received reports on Regulation 28 Prevention of Future Deaths reports and actions in place to address concerns raised, and learning;
- Received at each meeting a patient experience story, either from the patient directly or a relative of a patient, on their lived experience of the service, together with learning and improvements made as a result of the issues raised;

- Received at each meeting an update on the Quality Strategy Implementation Plan and discussed the pace at which this was progressing;
- Received at each meeting the Patient Experience and Community Involvement report, receiving assurance that the Trust was engaging with patients and the community through the Continuous Engagement Model;
- Focused on the Trust's preparedness for implementation of the Health and Social Care (Quality and Engagement) (Wales) Act 2020. Including the Trust's compliance with the Health and Care Standards;
- Approved the Clinical Audit and Outcome Review Plan 2022/23;
- Received the Infection Prevention Control Annual Report 2021/22;
- Received internal audits within the Committee's remit, and the audit tracker to monitor progress against recommendations;
- Reviewed the work of the safeguarding team via the Annual Safeguarding Report;
- Received the Board Assurance Framework and Corporate Risk Register at each meeting. The Committee agendas were built around the highest rated risks for the Committee;
- Reviewed its effectiveness and agreed changes to its operating arrangements and terms of reference for 2023/24 and approved its cycle of business for 2022/23.

Further details on the working of the Committee in 2022/23 can be found here.

Advisory Groups

In support of the Board, the Trust has established the Welsh Ambulance Services Partnership Team (WASPT) as the forum where senior leaders, trade unions and professional organisations work together to improve the Trust's services for the people of Wales. It is the principal partnership forum for the discussion of national priorities and strategies and where trade union partners and senior leaders engage with each other to inform, debate, and seek to agree priorities on workforce and health service issues. This Advisory Group provides the formal mechanism for consultation, negotiation and communication between the trade unions and the Trust's senior leadership.

During the pandemic, the Local Partnership Forum was stood down and a Trade Union Partnership Cell under the pandemic structure was formed. WASPT met in shadow form to revise its terms of reference in September 2022 and was formally re-established in November 2022. Reporting is to the People and Culture Committee at each meeting, with that Committee escalating issues to the Board and reporting via the AAA highlight report.

WASPT meets bi-monthly until such time as local sub-structures are agreed and established, at which time the intention is for it to move to quarterly meetings in keeping with its strategic remit. Meetings are held in private because of the sensitive nature of the discussions. The terms of reference for WASPT were approved by the Board on 30 March 2023.

The Trust does not have a stakeholder reference group or a healthcare professionals' forum (as defined in the IFRS NHS Wales Manual for Accounts) as these are not applicable to the Trust.

Joint and All-Wales Committees

The Emergency Ambulance Services Committee (EASC) is a joint committee of the seven Health Boards, with the three NHS Trusts as associate members, and was established in April 2014. It has responsibility for the planning and commissioning of emergency ambulance services on an all-Wales basis. The Committee is hosted by Cwm Taf Morgannwg University Health Board and regular activity reports are received by the Board. Further information on EASC and its commissioning role is set out in the Performance Report.

The Welsh Health Specialised Services Committee (WHSCC) was established in 2010 to ensure fair and equal access across NHS Wales to the full range of specialised services. The WHSSC is also a joint committee of the Health Boards in Wales. The Committee is hosted by Cwm Taf Morgannwg University Health Board and regular activity reports are received by the Board. The Trust Chief Executive Officer is an Associate member of the Committee.

The NHS Wales Shared Services Partnership Committee was established in 2012 and is hosted by Velindre NHS Trust. It looks after the shared functions for NHS Wales, such as procurement, recruitment, and legal services. Regular activity reports of the Committee are received by the Board. The Trust's Executive Director of Finance and Corporate Resources is a member of this Committee. Reports from these Committees are included in each Board pack.

Improvements to the Governance Framework

The Trust Board routinely assesses the effectiveness of its governance arrangements, of which the Board's Committees are an integral element. Annual Committee effectiveness reviews have been undertaken for each of the Committees of the Board, and in addition to the outcomes of the regular Board Development activity, a series of adjustments to operating arrangements and terms of reference were proposed to the Board in May 2023. The most significant of these changes are:

- Academic Partnerships Committee: the approval of the research governance framework and oversight of its implementation in accordance with the Welsh Government Research Governance Framework for Health and Social Care has transferred to this Committee from QuEST;

- Charitable Funds Committee: given the focus during 2022/23 on developing the strategy for the charity, it was felt the Committee required a change of name to better reflect its remit, and it is proposed that the Committee is known as the Charity Committee;
- Finance and Performance Committee: cyber resilience and cyber security have been added to its remit;
- Quality, Patient Safety and Experience Committee: a further review of its terms of reference will take place during 2023 to ensure robust alignment to the Duty of Quality and Duty of Candour.

Changes to operating arrangements that affect all Committees include: -

- Period of reflection at the end of each meeting to take note of a summary of actions and decisions, and an invitation to members to give feedback on the meeting in terms of any learning/continuous improvement to take forward – effective from 01 April 2023;
- The Committee Highlight Reports (AAA reports) will be distributed to all Committee members and attendees after the meeting and the Chair will feedback on escalations raised to the Trust Board in matters arising as well as where appropriate, throughout the meeting – effective from 01 April 2023;
- A Board Visits Standard Operating Procedure developed to demonstrate visibility of Committee members – this was approved at the May 2023 Board;
- Presenters of papers take the papers as read and draw out highlight, lowlights, and red flags only, providing more time for challenge, support, and questions;
- Revised paper template and guidance to aid report writers in compiling concise papers and encouraging appendices and succinct executive summaries – to be implemented for quarter two 2023/24;
- Closer attention to allocated time both at agenda setting but also in the time leading up to the meeting – started but will be complete with corporate governance Standard Operating Procedure to be implemented for quarter two 2023/24;
- Board development/guidance on the constituent parts of the Board Assurance Framework to enable members to scrutinise controls, assurances, gaps, and action plans – guidance developed and wider Board development in 2023/24 as part of the risk transformation programme.

c) The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risks; it can therefore only provide reasonable and not absolute assurances of effectiveness.

The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively, and economically.

The system of internal control has been in place for the year ended 31 March 2023 and up to the date of approval of the Annual Report and Accounts.

d) Capacity to handle risk

The Trust is committed to actively and effectively managing risk as a key element in the successful delivery of its business and strategic objectives, and service provision to the public and remains committed to ensuring staff throughout the organisation are trained and equipped to identify, analyse, evaluate, treat, and escalate risks.

Managing risk is a key, collective responsibility for the Trust Board and remains an integral part of the governance arrangements to further strengthen and positively impact the development of the Trust's future strategic ambition. It provides clarity on the risks that would prevent us from achieving our organisational objectives.

The Chief Executive, as Accountable Officer, has overall responsibility for ensuring that the Trust has an effective risk management framework and system of internal control in place; however, Directors have responsibility for the ownership and management of principal and operational risks within their portfolios.

The Board Secretary has responsibility for leading on the design, development and implementation of the Risk Management and Board Assurance Framework (BAF) that provides a line of sight to the controls and related assurances, and the actions the Trust will take to mitigate the risks.

The ambition for the risk management framework as set out in the Integrated Medium-Term Plan (IMTP) 2023/26 is to develop and deliver a strategic risk management framework as a key enabler of our long-term strategy and decision making.

During 2022/23 a detailed review of corporate risks was undertaken and each was re-articulated in an '*if, then, resulting in*' format to provide a clearer understanding of the risk. This led to a transitional BAF template being introduced in July 2022 which built further on the re-articulation of these risks to provide the Board and Committees with detail on controls, assurances, gaps, and actions to further mitigate the risks.

The transitional BAF is mapped to the IMTP deliverables and by extension to the strategic objectives. The link to the BAF and the risk report discussed at the Trust Board on 30 March 2023 can be found here. The IMTP 2023/26 provides for the next stage of maturity of risk in the development of a strategic BAF and risk appetite statements to support decision making.

The Risk Register Development Guide describes the Trust's processes to assess and treat risk through local, directorate and corporate risk registers. The Datix Risk Management System is the platform within which risks are centrally held and supports the management of the risks on these registers. The Guide allows risk owners to apply appropriate inherent, current and target risk scores using a 5 x 5 matrix for likelihood and consequence. The frequency of monitoring risks and the levels of escalation are set out in these documents to enable lower rated risks to be managed locally by the risk owner and delegated officers, teams and managers best placed to mitigate them. Once for Wales amendments to this scoring matrix were received by the Audit Committee and the Board in July 2022.

The Trust operates as part of a publicly funded healthcare system in Wales and does not have unlimited resources, therefore it determines the appropriateness and cost of resources required to address principal risks.

Whilst risk is inherent in many of the Trust's activities, it will not accept risks that materially impair the ability to deliver services to a high standard of safety and quality, its reputation or those that may cause any disrepute with its stakeholders. The Trust focuses on actions to mitigate risk, with regular review and oversight to ensure those actions have the desired impact. Formal risk appetite statements will be developed as part of the IMTP 2023/26 and aligned to the BAF.

In two key areas the Trust's risk appetite is risk averse, which means that risks will be eliminated or reduced to the lowest practical level should they impact negatively upon:

- The quality and safety (including physical and/or psychological harm) of its patients, workforce, and the public, and
- Compliance with statutory duty, regulatory compliance, or accreditation.

Nonetheless, sustained and extreme pressure across the Welsh NHS urgent and emergency care system is negatively impacting on patient flow leading to avoidable patient harm and death. Internal and external factors are putting services under severe pressure which presents risks to patient safety and delivery of agreed plans for service transformation.

This means that the Trust's highest rated risks, ID 223, and ID 224, scoring 25, remain unchanged despite a series of mitigating actions being in place. These risks are in relation to delays in community response and delays in transfers from the ambulance on arrival at the emergency department to a suitable hospital bed, continue to be closely monitored by management, Board Committees, and the Trust Board.

At its July 2022 meeting the Trust Board received and discussed a report relating to avoidable harm which included a series of actions being taken by the Trust and system stakeholders to mitigate this. The Board continue to receive progress reports at each meeting in relation to each of the 32 actions which are directly related to risks ID 223 and ID 224.

Matters have continued to be escalated at the highest level to seek to influence further mitigations to these risks in the wider systems, including to the Minister for Health and Social Services, Welsh Government, the Director General for Health and Social Services and Chief Executive of the NHS in Wales, the Chief Ambulance Service Commissioner and the Chief Executives of Health Boards raising concern regarding the level of risk that the Trust is carrying and its inability to respond to patients resulting in patient harm and death.

The Performance Report within the 'Managing Risk' section provides details of the high-level mitigations in place for these risks and other highest rates risks. The Board Assurance Framework available on the Trust via this link - provides further detail of mitigating actions for all principal risks, and these are updated when risks are reviewed according to their risk tolerance.

Risk Profile

The risk profile of the Trust, described in the table below, is subject to senior management scrutiny. As at the 30 March 2023 Trust Board meeting there were seventeen organisational wide, principal risks on the Trust's Corporate Risk Register. There are twelve principal risks scoring 15 and above which are detailed below.

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)** ➡

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

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
139 FPC	Failure to Deliver our Statutory Financial Duties in accordance with legislation	**IF** the Trust does: • not achieve financial breakeven and/or • does not meet the planning framework requirements and/or • does not work within the EFL and/or • fails to meet the 95% PSPP target and/or • does not receive an agreement with commissioners on funding (linked to 458) **THEN** there is a risk that the Trust will fail to achieve all its statutory financial obligations and the requirements as set out within the Standing Financial Instructions (SFIs) **RESULTING IN** potential interventions by the regulators, qualified accounts and impact on delivery of services and reputational damage	Director of Finance & Corporate Resources	**16 (4x4)** →
245 FPC	Failure to have sufficient capacity at an alternative site for EMS Clinical Contact Centres (CCCs) which could cause a breach of Statutory Business Continuity regulations	**IF** CCCs are unable to accommodate additional core functions and do not have alternative site arrangements in place in the event of a business continuity incident	Director of Operations	**16 (4x4)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		THEN there is a risk that EMS CCCs cannot utilise other CCC's space, accommodation and facilities **RESULTING IN** potential patient harm and a breach of the requirements of the Civil Contingencies Act (2004) and Contingency Planning Regulations (2005)		
458 FPC	A confirmed commitment from EASC and/or Welsh Government is required in relation to funding for recurrent costs of commissioning	**IF** sufficient recurrent funding is not forthcoming there is a risk that the Trust will be committed to additional expenditure through delivery of the IMTP and in year developments which are only recognised by commissioners on a cost recovery basis **THEN** there is a risk that the Trust may not be able to deliver services and there will be a lack of funding certainty when making recurrent cost commitments. Any potential 'exit strategies' from developed services could be challenging and harmful to patients.	Director of Finance & Corporate Resources	**16 (4x4)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		RESULTING IN patients not receiving services, the Trust not achieving financial balance and a potential failure to meet statutory obligations causing reputational damage		
557 PCC	Potential impact on services as a result of Industrial Action	**IF** trade unions take industrial action in response to the national pay award **THEN** this is likely to disrupt our ability to provide a safe, efficient and good quality service in the 6 core areas the business **RESULTING IN** potential harm to patients, adverse effect to patient outcomes, increase in SAIs/concerns/coroners cases, negative media reports, and impact on the Trust's corporate reputation	Director of Workforce & Organisational Development	**16 (4x4)**
199 PCC	Failure to embed an interdependent and mature health and safety culture which could cause harm and a breach in compliance with Health & Safety statutory legislation	**IF** there is a failure to embed an interdependent and mature health and safety culture, effective arrangements and associated governance **THEN** there is a risk of a potential breach in compliance with the requirements of the Health & Safety at Work etc. Act 1974 and associated regulations and other statutory instruments	Director of Quality & Nursing	**15 (3x5)** ➡

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		RESULTING IN death or serious injury, and punitive actions from multiple enforcement agencies including penalties and adverse publicity leading to damage to reputation		
260 FPC	A significant and sustained cyber-attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems	**IF** there is a large-scale cyber-attack on WAST, NHS Wales and interdependent networks which shuts down the IT network and there are insufficient information security arrangements in place **THEN** there is a risk of a significant information security incident **RESULTING IN** a partial or total interruption in WAST's ability to deliver essential services, loss or theft of personal/patient data and patient harm or loss of life	Director of Digital Services	**15 (3x5)** →
543 FPC	Major disruptive incident resulting in a loss of critical IT systems	**IF** there is an unexpected or uncontrolled event e.g. flood, fire, security incident, power failure, network failure in WAST, NHS Wales or interdependent systems **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)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
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)** →

The timely review of risk and associated mitigation plans has been impacted by the challenges faced as a result of our preparation and response to winter pressures and industrial action. These risks have, nevertheless, been subject to scrutiny and challenge by the Trust Board and relevant Board Committees at each meeting.

Risks 223, 224, 201 and 160, the Trust's highest scoring principal risks have been subject to regular and full review throughout the period of sustained operational pressures.

Risk Assessment and Risk Review Process

The Trust's Assistant Director Leadership Team, Executive Management Team, Audit Committee and Trust Board regularly received, considered, and commented on the Corporate Risk Register during 2022/2023. Furthermore, risks relevant to the remit of the Finance and Performance, People and Culture, and the Quality, Patient Experience and Safety Committees were reported at each meeting for scrutiny and challenge. The Committee agenda is developed and aligned to risks within their remit and deep dives on particular mitigations of risks feature regularly for detailed discussion. In addition, the Board receives a stand-alone report on all principal risks on the Corporate Risk Register with a particular focus on the highest rated risks (those scored 20 and 25) at each Board meeting.

On each occasion, commentary was provided to explain progress made by the Trust (including partners and stakeholders as appropriate) to mitigate existing risks and to set out all new and emerging risks to the organisation.

The Assistant Directors Leadership Team (ADLT) continue to review the risk assessments on all new principal risks in addition to reviewing any changes to existing risks and mitigating actions. Each of the principal risks have been developed by the delegated, responsible officers and the risk owners and are agreed at Directorate Business Meetings prior to review by the ADLT. The activity is then reported to the Executive Management Team, relevant Board Committees and Trust Board.

The Trust recognises that managing several of its key risks relies on close partnership working with stakeholders (e.g., Health Boards) to ensure risks are understood and mitigating actions are carried out in partnership, where necessary. The highest scoring risks are regularly shared across peer networks such as the Directors of Nursing and Chief Operating Officer meetings and are discussed at the All- Wales Chief Executive's forum and with Welsh Government. In addition to this, as part of the Trust's risk maturity, the ambition is to undertake joint discussions on corporate risks at national risk management forum meetings.

The Trust receives information from a variety of other sources which helps inform the Trust's risks and mitigating actions. These sources include feedback from patients and the public, concerns raised with the Trust and serious adverse incidents.

Internal Audit undertook a further, planned audit on risk management in Quarter 4 2022/23, with the overall objective to review the Trust's framework of organisational assurances in place and report on risk management. That review concluded that there was reasonable assurance on risk management and assurance arrangements for the Trust, with four recommendations raised. The areas highlighted that could be strengthened will form part of the Risk Management Improvement Programme under the IMTP 2023/26.

Stakeholder Involvement in Risk Management

The Trust recognises that managing several of its key risks relies on close partnership working with stakeholders (e.g., Health Boards) to ensure risks are understood and mitigating actions are carried out in partnership where necessary. Risks ID 223 and 224 (set out above) in particular require close involvement from system partners to support the mitigation of these highly rated risks.

The Trust receives information from a variety of other sources which helps inform the Trust's risks and mitigating actions. These sources include (but are not limited to) feedback from patients and the public, concerns raised with the Trust and serious adverse incidents.

Working with partner organisations is a prominent factor in delivering the Trust's services and ambitions as set out in the IMTP which will result in significant benefits for the population. However, in doing so, the Trust recognises that this will impact on the environment where services and projects are delivered and can lead to additional partnership and programme risks.

Risk Management Training

The continuing impact of operational pressures including winter and industrial action has meant that face to face training has been paused. However, the Trust has been committed to continuing to deliver risk training and the Head of Risk/Deputy Board Secretary, has delivered virtual training sessions at the Assistant Directors' Leadership Team meeting, Directorate business meetings, the Operational Heads of Service away day and Operational Team Leader and Duty Operations Managers' induction programmes.

The training captured the fundamentals of risk management including the identification and escalation of risk and how to manage risks via the Datix Risk Management System, as well as discussion on the Trust's highest scoring risks and the role all staff have in mitigating risk.

The Head of Risk/Deputy Board Secretary is continuing to work with colleagues across NHS Wales to develop a consistent training needs analysis and risk training modules that will align to the new Once for Wales System for Risk Management.

Guidance has been developed to aid in the interpretation of the component parts of the BAF to support Board members in the questions they ask to seek appropriate levels of assurance.

Risk Management Improvement Programme – Focus for 2023/24

A 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 IMTP as one of the fundamentals of a quality driven, clinically led, value focussed organisation.

The Trust has embedded a positive risk culture during 2022/23 with the re-articulation of the principal risks and the introduction of a transitional BAF. The maturity of the BAF as a vehicle to support the Board in delivery of the organisation's long-term goals is the focus for the IMTP.

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.

The maturation of the risk management framework in the 2023/26 IMTP will support the Trust to focus on whether mitigation actions are achieving their intended impact on significant and ongoing risks and challenges, and to challenge where that impact is not being demonstrated or sustained.

Emergency Preparedness and Specialist Operations

As a Category One NHS organisation, under the Civil Contingencies Act 2004, the Trust has ensured that we have maintained emergency plans and business continuity arrangements through 2022/23, that consider our duties under the Act and under the NHS Wales Emergency Planning Core Guidance issued by the Welsh Government. The Trust has submitted its annual Emergency Planning Report to Welsh Government, setting out our level of compliance in meeting these requirements, this submission has included the Trust's Incident Response Plan, Emergency Preparedness Resilience and Response (EPRR) structure and the Trust's response structure to an incident.

The Trust has reviewed and updated its Incident Response Plan taking into account national updates in command arrangements, such as the updated Joint Emergency Services Interoperability Principles and learning from national events identified through national mechanisms such as Joint Organisation Learning (JOL). These have included learning from the London attacks and incidents on the railways. The updates have also included learning from internal events such as Business Continuity Incidents, Critical incidents, and Major Incident Stand-by incidents.

Planned and spontaneous events, such as the death of the late Queen Elizabeth II, large events across Wales, the cyber-attack on the NHS and the continuing pressure on the Trust from hospital delays, have allowed the organisation to test its command-and-control arrangements on a number of occasions over the past year.

The Trust has continued to work with Local Resilience Forum partners in reviewing national and local risks. Working with partners, a number of risks have been identified that had an increased potential impact on the Trust. This work has led to the introduction of new Business Continuity Plans, including a Power Outage Plan and an Industrial Action Plan.

Reliance on technology is ever increasing and, in summer 2022, we reviewed our resilience, business continuity and disaster recovery posture with this perspective - stress-testing departmental and organisational plans in the event of a major cyber-attack or ICT systems failure.

As the organisation approached the winter period in 2022, the pressures on the Trust were increasing, with hospital delays impacting on the Trust's ability to respond to our patients in the community. Other factors facing the trust included the war in Ukraine potentially impacting on power supplies, industrial action impacting the organisation and the expected increase in demand on the 999 and 111 services. Learning from the Pandemic had shown the Trust that having senior managers with an oversight of the overall risks to the Trust had worked well; this approach was deployed again over the winter period. Our senior management team convened a Senior Business Continuity Planning Team to ensure the risks were mitigated to the best ability of the organisation; this team worked well and convened subgroups as required, to mitigate impacts on the Trust.

Details of how we moved from pandemic recovery phase at the beginning of the year in April 2022 to the 'new normal' throughout the year is set out in the Performance Report within the 'Delivery, Quality and Performance Analysis' section.

The Trust has sustained a full Hazardous Area Response Team (HART) and Specialist Operational Response Team (SORT). A further expansion of SORT has been outlined in a Business Case that was submitted to Welsh Government in 2022 for consideration, in line with the expansion that has already been funded and is in place within English ambulance services. Without this funding, the organisation is presently not able to guarantee the deployment of the number of SORT staff to a chemical, biological, radiological, and nuclear / hazmat incident that is recommended in the related National Ambulance Service. The outcome of this Business Case is yet to be received.

The Trust has continued to work in partnership, through Local Resilience Fora, to address and mitigate the wide impacts of risks on the population and our organisation. We have been key members of the four Local Resilience Fora Executive planning groups, training and co-ordination groups and the Local Resilience Fora subgroups. The Trust has been fully engaged, alongside partners, in the Civil Contingencies Review that has been undertaken across Wales and continues to support Welsh Government and the Local Resilience Fora with the review as it comes to its conclusion.

2023/24 will present challenges to the organisation within the emergency preparedness field. The Manchester Arena Inquest report has a number of recommendations that relate directly to ambulance services and a number that will involve the Trust working with its partners to address. The Trust has recognised that this report will lead to changes having to be made to ensure our response to a mass casualty incident is robust. The UK Government Resilience Framework was released in December 2022 and although resilience is devolved within Wales, this document will no doubt impact on the Wales Civil Contingencies review and lead to changes within the Emergency Planning for all Category One responders within Wales. The Trust has a Civil Contingencies Risk on the risk register.

The Trust continues to engage and support at a national and local level to remain prepared to respond to any likely event, incident or set of circumstances that impacts on the organisation and population.

e) The Control Framework

Quality Governance Arrangements

Over 2022/23, regular reporting of quality governance has continued to provide assurance to the Quality, Patient Experience and Safety Committee (QuEST). Regular quality reports have ensured continued compliance with the Health and Care Standards and Commissioning Framework. Over the period, the Trust has continued to engage with Welsh Government and wider system partners in developing the Duty of Quality and Duty of Candour requirements, arising from the Health and Social Care (Quality & Engagement) (Wales) Act 2020. The legislation came into force on 01 April 2023.

The Trust Quality Strategy 2021/24 which sets out our high-level ambitions to ensure our services are safe, effective, and provide positive experiences, is monitored by the QuEST Committee, including the development of functions and forums to integrate the citizens' voice, the design and development of quality leadership roles and management systems to secure high quality clinical service delivery through our Clinical Quality and Governance Group; and, enabling a positive quality-focused and learning culture across the organisation.

As is evident in the Performance Report, the year continued to be operationally challenging, presenting significant risks to the organisation and our patients. Hospital handover delays continue to impact on the availability and responsiveness of ambulance resources across our communities. Patients and staff have endured excessive waits from arriving at hospital to being taken into the department. Not only is this a very poor patient and staff experience, but it also further increases clinical risks to our patients through delays in clinical assessment and treatment and, not having fundamental care needs appropriately met, while waiting on a stretcher in an ambulance for prolonged periods. Regrettably, this challenge generates further risk to the communities we serve. Whilst finite ambulance resources are unable to respond due to hospital handover delays, patients awaiting an emergency ambulance response are not receiving a timely service. This has resulted in multiple serious adverse incidents, resulting in actual harm and death of patients waiting in the community.

Improvements to the Joint Investigation Framework have been made as part of the Quality Governance Review. The improvements have been developed collaboratively by an All-Wales NHS Task & Finish Group. This work is reflected in the NHS Wales Executive National Policy on Patient Safety Incident Reporting and Management. Supporting Section 4 of the Policy covers the Joint Investigation process. This section provides guidance and a structure for joint investigations involving multiple organisations. The Trust will adopt the Policy at its QuEST Committee meeting in August 2023 and will work collaboratively with all Health Boards across Wales where cases are identified as requiring joint investigation.

The Trust has separately published an annual report for Safeguarding that sets out the work undertaken with partner agencies across Wales to ensure all possible steps are taken to safeguard the children, young people, and vulnerable adults we care for across the country.

The Trust has a Clinical Audit Plan which contributes to improving the level of care delivered to patients. Some of the factors that influence audit topics include the efficacy of treatment for specific conditions, new initiatives, pilot projects, and identifying themes and trends from adverse incidents. Recommendations and actions resulting from clinical audits are approved at the Clinical Intelligence & Assurance

Group, and are included on an action tracker, with progress to the plan and action tracker monitored by various groups and the QuEST committee. During 2022/23, seven clinical audits were completed and approved, five of these were electronic Patient Clinical Record (ePCR) clinical data assurance audits for clinical indicators and influenced improvement plans and changes to the user interface of the ePCR.

The Trust reports on monthly clinical indicators that measure specific criteria to demonstrate the level of care delivered to patients, compliance to these is monitored and improvement plans developed as required. The clinical indicators include stroke, STEMI (heart attack), hip fracture, hypoglycaemia (diabetes) and ROSC (return of spontaneous circulation from cardiac arrest). These indicators are reported on internally and form part of the Ambulance Quality Indicators reported on by the Emergency Ambulance Services Committee.

Since the implementation of the ePCR from 01 April 2022, clinical indicators now use data directly inputted by clinicians into their ePCR devices. Prior to this, the Clinical Intelligence and Assurance Team (CIAT) audited non-compliant clinical indicators to ensure a more complete picture of clinical performance. A reduction in compliance to clinical indicators following the implementation of the ePCR was anticipated due to clinicians working on a new system and will improve with increasing familiarity with the technology and implementation of action plans to support staff in ePCR completion. The reduction in compliance was anticipated and added to the Directorate's risk register. The CIAT continue to contribute to assuring the quality of the clinical data being used by the Trust and mitigating actions have been undertaken to provide assurance that patients are appropriately receiving the designated pre-hospital care bundle.

The implementation of the ePCR has provided the Trust with an opportunity to report on a wider range of data, combine time-based measures with clinical data and ultimately to link this data with the wider healthcare system to look at outcomes. Collaborative work has commenced to look at time-based metrics for stroke and STEMI and for outcome by response type.

Information Governance Arrangements (including Data Security)

The Trust operates a robust Information Governance Framework and has a statutory responsibility to ensure that effective governance controls and arrangements are in place in order to ensure its information processing is in accordance with the law and associated standards. The framework consists of an established suite of information governance and information security policies, procedures, guidance, manuals, and processes to inform and guide the organisation to ensure compliance is met in practice. The framework includes monitoring and reporting arrangements, audits and compliance assessments, improvement initiatives along with incident and risk management.

Information security remains a significant risk across NHS Wales, but with continuous evolution of mitigations. With a risk-led approach, the Trust has focused on improving the technology, processes, and people aspects to ensure cyber resilience. A message of shared responsibility has been communicated across the Trust, and regular exercises conducted to test resilience and refine business continuity plans. The Audit Wales paper "Learning from cyber-attacks", published in October 2022, has been reviewed by the Finance and Performance Committee to inform ongoing cyber resilience and information security training plans.

An Information Governance Steering Group is established with Executive and senior level membership, which receives reports on information governance and data protection matters, developments, and performance. The Information Governance Steering Group provides assurance on the Trust's compliance with relevant Information Governance standards, with the Quality, Patient Experience and Safety Committee having overall oversight of information governance.

The Trust continues to provide annual submissions to the Welsh Information Governance Toolkit. The Welsh Information Governance Toolkit is a self-assessment tool that enables organisations to measure their level of compliance against national Information Governance standards and legislation. Following previous submissions, an improvement plan has been developed and is subject to ongoing monitoring, review, and update by the Information Governance Team, which is overseen by the Information Governance Steering Group.

The Trust uses the Once for Wales Concerns Management System to capture information governance incidents via the incident reporting module. Each reported information governance incident is reviewed and assessed in accordance with the NHS Wales Guidelines on the Categorisation and Notification of Personal Data Breaches, which provides detailed guidance for assessing and reporting incidents. Any remedial actions are taken where required. Incidents figures are reported to the Information Governance Steering Group and as part of the Monthly Integrated Quality and Performance Report. Depending on the nature and severity of the incident, the incident reports may be required to be notified to the Information Commissioner's Office (ICO). During the reporting period (01 April 2022 to 31 March 2023), one incident was notified to the ICO and following notification, no further action was taken by the ICO.

Corporate Governance Code Compliance

An assessment against the Corporate Governance in Central Governance Departments: Code of Good Practice 2017, has been completed using the "Comply" or "Explain" approach. Whilst there is no requirement to comply with all elements of the Corporate Governance Code for Central Government Departments, an assessment was undertaken in March 2023 against the main principles as they relate to an NHS public sector organisation in Wales.

The Trust is satisfied that it is complying with the main principles of and is conducting its business in an open and transparent manner in line with the Code. There were no reported/identified departures from the Corporate Governance Code during the year.

A self-assessment has also been completed against the Governance, Leadership and Accountability domains in the Health and Care Standards 2015. There were some areas that were partially met, and improvement plans are in place. Both self-assessments were reviewed by the Executive Management Team and by the Audit Committee in April 2023.

Local Counter Fraud Services

The Local Counter Fraud Specialist (LCFS) is an accredited counter fraud professional who delivers both proactive work (e.g., raising fraud awareness, preventing, and deterring fraud) and reactive work to hold those who commit fraud to account (e.g., fraud investigations). The LCFS provides reports to Audit Committee and the Executive Management Team in relation to the quality and effectiveness of all counter fraud bribery and corruption work undertaken.

Counter fraud, bribery and corruption objectives are discussed and reviewed at a strategic level within the organisation. The Audit Committee is accountable for gaining assurance that sufficient control and management mechanisms in relation to counter fraud, bribery and corruption are present.

This is achieved through quarterly updates to the Committee from the LCFS, supported by an annual report on counter fraud, bribery and corruption work which complies with the NHS Counter Fraud Authority's guidance in relation to content regarding all applicable standards for fraud, bribery, and corruption; and provides a clear update on progress against work plan objectives.

The Committee must satisfy itself that the Trust has adequate arrangements in place for countering internal fraud and reviews the outcomes of that work, and acknowledges work completed against presented risks and an agreed work plan. The Committee reviews and approves the internal counter fraud arrangements on an annual basis.

f) Planning Arrangements

In accordance with expectations from Welsh Government, the Trust submitted its 2022/25 Integrated Medium Term Plan (IMTP) by 31 March 2022 following its approval by the Board on 24 March 20222. The IMTP was developed with involvement from our stakeholders including our staff, particularly during Chief Executive Roadshows in 2022/23.

The Trust's IMTP for 2022/25 was approved by Welsh Government on 13 July 2022 with the following conditions set out in a subsequent accountability letter dated 22 July 2022.

Further details on the Trust's IMTP and planning arrangements are set out in the Performance Report contained within the Performance Overview section of the Performance Report.

g) Disclosure Statements

The Trust confirms that in accordance with the requirements of the Governance Statement:

- Control measures are in place to ensure that all the Trust's obligations under equality, diversity and human rights legislation are complied with. The Strategic Equality Plan 2020/2024 sets out the Trust's meaningful commitment to work with staff and volunteers to help them recognise, promote, and celebrate equality, diversity, and inclusion. This Plan includes our approach to compliance with the Equality Act 2010 and Public and Socio-Economic Duties. It also outlines how the Trust will ensure the people who use ambulance services, including those with protected characteristics, have equal access and outcomes.

- As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

- The Trust undertakes risk assessments and has carbon delivery plans to comply with the emergency preparedness and civil contingency elements of the UKCIP (UK Climate Impacts Programme) 2009 weather projections to meet the Trust's obligations under the Climate Change Act and the Adaptation Reporting Requirements. The Trust has in place a Severe Weather Plan. In addition, the EPRR team uses intelligence from the Met Office to plan ahead for adverse weather, and weather warnings are a high priority trigger in our weekly consideration of Trust escalation levels.

The Trust works with partner agencies in our Local Resilience Fora across Wales to inform any multi-agency geographical response and the new Emergency Alert system allows for notification and warning in the event of adverse weather threats with risk to life. Planning, training, and exercising are a key aspect of the Trust's Civil Contingency responsibilities as a category one responder.

- The Trust had no reported serious untoward incidents during 2022/23 in relation to data security. In reporting period (01 April 2022 to 31 March 2023), one incident was notified to the Information Commissioner's Office, but no further action was taken.

Quality of Data

Quality of data generated and utilised by the Trust's core service areas is considered a collective responsibility but overseen by the Digital Directorate. Through a mature data pipeline and robust processes, the Trust maintains a strong level of data quality throughout. Where information-related anomalies do occur, these are investigated collaboratively by a domain expert, informatics analyst, and data quality lead. This can often involve liaising with system suppliers and Clinical Contact Centres to improve data capture and data entry.

On a monthly basis, the Trust reports key metrics of performance to Welsh Government in an Official Statistics Release. These submissions require thorough checks across all dimensions of data quality (namely: accuracy, completeness, consistency, validity, timeliness, and uniqueness), both at the call / incident level and aggregated to the higher-level views. This exercise can also involve investigation to data entries at the most granular level, whereby any issues in system, process or reporting can be identified and fixes proposed; demonstrating that data quality within the Trust takes on a full end-to-end approach. Only once the checks and balances have been signed off by senior Informatics staff are the submissions supplied; given the stringent nature of this quality assurance, the Trust is named on The Official Statistics (Wales) Order 2017, which is part of the Statistics and Registration Services Act 2007.

Similarly, intelligence is offered to the Board through a variety of reports which first pass through several rounds of appropriate governance for scrutiny and discussion. Any significant changes made to data or reporting are subject to initial approval at the Health Informatics Changes Advisory Board and, should the findings of any impact analysis dictate a higher level of approval is required, this would be further escalated prior to implementation. In future it could be possible for Board level intelligence to be accompanied by individual data quality scores per metric or topic.

Ministerial Directions

Ministerial Directions are published by Welsh Government as part of their health and social care publications and can be found here. There were no Ministerial Directions published during the period 01 April 2022 to 31 March 2023 which were relevant to the Trust.

Welsh Health Circulars

Welsh Health Circulars provide a streamlined, transparent, and traceable method of communication between NHS Wales and NHS organisations. The Circulars relate to different areas such as policy, performance and delivery, planning, legislation, workforce, finance, quality and safety, governance, information technology, science, research, public health, and letters to health professionals.

A number of Circulars were received during the year, and these are assigned to a lead Director who is responsible for the implementation of required actions. A log of circulars is maintained by the Trust.

h) Review of Effectiveness

As Accountable Officer for the Trust, the Chief Executive has responsibility for reviewing the effectiveness of the system of internal control. The review of the system of internal control is informed by the work of the internal auditors, and the executive officers within the Trust who have responsibility for the development and maintenance of the internal control framework, and comments made by external auditors (Audit Wales) in their audit letter and other reports, including the Structured Assessment 2022 and Quality Governance Review 2022.

Standing Orders, Committee terms of reference and the Governance Code require that Boards should routinely assess the effectiveness of their governance arrangements, of which the Board's Committees form an integral part.

Each Board Committee has undergone extensive effectiveness reviews in Quarters 3 and 4 of 2022/23 resulting in changes to terms of reference and membership to strengthen assurance and scrutiny to the Board. Additionally, changes to operating arrangements have been identified and will be implemented throughout 2023/24. The annual reports of the Committees referred to above and the 'Improvements to the Governance Framework' section set these out in more detail.

The Chair's performance is evaluated annually by the Minister for Health and Social Services. Annual performance appraisals for the Vice Chair, Chief Executive and Non-Executive Directors are carried out by the Chair, and for the Executive Directors and Directors by the Chief Executive. The Remuneration Committee receives the Chief Executive's outturn position and upcoming year's objectives as well as assurance that these objectives are cascaded to the Executive Management Team.

Joint Escalation and Intervention Arrangements

Under the Joint Escalation and Intervention Arrangements, Health Inspectorate Wales meets with Welsh Government and Audit Wales to discuss the overall assessment of the Trust.

While the tripartite evaluation involves assessment of each NHS body based on the work undertaken by the tripartite members, it is the Minister for Health and Social Services rather than the tripartite members who determines the escalation status of NHS bodies. At the tripartite meeting held in March 2022 the escalation status of the Trust remained unchanged at 'routine arrangements'.

Health Inspectorate Wales

Healthcare Inspectorate Wales' report 'Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover' was published in 2022, and the Trust's response is set out in the Performance Report in the 'Engagement' sub-section of the Delivery, Quality and Performance Analysis section of the Performance Report.

Internal Audit

Internal Audit provides the Accountable Officer and the Board with a flow of assurance on the system of internal control. The Accountable Officer commissioned a programme of audit work which was delivered subject to agreed amendments and in accordance with Public Sector Internal Audit standards by the NHS Wales Shared Services Partnership. The scope of this work is agreed with the Audit Committee and the Executive Management Team and is focussed on significant risk areas and local improvement priorities.

The overall opinion by the Head of Internal Audit on governance, risk management and control is a function of this risk-based audit programme and contributes to the picture of assurance to the Board in reviewing effectiveness and supporting our drive for continuous improvement.

The programme has been impacted by the pressures experienced in the wider healthcare system as a whole, but also because of seasonal and protracted industrial actions impacts. This meant that two audits had to be deferred and are reflected in the 2023/24 Audit Plan. The Head of Internal Audit is satisfied that there has been sufficient internal audit coverage during the reporting period to provide the Head of Internal Audit Annual Opinion. In forming the Opinion, the Head of Internal Audit has considered the impact of the audits that have not been completed as planned in 2022/23.

The Trust develops an annual Internal Audit plan in conjunction with Internal Auditors. The plan is risk based which directs the reviews to areas where management and the Audit Committee considers there may be potential weaknesses. In this regard, the Trust expects to receive some limited assurance reports, and these should not detract from the overall progress the Trust continues to make. **The Head of Internal Audit has concluded**:

 - + Yellow	The Trust Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved.

This conclusion is consistent with the Reasonable Assurance Head of Internal Audit Opinion reported in the Trust's 2021/22 Annual Governance Statement.
The 2022/23 reasonable assurance conclusion is derived from 19 Internal Audit reviews.

Internal Audit Assurance Conclusion	Number of Reports
No Assurance	0
Limited Assurance	3
Reasonable Assurance	15
Substantial Assurance	0
Advisory	1
Total	**19**

For the fifth consecutive year there have been no 'No Assurance' Internal Audit Reports of Trust business. Set out below are the three reports that had a conclusion of Limited Assurance that were reported to Audit Committee during 2022/23.

Trade Union Release Time
The objective of this audit was to provide assurance on the deployment of the refreshed Trade Union Facilities Agreement and to include a review of progress made to implement recommendations raised in the 2018/19 report (limited assurance).

Four recommendations for action were identified, of which three were categorised as high priority. Whilst the refreshed Facilities Agreement recommends processes to follow, these are not mandated, and several methods of recording facility time are in place. The lack of integrated systems for capturing this data at an organisational level further reduces visibility and compliance. The findings replicate the recommendations raised in the 2018/19 limited assurance report.

The management action plan was reviewed by the Audit Committee in July 2023 and progress will be monitored by People and Culture Committee and the Audit Committee during 2023/24.

Pain Management
The audit reviewed the application of pain relief methods and their effect on patient outcomes in terms of pain relief and patient satisfaction.

Three recommendations were identified, of which two were categorised as high priority; these were in relation to Patient Group Directions not reviewed on a regular basis and poor compliance rates, with no monitoring at group / Committee level, and a lack of oversight into pain scores and administration of analgesia. The management action plan was reviewed by the Audit Committee in July 2023 and will be monitored by that Committee during 2023/24.

Standards of Business Conduct
The audit was undertaken to review compliance with standards of business conduct, including arrangements in place to manage declarations of interest, gifts, and hospitality.

Seven recommendations were identified, of which two were categorised as high priority; these were in relation to expanding the cohort of declarations on the register to decision makers, and proper completion of the gifts and hospitality forms. The management action plan was reviewed by the Audit Committee in March 2023 and will be monitored by that Committee during 2023/24.

Copies of all Internal Audit reports and progress reports can be obtained in the Audit Committee papers section on the Trust's website. The full Head of Internal Audit Report 2022/23 can also be found via this link having been considered by Audit Committee at the 25 July 2023 meeting.

External Audit – Audit Wales

The Auditor General for Wales is the Trust's statutory external auditor and, since 01 April 2020, the Auditor General for Wales and the Wales Audit Office are known collectively as Audit Wales. Audit Wales scrutinises the Trust's financial systems and processes, performance management and key risk areas.

Performance Reports are produced by Audit Wales in line with an Audit Committee approved annual programme of work and include management responses by the Trust for reports which contain recommendations. All Audit Wales reports are considered by the Audit Committee and, where appropriate, the relevant Committee and the Board. Their recommendations are subsequently recorded in the Trust's audit recommendations tracker, which is reported to each Audit Committee meeting to provide assurance on their implementation.

The key annual governance report on Trust matters produced by Audit Wales is the Structured Assessment. In 2022 Audit Wales also undertook a review of Quality Governance at the Trust.

Structured Assessment 2022

The key focus was on the Trust's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically, with a specific focus on the organisation's governance arrangements; strategic planning arrangements; financial management arrangements; and arrangements for managing the workforce, digital assets, the estate, and other physical assets. Key messages included:

- *"Overall, we found that the Trust has taken positive steps to improve aspects of its corporate governance arrangements, but further work is needed to provide the strong internal challenge and continued external influence required to overcome some of the unprecedented operational challenges it currently faces.*

- *The Board is committed to public transparency, self-reflection, and hearing directly from patients and staff. The Trust has effectively filled key board-level posts in the past year, including a new Chair and the process for recruiting a new vice-Chair is underway. Meetings of the Board and committees are conducted appropriately and are supported by clear Schemes of Delegation. The Trust is continuing to refine its governance arrangements, such as developing cycles of business. However, there is scope to strengthen these arrangements further, particularly around improving the timeliness of publishing Board and committee papers and increasing the public transparency of decisions made in private sessions of the Board.*

- *The Trust is strengthening its risk framework. While the Trust regularly reviews its corporate risks, the scores for several significant risks have remained unchanged despite mitigating actions in recent months. This suggests that mitigating action to reduce the risk is not always having the desired effect. The Board receives regular information about the impact of wider system failings on its own performance and related quality concerns for patients. Recognising that many factors are beyond the Trust's direct control, the Trust must continue to seek opportunities to influence its partners to secure improvement as well as focussing on the impact of actions taken locally to address these issues. There is also a need to better respond to concerns and poor experiences captured within the patient experience report.*

- *The Trust has a Board-approved long-term vision and clinical strategy, which are rooted in population health and aligned to key national strategies. The Trust recognises that delivery of its longer-term aspirations will depend on the buy-in of partners, therefore external engagement must remain a priority. The Trust has a balanced and approved Integrated Medium-Term Plan for 2022/25, which has clear milestones and good alignment with key plans. The planning approach creates a line-of-sight for the Trust's combined strategic frameworks to be monitored at a high-level quarterly via the Finance and Performance Committee and Board, supplemented by detailed monitoring for key programmes. However, there is a need to improve staff involvement in the planning process.*

  The Trust achieved its financial duty for 2021/22 and has a clear financial plan for 2022/25. While this year's savings plan has an increasing focus on transformational savings, opportunities remain to reduce reliance on vacancy control as a means of achieving short-term non-recurring cost reduction. The well documented whole system issues which are contributing to significant emergency ambulance handover delays also result in significant financial inefficiencies for the Trust. The Trust continues to have good systems of financial control and is taking steps to reduce the number of single tender waivers used. The organisation's financial reports are clear and regularly received by the Finance and Performance Committee and the Board.

- *The Trust has developed a broad programme to support staff well-being which appears to be well-utilised. However, the Trust is not yet evaluating the impact of these services to ensure they are making a real difference. Managing sickness absence is a key area of focus, but rates remain very high particularly amongst Trust staff members in Emergency Medical Services.*

- *The Trust's digital strategy is being implemented but there is scope to strengthen and improve oversight of the entirety of its digital programme.*

- *The Trust plans to prioritise estate investment but faces challenges because of reducing available capital financing. It must, at the same time, ensure appropriate strategic decisions to support longer-term estates needs and the organisation's decarbonisation agenda."*

The Structured Assessment was considered by the Audit Committee in March 2023 and the Board in January 2023. The recommendations made in the Structured Assessment and all management responses covering some of the key areas of concern set out above were accepted and are being monitored by the Executive Management Team and the Audit Committee. The majority of these recommendations are complete.

Quality Governance Review 2022

This audit examined whether the Trust's governance arrangements support delivery of high quality, safe and effective services. It focused on both the operational and corporate approach to quality governance, organisational culture and behaviours, strategy, structures and processes, information flows and reporting. Key messages included:

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

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

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

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

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

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

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

- *Whilst the Trust's internal system for managing concerns and serious incidents is sound, the joint escalation framework for managing serious incidents across organisational boundaries is no longer effective, and the Trust must work with its commissioners and health board partners to improve this".*

Eight recommendations were made in this review and all management responses were accepted and are being monitored by the Quality, Patient Experience and Safety Committee. The majority of these recommendations are complete.

i) Conclusion

The corporate governance framework at the Trust provides that the Committees are equipped – both in terms of their effective operating arrangements and membership – to receive clear delegations from the Board. This allows the Board to focus on priority areas in the knowledge that the Committees are scrutinising and overseeing areas within their remit with a greater degree of detail than would be possible at the Board. Clear reporting from the Committees on an alert, advise, assure basis, strengthens the confidence the Board holds in this framework.

This was particularly prevalent in 2022/23 as Committee Chairs escalated their significant concerns regarding the performance and quality of services in the context of unscheduled care system pressures to the Board. The Trust Board has prioritised discussions on mitigating avoidable patient harm at each of its meetings since May 2022 and continues to seek to influence change in the wider system. While several actions have been implemented from the Trust's perspective over recent months, they are not able to offset the impact of increasing handover delays.

The need to plan and respond to sustained handover delays, financial challenges, Winter pressures and prolonged industrial action has had a significant impact on the organisation and the wider NHS in Wales. It has required a dynamic response which has presented a number of opportunities in addition to challenges.

The corporate governance framework will continue to improve in 2023/24, with a focus on integrated governance and assurance frameworks, support for report writers and presenters, and a Board and Committee standard operating procedure to provide consistency and improve quality and timeliness. The Board visits standard operating procedure approved by the Board in May 2023 will support members to triangulate assurance and promote visible leadership.

There is commitment to the Welsh Ambulance Services Partnership Forum – the Trust's only Advisory Group - having a strategic focus to strengthen the relationship with our Trade Union partners and this will complement and align its operating arrangements with the suite of Board Committees already in place.

As Accountable Officer for the Welsh Ambulance Services NHS Trust, I confirm that the statements made in this report are correct for the year ended 31 March 2023 and up to the date of approval of the Annual Report and Accounts, that there have been no significant internal or governance issues and I confirm that there were sound systems of internal control in place to support the delivery of the Trust's policy aims and objectives.

SIGN

Jason Killens

Chief Executive Officer

Dated: 28 July 2023

j) Governance Statement Appendices

Appendix 1: Board and Committee Membership and Attendance

The Board has been constituted to comply with the National Health Service (Wales) Act 2006 and the National Health Service Trusts (Membership and Procedure) Regulations 1990 (SI 1990 No. 2024). In addition to responsibilities and accountabilities set out in terms and conditions of appointment, Board members also fulfil a number of champion roles where they act as ambassadors for these matters.

The table below sets out the number of meetings that each Board member has attended during 2022/23 (Committee attendance figures as recorded in Committee Highlight Reports presented to Trust Board).

Name	Position	Board and Committee Record of Attendance (Actual attendance of total held meetings or total meetings available to attend, dependent on appointment dates)
Colin Dennis	Trust Board Chair	Trust Board (Public): 2 of 3 (from appointment date) Trust Board (Private): 2 of 3 (from appointment date) Remuneration Committee: 4 of 4 (from appointment date)
Kevin Davies	Vice Chair	Trust Board (Public): 5 of 7 Trust Board (Closed): 7 of 9 Academic Partnership Committee: 4 of 4 Charitable Funds Committee: 5 of 6 Finance and Performance Committee: 4 of 6 Quality, Patient Experience & Safety Committee: 3of 4 Remuneration Committee: 3 of 7
Bethan Evans	Non-Executive Director	Trust Board (Public): 6 of 7 Trust Board (Closed): 9 of 9 Charitable Funds Committee: 4 of 6 Finance and Performance Committee: 5 of 6 People and Culture Committee: 4 of 4 Quality, Patient Experience & Safety Committee: 4 of 4 Remuneration Committee: 4 of 7
Paul Hollard	Non-Executive Director	Trust Board (Public): 6 of 7 Trust Board (Closed): 8 of 9 Academic Partnership Committee: 3 of 4 Audit Committee:3 of 4 People and Culture Committee: 4 of 4 Quality, Patient Experience & Safety Committee: 4 of 4 Remuneration Committee: 5 of 7
Ceri Jackson	Non-Executive Director	Trust Board (Public): 6 of 7 Trust Board (Closed): 8 of 9 Audit Committee: 3 of 4 Charitable Funds Committee: 6 of 6

Name	Position	Board and Committee Record of Attendance (Actual attendance of total held meetings or total meetings available to attend, dependent on appointment dates)
		Finance and Performance Committee: 5 of 6 Quality, Patient Experience & Safety Committee: 4 of 4 Remuneration Committee: 4 of 7
Hannah Rowan	Non-Executive Director	Trust Board (Public): 3 of 7 Trust Board (Closed): 5 of 9 Academic Partnerships Committee: 4 of 4 Charitable Funds Committee: 2 of 6 People and Culture Committee: 2 of 4 Quality, Patient Experience & Safety Committee: 2 of 4 Remuneration Committee: 2 of 7
Joga Singh	Non-Executive Director	Trust Board (Public): 5 of 7 Trust Board (Closed): 8 of 9 Audit committee: 4 of 4 People and Culture Committee: 3 of 4 Finance and Performance Committee: 5 of 6 Remuneration Committee: 2 of 7
Martin Turner	Non-Executive Director	Trust Board (Public): 6 of 7 Trust Board (Closed): 8 of 9 Academic Partnership Committee: 1 of 4 Audit Committee: 4 of 4 Remuneration Committee: 4 of 7
Jason Killens	Chief Executive	Trust Board (Public): 7 of 7 Trust Board (Closed): 9 of 9 Remuneration Committee: 7 of 7
Lee Brooks	Executive Director of Operations	Trust Board (Public): 6 of 7 Trust Board (Closed): 8 of 9 Audit Committee: 2 of 4 Charitable Funds Committee: 3 of 6 Finance and Performance Committee:4 of 6 People and Culture Committee: 3 of 4 Quality, Patient Experience & Safety Committee: 4 of 4
Angela Lewis (From 12 September 2022)	Director of Workforce and Organisational Development	Trust Board (Public): 4 of 4 (from appointment date) Trust Board (Closed): 4 of 4 (from appointment date) Audit Committee: 3 of 3 (from appointment date) Academic Partnerships Committee: 1 of 2 (from appointment date) Charitable Funds Committee: 3 of 4 (from appointment date) People and Culture Committee: 2 of 2 (from appointment date) Remuneration Committee: 4 of 4 (from appointment date)
Estelle Hitchon	Director of Partnerships and Engagement	Trust Board (Public): 7 of 7 Trust Board (Closed): 7 of 9 Academic Partnership Committee:4 of 4 People and Culture Committee: 3 of 4
Brendan Lloyd	Executive Medical Director	Trust Board (Public): 7 of 7 Trust Board (Closed): 7 of 9

Name	Position	Board and Committee Record of Attendance (Actual attendance of total held meetings or total meetings available to attend, dependent on appointment dates)
Rachel Marsh	Executive Director of Strategy, Planning and Performance	Trust Board (Public): 6 of 7 Trust Board (Closed): 8 of 9 Finance and Performance Committee: 6 of 6 Quality, Patient Experience & Safety Committee: 3 of 4
Trish Mills	Board Secretary	Trust Board (Public): 7 of 7 Trust Board (Closed): 7 of 9 Academic Partnership Committee: 3 of 4 Audit Committee: 4 of 4 Charitable Funds Committee: 5 of 6 Finance and Performance Committee: 6 of 6 People and Culture Committee: 4 of 4 Quality, Patient Experience & Safety Committee: 4 of 4 Remuneration Committee: 6 of 7
Leanne Smith (From 01 August 2022)	Director of Digital Services	Trust Board (Public): 5 of 5 (from appointment date) Trust Board (Closed): 6 of 6 (from appointment date) Finance and Performance Committee: 4 of 4 (from appointment date) Quality, Patient Experience & Safety Committee: 3 of 3 (from appointment date)
Andy Swinburn	Director of Paramedicine	Trust Board (Public): 7 of 7 Trust Board (Closed): 8 of 9 Academic Partnerships Committee: 2 of 4 Charitable Funds Committee: 3 of 6 People and Culture Committee: 4 of 4 Quality, Patient Experience & Safety Committee: 4 of 4
Chris Turley	Executive Director Finance and Corporate Resources	Trust Board (Public): 7 of 7 Trust Board (Closed): 9 of 9 Audit Committee: 4 of 4 Charitable Funds Committee: 6 of 6 Finance and Performance Committee: 6 of 6 People and Culture Committee: 3 of 4
Liam Williams (From 01 August 2022)	Executive Director of Quality and Nursing	Trust Board (Public): 4 of 4 (from appointment date) Trust Board (Closed): 6 of 6 (from appointment date) Audit Committee: 1 of 3 (from appointment date) Finance and Performance Committee: 3 of 4 (from appointment date) People and Culture Committee: 2 of 3 (from appointment date) Quality, Patient Experience & Safety Committee: 3 of 3 (from appointment date)
Catherine Goodwin (Until 11 September 2022)	Interim Director of Workforce and Organisational Development	Trust Board (Public): 3 of 3 (until appointment ended) Trust Board (Closed): 3 of 5 (until appointment ended) Audit Committee: 0 of 1 (until appointment ended) Academic Partnerships Committee: 2 of 2(until appointment ended) Charitable Funds Committee: 1 of 2 (until appointment ended) People and Culture Committee: 2 of 2 (until appointment ended) Remuneration Committee: 2 of 3 (until appointment ended)
Andy Haywood (Until 31 July 2022)	Director of Digital Services	Trust Board (Public): 3 of 3 (until appointment ended) Trust Board (Closed): 3 of 3 (until appointment ended) Finance and Performance Committee: 2 of 2 (until appointment ended) Quality, Patient Experience & Safety Committee: 1 of 1 (until appointment ended)

Name	Position	Board and Committee Record of Attendance (Actual attendance of total held meetings or total meetings available to attend, dependent on appointment dates)
Wendy Herbert (Until 31 July 2022)	Executive Director Quality and Nursing	Trust Board (Public): 3 of 3 (until appointment ended) Trust Board (Closed): 3 of 3 (until appointment ended) Audit Committee: 0 of 1 (until appointment ended) Finance and Performance Committee: 2 of 2 (until appointment ended) People and Culture Committee: 1 of 1 (until appointment ended) Quality, Patient Experience & Safety Committee: 1 of 1 (until appointment ended)
Claire Vaughan (Until 22 April 2022)	Executive Director Workforce and OD	n/a
Martin Woodford (Until 30 September 2022)	Trust Board Chair	Trust Board (Public): 4 of 4 (until term ended) Trust Board (Private): 6 of 6 (until term ended) Remuneration Committee: 3 of 3 (until term ended)

Appendix 2: Board and Committee Meeting Dates

The following Table sets out the dates of all of the Trust Board and Committee meetings held in 2022/23. All Trust Board and Board Committee meetings in 2022/23 achieved quorum.

Meeting Title	Meeting Dates 2022/23
Trust Board (Public)	26/05/2022; 13/06/2022; 28/07/2022; 29/09/2022; 24/11/2022; 26/01/2023; 30/03/2023
Trust Board (Closed)	26/05/2022; 13/06/2022;04/07/2022; 03/08/2022; 01/09/2022; 29/09/2022; 24/11/2022; 26/01/2023; 30/03/2023
Academic Partnership Committee	26/04/2022; 19/07/2022; 25/10/2022; 17/01/2023
Audit Committee	07/06/2022; 15/09/2022; 01/12/2022; 02/03/2023
Charitable Funds Committee	05/05/2022; 06/07/2022; 10/10/2022; 21/11/2022; 30/01/2023; 16/02/2023
Finance and Performance Committee	16/05/2022; 18/07/2022; 20/09/2022; 14/11/2022; 16/01/2023; 21/03/2023
People and Culture Committee	10/05/2022; 05/09/2022; 29/11/2022; 14/03/2023
Quality, Patient Experience and Safety Committee	12/05/2022; 11/08/2022; 10/11/2022; 09/02/2023
Remuneration Committee	10/05/2022; 15/07/2022; 03/08/2022; 14/12/2022; 23/12/2022; 07/03/2023; 13/03/2023

2.2 Modern Slavery Act 2015 – Transparency in Supply Chains

The Trust has signed up to and is fully committed to the Welsh Government Code of Practice Ethical Employment in Supply Chains. This has been established by the Welsh Government to support the development of more ethical supply chains to deliver contracts for the Welsh public sector and third sector organisations in receipt of public funds. The procurement function is a key area for ethical employment in supply chains. This is run by NHS Wales Shared Services Partnership (NWSSP) and is a Committee of Velindre University NHS Trust. More information can be found on the work done on the Health Board's behalf by NWSSP on the Shared Services Partnership website.

2.3 Remuneration and Staff Report

The Remuneration and Staff Report contains information about senior managers remuneration. It will detail salaries and other payments, the Trust's policy on senior managers remuneration and whether there were any exit payments or other significant awards to current or former senior managers.

The definition of senior managers is: 'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS body. This means those who influence the decisions of the entity as a whole rather than the decisions of individual directorates or departments".

For the Trust, the senior managers are considered to be the Board's members, i.e., the Executive and Non-Executive Directors including the Chair and Chief Executive; four further (non-voting) Directors, and the Board Secretary.

In addition to presenting data on senior managers' remuneration, the Remuneration and Staff Report sets out the membership of the Trust's Remuneration Committee, and staff information with regards to numbers, composition, and sickness absence, together with expenditure on consultancy and off payroll expenditure.

Membership of the Remuneration Committee

Details of the members of the Remuneration Committee are shown in the Governance Statement.

Statement of Policy on the Remuneration of Senior Managers

All senior managers' pay and terms and conditions of service have been, and will be, determined by the Remuneration Committee within the framework set by the Welsh Government. Performance of senior managers is assessed against personal objectives and the overall performance of the Trust. The process sets objectives for the year and assesses individual performance against the objectives. The Trust does not make performance or other related bonus payments.

In keeping with the Welsh Government Circulars on pay for senior managers in NHS Wales for 2022/23, a £1400 consolidated increase was applied to all pay scales for individuals holding executive and senior posts, effective from 01 April 2022.

A one-off, non-consolidated payment of 1.5%, was made to individuals holding executive and senior posts and was based on the revised pay bands at 01 April 2022.

A further 1.5% consolidated pay uplift was then applied to the pay bands for individuals holding executive and senior posts effective from 01 April 2022. These uplifts have been applied to all pay scales, including those senior staff of the Trust who are on individually negotiated spot rates in accordance with the pay Circulars.

Policy on Duration of Contracts and Notice Periods

The Trust utilises permanent and fixed term contracts of employment as well as secondment opportunities.

The Chair and other Non-Executive Directors can be appointed on up to a four-year term, which may be extended to a maximum of eight years in total. Senior managers are appointed to permanent contracts in line with Welsh Government guidance and are required to give three months' notice of termination of employment.

For other staff, the contractual notice employees are required to give to the Trust and which employees are entitled to receive, is as follows: Bands one-six = four weeks; Band seven = eight weeks; Bands eight and nine = 12 weeks.

The notice provisions for Pay Bands one-seven outlined above are the normal notice periods of notice. However, these provisions do not override the statutory notice requirements the Trust is required to provide employees. According to length of service, employees may be entitled to a greater period of notice and receive one weeks' notice for each completed year of service up to and including a maximum of 12 weeks' notice after 12 years of continuous employment.

This refers to the notice periods employees must give; however, this does not preclude individuals requesting an earlier release from their post. This does not affect the right of either party to terminate the contract without notice by reason of the conduct of the other party. The Trust may, depending on circumstances, pay salary in lieu of notice.

Senior Manager Contracts and Awards

Details of senior manager contracts are shown in the tables below. There was no payment for early termination to senior managers' contracts during 2022/23.

Remuneration Relationship

Details of the Trust's remuneration relationship are set out in Note 10.6 of the 2022/23 Annual Accounts.

Senior Managers in Post in 2022/23

Name	Position Title	Assignment Category	Start Date in Position	Fixed Term End Date
Colin Dennis	Chair	Fixed Term	01 October 2022	30 September 2026
Kevin Davies	Vice Chair	Fixed Term	01 April 2019	30 June 2023
Bethan Evans	Non-Executive Director	Fixed Term	06 December 2019	5 December 2026
Paul Hollard	Non-Executive Director	Fixed Term	01 April 2016	31 March 2024
Ceri Jackson	Non-Executive Director	Fixed Term	01 April 2021	31 March 2026
Anoop Joga Singh	Non-Executive Director	Fixed Term	09 December 2019	8 December 2025
Martin Turner	Non-Executive Director	Fixed Term	13 December 2019	12 December 2023
Hannah Rowan	Non-Executive Director	Fixed Term	01 April 2022	31 March 2026
Jason Killens	Chief Executive Officer	Permanent	Prior to 01 April 2021	Not Applicable
Brendan Lloyd	Executive Director	Permanent	Prior to 01 April 2021	Not Applicable
Christopher Turley	Executive Director	Permanent	Prior to 01 April 2021	Not Applicable
Angie Lewis	Executive Director	Permanent	12 September 2022	Not Applicable
Liam Williams	Executive Director	Permanent	01 August 2022	Not Applicable
Lee Brooks	Director	Permanent	Prior to 01 April 2021	Not Applicable
Estelle Hitchon	Director	Permanent	Prior to 01 April 2021	Not Applicable

Name	Position Title	Assignment Category	Start Date in Position	Fixed Term End Date
Rachel Marsh	Executive Director	Permanent	Prior to 01 April 2021	Not Applicable
Trish Mills	Board Secretary	Permanent	02 August 2021	Not Applicable
Andy Swinburn	Director	Permanent	01 December 2021	Not Applicable

Further details of the contract arrangements of the Trust's senior managers in 2022/23 can be found in the Remuneration Table (and Notes) set out later in this Remuneration and Staff Report.

Senior Managers Filling posts on an interim Basis during 2022/23

Name	Position Title	Assignment Category	Start Date in Position	End Date
Wendy Herbert	Interim Executive Director of Nursing and Quality	Interim	07 March 2022	31 July 2022
	Interim Director of Nursing and Quality		01 August 2022	31 August 2022
Catherine Goodwin	Acting Executive Director of Workforce and OD	Interim	11 April 2022	21 April 2022
	Interim Director of Workforce & Organisational Development		22 April 2022	11 September 2022

Leanne Smith	Director of Digital Services	Interim	01 August 2022	Interim until a substantive Director is appointed and commences in post

Senior Managers who left the Trust during 2022/23

Name	Position Title	Assignment Category	Start Date in Position	Leaving Date
Andy Haywood	Director of Digital Services	Permanent	20 January 2020	31 July 2022
Claire Vaughan	Executive Director of Workforce & OD	Permanent	17 January 2015	22 April 2022
Martin Woodford	Chair	Fixed Term	01 April 2018	30 September 2022

Hutton Report Information (audited information)

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director/employee in their organisation and the 25th percentile, median and 75th percentile remuneration of the organisation's workforce. The 2021/22 financial year was the first-year disclosures in respect of the 25th percentile pay ratio and 75th percentile pay ratio were required.

		2022-23	2022-23	2022-23		2021-22	2021-22	2021-22
		£000	£000	£000		£000	£000	£000
Total pay and benefits		**Chief Executive**	**Employee**	**Ratio**		Chief Executive	Employee	Ratio
	25th percentile pay ratio	167,500	26,462	**6.33:1**		162,500	24,565	6.62:1
	Median pay	167,500	34,225	**4.89:1**		162,500	31,805	5.11:1
	75th percentile pay ratio	167,500	46,920	**3.57:1**		162,500	44,814	3.63:1
Salary component of total pay and benefits								
	25th percentile pay ratio	172,500	23,525			167,500	21,777	
	Median pay	172,500	26,676			167,500	24,882	
	75th percentile pay ratio	172,500	41,197			167,500	39,027	
Total pay and benefits		**Highest Paid Director**	**Employee**	**Ratio**		Highest Paid Director	Employee	Ratio
	25th percentile pay ratio	167,500	26,462	**6.33:1**		162,500	24,565	6.62:1
	Median pay	167,500	34,225	**4.89:1**		162,500	31,806	5.11:1
	75th percentile pay ratio	167,500	46,920	**3.57:1**		162,500	44,814	3.63:1
Salary component of total pay and benefits								
	25th percentile pay ratio	172,500	23,525			167,500	21,777	
	Median pay	172,500	26,676			167,500	24,882	
	75th percentile pay ratio	172,500	41,197			167,500	39,027	

In 2022/23, 1 (2021/22, 0) employee received remuneration in excess of the highest-paid director. Remuneration for all staff ranged from £21,069 to £172,500 (2021/22, £18,576 to £167,500). The all-staff range includes directors (including the highest paid director) and excludes pension benefits of all employees.

*In terms of these disclosures, the Chief Executive is also the highest paid Director.

Financial Year Summary (audited information)

The total pay and benefits figure for the Chief Executive/Highest Paid Director is lower than the salary component due to a salary sacrifice scheme.

The employee who received remuneration in excess of the Chief Executive is a temporary agency worker who was in post as at the 31 of March and is not a Director.

In keeping with the Welsh Government circulars on pay, included in the calculations are a £1,400 consolidated increase and a one-off non-consolidated payment of 1.5%, along with an accrual for the consolidated 1.5% which was payable in 2022/2023 and will be paid in May 2023.

Percentage Changes		**2021-22 to 2022-23**	2020-21 to 2021-22
% Change from previous financial year in respect of Chief Executive		**%**	%
	Salary and allowances	**3.1**	-3
	Performance pay and bonuses	**0**	0
% Change from previous financial year in respect of highest paid director			
	Salary and allowances	**3.1**	-3
	Performance pay and bonuses	**0**	0
Average % Change from previous financial year in respect of employees taken as a whole			
	Salary and allowances	**6.1**	3.6
	Performance pay and bonuses	**0**	0

The reduction of -3% reported in 2021/22 notes was in relation to a salary sacrifice scheme entered into by the Chief Executive which reduces the salary banding. The 3% shown in 2022/23 is in relation to the pay award received and accrued for during 22/23.

The 3.6% reported in 2021/22 notes in terms of the average pay per WTE related to the agreed AfC pay increases across the organisation. The 6.1% in 22/23 notes is related to the pay award receive and accrued for during 2022/23.

Salary and Pensions Entitlements of Senior Managers

a) Remuneration (audited information)

Salary and Pension entitlements of senior managers

A) Remuneration (audited information)

Name and Title	2022-23				2021-22			
	Salary (bands of £5000) (Note 22 &	Benefits in Rounded to the nearest £100	Pension Rounded to the nearest £1000	Total (bands of £5000)	Salary (bands of £5000)	Benefits in Rounded to the nearest £100	Pension Rounded to the nearest £1000	Total (bands of £5000)
Martin Woodford (Chairman) (Note 1)	20-25			20-25	40-45			40-45
Colin Dennis (Chairman) (Note 2)	20-25			20-25				
Kevin Davies (Non Executive Director / Vice Chairman)	15-20			15-20	15-20			15-20
Emrys Davies (Non Executive Director) (Note 3)					5-10			5-10
Paul Hollard (Non Executive Director)	5-10			5-10	5-10			5-10
Martin Turner (Non Executive Director)	5-10			5-10	5-10			5-10
Anoop Joga Singh (Non Executive Director)	5-10			5-10	5-10			5-10
Bethan Evans (Non Executive Director)	5-10			5-10	5-10			5-10
Ceri Jackson (Non Executive Director)	5-10			5-10	5-10			5-10
Hannah Rowan (Non Executive Director) (Note 4)	5-10			5-10				
Jason Killens (Chief Executive) (Note 5)	165-170	-	15	185-190	160-165	600	35	195-200
Christopher Turley (Executive Director of Finance & Corporate Resources) (Note 6)	110-115	-	15	125-130	105-110	-	10	115-120
Dr Brendan Lloyd (Executive Director of Medical and Clinical Services) (Note 7)	80-85	-		80-85	135-140	-		135-140
Claire Vaughan (Executive Director of Workforce & OD) (Note 8)	5-10	-		5-10	35-100	-	36	135-140
Dr Catherine Goodwin (Acting Executive Director of Workforce & OD / Interim Director of Workforce & OD) (Note	45-50	-	10	55-60				
Angela Lewis (Director of Workforce & Organisational Development) (Note 10)	60-65	-	4	65-70				
Claire Roche (Executive Director of Quality and Nursing) (Note 11)					100-105	1,800	54	155-160
Gail Wendy Herbert (Interim Executive Director of Quality and Nursing / Interim Director of Quality and Nursing) (N	45-50	-	43	35-100	5-10	-	6	10-15
Liam Williams (Executive Director of Quality and Nursing) (Note 13)	75-80	-	14	90-95				
Estelle Hitchon (Director of Partnerships & Engagement) (Note 14)	100-105	-		100-105	95-100	-		95-100
Rachel Marsh (Director of Strategy Performance & Planning / Executive Director of Strategy Performance & Plannin	105-110	-		105-110	100-105	-	46	150-155
Lee Brooks (Director of Operations / Executive Director of Operations) (Note 16)	115-120	2,300	28	145-150	115-120	4,200	27	145-150
Andrew Haywood (Director of Digital Services) (Note 17)	35-40	-	5	40-45	110-115	-	28	135-140
Dr Leanne Smith (Interim Director of Digital Services) (Note 18)	75-80	-	16	90-95				
Andrew Swinburn (Director of Paramedicine) (Note 19)	115-120	-	93	205-210	100-105	400	84	185-190
Patricia Mills (Board Secretary) (Note 20)	95-100	-	22	115-120	60-65	-	14	75-80
Keith Cox (Board Secretary) (Note 21)					40-45	-	0	40-45

Note 1 - Martin Woodford left the Trust on 30th September 2022
Note 2 - Colin Dennis joined the Trust on 1st October 2022. Salary full year equivalent is 40-45 (bands of £5000)
Note 3 - Emrys Davies left the Trust on 31st March 2022
Note 4 - Hannah Rowan joined the Trust on 1st April 2022
Note 5 - Jason Killens' salary includes £3,212 in terms of annual leave sold and excludes £5,742 sacrificed in respect of NHS Fleet Solutions. 2021-22 salary excluded £4,785 sacrificed in respect of NHS Fleet Solutions
Note 6 - Christopher Turley's salary includes £4,500 in terms of annual leave sold and excludes £10,612 sacrificed in respect of NHS Fleet Solutions. 2021-22 salary included £3,112 for annual leave sold and excluded £10,612 sacrificed in respect of
Note 7 - Brendan Lloyd's tenure as Interim Deputy Chief Executive ended on 31st December 2021. Brendan retired on 31st December 2021, returning on 1st January 2022 to the role of Executive Medical Director on a 0.5 FTE basis. Salary includes
Note 8 - Claire Vaughan left the Trust on 22nd April 2022
Note 9 - Dr Catherine Goodwin was appointed Acting Executive Director of Workforce & OD from 11th April 2022 until 21st April 2022, then Interim Director of Workforce & OD until 11th September 2022. Salary full year equivalent is 105-110 (bands
Note 10 - Angela Lewis joined the Trust as Director of Workforce & Organisational Development on 12th September 2022. Salary full year equivalent is 105-110 (bands of £5000)
Note 11 - Claire Roche left the Trust on 4th March 2022
Note 12 - Gail Wendy Herbert was appointed Interim Executive Director of Quality and Nursing from 7th March 2022 until 31st July 2022, then Interim Director of Quality and Nursing until 31st August 2022. Salary full year equivalent is 110-115 (bands
Note 13 - Liam Williams joined the Trust as Executive Director of Quality and Nursing on 1st August 2022. Salary full year equivalent is 115-120 (bands of £5000)
Note 14 - Estelle Hitchon's salary includes £2,356 in terms of annual leave sold
Note 15 - Rachel Marsh's salary includes £2,854 in terms of annual leave sold and excludes £5,006 sacrificed in respect of NHS Fleet Solutions. This post changed from Director of Strategy Performance & Planning to Executive Director of Strategy Performance & Planning from 25th April 2022
Note 16 - Lee Brooks' salary excludes £3,472 sacrificed in respect of NHS Fleet Solutions. This post changed from Director of Operations to Executive Director of Operations from 1st April 2022
Note 17 - Andrew Haywood left the Trust on 31st July 2022
Note 18 - Dr Leanne Smith was appointed Interim Director of Digital Services from 1st August 2022. Salary full year equivalent is 110-115 (bands of £5000)
Note 19 - Andrew Swinburn was appointed Director of Paramedicine on 1st December 2021. Andrew was previously included as Associate Director of Paramedicine until 30th November 2021. Salary includes £2,144 in terms of annual leave sold. 2021-22 salary included £3,811 paid in terms of annual leave sold
Note 20 - Patricia Mills joined the Trust as Board Secretary on 2nd August 2021
Note 21 - Keith Cox retired on 1st August 2021
Note 22 - The salary column includes a £1400 consolidated increase applied to all A4C pay scales and individuals holding executive and senior posts, this did not apply to Board Chairs and Non-Executive Directors
Note 23 - The salary column also includes a 1.5% non-consolidated non-pensionable payment, along with a 1.5% consolidated accrual. As per the guidance from Welsh Government, this consolidated payment is not included within the pension benefits element of the above table. These payments did not apply to Board Chairs and Non-Executive Directors

Salary and Pensions Entitlements of Senior Managers

b) Pension Benefits (audited information)

Salary and Pension entitlements of senior managers

B) Pension Benefits (audited information)

Name and title	Accrued pension at pension age as at 31/3/23 and related lump sum £'000	Real increase in pension and related lump sum at pension age (bands of £'000	Cash Equivalent Transfer £'000	Cash Equivalent Transfer £'000	Real increase in Cash £'000
Jason Killens (Chief Executive)	50-55 plus lump sum of 115-120	0-2.5 plus lump sum of -5--2.5	922	859	14
Christopher Turley (Executive Director of Finance & Corporate Resources)	50-55 plus lump sum of 100-105	0-2.5 plus lump sum of -2.5-0	925	863	21
Dr Brendan Lloyd (Executive Director of Medical and Clinical Services) *	-	-	-	-	-
Claire Vaughan (Executive Director of Workforce & OD)	30-35 plus lump sum of 45-50	-2.5-0 plus lump sum of -2.5-0	495	474	-
Dr Catherine Goodwin (Acting Executive Director of Workforce & OD / Interim Director of Workforce & OD)	10-15 plus lump sum of 20-25	0-2.5 plus lump sum of 0-2.5	201	169	5
Angela Lewis (Director of Workforce & Organisational Development)	0-5 plus lump sum of 0-5	0-2.5 plus lump sum of 0-2.5	35	19	-
Gail Wendy Herbert (Interim Executive Director of Quality and Nursing / Interim Director of Quality and Nursing)	45-50 plus lump sum of 110-115	2.5-5 plus lump sum of 5-7.5	911	759	48
Liam Williams (Executive Director of Quality and Nursing)	35-40 plus lump sum of 70-75	0-2.5 plus lump sum of -2.5-0	664	610	13
Estelle Hitchon (Director of Partnership & Engagement) **	-	-	-	-	-
Rachel Marsh (Director of Strategy Performance & Planning / Executive Director of Strategy Performance & Plann	45-50 plus lump sum of 55-60	-2.5-0 plus lump sum of -5--2.5	768	736	- 5
Lee Brooks (Director of Operations / Executive Director of Operations)	30-35	0-2.5	394	354	14
Andrew Haywood (Director of Digital Services)	5-10	0-2.5	96	78	-
Leanne Smith (Interim Director of Digital Services)	5-10	0-2.5	62	43	1
Andrew Swinburn (Director of Paramedicine)	45-50 plus lump sum of 95-100	2.5-5 plus lump sum of 7.5-10	852	726	88
Patricia Mills (Board Secretary)	0-5	0-2.5	65	39	12

*Dr Brendan Lloyd chose to leave the pension scheme on 31st December 2021
** Estelle Hitchon chose not to be covered by the NHS pension arrangements in the prior year, as well as the current reporting year

Staff Numbers (audited information)

An analysis of staff numbers by category during 2022/23 are set out below. The figures relate to the average number of employees under contract of service in each month of the financial year, divided by 12 (and rounded to nearest Whole Time Equivalent). These figures have been calculated to include inward secondments and agency staff and to reconcile with the financial accounts.

Category	2022/23	2021/22	2020/21*
Additional Clinical Services	2,078	2,064	1,755
Professional, Scientific & Technical Staff	4	2	1
Administrative, Clerical and Board Members	618	581	558
Allied Health Professionals	1,092	1,052	1,106
Estates & Ancillary	64	62	62
Medical & Dental	1	1	1
Nursing and Midwifery	196	207	170
Total	**4,053**	**3,969**	**3,653**

**Note*: The 2020/21 figures have similarly been re-calculated to include inward secondments and agency staff to reconcile with the 2020/21 financial accounts.

Staff Composition

An analysis of the number of persons of each sex who are senior managers of the Trust (i.e., Non-Executive Directors, Executive Directors, Directors, Board Secretary) as at 31 March 2023, are set out below (excludes secondees out of the Trust). This compares to a Trust wide staff composition of 49% female, 51% male.

Gender	Headcount	%
Female	8	42
Male	11	58
Total	**19**	**100**

Sickness Absence Data

	2022/23	2021/22	2020/21
Days lost (long term)	88,732.85	100,910.74	65,017.51
Days lost (short term)	47,226.89	50,050.55	31,864.22
Total days lost	**135,959.74**	**150,961.30**	**96,881.73**
Total staff years	335.66	329.20	302.85
Average working days lost	21.09	23.96	16.79
Total staff employed in period (headcount)	4,315	4,231	3,907
Total staff employed in period with no absence (headcount)	917	1,035	1,496
Percentage staff with no sick leave	**21.09%**	**24.04%**	**36.61%**

Note 1: The percentage and total number of staff without absence in the year has been sourced from the standard Electronic Staff Record (ESR) Business Intelligence (BI) report. With regard to the reporting in relation to the percentage of staff with 'no sickness', the standard BI report excludes new entrants and also bank assignments. Therefore, the number of staff who have had a whole year with no sickness absence is being divided into a smaller number than the total headcount at the end of the year.

Note 2: "Total staff employed in period with no absence (headcount)" is purely sickness absence and does not include those isolating/shielding due to Covid-19.

The Trust continues to performance manage absence robustly and has implemented many actions in 2022/2023. There has been a reduction in absence from 11.88% in March 2022 to 7.99% in February 2023.

- The project plan for improving attendance continues to be updated and delivered and has made a significant difference to levels of absence in the Trust;
- Regular reports are provided to the Executive Management Team, People and Culture Committee, and Trust Board with deep dives into specific issues;
- Training delivery to managers continues and has been well received;
- Quarterly checks of Global Rostering System and Electronic Staff Record data were undertaken to ensure; consistency across both systems;
- Regular meetings continued to take place to manage sickness absence within the Trust in all regions across Wales;
- Regular case reviews were undertaken across the Emergency Medical Service to discuss complex sickness cases and alternative duties arrangements;
- An audit of managing attendance noted reasonable assurance and no high priority recommendations;
- The number of colleagues absent with long Covid is significantly reduced;
- Occupational Health support for colleagues is robust with the team working closely with People Services to support colleagues back to work;
- Staff continue to utilise and engage with the Employee Assistance Programme and the Thrive App. Other wellbeing offers such as Silvercloud and Health for Health Professionals are also offered for psychological support;

Health promotion activities have expanded, with regular internal communication campaigns, and the occupational health and wellbeing van visits accident and emergency departments in South Wales weekly offering Trauma Risk Management (TRiM) and wellbeing support as well as supporting health campaigns for staff.

Staff Policies Applied During the Year

The Trust has a policy framework in place which covers policies, procedures, and processes and how these should be introduced, amended, replaced, and approved. These policies address all matters relating to the Trust and cover such issues as employment, health and safety and infection control.

The Trust has policies on recruitment and selection, training and flexible working and a treating people fairly strategy. All these are designed to ensure that equality and diversity issues are fully considered in the recruitment, selection, and employment of staff. Staff can access these policy documents through the Trust's Intranet.

Other Employee Matters

During 2022/2023 we continued to develop our Allyship programme and are developing active bystander training to further engage and support a culturally responsible organisation that holds inclusion at its core and makes it the responsibility of all. This is not only aligning with our commitments set out in our Strategic Equality Objectives and Plan but aligns with our commitment to the Anti-racist action plan and LGBTQ+ action plan set out by Welsh Government, and our organisational behaviours.

Bespoke sessions under Allyship have also been developed, which have included a talk on Black History Month, a lived experience shared by the parent of a Trans young person, and a programme of awareness sessions on neurodiversity. Providing training to and sharing stories with our people so that they are equipped to support and meet the different needs of those they interact with, are part of the Trust's goals in delivering our Strategy Equality Objectives actions.

A Speaking Up Safely Task and Finish Group was established in 2022 to develop a framework for raising concerns which supports staff, addresses barriers to speaking up, encourages a positive culture of speaking up and ensures matters raised are used as opportunities for learning and improvement. The group concluded its work in March 2023 with the mandate to implement the framework being transferred to the Director of People and Culture. The framework is based around the All-Wales Procedure for Raising Concerns but will be further supported by a number of speaking up safely guardians, the Trust's voices network, and a confidential third-party platform. The People and Culture Committee have the implementation of this framework as one of its priorities for 2023/24.

The Trust has continued to support working carers and is an active member of Carers UK's business forum, Employers for Carers. Our membership includes access to efcdigital.org which offers a range of resources that can help us support staff who juggle work and caring responsibilities. At the end of November 2022, the Trust launched the Carer Passport scheme in conjunction with Employers for Carers' Rights who delivered a session for all line managers. The session was very well received with 90 people across the organisation attending the Teams meeting.

Alongside this, a section on the Trust's Equality, Diversity, and Inclusion intranet page was created to provide guides and support staff with the Carer Passport, Carers' Rights membership and supporting paperwork, with advice for managers. The Carer Passport is a record that moves with employees through their career that sets out support, services or other benefits that can be accessed. A Carer Passport helps to improve and embed identification, recognition, and support for carers in the day-to-day life of an organisation. The organisation will also be funding a Carers app with Employers for Carers that will be launched on Careers week in June 2023.

The development of an Integrated Impact Assessment Tool is underway being led by a Trust Task and Finish Group. This tool will encompass the requirements on the Trust under the Public Sector Equality Duties, which are aligned to the Equality Act 2010, and this includes the socio-economic duties. The tool will also include a template assessment against the requirements of the Well-being of Future Generations (Wales) Act 2015 and Welsh Language (Wales) Measure 2011.

The new Integrated Impact Assessment Tool is in draft and has been produced using recommendations from the report released by Audit Wales in December 2022, in respect of Equality Impact Assessments. Up to date training has been developed and was launched in early 2023 to guide staff in the proper undertaking of an Equality Impact Assessment.

The Trust is working with Purple Space to support us in setting up a disability network, and a network for our neurodiverse workforce. This was decided after engagement activities took place, and it was decided the two separate networks were needed as different needs arose for both.

As part of our wider equality, diversity, and inclusion work, the Trust has continued to celebrate and bring awareness across the protected characteristics with a focus of an intersectional lens throughout the year, working internally and with external organisations and charities as well as in an All -Wales approach.

Expenditure on Consultancy

Expenditure during 2022/23 in respect of consultancy costs was £611, 451.17 (in 2021/22 it was £878,000) across the following areas:

Human Resources, Training & Education	£77,218.71
Organisation and Change Management	£261,532.80
Programme and Project Management	£2,176.04
Property and Construction	£125,511.51
Technical	(£108.00)
Strategy	£139,775.00
IT/IS	£5,345.11
Total	**£611,451.17**

The consultancy costs were higher in 2021/22 due to the review where support was reduced in 2022/23.

Expenditure on Temporary Staff

Expenditure during 2022/23 in respect of temporary staff costs was £1.85m (2021/22 £1.745m). This equals a variance of £0.091m which was because of delays in recruitment to vacancies to the cohorting service delivered outside GUH and Morriston Hospitals.

Off-Payroll Engagements

The Trust has a nil return in 2022/23 for off-payroll engagements. This is consistent with that reported in 2021/22.

Exit Packages (audited information)

The Trust has a cost of £170, 966 in 2022/ 23 for six staff exit Trust packages. This compares to a return of £0.292m in 2021/22. Exit packages are described in Note 10.5 within the financial statements.

2.4 Senedd Cymru/Welsh Parliamentary Accountability and Audit Report

The Senedd Cymru/Welsh Parliamentary Accountability and Audit Report provides information on such matters as regularity of expenditure, fees and charges, and the audit certificate and report.

Regularity of Expenditure

The Trust is required to ensure regularity of its income and expenditure. Sufficient evidence of the assurance of this has been provided as part of the audit of the accounts process and the audit certificate for the accounts concludes that in all material respects, the expenditure and income in the financial statements have been applied to the purposes intended by Welsh Parliament and that the financial transactions recorded in the financial statements conform to the authorities which govern them. The Trust confirms its expenditure for the year is regular.

Fees and Charges

The Trust is required by Welsh Government to ensure that the full cost of providing commercial services is passed on in its fees and charges and confirms that proper controls were in place in 2022/23 over how, when and at what level charges were levied. The Trust confirms its fees and charges are in accordance with Welsh Government requirements.

Material Remote Contingent Liabilities

The Trust has no material remote contingent liabilities within its 2022/23 accounts. This is consistent to that reported in 2021/22.

Audit Certificate and Report

The certificate and report of the Auditor General to the Welsh Parliament is attached on the following pages.

The Certificate and independent auditor's report of the Auditor General for Wales to the Senedd

Opinion on financial statements

I certify that I have audited the financial statements of the Welsh Ambulance Services NHR Trust for the year ended 31 March 2023 under Section 61 of the Public Audit (Wales) Act 2004.

These comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Cash Flow Statement and the Statement of Changes in Taxpayers' Equity and related notes, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and UK adopted international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual.

In my opinion, in all material respects, the financial statements:

- give a true and fair view of the state of affairs of the Welsh Ambulance Services NHS Trust as at 31 March 2023 and of its surplus for the year then ended;
- have been properly prepared in accordance with UK adopted international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual; and
- have been properly prepared in accordance with the National Health Service (Wales) Act 2006 and directions made there under by Welsh Ministers.

Opinion on regularity

In my opinion, in all material respects, the expenditure and income in the financial statements have been applied to the purposes intended by the Senedd and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Basis for opinions

I conducted my audit in accordance with applicable law and International Standards on Auditing in the UK (ISAs (UK)) and Practice Note 10 'Audit of Financial Statements of Public Sector Entities in the United Kingdom'. My responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of my certificate.

My staff and I are independent of the Trust in accordance with the ethical requirements that are relevant to my audit of the financial statements in the UK including the Financial Reporting Council's Ethical Standard, and I have fulfilled my other ethical responsibilities in accordance with these requirements. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinions.

Conclusions relating to going concern

In auditing the financial statements, I have concluded that the use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work I have performed, I have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the body's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from when the financial statements are authorised for issue.

My responsibilities and the responsibilities of the directors with respect to going concern are described in the relevant sections of this certificate.
The going concern basis of accounting for the Welsh Ambulance Services NHS Trust is adopted in consideration of the requirements set out in HM Treasury's Government Financial Reporting Manual, which require entities to adopt the going concern basis of accounting in the preparation of the financial statements where it anticipated that the services which they provide will continue into the future.

Other Information

The other information comprises the information included in the annual report other than the financial statements and my auditor's report thereon. The Chief Executive is responsible for the other information contained within the annual report. My opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in my report, I do not express any form of assurance conclusion thereon. My responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or knowledge obtained in the course of the audit, or otherwise appears to be materially misstated. If I identify such material inconsistencies or apparent material misstatements, I am required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact. I have nothing to report in this regard.

Opinion on other matters

In my opinion, the part of the remuneration report to be audited has been properly prepared in accordance with the National Health Service (Wales) Act 2006 and directions made there under by Welsh Ministers.

In my opinion, based on the work undertaken in the course of my audit:

- the parts of the Accountability Report subject to audit have been properly prepared in accordance with the National Health Service (Wales) Act 2006 and directions made there under by Welsh Minsters' directions; and
- the information given in the Performance Report and Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements and in accordance with Welsh Ministers' guidance.

Matters on which I report by exception

In the light of the knowledge and understanding of the Trust and its environment obtained in the course of the audit, I have not identified material misstatements in the Performance Report and Accountability Report.
I have nothing to report in respect of the following matters, which I report to you, if, in my opinion:

- I have not received all the information and explanations I require for my audit;
- adequate accounting records have not been kept, or returns adequate for my audit have not been received from branches not visited by my team;
- the financial statements and the audited part of the Accountability Report are not in agreement with the accounting records and returns;
- information specified by HM Treasury or Welsh Ministers regarding remuneration and other transactions is not disclosed;
- certain disclosures of remuneration specified by HM Treasury's Government Financial Reporting Manual are not made or parts of the Accountability Report to be audited are not in agreement with the accounting records and returns; or
- the Governance Statement does not reflect compliance with HM Treasury's guidance.

Responsibilities of Directors and the Chief Executive for the financial statements

As explained more fully in the Statements of Directors' and Chief Executive's Responsibilities, the Directors and the Chief Executive are responsible for:

- maintaining adequate accounting records;
- the preparation of financial statements and annual report in accordance with the applicable financial reporting framework and for being satisfied that they give a true and fair view;
- ensuring that the annual report and financial statements as a whole are fair, balanced, and understandable;
- ensuring the regularity of financial transactions;
- internal controls as the Directors and Chief Executive determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; and

- assessing the Trust's ability to continue as a going concern, disclosing as applicable, matters related to going concern and using the going concern basis of accounting unless the Directors and Chief Executive anticipate that the services provided by the Trust will not continue to be provided in the future.

Auditor's responsibilities for the audit of the financial statements

My responsibility is to audit, certify and report on the financial statements in accordance with the National Health Service (Wales) Act 2006.

My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue a certificate that includes my opinion.

Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. I design procedures in line with my responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud.
My procedures included the following:

- Enquiring of management, internal audit and those charged with governance, including obtaining and reviewing supporting documentation relating to the Welsh Ambulance Services NHS Trust's policies and procedures concerned with:
  - identifying, evaluating and complying with laws and regulations and whether they were aware of any instances of non-compliance;
  - detecting and responding to the risks of fraud and whether they have knowledge of any actual, suspected or alleged fraud; and

  - the internal controls established to mitigate risks related to fraud or non-compliance with laws and regulations.
- Considering as an audit team how and where fraud might occur in the financial statements and any potential indicators of fraud. As part of this discussion, I identified potential for fraud in expenditure recognition, and management override;
- Obtaining an understanding of the Welsh Ambulance Services NHS Trust's framework of authority as well as other legal and regulatory frameworks that the Welsh Ambulance Services NHS Trust operates in, focusing on those laws and regulations that had a direct effect on the financial statements or that had a fundamental effect on the operations of the Welsh Ambulance Services NHS Trust;
- Obtaining an understanding of related party relationships.

In addition to the above, my procedures to respond to identified risks included the following:

- reviewing the financial statement disclosures and testing to supporting documentation to assess compliance with relevant laws and regulations discussed above;
- enquiring of management and the Audit Committee about actual and potential litigation and claims;
- reading minutes of meetings of the Audit Committee and the Board; and
- in addressing the risk of fraud through management override of controls, testing the appropriateness of journal entries and other adjustments; assessing whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluating the business rationale of any significant transactions that are unusual or outside the normal course of business.

I also communicated relevant identified laws and regulations and potential fraud risks to all audit team members and remained alert to any indications of fraud or non-compliance with laws and regulations throughout the audit.

The extent to which my procedures are capable of detecting irregularities, including fraud, is affected by the inherent difficulty in detecting irregularities, the effectiveness of the Welsh Ambulance Services NHS Trust's controls, and the nature, timing and extent of the audit procedures performed.

A further description of the auditor's responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website www.frc.org.uk/auditorsresponsibilities. This description forms part of my auditor's report.

Other auditor's responsibilities

I am also required to obtain evidence sufficient to give reasonable assurance that the expenditure and income recorded in the financial statements have been applied to the purposes intended by the Senedd and the financial transactions recorded in the financial statements conform to the authorities which govern them.

I communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

Report

I have no observations to make on these financial statements.

Adrian Crompton
Auditor General for Wales
28 July 2023

1 Capital Quarter
Tyndall Street
Cardiff
CF10 4BZ

PART 3: - FINANCIAL STATEMENTS

Head of Internal Audit Opinion & Annual Report 2022/2023

July 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

Report status:	Final
Draft report issued:	30 June 2023
Final report issued:	13 July 2023
Author:	Osian Lloyd, Head of Internal Audit
Executive Clearance:	Trish Mills, Board Secretary
Audit Committee:	25th July 2023

1. EXECUTIVE SUMMARY

1.1 Purpose of this Report

Welsh Ambulance Services NHS Trust's (Trust) Board is accountable for maintaining a sound system of internal control that supports the achievement of the organisation's objectives and is also responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system. A key element in that flow of assurance is the overall assurance opinion from the Head of Internal Audit.

This report sets out the Head of Internal Audit Opinion together with the summarised results of the internal audit work performed during the year. The report also includes a summary of audit performance and an assessment of conformance with the Public Sector Internal Audit Standards.

1.2 Head of Internal Audit Opinion 2022-23

The purpose of the annual Head of Internal Audit opinion is to contribute to the assurances available to the Chief Executive as Accountable Officer and the Board which underpin the Board's own assessment of the effectiveness of the system of internal control. The approved Internal Audit plan is focused on risk and therefore the Board will need to integrate these results with other sources of assurance when making a rounded assessment of control for the purposes of the Annual Governance Statement. The overall opinion for 2022/23 is that:

Reasonable assurance		The Board can take **Reasonable Assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved.

1.3 Delivery of the Audit Plan

Our internal audit plan has needed to be agile and responsive to ensure that the Trust's key developing risks are covered. As a result of this approach, and with the support of officers and non-executive directors across the Trust, the plan has been delivered substantially in accordance with the agreed schedule and changes required during the year, as approved by the Audit Committee (the 'Committee'). In addition, regular audit progress reports have been submitted to the Committee. Although changes have been made to the plan during the year, we can confirm that we have undertaken sufficient audit work during the year to be able to give

an overall opinion in line with the requirements of the Public Sector Internal Audit Standards.

The Internal Audit Plan for the 2022/23 year was initially presented to the Committee in March 2022. Changes to the plan have been made during the course of the year and these changes have been reported to the Audit Committee as part of our regular progress reporting.

There are, as in previous years, audits undertaken at NWSSP, DHCW, and EASC that support the overall opinion for NHS Wales health bodies (see section 3).

Our latest External Quality Assessment (EQA), conducted by the Chartered Institute of Public Finance and Accountancy (CIPFA) (in March 2023), and our own annual Quality Assurance and Improvement Programme (QAIP) have both confirmed that our internal audit work 'fully conforms' to the requirements of the Public Sector Internal Audit Standards (PSIAS) for 2022/23. We are able to state that our service 'fully conforms to the IIA's professional standards and to PSIAS.'

1.4 Summary of Audit Assignments

This report summarises the outcomes from our work undertaken in the year. In some cases, audit work from previous years may also be included and where this is the case, details are given. This report also references assurances received through the internal audit of control systems operated by other NHS Wales organisations (again, see section 3).

The audit coverage in the plan agreed with management has been deliberately focused on key strategic and operational risk areas; the outcome of these audit reviews may therefore highlight control weaknesses that impact on the overall assurance opinion.

Overall, we can provide the following assurances to the Board that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively in the areas in the table below.

Where we have given Limited Assurance, management are aware of the specific issues identified and have agreed action plans to improve control in these areas. These planned control improvements should be referenced in the Annual Governance Statement where it is appropriate to do so.

In addition, we also undertook a number of advisory and non-opinion reviews to support our overall opinion. A summary of the audits undertaken in the year and the results are summarised in table 1 below.

Table 1 – Summary of Audits 2022/23

Substantial Assurance	Reasonable Assurance
• N/A	• Risk management and assurance • Health and Safety (draft) • Infection prevention and control • Savings and efficiencies • Fleet maintenance • Major incidents • Hazardous Area Response Team • Immediate release directions • Attendance management • IMTP delivery • Cyber security • IM&T infrastructure • Data analysis • Electronic Patient Clinical Record • Follow up review
Limited Assurance	**Advisory/Non-Opinion**
• Pain management • Trade union release time • Standards of Business Conduct: Declarations	• Decarbonisation
No Assurance	
• N/A	

Please note that our overall opinion has also taken into account both the number and significance of any audits that have been deferred during the course of the year (see section 5.7) and also other information obtained during the year that we deem to be relevant to our work (see section 2.4.2).

2. HEAD OF INTERNAL AUDIT OPINION

2.1 Roles and Responsibilities

The Board is collectively accountable for maintaining a sound system of internal control that supports the achievement of the organisation's objectives and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The Annual Governance Statement is a statement made by the Accountable Officer, on behalf of the Board, setting out:

- how the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives;
- the purpose of the system of internal control, as evidenced by a description of the risk management and review processes, including compliance with the Health & Care Standards; and
- the conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures, together with assurances that actions are or will be taken where appropriate to address issues arising.

The Trust's risk management process and system of assurance should bring together all of the evidence required to support the Annual Governance Statement.

In accordance with the Public Sector Internal Audit Standards (PSIAS), the Head of Internal Audit (HIA) is required to provide an annual opinion, based upon and limited to the work performed on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. This is achieved through an audit plan that has been focussed on key strategic and operational risk areas and known improvement opportunities, agreed with executive management and approved by the Audit Committee, which should provide an appropriate level of assurance.

The opinion does not imply that Internal Audit has reviewed all risks and assurances relating to the Trust. The opinion is substantially derived from the conduct of risk-based audit work formulated around a selection of key organisational systems and risks. As such, it is a key component that the Board takes into account but is not intended to provide a comprehensive view.

The Board, through the Audit Committee, will need to consider the Head of Internal Audit opinion together with assurances from other sources including reports issued by other review bodies, assurances given by management and other relevant information when forming a rounded

picture on governance, risk management and control for completing its Governance Statement.

2.2 Purpose of the Head of Internal Audit Opinion

The purpose of the annual Head of Internal Audit opinion is to contribute to the assurances available to the Accountable Officer and the Board of Welsh Ambulance Services NHS Trust which underpin the Board's own assessment of the effectiveness of the organisation's system of internal control.

This opinion will in turn assist the Board in the completion of its Annual Governance Statement, and may also be taken into account by regulators including Healthcare Inspectorate Wales in assessing compliance with the Health & Care Standards in Wales, and by Audit Wales in the context of both their external audit and performance reviews.

The overall opinion by the Head of Internal Audit on governance, risk management and control results from the risk-based audit programme and contributes to the picture of assurance available to the Board in reviewing effectiveness and supporting our drive for continuous improvement.

2.3 Assurance Rating System for the Head of Internal Audit Opinion

The overall opinion is based primarily on the outcome of the work undertaken during the course of the 2022/23 audit year. We also consider other information available to us such as our overall knowledge of the organisation, the findings of other assurance providers and inspectors, and the work we undertake at other NHS Wales organisations. The Head of Internal Audit considers the outcomes of the audit work undertaken and exercises professional judgement to arrive at the most appropriate opinion for each organisation.

A quality assurance review process has been applied by the Director of Audit & Assurance and the Head of Internal Audit in the annual reporting process to ensure the overall opinion is consistent with the underlying audit evidence.

We take this approach into account when considering our assessment of our compliance with the requirements of PSIAS.

The assurance rating system based upon the colour-coded barometer and applied to individual audit reports remains unchanged. The descriptive narrative used in these definitions has proven effective in giving an objective and consistent measure of assurance in the context of assessed risk and associated control in those areas examined.

This same assurance rating system is applied to the overall Head of Internal Audit opinion on governance, risk management and control as to individual assignment audit reviews. The assurance rating system together with definitions is included at **Appendix B**.

The individual conclusions arising from detailed audits undertaken during the year have been summarised by the assurance ratings received. The aggregation of audit results gives a better picture of assurance to the Board and also provides a rational basis for drawing an overall audit opinion. However, please note that for presentational purposes we have shown the results using the eight areas that were used to frame the audit plan at its outset (see section 2.4.2).

2.4 Head of Internal Audit Opinion

2.4.1 Scope of opinion

The scope of my opinion is confined to those areas examined in the risk-based audit plan which has been agreed with senior management and approved by the Audit Committee. The Head of Internal Audit assessment should be interpreted in this context when reviewing the effectiveness of the system of internal control and be seen as an internal driver for continuous improvement. The Head of Internal Audit opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control is set out below.

Reasonable Assurance		The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved.

This opinion will need to be reflected within the Annual Governance Statement along with confirmation of action planned to address the issues raised. Particular focus should be placed on the agreed response to any Limited Assurance opinions issued during the year and the significance of the recommendations made (of which there were three audits in 2022/23).

2.4.2 Basis for Forming the Opinion

The audit work undertaken during 2022/23, and reported to the Audit Committee has been aggregated at Section 5.

The evidence base upon which the overall opinion is formed is as follows:

- An assessment of the range of individual opinions and outputs arising from risk-based audit assignments contained within the Internal Audit plan that have been reported to the Audit Committee throughout the year. In addition, and where appropriate, work at either draft report stage or in progress but substantially complete has also been considered, and where this is the case then it is identified in the report. This assessment has taken account of the relative materiality of these areas and the results of any follow-up audits in progressing control improvements (see section 2.4.3).

- The results of any audit work related to the Health & Care Standards including, if appropriate, the evidence available by which the Board has arrived at its declaration in respect of the self-assessment for the Governance, Leadership and Accountability module.
- Other assurance reviews which impact on the Head of Internal Audit opinion including audit work performed at other organisations (see Section 3).
- Other knowledge and information that the Head of Internal Audit has obtained during the year including cumulative information and knowledge over time; observation of Board and other key committee meetings; meetings with Executive Directors, senior managers and Non-Executive Directors; the results of *ad hoc* work and support provided; liaison with other assurance providers and inspectors; research; and cumulative audit knowledge of the organisation that the Head of Internal Audit considers relevant to the Opinion for this year.

As stated above, these detailed results have been aggregated to build a picture of assurance across the Trust.

In reaching this opinion we have identified that the majority of reviews during the year concluded positively with robust control arrangements operating in some areas.

From the opinions issued during the year, 15 were allocated Reasonable Assurance and three were allocated Limited Assurance. No reports were allocated a 'substantial assurance' or a 'no assurance' opinion. In addition, one advisory or non-opinion report was issued.

In addition, the Head of Internal Audit has considered residual risk exposure across those assignments where limited assurance was reported. Further, the Head of Internal Audit has considered the impact where audit assignments planned this year did not proceed to full audits following preliminary planning work and these were either: removed from the plan; removed from the plan and replaced with another audit; or deferred until a future audit year. The reasons for changes to the audit plan were presented to the Audit Committee for consideration and approval. Notwithstanding that the opinion is restricted to those areas which were subject to audit review, the Head of Internal Audit has considered the impact of changes made to the plan when forming their overall opinion.

A summary of the findings is shown below. We have reported the findings using the eight areas of the Trust's activities that we use to structure both our 3-year strategic and 1-year operational plans.

Corporate Governance, Risk Management and Regulatory Compliance

We have undertaken three reviews in this area.

The audit of **Risk management and assurance** derived **reasonable assurance**. Our review noted the continued maturity of risk scrutiny and reporting and the strengthening of the Board Assurance Framework element, which was assigned limited assurance in the prior year. This recognises the progress made by the Trust through delivery of its risk transformation programme.

Limited assurance was provided following our review of **Standards of business conduct: declarations.** Two high priority findings were raised around the absence of a central Declaration of Interest register, including the capture of key decision makers in line with other NHS Wales bodies, and non-compliance relating to the completion of gifts and hospitality forms. Other matters requiring attention include the completeness and accuracy of declarations of interest submissions, lack of evidence to support due diligence checks undertaken and the need to strengthen the gifts and hospitality register.

Our **Follow up review** delivered a **reasonable** assurance rating, which recognises the systems in place to monitor progress with the implementation of actions in response to internal audit reports.

A review of the draft **Annual Governance Statement** highlighted that it was generally consistent with our knowledge of the Trust through the audit work performed in the Internal Audit plan and a review of other organisational documents.

Strategic Planning, Performance Management & Reporting

We have undertaken one review in this area.

Our review of **IMTP delivery** received **reasonable** assurance rating, which recognised the effectiveness of the Strategic Transformation Board structures in delivering change programmes. We identified no significant issues for reporting. Three medium priority findings were raised, including the absence of benefit realisation plans and need to document quality management activity.

The **Strategy development** audit, to review the arrangements to support the development of the Trust's strategic ambitions, was deferred to 2023/24. The programme is still at the developmental phase due to the need to pause and re-prioritise key organisational activities to respond to the system pressures and continuing industrial action.

Financial Governance and Management

Both reviews undertaken in this area received **reasonable** assurance.

Our review of **Savings and efficiencies** evaluated savings plans and their monitoring arrangements. The Trust has a track record of achieving its savings programme, although this has predominantly been due to its reliance on non-recurrent savings such as vacancy management. Four medium priority findings were raised relating to developing documented guidance, provision of financial training and developing templates to ensure savings information is robustly recorded and reported. The Trust has recently established a Financial Sustainability Programme to address current financial challenges and to deliver further strategic development and transformation.

Our **Fleet maintenance** review gave a positive assessment of the application of the fleet management system and its impact in improving the coordination of fleet maintenance and cost control. However, two high priority findings were raised, highlighting the need to address inconsistencies between the Fleetwave and Oracle authorised signatory lists, and ensuring the appropriate procurement of suppliers and to enhance and regularly review supplier lists.

The audits of the payment systems provided by NWSSP, which we audit each year, concluded with positive assurance. The audits of Payroll and Accounts Payable both received reasonable assurance opinion ratings.

Quality & Safety

We have undertaken three reviews in this area.

Reasonable assurance was provided following our review of **Health and safety**. This reflects positively on the progress made by the Trust through delivery of its five-year Working Safely Programme.

Our review of **Infection prevention and control (IPC)** reported **reasonable** assurance. This demonstrated the heightened profile of IPC within the pandemic structures. However, we raised one high and five medium priority findings that require addressing in the return to business as usual.

Limited assurance was reported in relation to **Pain management**. Our audit found a poor completion rate of authorisation forms in respect of Patient Group Directions (PGDs), with a lack of monitoring at group / Committee level; PGDs are not reviewed on a regular basis; and a lack of oversight into pain scores and administration of analgesia. We also highlighted the need to improve record keeping, in order to identify the crew member administering the analgesia to ensure it is in line with protocol.

The **Clinical handover** audit was deferred to 2023/24, to recognise the operational nature of these reviews and the impact of service pressures and the continuing industrial action.

Information Governance & Security

All three reviews undertaken in this area received **reasonable** assurance.

Our review of the arrangements in place within the Trust to improve its **Cyber security** position resulted in a positive assessment. However, two high priority recommendations were raised in relation to establishing a formal reporting structure and encrypting backups in storage. There is also a need to approve the Cyber Security Plan and ensuring timescales for delivery are set.

The review of the management and operation of the Trust's **Information Management & Technology infrastructure** included a high priority issue on the recording of switches on the asset register and security patching. We also identified three medium priority matters, including to ensure the accuracy of the asset register, formalising the alert management process, and ensuring the services to be provided within the back-up site are appropriately prioritised.

The **Data analysis** review concluded that the Trust is a data-rich organisation and has the people and systems in place to manage and use its data to continuously monitor its performance and forecast future demand. Two high priority findings were raised around replacing legacy reporting software and fully defining and resourcing the CAD system administrator role.

Operational Service and Functional Management

Reasonable assurance was provided for the three reviews undertaken in this area.

The **Major incidents** review gave a positive assessment of the Trust's approach to prepare for such events. One high priority matter was raised to consider options to support more frequent exercising and testing of incident plans, including with multi-agency partners, and develop a system to capture these.

The audit of the **Hazardous Area Response Team** considered the arrangements the Trust in place to ensures the team is appropriately trained and equipped to respond to high-risk and complex emergency situations, in line with national standards of interoperability. Key matters arising concerned a high priority finding on the need to improve completion of training competencies and compliance monitoring, as well as seven medium priority findings.

The **Immediate release directions** review reflected positively on the arrangements in place within the Trust in relation to the release ambulances outside hospitals to respond to patient needs in the community, and

recognises the challenges it faces due to the significant volumes being made. We raised two high findings relating to the escalation of declined directions and the timely completion and review of Datix incidents.

Workforce Management

We have undertaken two reviews in this area.

Our review of **Attendance management** reported **reasonable assurance**, a positive reflection of the effectiveness of the early intervention mechanisms the Trust has put in place to improve staff attendance. Six matters were raised requiring management attention, including scope to improve analysis of underlying causes of sickness, alternative duties and their reporting, and the development of key performance indicators and data for evaluating quality and effectiveness of services.

The **Trade union release time** review derived **limited assurance**. Whilst the refreshed Facilities Agreement recommends processes to follow, these are not mandated, and several methods of recording facility time are in place. The lack of integrated systems for capturing this data at an organisational level, further reduces visibility and compliance. The findings replicate the recommendations raised in the 2018/19 limited assurance report.

Capital & Estates Management

We have undertaken two reviews in this area.

Reasonable assurance was provided following our review of the **Electronic patient clinical record**, reflecting the delivery and management arrangements in place to support the implementation of the system. The audit found that the programme was progressing within budget and target delivery, for a highly complex implementation involving multiple health bodies across Wales.

Decarbonisation audits were planned to be undertaken simultaneously across NHS Wales to provide assurance to respective NHS Wales bodies on their arrangements to reduce carbon emissions and control climate change. It was clear that in each instance the implementation plans had not been sufficiently developed to allow meaningful testing and to provide an assurance rating to respective Audit Committees. Accordingly, the decision was taken to report common themes to provide an overview of the overarching position across NHS Wales. A full audit review (with associated audit opinion) is provided within the agreed 2023/24 Internal Audit Plan for the Trust.

2.4.3 Approach to Follow Up of Recommendations

As part of our audit work, we consider the progress made in implementing the actions agreed from our previous reports for which we were able to give only Limited Assurance. In addition, where appropriate, we also consider

progress made on high priority findings in reports where we were still able to give Reasonable Assurance. We also undertake some testing on the accuracy and effectiveness of the audit recommendation tracker.

In addition, Audit Committees monitor the progress in implementing recommendations (this is wider than just Internal Audit recommendations) through their own recommendation tracker processes. We attend all audit committee meetings and observe the quality and rigour around these processes.

It is the role of Audit Committees to consider and agree the adequacy of management responses and the dates for implementation, and any subsequent request for revised dates, proposed by Management.

We have considered the impact of both our follow-up work and where there have been delays to the implementation of recommendations, on both our ability to give an overall opinion (in compliance with the PSIAS) and the level of overall assurance that we can give.

The Trust's recommendation tracking process continued during 2022/23. The Corporate Governance team has continued to review all outstanding recommendations with management and the outcomes have been reported to the Audit Committee. The Trust also continues to refer relevant extracts of the audit tracker to each Board Committee to support oversight and scrutiny of recommendations relating to their remit.

We have undertaken work towards the end of the year to validate the stated position for a sample of recommendations within the tracker. We were able to confirm the recorded position for the majority of the sampled recommendations and therefore provide the Audit Committee with additional assurance around the accuracy of the tracker.

2.4.4 Limitations to the Audit Opinion

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems.

As mentioned above the scope of the audit opinion is restricted to those areas which were the subject of audit review through the performance of the risk-based Internal Audit plan. In accordance with auditing standards, and with the agreement of senior management and the Board, Internal Audit work is deliberately prioritised according to risk and materiality. Accordingly, the Internal Audit work and reported outcomes will bias towards known weaknesses as a driver to improve governance risk management and control. This context is important in understanding the overall opinion and balancing that across the various assurances which feature in the Annual Governance Statement.

Caution should be exercised when making comparisons with prior years. Audit coverage will vary from year to year based upon risk assessment and

cyclical coverage on key control systems. In addition, the impact of COVID-19 on previous year's programmes makes any comparison even more difficult.

2.4.5 Period covered by the Opinion

Internal Audit provides a continuous flow of assurance to the Board and, subject to the key financials and other mandated items being completed in-year, the cut-off point for annual reporting purposes can be set by agreement with management. To enable the Head of Internal Audit opinion to be better aligned with the production of the Annual Governance Statement a pragmatic cut-off point has been applied to Internal Audit work in progress.

By previous agreement with the Trust, audit work reported to draft stage has been included in the overall assessment, with all other work in progress rolled-forward and reported within the overall opinion for next year.

The majority of audit reviews will relate to the systems and processes in operation during 2022/23 unless otherwise stated and reflect the condition of internal controls pertaining at the point of audit assessment.

Follow-up work will provide an assessment of action taken by management on recommendations made in prior periods and will therefore provide a limited scope update on the current condition of control and a measure of direction of travel.

There are some specific assurance reviews which remain relevant to the reporting of the organisation's Annual Report required to be published after the year end. Where required, any specified assurance work would be aligned with the timeline for production of the Trust's Annual Report and accordingly will be completed and reported to management and the Audit Committee subsequent to this Head of Internal Audit Opinion. However, the Head of Internal Audit's assessment of arrangements in these areas would be legitimately informed by drawing on the assurance work completed as part of this current year's plan.

2.5 Required Work

Please note that following discussions with Welsh Government we were not mandated to audit any areas in 2022/23.

2.6 Statement of Conformance

The Welsh Government determined that the Public Sector Internal Audit Standards (PSIAS) would apply across the NHS in Wales from 2013/14.

The provision of professional quality Internal Audit is a fundamental aim of our service delivery methodology and compliance with PSIAS is central to our audit approach. Quality is controlled by the Head of Internal Audit on an ongoing basis and monitored by the Director of Audit & Assurance. The

work of Internal Audit is also subject to an annual assessment by Audit Wales. In addition, at least once every five years, we are required to have an External Quality Assessment. This was undertaken by the Chartered Institute of Public Finance and Accountancy (CIPFA) in February and March 2023. CIPFA concluded that NWSSP's Audit & Assurance Services conforms with all 64 fundamental principles. It is therefore appropriate for NWSSP Audit & Assurance Services to say in reports and other literature that it conforms to the IIA's professional standards and to PSIAS.

The NWSSP Audit and Assurance Services can assure the Audit Committee that it has conducted its audit at Trust in conformance with the Public Sector Internal Audit Standards for 2022/23.

Our conformance statement for 2022/23 is based upon:

- the results of our internal Quality Assurance and Improvement Programme (QAIP) for 2022/23 which will be reported formally in the Summer of 2023;
- the results of the work completed by Audit Wales; and
- the results of the EQA undertaken by CIPFA in 2023.

We have set out, in **Appendix A**, the key requirements of the Public Sector Internal Audit Standards and our assessment of conformance against these requirements. The full results and actions from our QAIP will be included in the 2022/23 QAIP report. There are no significant matters arising that need to be reported in this document.

We also note that there have been no impairments to the independence of the Head of Internal Audit or to any member of NWSSP's Audit & Assurance Service who undertook work on the Trust's audit programme for 2022/23.

2.7 Completion of the Annual Governance Statement

While the overall Internal Audit opinion will inform the review of effectiveness for the Annual Governance Statement, the Accountable Officer and the Board need to take into account other assurances and risks when preparing their statement. These sources of assurances will have been identified within the Board's own performance management and assurance framework and will include, but are not limited to:

- direct assurances from management on the operation of internal controls through the upward chain of accountability;
- internally assessed performance against the Health & Care Standards;
- results of internal compliance functions including Local Counter-Fraud, Post Payment Verification, and risk management;
- reported compliance via the Welsh Risk Pool regarding claims standards and other specialty specific standards reviewed during the period; and

- reviews completed by external regulation and inspection bodies including Audit Wales and Healthcare Inspectorate Wales.

3. OTHER WORK RELEVANT TO THE TRUST

As our internal audit work covers all NHS Wales organisations there are a number of audits that we undertake each year which, while undertaken formally as part of a particular health organisation's audit programme, will cover activities relating to other Health bodies. These are set about below, with relevant comments and opinions attached, and relate to work at:

- NHS Wales Shared Services Partnership;
- Digital Health & Care Wales; and
- Emergency Ambulance Services Committee.

NHS Wales Shared Services Partnership (NWSSP)

As part of the internal audit programme at NHS Wales Shared Services Partnership (NWSSP), a hosted body of Velindre University NHS Trust, a number of audits were undertaken which are relevant to the Trust. These audits of the financial systems operated by NWSSP, processing transactions on behalf of the Trust, derived the following opinion ratings:

Audit	Opinion	Outline Scope
Accounts Payable	Reasonable	To evaluate and determine the adequacy of the systems and controls in place over the management of the NWSSP Accounts Payable service.
Payroll	Reasonable	To evaluate and determine the adequacy of the systems and controls in place for the management of Payroll Services.
Recruitment Services	Reasonable	To assess the adequacy and effectiveness of systems and controls for the management

		of Recruitment Services.
Procurement	Reasonable	Review of procurement activity within the new integrated procurement teams to establish consistency in processes and assess compliance with procurement guidance.

Please note that other audits of NWSSP activities are undertaken as part of the overall NWSSP internal audit programme. The overall Head of Internal Audit Opinion for NWSSP is Reasonable Assurance.

Digital Health & Care Wales (DHCW)

As part of the internal audit programme at DHCW, a Special Health Authority that started operating from 1 April 2021, a number of audits were undertaken which are relevant to the Trust. These audits derived the following opinion ratings:

Audit	Opinion	Outline Scope
Switching Services	Reasonable	To ensure that the Switching Service is maintained appropriately and that risks to the operation of the service are appropriately managed.
Embedding the Stakeholder Engagement Plan	Reasonable	To provide assurance on the arrangements for the management and the embedding of the DHCW External Stakeholder Engagement Strategy.
Centre of Excellence	Reasonable	To provide an opinion over the controls for the establishment of the Office 365 Centre of Excellence.

Technical Resilience	Substantial	To establish and assess the organisation's position to maintain acceptable service levels through, and beyond, severe disruptions to its critical processes and the IT systems which support them.
Cyber Security	Substantial	To provide assurance that the organisation is working to improve its cyber security position, and that appropriate reporting is in place that shows the current status.

Please note that other audits of DHCW activities are undertaken as part of the overall DHCW internal audit programme. The overall Head of Internal Audit Opinion for DHCW is Reasonable Assurance.

Emergency Ambulance Services Committee (EASC)

The work the Emergency Ambulance Services Committee (EASC) is undertaken as part of the Cwm Taf Morgannwg internal audit plan. These audits are listed below and derived the following opinion ratings:

Audit	Opinion	Outline Scope
EASC – Ambulance handover improvement arrangements	Substantial	We focused on the adequacy of the systems and controls in place within EASC for the development of the seven Welsh health boards' ambulance handover improvement plans and their Integrated Commissioning Action Plans (ICAPs) and ongoing monitoring.

While these audits do not form part of the annual plan for the Trust, they are listed here for completeness as they do impact on the organisation's activities. The Head of Internal Audit has considered if any issues raised in

the audits could impact on the content of our annual report and concluded that there are no matters of this nature.

Full details of the NWSSP audits are included in the NWSSP Head of Internal Audit Opinion and Annual Report and are summarised in the Velindre NHS Trust Head of Internal Audit Opinion and Annual Report. DHCW audits are summarised in the DHCW Head of Internal Audit Opinion and Annual Report, and the EASC audits are summarised in the Cwm Taf Morgannwg University Health Board Head of Internal Audit Opinion and Annual Report.

4. DELIVERY OF THE INTERNAL AUDIT PLAN

4.1 Performance against the Audit Plan

The Internal Audit Plan has been delivered substantially in accordance with the schedule agreed with the Audit Committee, subject to changes agreed as the year progressed. Regular audit progress reports have been submitted to the Audit Committee during the year. Audits that remain to be reported but are reflected within this Annual Report will be reported alongside audits from the 2023/24 operational audit plan.

The audit plan approved by the Committee in March 2022 contained 21 planned reviews. Changes have been made to the plan with two audits deferred/cancelled. All these changes have been reported to and approved by the Audit Committee. As a result of these agreed changes, we have delivered 19 reviews.

The assignment status summary is reported at section 5.

In addition, we may respond to requests for advice and/or assistance across a variety of business areas across the Trust. This advisory work, undertaken in addition to the assurance plan, is permitted under the standards to assist management in improving governance, risk management and control. This activity is reported during the year within our progress reports to the Audit Committee.

4.2 Service Performance Indicators

In order to monitor aspects of the service delivered by Internal Audit, a range of service performance indicators have been developed.

Indicator Reported to Audit Committee	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2022/23	G	March 2022	By 30 June	Not agreed	Draft plan	Final plan
Total assignments reported against adjusted plan for 2022/23	G	100%	100%	v>20%	10%<v<20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	84%	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	R	61%	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100%	80%	v>20%	10%<v<20%	v<10%

5. RISK BASED AUDIT ASSIGNMENTS

The overall opinion provided in Section 1 and our conclusions on individual assurance domains is limited to the scope and objectives of the reviews we have undertaken, detailed information on which has been provided within the individual audit reports.

5.1 Overall summary of results

In total 19 audit reviews were reported during the year. Figure 2 below presents the assurance ratings and the number of audits derived for each.

Figure 2 Summary of audit ratings

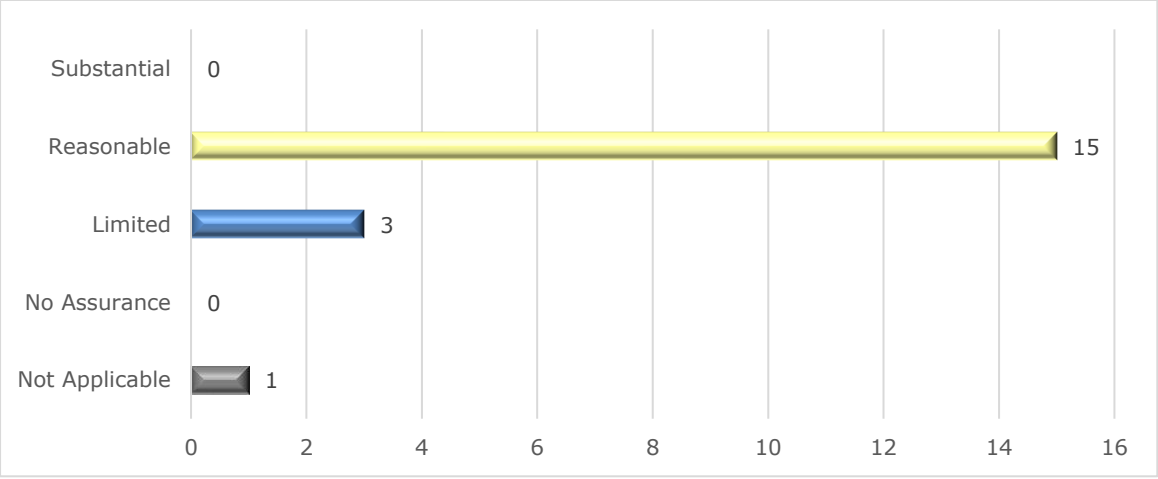


Figure 2 above does not include the audit ratings for the reviews undertaken at NWSSP, DHCW or EASC.

The assurance ratings and definitions used for reporting audit assignments are included in **Appendix B**.

In addition to the above, there were two audits which did not proceed following preliminary planning and agreement with management. In some cases, the impact of service pressures and industrial action on the Trust was the reason for the deferral or cancellation and in other cases, it was recognised that there was action required to address issues and/or risks already known to management and an audit review at that time would not add additional value. These audits are documented in section 5.7.

The following sections provide a summary of the scope and objective for each assignment undertaken within the year along with the assurance rating.

5.2 Substantial Assurance (Green)

No reviews were assigned a 'substantial assurance' opinion.

5.3 Reasonable Assurance (Yellow)

In the following review areas, the Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. Some matters require management attention in either control design or operational compliance and these will have low to moderate impact on residual risk exposure until resolved.

Review Title	Objective
Risk management and assurance	The audit sought to review the framework of organisational assurances in place and report on risk management.
Health and Safety (draft)	A review of the Trust's structures and arrangements for complying with the Health & Safety legislation. Commencement of fieldwork was deferred to April 2023 at the request of

Review Title	Objective
	management, due to system pressures and the impact of the continuing industrial action.
Infection prevention and control	The purpose of this audit was to assess adherence to organisational policies and the Standards for Health Services in Wales.
Savings and efficiencies	The audit was undertaken to provide assurance that savings plans are specific, realistic and measurable and that monitoring arrangements are effective.
Fleet maintenance	The audit assessed the application of the fleet management system and its impact in improving the coordination of fleet maintenance and cost control.
Major incidents	The overall objective of this audit was to assess the Trust's approach to prepare for major incidents and how it ensures it learns from such events.
Hazardous Area Response Team	The purpose of this audit was to review how the Trust ensures the team is appropriately trained and equipped to respond to high-risk and complex emergency situations.
Immediate release directions	The audit was a review of the effectiveness of the mechanisms in place to request the immediate release of ambulances outside hospitals to respond to patient needs in the community.
Attendance management	The objective of this audit was to evaluate the effectiveness of the early intervention mechanisms the Trust has put in place.
IMTP delivery	The purpose of this audit was to assess the effectiveness of the Transformation Programme structures as a mechanism to support delivery of the Trust's strategic ambitions.
Cyber Security	The audit was undertaken to provide assurance that the Trust is working to improve its cyber security position, and that appropriate reporting is in place that shows the current status.

Review Title	Objective
IM&T Infrastructure	This audit reviewed the management of the IM&T infrastructure and network.
Data analysis	This review sought to establish and assess data analysis within the Trust and the foundations for it becoming a data-led organisation.
Electronic patient clinical record	The objective of this audit was to review the delivery and management arrangements in place to progress the implementation of the electronic patient clinical record system.
Follow up review	The purpose of this audit was to review the systems in place to monitor progress with the implementation of actions in response to internal audit reports.

5.4 Limited Assurance (Amber)

In the following review areas, the Board can take only **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with moderate impact on residual risk exposure until resolved.

Review Title	Objective
Pain management	A review of the application of pain relief methods and their effect on patient outcomes in terms of pain relief and patient satisfaction.
Trade union release time	The objective of this audit was to provide assurance on the deployment of the refreshed Trade Union facilities agreement. To include review of progress made to implement recommendations raised in the 2018/19 'limited' assurance report.
Standards of Business Conduct: Declarations	The audit was undertaken to review compliance with the Standards of Business Conduct, including arrangements in place to manage declarations.

5.5 No Assurance (Red)

No reviews were assigned a 'no assurance' opinion.

5.6 Assurance Not Applicable (Grey)

The following reviews were undertaken as part of the audit plan and reported without the standard assurance rating indicator, owing to the nature of the audit approach. The level of assurance given for these reviews are deemed not applicable – these are reviews and other assistance to management, provided as part of the audit plan, to which the assurance definitions are not appropriate but which are relevant to the evidence base upon which the overall opinion is formed.

Review Title	Objective
Decarbonisation	The audit sought to determine the adequacy of management arrangements to ensure compliance with the Welsh Government decarbonisation strategy, and to provide assurance on capital allocations provided by Welsh Government to address decarbonisation issues across the estate.

5.7 Audits not undertaken

Additionally, the following audits were deferred for the reasons outlined below. We have considered these reviews and the reason for their deferment when compiling the Head of Internal Audit Opinion.

Review Title	Objective
Clinical handover	Deferred to quarter 1 of the 2023/24 Internal Audit Plan to recognise the operational nature of this review and the impact of the continuing industrial action.
Strategy development	Deferred to 2022/23 to allow time for processes to embed. The programme is still at the developmental phase due to the need to pause and re-prioritise key organisational activities to

Review Title	Objective
	respond to the system pressures and continuing industrial action.

6. ACKNOWLEDGEMENT

In closing I would like to acknowledge the time and co-operation given by Directors and staff of the Trust to support delivery of the Internal Audit assignments undertaken within the 2022/23 plan.

Osian Lloyd
Pennaeth Archwilio Mewnol / Head of Internal Audit
Gwasanaethau Archwilio a Sicrwydd/ Audit and Assurance Services
Partneriaeth Cydwasanaethau GIG Cymru/ NHS Wales Shared Services Partnership
July 2023

Appendix A – Conformance with Internal Audit Standards

ATTRIBUTE STANDARDS	
1000 Purpose, authority and responsibility	Internal Audit arrangements are derived ultimately from the NHS organisation's Standing orders and Financial Instructions. These arrangements are embodied in the Internal Audit Charter adopted by the Audit Committee on an annual basis.
1100 Independence and objectivity	Appropriate structures and reporting arrangements are in place. Internal Audit does not have any management responsibilities. Internal audit staff are required to declare any conflicts of interests. The Head of Internal Audit has direct access to the Chief Executive and Audit Committee chair. There have been no impairments to our independence during 2022/23.
1200 Proficiency and due professional care	Staff are aware of the Public Sector Internal Audit Standards and code of ethics. Appropriate staff are allocated to assignments based on knowledge and experience. Training and Development exist for all staff. The Head of Internal Audit is professionally qualified.
1300 Quality assurance and improvement programme	Head of Internal Audit undertakes quality reviews of assignments and reports as set out in internal procedures. Internal quality monitoring against standards is performed by the Head of Internal Audit and Director of Audit & Assurance. Audit Wales complete an annual assessment. An EQA was undertaken in 2018.
PERFORMANCE STANDARDS	
2000 Managing the internal audit activity	The Internal Audit activity is managed through the NHS Wales Shared Services Partnership. The audit service delivery plan forms part of the NWSSP integrated medium term plan. A risk based strategic and annual operational plan is developed for the organisation. The operational plan gives detail of specific assignments and sets out overall resource requirement. The audit strategy and annual plan is approved by Audit Committee.

	Policies and procedures which guide the Internal Audit activity are set out in an Audit Quality Manual. There is structured liaison with Audit Wales, HIW and LCFS.
2100 Nature of work	The risk-based plan is developed and assignments performed in a way that allows for evaluation and improvement of governance, risk management and control processes, using a systematic and disciplined approach.
2200 Engagement planning	The Audit Quality Manual guides the planning of audit assignments which include the agreement of an audit brief with management covering scope, objectives, timing and resource allocation.
2300 Performing the engagement	The Audit Quality Manual guides the performance of each audit assignment and report is quality reviewed before issue.
2400 Communicating results	Assignment reports are issued at draft and final stages. The report includes the assignment scope, objectives, conclusions and improvement actions agreed with management. An audit progress report is presented at each meeting of the Audit Committee. An annual report and opinion is produced for the Audit Committee giving assurance on the adequacy and effectiveness of the organisation's framework of governance, risk management and control.
2500 Monitoring progress	An internal follow-up process is maintained by management to monitor progress with implementation of agreed management actions. This is reported to the Audit Committee. In addition, audit reports are followed-up by Internal Audit on a selective basis as part of the operational plan.
2600 Communicating the acceptance of risks	If Internal Audit considers that a level of inappropriate risk is being accepted by management it would be discussed and will be escalated to Board level for resolution.

Appendix B - 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.

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

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Risk Management & Assurance
Final Internal Audit Report

July 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
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Contents

Review reference:	WAST-2223-01
Report status:	Final
Fieldwork commencement:	3rd May 2023
Fieldwork completion:	4th July 2023
Draft report issued:	6th July 2023
Management response received:	12th July 2023
Final report issued:	13th July 2023
Auditors:	Osian Lloyd, Head of Internal Audit Felicity Quance, Deputy Head of Internal Audit
Executive sign-off:	Trish Mills, Board Secretary
Distribution:	Julie Boalch, Head of Risk / Deputy Board Secretary
Committee:	Audit Committee

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

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

Disclaimer notice - please note
This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

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

Executive Summary

Purpose

To 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

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.

1. Introduction

1.1 The Welsh Ambulance Services NHS Trust (the 'Trust') recognises that risk management is an integral part of its governance arrangements. The Trust Board has a responsibility to ensure that the principles of good governance are underpinned by such frameworks for risk and assurance, to provide safe and effective care for patients and staff.

1.2 The Trust has a Board Assurance Framework (BAF) in place which includes principal risks, controls and assurances related to the achievement of the organisation's objectives, which are set out as part of its Integrated Medium Term Plan (IMTP).

1.3 Operational risks are held within risk registers across the Trust, with the Trust's principal risks held within a Corporate Risk Register (CRR). Risks within the CRR are owned by Executive Directors and reported to each Board meeting and to the relevant Committee for oversight and assurance. The Audit Committee retains oversight of the risk management process.

1.4 The IMTP 2022-25 had an ambition to develop and deliver a strategic risk management framework as a key enabler of its business strategy and decision making. The IMTP 2023-26 includes the development of a BAF that reflects more closely the Trust's strategic objectives articulated in its long-term strategy titled '*Delivering Excellence, Our Vision for 2030*'.

1.5 The Audit Wales Structured Assessment 2022 report found that '*while the Trust is strengthening its systems of assurance with regular reviews of risk, further work is required to understand whether the Trust's mitigating actions are achieving their intended impact on significant and ongoing risks and challenges.'*

1.6 The key risks considered at this review were:

i. Unintegrated and inconsistent approaches to managing and escalating risks resulting in ineffective and inefficient use of resources;
ii. Key risks to the achievement of the Trust's objectives are not managed effectively;
iii. Gaps in assurance are not identified, or appropriate action to address gaps are not taken; and
iv. Ineffective reporting of the assurance framework and risks to Board and/or committee level could undermine the ability to scrutinise and take assurance from their management.

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
Operating Effectiveness	-	3	-	3
Total	-	4	-	4

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: Risk management and assurance arrangements are defined within a strategy and framework, and aligned to the Trust's objectives and strategic direction.

2.3 Risk management is recognised as an integral part of the Trust's governance arrangements. A risk management transformation programme has been developed and included in the Integrated Medium Term Plan (2023-26) (IMTP): *"This programme will further strengthen and positively impact the development of the Trust's future strategic ambition and provide clarity on the risks that would prevent us from achieving our organisational objectives."*

2.4 One of the seven deliverables underpinning the transformation programme is to develop a Risk Management Policy and supporting procedures. Board approval of the Policy was originally anticipated in January 2023; however, due to operational pressures and resource challenges within the team this has not progressed as planned and is part of the programme within the 2023-26 IMTP. We understand that the Policy has been drafted, with approval by the Audit Committee now planned at the December 2023 meeting. We have therefore not raised a recommendation on this basis.

2.5 Risk management is coordinated and managed by the Corporate Governance Team. The Board Secretary has responsibility for leading on the design, development and implementation of the Risk Management and Board Assurance Framework (BAF). Given the level of risk the Trust carries, along with its ambition to deliver its risk transformation programme, resources for risk management are limited. The Trust does not have a dedicated risk management team outside of the Head of Risk/Deputy Board Secretary but has recently been successful in recruiting a Risk Officer which will help continue to drive improvements going forward.

2.6 The BAF is also coordinated by the Corporate Governance Team. A simple guidance note has recently been developed to assist Board and Committee members to interpret the BAF and to provide proportionate challenge on actions to mitigate the

risks and their intended impact. This addresses a recommendation raised in our prior year report.

2.7 The BAF was paused for a period of three months, with the approval of the Audit Committee in March 2022, to allow for a transitional BAF to be developed and populated. Presentation of the BAF includes recognition that principal risks to the achievement of IMTP deliverables are currently mapped from the Corporate Risk Register (CRR).

2.8 As noted in Audit Wales' recent Structured Assessment report, the BAF is not yet aligned to the Trust's broader long-term strategy and does not link with wider system controls and assurances. The Trust expects to transition to a more mature and strategic BAF during 2023/24 as part of the risk transformational programme (refer to objective 3 and **MA4**).

Conclusion:

2.9 Risk management is recognised as an integral part of the Trust's governance arrangements, with a transformation programme included within its IMTP. The Risk Management Policy has been drafted and a guidance note has recently been developed to assist interpretation and scrutiny of the BAF going forward. Noting this, we assign this objective **reasonable** assurance.

Audit Objective 2: Strategic and significant operational risks are managed via the BAF and CRR, and regularly reviewed by the Executive Management Team.

2.10 The Trust's principal risks are set out in its Corporate Risk Register (CRR). The Trust also operates directorate and local registers where risks are managed locally. Our previous reviews have included the role of Assistant Director Leadership Team (ADLT) and Executive Management Team (EMT) in the monitoring of Principal risks prior to their presentation to Committees and Trust Board. ADLT Terms of Reference include '*Monitoring, management and reviewing of Trust Corporate risks and make recommendations to EMT, including the interface with the Board Assurance Framework.*'

2.11 CRR entries are assigned a lead Executive for ownership and the risk is also assigned to a specified Committee for oversight and assurance. Directorates are responsible for managing their directorate and local risks and escalating risk to the Head of Risk/Deputy Board Secretary for inclusion on the CRR. Risks are escalated, amended or removed at corporate level on the basis of a recommendation made by ADLT to the EMT. We obtained papers for ADLT and EMT meetings which demonstrated regular review of the CRR and BAF ahead of presentation to the Audit Committee and Trust Board.

2.12 The development of risk appetite statements is another 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. This has been adopted as a best practice approach across NHS Wales.

2.13 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 as articulated in the Trust's Annual Report. We note the progress made in this area with plans in place to scope and develop the risk appetite statements with the Chair. **(See MA1)**

2.14 The Corporate Governance Team has strengthened the rearticulation of the Trust's highest scoring risks, presenting them in an '*if, then, resulting in*' structure. Further work has also been undertaken since our previous audit to map controls and sources of assurance, through the focus of principal risks in the new BAF format. Actions are assigned to address gaps identified, and these are owned by individual Officers.

2.15 During our prior year audit, we raised that the ADLT had not been fulfilling one of the responsibilities set out in its Terms of Reference, relating to the regular review of directorate risk registers. We also identified an inconsistent approach to the review of risks at directorate and operational levels. We recommended that the Trust consider arrangements to support the consistency and monitor the completeness of directorate risk registers. We note that this work will be undertaken by the newly appointed Risk Officer and have not performed a detailed review of the risk registers during our audit on this basis.

2.16 There are seventeen risks on the Trust's CRR, including twelve scoring 15 and above. As has been recognised by the Trust, the timely review of risk and associated mitigation plans has been impacted by the challenges faced as a result of winter pressures and industrial action. Despite this; however, the highest scoring risks has continued at Trust Board and Committee level.

Conclusion:

2.17 An appropriate governance framework is in place to manage both strategic and operational risks at the Trust. Work has been carried out to strengthen the rearticulation of the Trust's highest scoring risks and to map controls and sources of assurance. Plans are in place to develop the risk appetite statements and to review arrangements to support the consistency and completeness of directorate risk registers. We provide **reasonable** assurance for this objective.

Audit Objective 3: The BAF has been integrated with wider risk management arrangements and there is action to address gaps in controls or assurance.

2.18 As per para 2.7, in order to strengthen the BAF, reporting was paused for a period of three months. As this resulted in a temporary gap in the reporting of risks against the Trust's strategic objectives, we provided a limited assurance rating.

2.19 A significant amount of work has been undertaken by the Trust to refresh its BAF, with regular updates on progress presented to both Audit Committee and Trust Board. Positive feedback has been received, with recognition that the Trust is on a journey towards developing a more traditional BAF. The Audit Wales Structured

Assessment report was positive in terms of the progress made. It stated that *"the new version is more detailed and comprehensive, with much greater articulation of the controls and assurances in place."*

2.20 However, the report also highlighted that whilst "*the BAF clearly identifies how the Trust is monitoring risks and the associated mitigating controls, it currently only provides limited assurance on the impact of the controls in terms of whether they are effectively reducing the risks."* We note that the recent development of the BAF guidance document should assist with scrutiny in this respect going forward. **(See MA4)**

2.21 As highlighted in para 2.8, the BAF focusses on the principal risks from the CRR. Whilst this is not yet aligned to the Trust's broader long-term strategy, and does not link with wider system controls and assurances, the BAF does cross-reference to the IMTP deliverables which largely delivers the long-term strategy. The IMTP 2023-26 includes the development of a BAF that reflects more closely the Trust's strategic objectives against its long-term strategy – *Delivering Excellence: Vision 2030*. **(See MA4)**

2.22 The revised BAF maps the controls and assurances in place for the principal risks, and where relevant, identifies gaps and associated actions. Actions marked as 'complete' by the executive leads and their teams will then be assessed for inclusion as either a key control or form of assurance (refer also to objective 5).

Conclusion:

2.23 Further to our previous limited assurance conclusion in this area, the Trust has undertaken significant work to update and refresh the BAF, but it is recognised there still remain opportunities to enhance it further. This has also been endorsed by Audit Wales within their Structured Assessment report. Accordingly, we assign this objective **reasonable** assurance.

Audit Objective 4: Appropriate training and guidance is available to the Board and to support staff at all levels of the organisation.

2.24 Our prior year review noted limited guidance was available to support staff through the Trust SharePoint site. The development and delivery of guidance and training across all levels of the organisation was an IMTP deliverable and would align with the all-Wales programme. Whilst there was intention to address this area, we could only assign a limited assurance rating.

2.25 We were informed by management that following the recent appointment of the Risk Officer, the risk management section that currently sits under Quality Safety & Patent Experience Directorate on the Trust's SharePoint site will be transferred to the Corporate Governance section and refreshed to improve the guidance provided to staff. **(See MA2)**

2.26 The All Wales Risk Management Community of Practice Group has developed a training needs analysis to be provided across three levels: all staff/induction, staff with responsibility for operational risk management and senior management/board

members. The training will align with the new Once for Wales risk management module within Datix, the implementation of which has been delayed (outside of the Trust's control). The Trust continues to utilise the extant Datix system as a central repository of risks, to which all officers have ready access for risk entry, update and reporting.

2.27 The continuing impact of operational pressures including winter and industrial action has meant that face to face training has been paused. However, the Trust has delivered virtual training sessions at the ADLT meeting, the Operational Heads of Service away day and Operational Team Leader and Duty Operations Managers induction programmes. We were provided with training slides which captured the fundamentals of risk management, including the identification and escalation of risk and how to manage risks via Datix.

2.28 We recommend that next steps include ensuring that what is learnt in the training is carried through into practice. This could include issuing surveys to staff that attended the training to gather their views on the impact it has had on their understanding of risk management principles and practice, and to identify areas of further training need and improvement. Information on the use of key fields within the risk register could also be analysed, to promote more active and effective use of risk registers, and to strengthen reporting in this area to provide assurance over the management of risk. **(See MA3)**

2.29 The delivery of Board education on Risk Management is included within the Trust's risk management transformation programme, which is to be scoped and planned with the Chair.

Conclusion:

2.30 Following our previous limited assurance conclusion in this area, the Trust has delivered virtual risk management training sessions. We note that there is scope to analyse the effectiveness of the risk management training and enhance reporting. The Trust should develop a SharePoint site to ensure guidance on risk management and assurance arrangements is made available to staff. Therefore, we assign this objective **reasonable** assurance.

Audit Objective 5: Established processes are in place to support the monitoring and review of key risks and assurance mechanisms across the Trust, including at Committee and Board level.

2.31 As per para 2.11, CRR entries are assigned a lead executive for ownership and the risk is assigned to a relevant Committee for oversight and assurance. Updates on the CRR are provided to Audit Committee and Trust Board meetings during each meeting cycle. Each of the IMTP deliverables, one of which is risk management, and delivery timeframes are monitored at the Strategic Transformation Board (STB), with regular update reports presented on progress.

2.32 Risk papers, including the BAF, are presented at each of the Committee meetings in line with the agreed cycles of business and are used to inform work programmes.

To support its responsibility for maintaining oversight of the Trust's general risk management structures, processes and responsibilities, the Audit Committee receives and considers an update report of the CRR and BAF. This includes discussion and any escalations from Committees, consistent with those set out in a dedicated section of the 'Alert, Advise and Assure' report to the Board (addressing a recommendation raised in our prior year report), and regular updates on risk management arrangements throughout the year – including progress made in respect of the Risk Management Transformation Programme.

2.33 A detailed paper was produced in March 2023, following a request by the Chair of the Audit Committee at the Board meeting on 26 January 2023, which provided further clarity on the roles and responsibilities for risk management within the existing framework, in particular the role of the Executives, the Committees and the Board with respect to the higher rated risks particularly. The paper also outlined the outcome of recent effectiveness surveys for Committees, which received positive feedback on the Committee's review of key risks. This included that there was agreement on the whole that principal risks are discussed at each meeting, including controls, assurances against controls and mitigating actions to address any gaps.

2.34 Further to para 2.16 above, the Trust's highest scoring principal risks, *223 The Trust's inability to reach patients in the community causing patient harm and death; 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; 160 High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service; and 201 Damage to Trust reputation following a loss of stakeholder confidence*, have been subject to regular and consistent review throughout the period of sustained operational pressures.

2.35 At its July 2022 meeting, the Board received and discussed a paper on *'Actions to mitigate real time avoidable patient harm in the context of extreme and sustained pressure across urgent and emergency care*'. The Trust's CEO has presented regular progress updates on the actions undertaken by the Trust and system stakeholders to mitigate this, actions which are directly related to risks 223 and 224. These risks scores have remained unchanged despite these actions and matters have continued to be escalated at the highest level, including with Welsh Government, the Chief Ambulance Service Commissioner and the Chief Executives of Health Boards.

2.36 Audit Wales highlighted in their Structured Assessment report that "*each committee receives and discusses the risks relevant to their remit at every meeting, with any issues escalated in via highlight reports to Board. However, despite regular review, several CRR risks have remained static or deteriorated in recent months, suggesting actions for mitigating risks are not having the intended effect. While this is, in part, due to the risks being impacted by external pressures and partners, the Trust must apply robust challenge to ensure its mitigating actions are achieving their maximum impact.*"

2.37 The report also found that "*while the BAF is a standing agenda item on each Board and Committee agenda, there is a need to better focus discussions on the effectiveness and impact of controls in reducing the strategic risks facing the organisation.*" As noted in para 2.20 above, the recent development of the BAF guidance document should assist with scrutiny in this respect going forward. **(See MA4)**

Conclusion:

2.38 There are established processes, with appropriate delegated responsibilities in place, at both Committee and Executive level, to monitor and review the principal risks across the Trust. Whilst this was recognised by Audit Wales in their recent report, they also identified the need to better focus discussions on the effectiveness and impact of controls and mitigating actions in reducing the strategic risks, a number of which have remained static over time. Noting this, we provide **reasonable** assurance for this objective.

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
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.	June 2024	Julie Boalch, Head of Risk / Deputy Board Secretary / Trish Mills, Board Secretary

Matter Arising 2: Risk management and assurance sharepoint site (Design)			Impact
Our prior year review noted that limited guidance was available to support staff through the Trust SharePoint site and noted the same during this review. For example, the Risk Management guidance remains listed under the Quality Safety & Patent Experience Directorate within the Trust SharePoint 'Siren' page. We were informed that the recently appointed Risk Officer will be tasked with refreshing this.			Potential risk of: • Lack of guidance and/or clarity of risk management arrangements for staff.
Recommendations			**Priority**
2.1	The Trust should develop a SharePoint site to ensure guidance on risk management and assurance arrangements is made available to staff.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	Accepted.	September 2023	Julie Boalch, Head of Risk / Deputy Board Secretary

Matter Arising 3: Validation of risk management training (Operation)			Impact
The continuing impact of operational pressures including winter and industrial action has meant that face to face training has been paused. However, the Trust has delivered virtual training sessions, including at the ADLT meeting, the Operational Heads of Service away day and Operational Team Leader and Duty Operations Managers induction programmes. We were provided with training slides which captured the fundamentals of risk management, including the identification and escalation of risk and how to manage risks via Datix.			Potential risk of: • Lack of clarity of risk management arrangements for staff.
Recommendations			**Priority**
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.		**Medium**
3.2	To demonstrate learning from the risk management training delivered is carried through into practice and to help promote more active and effective use of risk registers, management should explore the analysing information on the use of key fields within Datix. Information on the use of key fields within the risk register could also be analysed, to promote more active and effective use of risk registers, and to strengthen reporting in this area to provide assurance over the management of risk.		
Agreed Management Action		**Target Date**	**Responsible Officer**
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.	Sept 2024	Julie Boalch, Head of Risk / Deputy Board Secretary

3.2	Not accepted. There will be no analysis of key fields in Datix at this time particularly as the Once for Wales Datix risk management module is in development and reporting will be designed as part of that. The Trust does not monitor Risk Management training through Datix currently and this is not a priority for the current resource that is available.		

Matter Arising 4: Strengthening of Board Assurance Framework (Operation)		Impact
A significant amount of work has been undertaken by the Trust to refresh its BAF, with regular updates on progress presented to both Audit Committee and Trust Board. Positive feedback has been received, with recognition that the Trust is on a journey towards developing a more traditional BAF. The Audit Wales Structured Assessment report was positive in terms of the progress the Trust has made, although it did note that the BAF is not yet aligned to the Trust's broader long-term strategy and does not link with wider system controls and assurances. The report also highlighted that whilst "*the BAF clearly identifies how the Trust is monitoring risks and the associated mitigating controls, it currently only provides limited assurance on the impact of the controls in terms of whether they are effectively reducing the risks*." The Trust expects to transition to a more mature and strategic BAF during 2023/24 as part of the risk transformational programme, and we note that the recent development of the BAF guidance document should assist with scrutiny in this respect going forward.		Potential risk of: • Key risks to the achievement of the Trust's objectives are not managed effectively; • Gaps in assurance are not identified, or appropriate action to address gaps are not taken; and • Ineffective reporting of the assurance framework and risks to Board and/or committee level could undermine the ability to scrutinise and take assurance from their management.
Recommendations		**Priority**
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 the effectiveness and impact of controls and mitigating actions in reducing the strategic risks.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
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.	March 2024	Julie Boalch, Head of Risk / Deputy Board Secretary
	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.	March 2024	Julie Boalch, Head of Risk / Deputy Board Secretary

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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Savings & Efficiencies
Final Internal Audit Report

May 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
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Contents

Review reference:	WAST-2223-04
Report status:	Final
Fieldwork commencement:	20 February 2023
Fieldwork completion:	21 March 2023
Draft report issued:	13 April 2023
Draft report meeting:	17 April 2023
Management response received:	12 May 2023
Final report issued:	15 May 2023
Auditors:	Osian Lloyd, Head of Internal Audit Felicity Quance, Deputy Head of Internal Audit Lisa Harte, Internal Audit Manager
Executive sign-off:	Chris Turley, Director of Finance and Corporate Resources
Distribution:	Navin Kalia, Deputy Director of Finance & Corporate Resources Jason Collins, Head of Financial Management
Committee:	Audit Committee

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

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

Executive Summary

Purpose

To review the arrangements in place at the Trust to ensure that savings plans are specific, realistic, and measurable and that monitoring arrangements are effective.

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- Developing documented guidance to assist staff in developing, assessing, and approving savings plans.
- Providing financial training to reinforce documented guidance.
- Developing templates to ensure savings information is robustly recorded and reported.

Report Classification

Reasonable Assurance

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved

Assurance summary[1]

Objectives		Assurance
1	Robust Savings & Efficiencies Plans	Reasonable
2	Reducing Budget to Reflect Savings	Reasonable
3	Appropriate governance arrangements	Reasonable

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1.1, 1.2	Developing Documented Guidance	1,3	Design	Medium
2.1, 2.2	Provision of Financial Training	1	Design	Medium
3.1	Robust Savings Plans	1	Design	Medium
4.1	Robust Savings and Efficiencies Reporting	3	Design	Medium

[1] We do not necessarily give equal weighting to the objectives and associated assurance ratings when formulating the overall audit opinion.

1. Introduction

1.1 The Trust approved the Integrated Medium-Term Plan (IMTP), which incorporates the Financial Plan for 2022/25, at its meeting on 24 March 2022. Developing the Financial Plan was a challenge on the back of the Covid-19 pandemic, and due to the significant cost pressures faced by the Trust. The Plan details that savings and efficiencies of £4.3m are required to achieve financial balance in 2022/23, a 54% increase in the level of savings to achieve from 2021/22. At month 11, savings of £4.026m have been achieved against a target of £3.942m and the Trust continues to forecast that it will deliver the total planned savings by the end of the financial year.

1.2 Recognising the ability to achieve financial balance in future years will be a greater challenge, the Financial Plan details the approach being developed to achieve further financial sustainability, including establishing a programme and workstreams to support the Trust in addressing its current financial challenges and in delivering further strategic development and transformation.

1.3 Embedding a transformative savings plan and regular reviews of savings targets are included as key controls to manage the following major risk (139), "*Failure to Deliver our Statutory Financial Duties in accordance with legislation*" detailed within the Corporate Risk Register.

1.4 Our audit has focused on the 2022/23 financial year, reviewing the arrangements in place to ensure that savings plans are specific, realistic, and measurable and that monitoring and reporting is effective. We did not review the effectiveness of the Financial Sustainability Programme as we plan to address within the 2024/25 Internal Audit plan, nor did we consider budgetary control arrangements as this was covered within the Financial Planning & Budgetary Control audit (issued August 2021: reasonable assurance).

1.5 Additionally, whilst undertaking this audit, we have considered the content of Audit Wales, '*Structured Assessment 2022 – Welsh Ambulance Services NHS Trust*' (January 2023), which included reviewing the Trust's management of its financial resources, including savings and governance arrangements.

1.6 The key risks considered at this review were:

- Balanced financial position not achieved therefore breaching its statutory duty to break-even;
- Decisions undertaken without sufficient financial scrutiny;
- Corrective action for currently unsustainable services not taken in sufficient time; and
- Savings and efficiencies schemes prove to be detrimental to the quality of service delivery and lead to the failure to meet IMTP objectives.

2. Detailed Audit Findings

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

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	-	4	-	4
Operating Effectiveness	-	-	-	-
Total	-	4	-	4

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

Audit Objective 1: There are robust plans in place to achieve savings and efficiencies targets, which have been assessed to confirm the accuracy of costs and achievable timescales, and with appropriate defined success measures to improve service delivery.

2.3 Historically, the Trust has taken a predominantly 'top-down' approach to identifying savings, but with the Financial Sustainability Programme in place, directorates are increasingly generating ideas for efficiencies. The Trust's Budget Manual emphasises this commitment, *the Trust is committed to a mix of bottom up / top down approach to budget setting by involving managers in the setting and ownership of Budgets*, which follows acknowledged best practice.

2.4 The Finance Directorate has developed a Budget Manual to assist budget holders in carrying out their roles and responsibilities for budgetary control. The Manual briefly refers to the savings and efficiency framework, but there is no detailed guidance to support budget holders through the process and ensure consistency (see **Matter Arising 1**). Having documented guidance would also be beneficial in embedding the Financial Sustainability Programme.

2.5 Providing budget holder training would also assist in clarifying the process and reinforce the need for transformational savings. There has been informal training provided to both finance managers and non-budget holder staff (i.e., Duty Operational Managers) through presentations and discussions on financial processes as part of recent restructures, but there has been no recent formal training (see **Matter Arising 2**). We understand that financial training for both Trust Board and Finance & Committee members has been planned for April 2023.

2.6 The 2022/23 schedule of savings (see Table 1), detailed within the Financial Plan, covers thirteen areas totalling £4.3m. Three areas totalling £1.7m were defined as non-recurring.

2.7 Subsequent reporting of the savings programme (see Table 2) in line with Welsh Government reporting requirements consolidates the thirteen areas into six themes.

Table 1

Schedule of Savings 2022/23 - DRAFT				Rec	Non Rec
	£M	£M	Assumption	£M	£M
Operations					
Workforce Efficiencies	1.80		Overtime, Sickness, Skill Mix, Vacancy Management (non frontline)	1.80	
Uniform	0.03		Utilise 21/22 purchased stock - cfwd benefit / stock control / new uniform supplier from Sept 22	0.03	
Fuel	0.05		Savings from swipe and save / Fuel provider contract	0.05	
M&S Stock Control	0.13		Stock control - minimum / maximum levels	0.13	
Medical Gases	0.02		Reduce cylinder holdings	0.02	
Travel & Subsistence	0.05		linked to overtime reduction	0.05	
Additional Income / External Contracts	0.24		seek to maximise / Contract reviews		0.24
In House Training (previously outsourced)	0.02		ad hoc	0.02	
		2.34			
Vacancy Management (Corporate Departments)		1.30			1.30
Estate utilisation, efficiencies and sustainability impacts		0.33		0.33	
Fleet Maintenance Efficiencies		0.08		0.08	
Non Pay Local Schemes / CIP / budget management (Corporate Directorates)		0.09		0.09	
Balance Sheet Management		0.16			0.16
Current Total Savings Plan		**4.30**		**2.60**	**1.70**

Table 2

	Annual	In Month			Cumulative			Forecast		
	Plan	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Workforce Efficiencies & Transformation	1,969	201	189	**12**	1,767	1,711	**56**	1,969	1,823	**146**
Fleet Efficiencies	81	7	0	**7**	74	6	**68**	81	6	**75**
Management of non operational vacancies (nr)	1,543	88	99	**-11**	1,453	1,838	**-385**	1,543	1,946	**-403**
Fuel	48	4	4	**0**	44	40	**4**	48	44	**4**
Local Schemes (non pay)	325	27	16	**11**	297	171	**127**	325	197	**129**
Estates	334	28	25	**3**	307	259	**48**	334	284	**50**
Totals	**4,300**	**355**	**333**	**22**	**3,942**	**4,025**	**-83**	**4,300**	**4,300**	**0**

2.8 While we were advised that changes have been minimal for 2022/23, there is no clear record of what changes have been made; and while £2.6m was initially identified, the level of recurring savings is not captured in ongoing reporting (see **Matter Arising 3**).

2.9 We were advised that the Director of Finance and Corporate Resources and the Chief Executive met with the relevant director to discuss their annual budgets, which highlighted savings. Evidence was supplied to confirm the correspondence with the directors as well as the meeting dates, but meetings were not minuted. We were informed that set up of an approvals panel is planned to strengthen the assessment and approval of individual plans going forward.

2.10 We reviewed a sample of five savings plans (Finance, Estates, Fleet, Planning & Performance; and Quality Safety & Patient Experience), and while a consistent template was used, enhancements were identified including providing detail for the rationale/ impact of the saving, robust success measures, and demonstrating

alignment to the IMTP (see **Matter Arising 3**). Tightening up on the identification and delivery of savings and efficiencies will be particularly important going forward, recognising the ability to achieve financial balance in future years will be a greater challenge for the Trust.

Conclusion:

2.11 The recording of savings schemes is consistent within directorates but are insufficiently detailed and will not assist in determining the confidence in delivering the savings proposal. This may be symptomatic of a lack of documented guidance to outline the process for developing savings plans. While informal financial training has been provided, the process needs to be formalised to confirm that staff receive training appropriate to their needs. Therefore, we provide **reasonable** assurance.

Audit Objective 2: Review and reporting of operational budgets to confirm these are reduced to reflect the delivery of recurrent savings.

2.12 We reviewed a sample of nine savings schemes (relating to non-pay and vacancy management savings within the directorates of Finance, Chief Executive, Partnership & Engagement, Planning & Performance, and Quality Safety & Patient Experience) and confirmed that they had been removed from the operational budget at the start of the 2022/23 financial year.

2.13 There is no mechanism in place to enable post-evaluation of savings plans to determine benefit realisation and lessons learnt. This would be beneficial to confirm the impact of the savings on service delivery, and understand the reason where savings plans are not being delivered. It is noted that a recommendation, regarding the inclusion of benefit realisation plans within programmes, was included in the IMTP Delivery report (issued February 2023 – reasonable assurance) therefore will not be replicated in this report. Discussions with the project manager confirmed that benefit mapping and lessons learnt were being implemented as part of the Financial Sustainability Programme.

Conclusion:

2.14 Savings have been removed from operational budgets promptly, but there is no benefit realisation plan in place to confirm that the saving plan's outcomes and benefits have been achieved, and identify any lessons learnt. We provide **reasonable** assurance for this objective.

Audit Objective 3: Appropriate governance arrangements are in place for the allocation and oversight of the delivery of savings and efficiencies, including an escalation process where financial sustainability is not achieved/ recovered.

Delivery Oversight

2.15 An appropriate governance framework for approval of the 2022/23 Financial Plan was evidenced – discussed by Finance & Performance Committee (17 March 2022);

endorsed by Executive Management Team (EMT) (21 March); and approved by the Board (24 March).

2.16 With regard to delivery, there is regular oversight of savings and efficiencies achievement by the Board, ADLT (Assistant Director Leadership Team), EMT, Finance & Performance Committee and Welsh Government. The Finance & Performance Committee's terms of reference, approved by Board in May 2022, explicitly refers to their role monitoring achievement of both in-year and recurring cost improvement plans and efficiencies.

2.17 A report to the Chair's Action Meeting in March 2022 detailed that savings performance reporting for the 2022/23 financial year will be incorporated in financial reports to EMT via Executive Finance Group (EFG).

2.18 Both ADLT and Finance & Performance Committee receive a Savings & Efficiency Highlight report that reflects on overall progress with each of the six savings themes, as well as highlighting risks and a thematic action plan to deliver the savings. Report recipients are provided with an overview of the savings programme, but the template could be enhanced by clarifying risks and progress to date, as well as having a robust action to assist with the delivery of the saving (see **Matter Arising 4**).

2.19 Evidence was provided of regular financial reporting to directorates that encompassed progress made against savings schemes – these reports replicate the information reported to Finance & Performance Committee. We did not review meeting notes to demonstrate key actions arising from budget meetings as this had been covered as part of the Finance & Budgetary Control audit (see para 1.4).

Escalation Process

2.20 From review of Finance & Performance Committee meeting minutes, scrutiny of the status of the savings programme was not routinely evidenced. We appreciate that this may be because the Trust is overall overachieving against its programme (see para 1.1), but five of the six saving themes have been consistently underachieving (see Table 3). Achievement of the savings programme is predominantly due to the Trust's reliance on vacancy management, and we note that Audit Wales have previously highlighted risks around this and the Trust's reliance on non-recurrent savings. We also note that the recent industrial action will also have impacted on progress with savings delivery and engagement.

Table 3 – Month 11 overview

Theme	Annual Target	YTD Target	YTD Delivery	YTD Variance		Assessment of delivery (RAG)
	£000	£000	£000	£000	%	
Workforce, Efficiency, Transformation	1,969	1,767	1,711	56	3.2%	
Fleet Efficiencies	81	74	6	68	91.9%	

Management of non-operational vacancies	1,543	1,453	1,838	(385)	(26.5%)	
Fuel	48	44	36	8	18.2%	
Local Schemes	325	297	171	126	42.4%	
Estates	334	307	259	48	15.6%	
Total	**4,300**	**3,942**	**4,025**	**(83)**	**(2.11%)**	

2.21 Furthermore, while there will be discussions operationally and reporting clearly details the performance with schemes, there is not a documented process to define the escalation of savings that are not being achieved in line with target timescales or will not be achieved (see **Matter Arising 1**). This would ensure that prompt action can be taken to prevent the Trust incurring additional financial pressure if savings are not delivered.

Savings Programme

2.22 As the Trust is facing a more challenging financial situation, requiring transformative savings of £6m to be achieved for financial year 2023/24, the Finance & Performance Committee will need to clearly demonstrate their scrutiny and how they are acting as a 'critical friend' to the Trust. In July 2022, the Financial Sustainability Programme was approved to identify 2023-24 savings projects at an earlier stage using two workstreams (covering achieving efficiency and income generation). The Director of Workforce and Organisational Development is the Senior Responsible Officer for the Programme, and a Project Manager has been appointed. At the date of fieldwork, the relevant project management documentation (including a Project Initiation Document) was being developed. Regular updates on the progress with the Financial Sustainability Programme have been reported, including a presentation to EFG in December 2022.

2.23 Further changes are planned to governance arrangements, e.g., putting in place a programme board reporting to the Strategic Transformation Board, so we suggest that a report is taken to Committee to approve any revisions to those originally agreed.

Conclusion:

2.24 There are effective governance arrangements through regular oversight over the savings and efficiencies framework. Enhancements to the reporting templates have been recommended to allow more effective scrutiny and to demonstrate that appropriate action is being taken to realise savings. The Trust is currently overachieving on its overall saving target, due to the continued reliance on non-recurrent items, particularly vacancy management; but there are several savings schemes that are under-achieving. There needs to be a defined process for taking prompt action against underachieving schemes so that it does not impact the

overall financial position. The Trust has recently established a Financial Sustainability Programme to address current financial challenges and to deliver further strategic development and transformation. We provide **reasonable** assurance for this objective.

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Appendix A: Management Action Plan

Matter Arising 1: Developing Documented Guidance (Design)		Impact
The Finance Directorate maintains a Budget Manual, which refers to the savings and efficiency framework as part of the budget setting process. The manual was updated within the last two years, but the document does not detail a date for its next review (this was raised as part of a wider recommendation within the Financial Planning & Budgetary Control audit in 2021/22). There is no further documented guidance to ensure that roles and responsibilities are clear, and that a consistent approach is undertaken when developing, assessing, and approving savings plans. Also, there is nothing documented to confirm the escalation process for any under-achievement of savings and efficiencies. Since May 2022, the Trust has been undertaking a Financial Sustainability Programme with an agreed terms of reference for delivery of governance arrangements. Developing documented procedures will assist in embedding this new approach.		Potential risk of: • Process being managed inconsistently resulting in savings and efficiency schemes not being achieved • Roles and responsibilities are unclear resulting in a lack of accountability and oversight.
Recommendations		**Priority**
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 being achieved in line with target timescales.	**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.	

Agreed Management Action		Target Date	Responsible Officer
1.1	Guidance on roles and responsibilities, documentation and escalation to be developed and shared by Financial Sustainability Programme.	End of July 23	Deputy Director of Finance / FSP Project Manager
1.2	Budget Manual to be updated for 23/24 and then annually reviewed.	End of July 23	Head of Financial Management

Matter Arising 2: Provision of Financial Training (Design)	Impact
Clause 5.2.7 of the Standing Financial Instructions (SFIs) states that it should be ensured, "*that adequate training is delivered on an ongoing basis to assist budget holders managing their budgets successfully*". Section 1.1 of the Budget Manual 2021/22 also details, "*All staff who have been given management responsibility for budgets should receive appropriate training (either formal or on the job), and procedure/ guidance notes. It is the responsibility of the Director of Finance to ensure training is available through the most appropriate medium. E.g. Face to face as part of budget review meetings, workshops, manuals, external training courses etc. In addition, budget managers should ensure sufficient financial management training is received*". While we appreciate that the Covid-19 pandemic and recent industrial action will have impacted, there has been no recent formal financial training provided to budget holders. We acknowledge, however, that this is a Finance objective for the forthcoming financial year (2023/24). Informal training has been delivered through powerpoint presentations, which incorporated the savings programme, and due to recent restructures, some budget holders will have been provided with verbal advice on financial processes. However training requirements need to be closely monitored so that assurance can be provided that all budget holders are proficient.	Potential risk of: • Poor decision-making impacting service delivery and financial sustainability.

Recommendations		Priority
2.1	A formal programme of financial training should be provided to budget holders to allow them to effectively carry out their role.	**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.	

Agreed Management Action		Target Date	Responsible Officer
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.	End of December 23 (commenced in April 23)	Head of Financial Management
2.2	Schedule of Training and who has attended to be recorded.	End of December 23 (commenced in April 23)	Head of Financial Management

Matter Arising 3: Robust Savings Plans (Design)	Impact
A review of a sample of savings plans (see para 2.10) submitted for financial year 2022/23 identified that the following were not detailed in any of the plans: • the detail over the individual savings proposal nor the rationale to support the business case, instead theme headings were used, e.g. local schemes non-pay, vacancy management, etc; • an assessment of impact to service delivery and success measures that are aligned to the objectives in the Integrated Medium-Term Plan (IMTP) were not detailed; • whether the saving was recurring or one-off nor how it was calculated; and • risks and their impact were recorded, but the same risk and impact was detailed for every savings proposal, and there was no risk assessment to determine the confidence in delivering the proposal. We were informed that set up of an approvals panel is planned to strengthen the assessment and approval of individual plans going forward. While we were advised that changes to the overall savings programme for 2022/23 have been minimal, there is no clear audit trail to record any significant changes made to the programme throughout the year. For example, detailing the reason for the removal or amendments of any savings plans, or rationale for savings amendment from recurring to non-recurring. Outlining a clear rationale along with any perceived risks and impact will also improve decision making.	Potential risk of: • Savings and efficiencies schemes prove to be detrimental to the quality of service delivery and lead to the failure to meet IMTP objectives.

Recommendations		Priority
3.1a	Savings and efficiency plans should be enhanced using SMART criteria to define success and provide realistic timescales.	**Medium**
3.1b	Noting the expected future financial challenges, there should be prioritisation and recording of recurring funding against one-off savings to assist with financial sustainability.	
3.1c	A log should be implemented to enhance the current process recording changes to the savings programme, during the financial year, from that originally approved.	

Agreed Management Action		Target Date	Responsible Officer
3.1a	Will be evidenced by project management principles being applied to every individual savings schemes as it is identified and its ongoing monitoring.	March 24 (as this could be ongoing)	Deputy Director of Finance / FSP Project Manager / Scheme Lead
3.1b	Impact of Non-recurring schemes in 23/24 will be addressed by FSP and as part of WAST Financial Plan for future financial years.		FSP / Deputy Director of Finance
3.1c	Schedule of 23/24 agreed plans and any additions will be controlled through FSP.		FSP / Deputy Director of Finance/Head of FM

Matter Arising 4: Robust Savings and Efficiencies Reporting (Design)	Impact
A Savings and Efficiency Highlight Reporting template has been developed when reporting to the Assistant Director Leadership Team (ADLT) and Finance & Performance Committee. It is a useful tool reporting on progress with individual savings schemes; however, review noted some areas for enhancement that would provide more contextual information and encapsulate SMART criteria clearly detailing progress, significant changes, and providing robust actions to assist with future delivery of efficiencies: • Detailing the progress made with implementation of each savings project since the last performance report was issued, as sometimes it was unclear what progress had been made. • Defining how the risk score was determined (RAG status), which should be aligned to other risk reporting. • Action plans need to be updated providing robust actions to assist with future savings delivery, have action owners, and clear targets when actions will be completed. • Detailing any significant changes to the savings programme since the last performance report was issued.	Potential risk of: • Ineffective reporting arrangements are in place resulting in savings and efficiencies not being sufficiently monitored or scrutinised.

Recommendations		Priority
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.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
4.1	Review of the current monthly savings report.	End of July 23	Head of Financial Management

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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Trade Union Release Time
Final Internal Audit Report

July 2023

Welsh Ambulance Services NHS Trust

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

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

Contents

Review reference:	WAST-2223-009
Report status:	Final
Fieldwork commencement:	11 October 2022
Fieldwork completion:	16 January 2023
Draft report issued:	3 February 2023
Debrief meeting:	31 January 2023
Management response received:	20 February 2023 / 5 June 2023 (post meeting with TU partners) / 11 July 2023 (post further internal discussions)
Final report issued:	11 July 2023
Auditors:	Osian Lloyd, Head of Internal Audit Felicity Quance, Deputy Head of Internal Audit Johanna Butt, Principal Auditor
Executive sign-off:	Angela Lewis, Director of Workforce & OD
Distribution:	Liz Rogers, Deputy Director of Workforce & OD
Committee:	Audit Committee

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

Acknowledgement

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

Executive Summary

Purpose

To provide assurance on the deployment of the refreshed Trade Union facilities agreement and to include a review of progress made to implement recommendations raised in the 2018/19 report (limited assurance).

Overview

We have issued limited assurance on this area. The significant matters which require management attention include:

- Whilst the Facilities Agreement recommends processes to follow, these are not mandated and owing to the caveats included compliance with the process is further reduced;
- There are inconsistencies in the process of recording and approving facility time;
- The Trust does not have a complete and accurate record of facility time; and
- There is currently no monitoring and reporting of time spent or cost of facility time.

All of the above replicate the recommendations raised in the 2018/19 report. We acknowledge that whilst progress has been made to revise the facilities agreement, the majority of issues and concerns raised previously remain.

Report Classification

		Trend
Limited 	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.	⇔

Assurance summary[1]

Assurance objectives		Assurance
1	Clear Facilities agreement in place.	Reasonable
2	Entitlement to facility time defined.	Reasonable
3	Requesting and approval of facility time.	Limited
4	Arrangements to capture and record facility time.	Limited
5	Management information regularly monitored.	No
6	Appropriate governance and oversight.	Limited

Key matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
1	The requirements of the Facilities Agreement are recommended rather than mandated.	1, 2	Design	High
2	There continues to be no standardised process for the requesting and approval of facility time.	3	Operation	High
3	There is no complete report available of all TU facility time taken by the TU representatives.	3, 4	Design	High
4	There is minimal management information produced on time spent, and cost, of facility time.	5, 6	Operation	Medium

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

1. Introduction

1.1 Release time (also known as 'facility time') is time off for an employee from their regular paid job, granted by their employer, to enable them to carry out trade union roles in the workplace.

1.2 The Welsh Ambulance Services NHS Trust's ('the Trust') revised '*Facilities Agreement: Time off and Facilities for Trade Union Partners*' (the 'Agreement'), was approved by the People and Culture Committee (PCC) on 30 November 2021 and presented at the Trade Union Partner Cell on the 7 December 2021 for adoption and communication. The Agreement was effective from 17 February 2022.

1.3 The Agreement demonstrates that the Trust is committed to the principles of partnership working and staff engagement. It recognises that the systematic and routine involvement of Trade Union Partners in shaping services and the decision-making process can contribute to delivering improved services to patients and users. It sets out the arrangements for the granting of facility time requests for accredited representatives and members of Trade Unions (TUs) / professional organisations, which are recognised under the Trust's Recognition Agreement. The Trust has accredited representatives with four recognised Trade Unions, being Royal College of Nursing (RCN), UNITE, GMB and UNISON.

1.4 Our previous audit and follow-up audit of Trade Union Release Time, undertaken in 2018/19 and 2019/20 respectively, both provided 'limited' assurance in this area.

1.5 The potential risks considered in this review were:

- Insufficient arrangements in place for requesting and authorising facility time, leading to inconsistent practices being applied and non-compliance with statutory legislation;
- The level of engagement expected by Union Officials to carry out their activities could lead to potentially excessive workloads which has implications on staff wellbeing;
- Insufficient arrangements in place to provide work cover when facility time is taken; and
- Accurate records of facility time not maintained and monitored, neither at an individual nor at a Trust level.

1.6 Our detailed work was coordinated to ensure alignment with, but not duplicate, proactive work undertaken by Counter Fraud.

2. Detailed Audit Findings

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

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	2	-	-	2
Operating Effectiveness	1	1	-	2
Total	3	1	-	4

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

Audit objective 1: The Facilities Agreement is clear on roles and responsibilities in respect of partnership working arrangements, and has been appropriately communicated to the Trust's Trade Union representative and managers.

2.3 As per para 1.2, the '*Facilities Agreement: Time off and Facilities for Trade Union Partners*' (the agreement) has been approved within the Trust and was communicated to all staff via the staff intranet 'Siren'.

2.4 The agreement outlines the arrangements for the granting of facility time for accredited representatives and members of TUs / professional organisations which are recognised under the Trust's Recognition Agreement. It also sets out a clear expectation that trade union partners are responsible for ensuring their facility time is used and recorded appropriately and transparently.

2.5 To support adherence, a '*Standardised Process to Formally Request and Record Trade Union Facility Time*' has been included as an appendix within the agreement. Additionally, spreadsheets have been developed to support the recording of trade union time spent and to capture declined requests.

2.6 Section 6.1.6 of the agreement states that '*The standardised process to formally request and record Trade Union facility time is contained within Appendix 1c, and is recommended for all Trade Union Partners to use as a consistent approach, and best practice as part of the organisation's toolkit to assist with partnership working arrangements'*.

2.7 Discussions with Workforce and Organisational Development (WOD) staff and TU leads, and review of communication of the agreement on the Trust's intranet, confirmed that: '*the Facilities Agreement recommends, <u>but does not mandate</u>, using a standardised process and template Excel Form to both request and record Trade Union facility time, in order to support Trade Union Partners and line managers to be transparent in the appropriate use of paid facilities time'*. With

such narrative used, the current agreement lacks clarity and formal defined guidelines and is open to interpretation. See **MA1**

2.8 Section 6.4.3 of the agreement details reasons why the Trust may refuse release requests, including unreasonable notice periods and activities not sanctioned by the union / service needs.

2.9 In addition, section 6.8 of the agreement provides guidance to manage disputes on the application of the agreement, and signposts to the Trust's Respect and Resolution Policy where it is not possible to resolve informally.

2.10 Review and monitoring arrangements are referenced in section 10 of the agreement relates, which states that '*An annual report will be presented to the People and Culture Committee and the Trust Partnership Forum, which will include details of activities and training which have taken place, including costs'*. Whilst the annual report was presented to the PCC in May 2022, this report did not include costs (see ***audit objectives 5 & 6***).

2.11 Section 8 of Appendix 1c to the agreement further details that '*A record of all approved applications for Trade Union time must be submitted to the Resources department and recorded on ESR (where appropriate, e.g. for Trade Union Partners who work within corporate teams) for information, monitoring and reporting purposes*; and '*Managers will be required to report on applications which are received and declined on the standardised spreadsheet for declined requests, so that an oversight and understanding of the reasons for refusal can be maintained'*.

Conclusion:

2.12 The Trust, in partnership with the Trade Union Partner Cell have developed, agreed and communicated a revised Facilities Agreement and associated appendices. The agreement sets out a clear expectation that trade union partners are responsible for ensuring their facility time is used and recorded appropriately and transparently. A standardised process to request and record facility time has also been developed to support Trade Union Partners and line managers to be transparent, although we note that this has been recommended rather than mandated. Noting this, we have assessed this objective as **reasonable** assurance.

Audit objective 2: The Facilities Agreement clearly identifies who is entitled to facility time and the duties and activities for which it can be used.

2.13 The agreement details that accredited representatives from the four nationally recognised unions are entitled to facility time. At the time of the audit, we were informed that the representatives from the RCN were not currently undertaking union duties.

2.14 A list of accredited union representatives is published on the Trust's intranet site. As at the end of September 2022, this detailed 92 accredited representatives across the four unions: UNISON (17), UNITE (37), GMB (36) and RCN (2). All 10

individuals selected for our sample (see para 2.21) were included on the list of accredited trade union representatives.

2.15 Sections 6.1.5, 6.2.4 and 6.4 of the agreement details eligible trade union activities, which includes but is not limited to:

- time to prepare for meetings and disseminate information and outcomes to members during working hours;
- negotiation and/or meaningful consultation on matters relating to terms and conditions of employment or agreed partnership processes;
- an expectation that TU Partners will, in addition to their core/basic Trade Union accredited representative course, attend other relevant courses e.g. job evaluation training;
- attend executive committee meetings or annual conference or regional union meetings;
- vote in properly conducted ballots on industrial relations;
- vote in union elections; and
- attend meetings to discuss urgent matters relating to the workplace and recruit, retain and organise members.

2.16 The agreement also makes several references to 'reasonable' time, however, it does not provide further detail to define 'reasonable' for the different types of TU activity. Whilst we acknowledge that it might not be feasible for the length of time for activities to be defined, given the variety of roles and responsibilities of TU representatives, the agreement could provide an expectation of the percentage of time individuals should work their substantive post to ensure skills are maintained, in particular for clinical staff. See **MA1**

Conclusion:

2.17 The agreement details the eligible trade union duties and activities that the assigned representatives can undertake as facility time. However, there is a lack of definition for 'reasonable' time within the agreement, and that of a minimum expectation of time to be spent on the substantive post to help maintain clinical skills. Noting these limitations, we have assessed this objective as **reasonable** assurance.

Audit objective 3: There is a process in place for requesting and approving facility time.

2.18 Section 6.1.6 of the agreement details that "*Individual trade union partners will be responsible for ensuring their Trade Union facility time is used and recorded appropriately and transparently, as this may be subject to future audit*". As per para 2.11, a '*Standardised Process to Formally Request and Record Trade Union Facility Time*' is also included as an appendix within the agreement, and supporting forms have been developed to capture these.

2.19 We requested a report of all facility time claimed between 1 April 2022 and 31 October 2022. The only report available was generated from the Global Rostering System (GRS), the detail of which is limited to facility time taken where there has been abstraction from an operational shift. It doesn't record TU duties undertaken on rest days, annual leave or outside rostered hours, and only captures EMS and NEPTS staff and not other staff groups including NHSD/111 and Corporate (see **MA3**).

2.20 Review of the report identified 37 individuals that had been abstracted from operational shifts for TU duties or TU partner training (see ***audit objective 4*** for further detail). Our sample included a spread of TU representatives across the three unions, all regions and included a mixture of EMS and NEPTS staff.

2.21 We requested facility time records from the sample of 10 TU representatives selected (see para 2.14) in order to confirm they had been appropriately requested and approved; and to ensure they were accurately recorded within GRS. One individual did not respond to the request for information. Only one individual had records that reconciled to the GRS report; with inconsistencies between the responses provided and the information recorded on GRS for the remainder of the sample. See **MA2**.

2.22 In addition, there was a lack of audit trail to demonstrate the appropriate and timely request and approval of facility time (see **MA2)**. We acknowledge that where there was evidence of request and approval this was received from line managers, and resource co-ordinators were also included to ensure that the individual was abstracted from their operational shift and the shift offered as overtime (where necessary).

2.23 The agreement details that facility time should be requested and approved in advance but recognises that there are occasions where this may not be possible, e.g., where it is a rest day and the representative has been asked to attend a meeting.

2.24 As per para 2.7, the use of the spreadsheet for recording declined requests has not been mandated and there is currently no log of declined requests (see **MA2**). However, TU partners interviewed during fieldwork, and the individuals included in the sample, confirmed that requests are rarely refused and there is a valid reason where they are.

Conclusion:

2.25 The agreement details the process to follow for requesting and approving facility time, however the supporting spreadsheets to record this time have not been mandated. For the sample selected, noting the limitations on the availability of reporting of facilities time, there were inconsistencies between the responses provided and the information recorded on GRS. Additionally, there was a lack of audit trail to demonstrate the appropriate and timely request and approval of facility time and there is no log of declined requests. Noting this, we have assessed this objective as **limited** assurance.

Audit objective 4: Appropriate arrangements are in place to capture and record facility time.

2.26 Discussions with WOD, TU leads and testing undertaken of records from a sample of TU representatives highlighted that the process in place to capture and record facility time varies. This is a symptom of the Trust not mandating a prescribed format and process, allowing flexibility to individuals to determine how they record their facility time. We were also informed that where staff have looked to use the recommended spreadsheet, feedback has been given of difficulties experienced in accessing the document via their iPads. See **MA3**.

2.27 As noted in para 2.19, the Trust could only provide reports on facility time from GRS, and these only detail facility time taken by Emergency Medical Services (EMS) staff and Non-Emergency Patient Transport Service (NEPTS) where there has been abstraction from an operational shift. The report also only details the 'general' headings of TU duties or TU partner training, it does not provide a breakdown of the agreed duties and activities as detailed within para 2.15. Additionally, on the report, where TOIL is recorded, it does not detail whether this is for TU facility time. See **MA3**.

2.28 Section 6.7 of Appendix 1c within the agreement states: '*All Trade Union Partners within NHSD/111 are required to request the Trade Union time via Shift Track. If the Trade Union Partner does not use the Global Rostering System (GRS) or Shift Track (e.g. Trade Union Partners within corporate teams), the Trade Union Partner is required to record the approved request on ESR as Special Increasing Balance > Trade Union Duties'*. WOD staff confirmed that the functionality to record Trade Union duties within ESR is not active and as such it is not possible to generate a report of facility time from the system. We were not provided with an explanation as to why there was no report available from Shift Track. See **MA3.**

Conclusion:

2.29 There are different arrangements in place to capture and record facility time as the process for recording facility time has not been mandated by the Trust. The GRS report only records TU duties and TU training where the representative has had to be extracted from duties. The functionality to record facility time on ESR is not active, and no report was available from Shift Track. Noting this, we have assessed this objective as **limited** assurance.

Audit objective 5: Accurate and timely management information is available, which is reviewed and monitored on a regular basis.

2.30 The requirements in respect of monitoring and reporting is detailed within ***audit objective 1***.

2.31 A paper on 'The Welsh Ambulance Service Trade Union Partner Cell Activity Report 2021-22' was presented at the PCC meeting in May 2022. The report highlighted developments which had been undertaken in partnership and reported through

the Welsh Ambulance Services NHS Trust Trade Union Partner (TUP) Cell during the period.

2.32 However, there was no evidence of management information on facility time being produced, which is a requirement of the agreement (see ***audit objective 1***). Given that there isn't one system that draws together all trade union release time (see ***audit objective 4***), including by staff group, the type of activities or duties, when it was taken, or the associated costs, it is not currently possible to produce complete and accurate management information. See **MA4.**

2.33 From our review of the GRS report, (see ***audit objective 2***), it was evident that a small number of individuals spend the majority of their time on TU duties. As per para 2.14, the Trust has 92 accredited representatives across the four unions so there is a need to spread this workload to ensure staff wellbeing and professional development i.e., clinical contact hours. A breakdown of TU activity would provide a better understanding of the workload and where the TU duties could be distributed more evenly. We understand that a small number of trade union representatives spend the majority of their time on TU duties which results in TOIL and overtime and minimal operational shifts being worked.

Conclusion:

2.34 There is no evidence of complete, accurate and timely management information being produced on facility time activities, or the associated costs, at an individual or Trust level. From review of the limited information that the Trust is able to produce, it is apparent that a small number of individuals are undertaking the majority of TU duties, which could negatively impact wellbeing and their professional development with regards to clinical contact hours. Noting this, we have assessed this objective as **no** assurance.

Audit objective 6: There are appropriate governance and oversight arrangements within the Trust.

2.35 The Board has delegated responsibility for the oversight of Trade Union arrangements to the People and Culture Committee (PCC). As per paras 2.10 and 2.31, the agreement states that an annual report will be presented to the PCC and we confirmed this requirement was met at the May 2022 meeting. The report included details of key areas of development undertaken in partnership through the Trade Union Partner (TUP) Cell, along with updates on the development of the agreement. However, the report lacked detail of duties and activities which have taken place, and an analysis of the associated time and costs. See **MA4**.

2.36 The Executive Management Team (EMT) reviews updates prior to each PCC meeting. However, this has again been limited to the development of the facilities agreement. See **MA4**.

2.37 Counter fraud have done some proactive work in this area and have reported to the Director of Workforce & OD. Some recommendations have been raised for the Trust to take forward and these align with the themes included in this report.

Conclusion:

2.38 Governance arrangements were evidenced through reporting and oversight of the facilities agreement at EMT and PCC; and the communication of key areas of the TU Partner Cell activities. However, there is currently no Trust wide reporting and oversight of TU activity. Noting this, we have assessed this objective as **limited** assurance.

Appendix A: Management Action Plan

Matter arising 1: Facilities agreement (Design)	Impact
We made a high priority recommendation in our previous audit that "*In partnership with the trade unions, the Trust should review the Facilities Agreement and ensure it is updated to clearly reflect agreed processes and practices*". The Trust and the trade unions have worked in partnership to produce, agree and communicate a new agreement which was implemented in February 2022. A standardised process to formally request and record trade union facility time has also been developed and is included as Appendix 1c of the agreement. However, we note that his has been recommended rather than mandated and, as such, is open to interpretation. This is evident by the findings contained within this report with regards to the process of requesting and approving, recording and monitoring and reporting facility time (see **MA2, 3 & 4**). The agreement makes several references to 'reasonable time' but does not define 'reasonable'. Whilst we acknowledge that it might not be feasible for the length of time to be defined, given the different roles and responsibilities of each TU representative, the agreement does not provide an expectation of the percentage of time individuals should work their substantive post to ensure skills are maintained, in particular for Paramedic and EMT staff.	Potential risk of: • Inconsistent process within the Trust; and • Loss of skills of frontline staff.

Recommendations	Priority
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.	High

Management response	Target Date	Responsible Officer
1.1 We note the comments and the audit recommendation. There were significant and lengthy discussions with TU partners regarding the update of the facilities agreement in 2021 and it took many months to get to sign off. We confirm that it has not been possible to provide an agreed definition of "reasonable time" for our TU representatives. Factors such as the number of members supported, seniority and experience of the rep and the internal organisational factors at the time will all impact the commitment which therefore makes it very difficult to do and flexibility is required by the organisation.		

In the context of ongoing industrial action, we will not be in a position to revisit the agreement in the short term but we will revisit in the context of resetting the relationship with TU partners after the industrial action issues are resolved.

We have a handful of senior representatives who have not practiced for some time and therefore are not safe to practice currently and this is affected by the length of time they spend on TU activities. The recommendation to maintain clinical practice and registration for competency depends on the role and clinical grade e.g. paramedics have to maintain registration whilst EMTs don't. We need to ensure we have flexibility on TU duties and this has been played out particularly during the last 6-12 months. Alongside this, we will also engage with senior TU reps on a regular basis to ensure we are aware of volumes of activity with a particular emphasis on periods of increased workload to ensure there is organisational oversight and understanding of impact.

Please note the context of ongoing industrial action and the challenges with TU relationship which impacts on the capacity to engage this issue. This will impact on the timeline for the discussions and the pace of moving forward.

We will be able to review this action at a point in the future, however not at present due to the ongoing relationship challenges with Trade Unions. The actions noted below will be part of the journey to reach this position.

Actions:

Internal conversation on whether full time representative are appointed in WAST	31 March 2024	Liz Rogers, Deputy Director of Workforce & OD
Broader discussion with TU reps regarding maintenance and development of clinical skills whilst undertaking TU duties with the aim of reaching a shared understanding	31 March 2024	Liz Rogers, Deputy Director of Workforce & OD
Regular discussions with senior TU reps in WAST re time for TU duties, trends and peaks in activity (*dates on engagement with the TUs are dependent on TU relationships)*	Ongoing	Angie Lewis, Director of Workforce & OD; and Liz Rogers, Deputy Director of Workforce & OD

Matter arising 2: Requesting and approving of facility time (Operation)	Impact
We made a high priority recommendation in our previous audit that "*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*". Section 6.1.6 of the agreement details that "*Individual trade union partners will be responsible for ensuring their Trade Union facility time is used and recorded appropriately and transparently, as this may be subject to future audit*". We selected a sample of 10 TU representatives from the GRS report for the period 1 April 2022 – 31 October 2022 and obtained, and reviewed, the records from nine of the individuals selected (one did not respond to the request). It is noted that a spreadsheet has been produced for recording requests for facility time and another for recording declines. However, the use of these spreadsheets has not been mandated. As such it was confirmed that there would be different methods for recording trade union requests including diaries, outlook calendar, e-mails etc. Only one individual from our sample had records that fully matched the GRS report. There was a minimal audit trail for both requests and authorisation of facility time for the others. In the instances where there was evidence of request and approval this was from line managers and Resources were also included to ensure that the individual was abstracted from their operational shift and the shift offered as overtime (where necessary). Section 4 of Appendix 1c details that "*It is particularly important that requests for paid facility time outside of rostered hours (e.g. whilst on annual leave and rest days) are made to the manager, to ensure that time is properly accounted for and the wellbeing of Trade Union Partners is fully considered*". From our discussions with TU representatives, it was confirmed that not all facility is requested in advance, for example where it is a rest day and they have been asked to attend a meeting. Another example provided was where the Chief Executive requests a meeting, it would not be necessary to request approval from a line manager as the request has come from the Chief Executive. There is currently no log of declined requests. However, all individuals included in the sample and interviewed during the audit confirmed that requests are rarely refused. As such, the original recommendation is still valid.	Potential risk of: • Insufficient audit trail maintained; • Adverse impact on TU representatives wellbeing; and • Insufficient arrangements to provide work cover

Recommendations	Priority
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.	High

Management response	Target Date	Responsible Officer
2.1 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.		
Actions:		
Discussion with TU colleagues on feedback from the audit and the need to record time appropriately	Completed	Angela Lewis, Director of Workforce & OD; and Liz Rogers, Deputy Director of Workforce & OD
Revisit manager's responsibilities in signing off TU time with managers across WAST.	31 December 2023	Liz Rogers, Deputy Director of Workforce & OD
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).	30 September 2024	Angela Lewis, Director of Workforce & OD; and Liz Rogers, Deputy Director of Workforce * OD

Matter arising 3: Recording of facility time (Design)	Impact
We made a high priority recommendation in our previous audit that "*A standardised process to formally record facility time, and in sufficient detail, should be agreed and implemented*". Section 3 of Appendix 1c of the agreement details the Trust's agreed set of eight principles of partnership working. Principle 3 details "*We should proactively seek to ensure we safeguard the wellbeing of Trade Union Partners to ensure a small core of representatives are not overburdened or overcommitted*". Section 6.7 of Appendix 1c details that "*All Trade Union Partners within NHSD/111 are required to request the Trade Union time via Shift Track. If the Trade Union Partner does not use the Global Rostering System (GRS) or Shift Track (e.g. Trade Union Partners within corporate teams), the Trade Union Partner is required to record the approved request on ESR as Special Increasing Balance > Trade Union Duties*". Management provided a report detailing the number of hours spent on union activity which was generated from the GRS system. As such, it only related to hours which had been abstracted from the roster and did not include union time undertaken on rest days, annual leave days and time outside rostered hours and claimed through overtime or TOIL. The report also only details TU duties or TU partner training. It does not provide a breakdown of the sub categories of agreed activities e.g. disciplinary, branch meeting etc. Additionally, on the report, where TOIL is recorded, it does not detail whether this is for TU facility time. It was not possible to run a report from ESR to establish how much TU facility time has been provided to corporate staff. From discussions with WOD staff it was confirmed that the functionality to record TU duties is not active. As such, the process described in Section 6.7 of Appendix 1c is not currently possible for Corporate staff. We were not provided with a report from Shift Track or an explanation as to why there wasn't a report available. The Trust was unable to provide a complete report of all TU facility time taken by all TU representatives. As such, the original recommendation is still valid.	Potential risk of: • Complete and accurate records of facility time are not maintained at an individual or Trust level; • Failure identify where representatives are overburdened or overcommitted; and • Inability to provide complete, accurate and meaningful management information.

Recommendations	Priority
3.1 A standardised process to formally record facility time, and in sufficient detail, should be agreed and implemented.	High

Management response		Target Date	Responsible Officer
3.1	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.		
	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.	30 November 2023	Liz Rogers, Deputy Director of Workforce & OD
	We will review the recording of time in shift track for 111/ CSD colleagues	30 November 2023	Liz Rogers, Deputy Director of Workforce & OD

Matter arising 4: Monitoring and reporting of facility time (Operation)	Impact
We made a medium priority recommendation in our previous audit that "*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*". Section 3 of Appendix 1c of the agreement details the Trusts agreed set of eight principles of partnership working. Principle 4 details "*Facilities time should be properly accounted for so that the contribution and investment in Trade Union partnership can be demonstrated and recognised within the organisation*". Whilst there was evidence of reporting on the key areas of activity which have been undertaken in partnership through the Trade Union Partner (TUP) Cell. There was no evidence of management information being produced on time spent and cost of facility time. However, given that there isn't one system that draws together all trade union release time (as detailed in MA3), it is not currently possible to produce this management information. As such, the original recommendation is still valid.	Potential risk of: • Facility time is not adequately monitored at an individual or Trust level.

Recommendations	Priority
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.	Medium

Management response	Target Date	Responsible Officer
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.	31 March 2024	Liz Rogers, Deputy Director of Workforce & OD

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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Pain Management
Final Internal Audit Report

July 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

EXTERNAL • QUALITY • ASSESSMENT

Contents

Review reference:	WAST-2223-012
Report status:	Final
Fieldwork commencement:	23 November 2022
Fieldwork completion:	12 June 2023
Debrief meeting:	17 May 2023
Draft report issued:	15 June 2023
Management response received:	7 July 2023
Final report issued:	10 July 2023
Auditors:	Osian Lloyd, Head of Internal Audit Felicity Quance, Deputy Head of Internal Audit Ross Hughes, Principal Auditor
Executive sign-off:	Andy Swinburn, Director of Paramedicine
Distribution:	Kevin Webb, Head of Clinical Intelligence and Assurance Chris Moore, Head of Medicines Management Duncan Robertson, Assistant Director of Clinical Development Greg Lloyd, Assistant Director of Clinical Delivery
Committee:	Audit Committee

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

Acknowledgement

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

Executive Summary

Purpose

To review the application of pain relief methods and their effect on patient outcomes in terms of pain relief and patient satisfaction.

Overview

We have issued limited assurance on this area.

The matters requiring management attention include:

- Poor compliance rates in Patient Group Direction completion for Advanced Paramedic Practitioners, with no monitoring at group/ Committee level. Whilst it is recognised that not all are specific to analgesia, for the four that are, only one has achieved the target compliance rate of 75%.
- Patient Group Directions not reviewed on a regular basis, noting that of those that have surpassed their review date, two are in relation to analgesia.
- Lack of oversight into pain scores and administration of analgesia.
- Administration of analgesia by appropriately qualified clinicians.

Report Classification

		Trend
Limited 	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.	N/A

Assurance summary[1]

Assurance objectives		Assurance
1	Policy and procedures	Reasonable
2	Patient Group Directions	Limited
3	Administration of analgesia	Limited
4	Management information	Limited
5	Monitoring and reporting	Reasonable

Key matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
1	Patient Group Directions	2	O	High
2	Lack of oversight for pain scoring and administration of analgesia	3,4	O	High
3	Administration of Analgesia	3	O	Medium

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

1. Introduction

1.1 Assessment and documentation of a patient's pain experience is a crucial component in providing effective pain management. Accurate and systematic documentation of pain, pre and post pain relief medication (analgesia), supports the Paramedic's clinical decision relating to the administration of an appropriate analgesic, and the following evaluation of its efficacy. It also demonstrates the ability to achieve, for the patient: a reduced experience of pain; increased comfort; improved physiological, psychological and physical function; and increased satisfaction with pain management.

1.2 The Joint Royal College Ambulance Liaison Committee (JRCALC) Clinical Practice Guidelines state:

- *Analgesia should be administered as soon as clinically possible after arriving on scene, although this can be done en-route so as not to delay time critical patients.*
- *There is no reason to delay relief of pain because of uncertainty with definitive diagnosis. It does not affect later diagnostics efficacy.*
- *All patients with pain must have a pain severity score undertaken and should be repeated after each intervention.*

1.3 In addition to the above, the Trust must adhere to national legislation, including The Misuse of Drugs Act 1971 and The Human Medicines Regulations 2012, when administering pain relief. Further, to support Paramedics in administering analgesia, the Trust will issue Patient Group Directions (PGDs) which are written instructions to help the user supply or administer medicines to patients if they believe there is an advantage to the patient without compromising their safety.

1.4 The risks considered during the review were as follows:

i. Breach of legislation due to non-compliance with policies and procedures;
ii. Controlled drugs are not being managed / used safely resulting in patient harm; and
iii. Lack of oversight of incidents / issues relating to pain management within the Trust

1.5 The review did not assess the clinical outcomes of drugs administered or the cost effectiveness of drugs in use / looking to be introduced into the Trust.

2. Detailed Audit Findings

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

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

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

Audit objective 1: There are policies and procedures in place outlining the Trust's approach to pain management.

2.3 Management confirmed that there is no Trust policy specific to pain management. However, the following policies, which are available to all staff via the Siren SharePoint policy library (Medical and Clinical Services section), include reference to pain management:

	Medicines Management Policy	Management of Controlled Drugs policy
Approved By	Quality Patient Experience & Safety (QuEST) Committee	QuEST & Policy Group
Date of Approval	25/02/2020	27/07/2021
Review Date	3 years from approval date (25/02/2023)	3 years from approval date (27/07/2024)

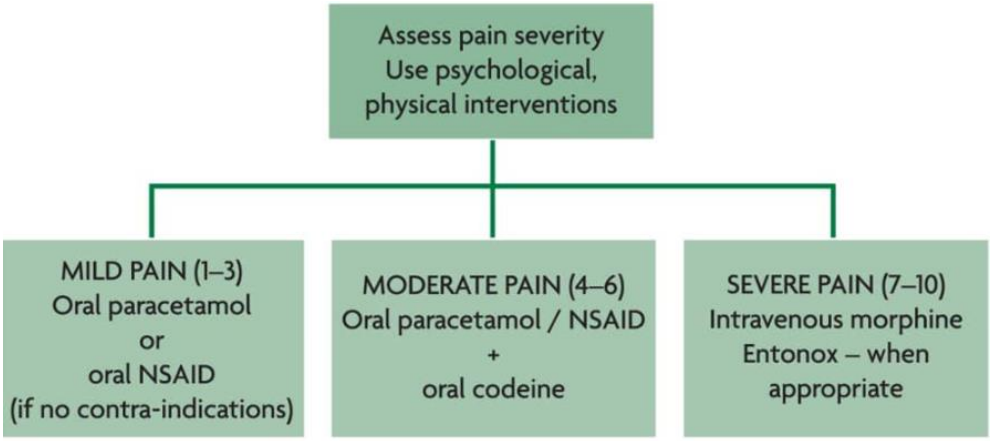
2.4 The Medicines Management Policy (Appendix 3) details a comprehensive table of drugs available within the Trust, with the relevant clinical situations in which the drugs may be required to manage pain; and which staff group are permitted to administer them. It is noted that, at the date of fieldwork, the policy was due for review. Management confirmed that the updates required have been made and are currently out to consultation; therefore, noting the review process is underway no recommendation has been raised at this report.

2.5 The Management of Controlled Drugs Policy provides the user information on how to use analgesia (e.g., Morphine Sulphate, Ketamine and Midazolam) whilst also informing how to record its use.

2.6 In addition to these policies, the Trust follows the guidelines set out within the Joint Royal Colleges Ambulance Liaison Committee Guidance (JRCALC), which are available via an electronic application. The Trust issues its Clinical Staff with an electronic tablet – each one has the JRCALC app embedded within it; and we

understand from discussions with management that the tablets are automatically updated ensuring current JRCALC guidance is available at all times. A review of the JRCALC noted that there are specific sections with the guidelines around Pain Management in adults (see diagram 1) and in children (use of the Wong-Baker 'faces' scale or the FLACC scale). For compliance with these guidelines, refer to audit objective 3.

Diagram 1



Conclusion:

2.7 Whilst it is noted that the Trust have policies in place which incorporate reference to pain management the overarching guidance is via the JRCALC. Updates to drugs details, and expectations for the administering of such, have been confirmed through this application. Noting this, **Reasonable** assurance has been determined.

Audit objective 2: There are appropriate processes in place for the communication, approval and acceptance of Patient Group Directions in place for the administration of analgesia.

2.8 Patient Group Directions (PGDs) are legal mechanisms that permit paramedics to administer drugs that are not currently included in Schedule 17 of the Human Medicines Regulations (2012).

2.9 Section 14 of the Medicines Management Policy sets out the process for the development of PGDs including:

- '*review every three-years to ensure they remain up to date and fit for purpose…undertaken by the Medicines Management Lead, Pharmacist Advisor and at least one Advanced Practitioner'; and*
- '*When a justifiable case is made by a practitioner for a specific medicine to enhance their practice, or a change is driven by national guidance, the practitioner will be provided with the necessary support to develop a draft version of their PGD. The draft will then be refined by the Medicines Management Lead, before being shared with relevant professionals*

including the Trust Pharmacy Advisor and Executive Medical Director, before final sign off'.

2.10 The Medicines Management Policy (Appendices 3 and 4) lists PDGs which have been approved by the Trust – 'Advanced Practice' PGDs (19) and 'Additional Miscellaneous' PGDs (7) respectively. The 'Advanced Practice' drugs are specifically for use by Advanced Paramedic Practitioners (APP). The miscellaneous PGDs include enhanced analgesia drugs to which access is restricted to Senior Paramedics that have been granted a profile with their Abloy key (access to Abloy protected controlled drugs safe / cabinets); 'paramedic' PDG drugs (see para 2.12); and drugs which are managed by Occupational Health e.g. flu and MMR vaccines.

2.11 To confirm adherence with the expected review process, we reviewed all PGDs that are currently in use within the Trust. It was noted that 12 of the 26 PGDs have surpassed their review period **(See MA1).** Of the 26 PGDs, five relate to analgesia (Codeine phosphate, Diazepam, Paracetamol, Ibuprofen and Ketamine), with the latter two having surpassed their review period (11 months and 3 months respectively).

2.12 As part of the Medicines Management process, a database is maintained for signed and authorised PGDs within the Trust, which confirms that individual paramedics have signed the required form to allow them to administer the drugs. The compliance levels for the following Emergency Medical Service (EMS) specific PGDs are reported via the Medicines Management Assurance Report, which is issued monthly to the Ambulance Practice Steering Group:

- Co-amoxicalv;
- Tranexamic Acid; and
- Diazepam (*note: when administered by EMS, is used as an anticonvulsant rather than analgesia. The drug is only administered as analgesia by APP's (see Appendix C)*).

Management confirmed monitoring is undertaken of these as they are deemed high risk as are applicable for use by all Paramedics; and is also recognised that none are administered as an analgesia.

2.13 During discussion with the Head of Medicines Management it was noted that EMS PGDs compliance levels, at January 2022, were below the expected level. This was discussed with the Local Duty Operations Managers with a goal set of achieving an overall 95% compliance rate within the Trust. A review of the Medicines Management Assurance Reports highlighted a gradual increase in compliance month on month with the March 2023 report noting all three exceeding the target:

Table 1 (improvement since January 2022)

Month	Diazepam	Tranexamic Acid	Co-amoxiclav
January 2022	76%	67%	82%
November 2022	97%	94%	98%
March 2023	99%	97%	99%

Table 2 (Compliance levels per health board locality)

Health Board Locality	Diazepam	Tranexamic Acid	Co-amoxiclav	Total (All 3 PGDs)
Aneurin Bevan	94%	91%	96%	**94%**
Betsi Cadwaladr	98%	94%	94%	**95%**
Cardiff & Vale	100%	100%	100%	**100%**
Cwm Taf	99%	99%	100%	**99%**
HART	100%	100%	100%	**100%**
Hywel Dda	99%	96%	100%	**98%**
Powys	100%	100%	100%	**100%**
Swansea Bay	100%	99%	100%	**100%**
Overall	**99%**	**97%**	**99%**	**98%**

2.14 Whilst we note the Head of Medicines Management monitors compliance of the APP specific PDGs, no formal reporting is undertaken. A review of the APP PGD compliance rates noted poor compliance, with rates ranging from 32% to 81% across the Trust and with 13 of the 19 PGDs failing to achieve a 75% compliance rate. It is also noted that in the South East locality, compliance rates for Co-Amoxiclav, Flucloxacillin and Penicillin V are currently at 0%. Management further confirmed that four of these APP PGDs relate to analgesia; of which only one (ibuprofen) has achieved the compliance rate and the remaining three (codeine-phosphate; diazepam and paracetamol) achieving a 52% compliance rate at the date of fieldwork. (**See MA1** and **Appendix C**). We recognise that further work has been undertaken to improve the compliance rates with 62%, 62% and 54% respectively being reported.

2.15 At the outset of our review, management confirmed that discussions were ongoing as to the potential introduction of a new type of emergency pain relief (Penthrox). At the date of reporting, it is noted that such discussions had suitably progressed with the introduction of the drug (3 May 2023) into the Trust's suite of pain-relieving drugs; and to be used by all clinicians, including Community First Responders. A clinical notice was issued to all staff via the May 11th Siren newsletter.

2.16 A PGD was not required for the new drug, however a protocol for the use of Penthrox has been prepared by the Health Board Clinical Leads, supported by the Head of Medicines Management and Regional Clinical Lead (Consultant

Paramedic). The protocol was approved by the Executive Medical Director and Pharmacist Advisor prior to approval by the Ambulance Practice Steering Group (APSG) in February 2023. The minutes for APSG note submission of the protocol for approval from the Clinical & Quality Governance Group (CQGG); and this confirmed as submitted to the March 2023 meeting.

Conclusion:

2.17 The Trust monitors and formally reports to the APSG on the compliance levels, for which target compliance has been met, for only the three EMS PGDs. Whilst compliance for the remaining PGDs is monitored, and noting compliance rates are below target, there is no evidence of formal reporting of the same. Further, a number of the PGDs have not been reviewed within the required three-year period.. It is recognised, that not all of the PGDs are specific to analgesia and, therefore, are outside the scope of this review. However, improvements to the compliance and monitoring process is required for those specific to analgesia, therefore **limited** assurance has been determined.

Audit objective 3: The administering of pain management is carried out in accordance with the policy and operating procedures.

2.18 As per para 2.6, the Trust follows the guidance set out by the JRCALC, which is readily available on the tablets issued to each clinician. To confirm compliance, sample testing was undertaken to ensure:

- There was a pain score recorded prior to the administration of analgesia;
- There was a pain score recorded post analgesia to determine its effectiveness; and
- An appropriately qualified clinician administered the analgesia.

2.19 We requested the data for September and November 2022 on all callouts for the following conditions:

- Head injury (64);
- Upper Limbs (93);
- General back injury (69);
- Dislocation of joint (101); and
- Any call out to a child receiving analgesia.

We were informed that the Trust does not routinely produce reports for these clinical codes, noting it would take a considerable amount of time and resource to create the required pathways within the ePCR software (**see MA2**). It was, however, highlighted that pathways to extract similar information on Fractured Neck of Femur (NOF) and ST Elevation Myocardial Infraction (STEMI) were already in place. Due to this our sample testing consisted of call outs undertaken in September 2023 for NOF (5), STEMI (5) and Children receiving analgesia (5).

2.20 From review of the ePCR form provided for each of our sample, the following was noted (refer to Appendix B for full details of testing):

NOF	STEMI	Children
Three patients received multiple administration of analgesia during the care provided (total of 12 administrations).	Pain scores taken prior to the administration of analgesia (3 of the 4 administrations).	Two patients received multiple administration of analgesia during the care provided (total of 7 administrations).
Pain scores taken prior to administration of analgesia (9 of the 12 administrations).	Pain scores taken post administration of analgesia (2 of the 4 administrations).	Pain scores taken prior to administration of analgesia (6 of the 7 administrations). Noting the exception was a toddler
Pain scores taken post administration of analgesia (8 of the 12 administrations).	Where both pain scores recorded, analgesia deemed effective (2 of the sample of 4 – noting that analgesia was not required for 1 patient).	Pain scores taken post administration of analgesia (4 of the 7 administrations).
Where pain scores recorded, analgesia deemed effective (3 of the 4 sampled – noting that analgesia was not required for 1 patient).		Analgesia deemed effective for 3 of the 5 sample, due to the lower pain score recorded.

2.21 The ePCR forms had elements of information redacted i.e. patients details, but also the name of the paramedic completing the ePCR form. Therefore, we were unable to identify the crew member administering the analgesia to ensure it was in line with protocol. On request for this information, we were informed that, the most senior level of clinician who is involved in the callout assumes responsibility for the overall care of the patient. Management noted that it is assumed the senior clinician will have administered the analgesic even if it is documented by a lower grade of staff, whose scope of practice does not allow administration of a particular analgesia. **(See MA3).** This is because the senior clinician is deemed responsible for the administration under their supervision. It is, however, noted that there was only instance in our sample testing where the analgesia administered would have fallen to the remit of a senior clinician.

Conclusion:

2.22 We were unable to test a wider sample of clinical codes, as the Trust currently only extracts and monitors pain score data for two clinical codes (STEMI and NOF). Sample testing undertaken noted that pain scores, both pre and post analgesia not routinely recorded for patients. Where both have been recorded (66% of the sample tested), however, the analgesia was determined to be effective. Whilst the ePCR forms don't categorically confirm the member of staff administering the pain relief, for the sample reviewed, the analgesia (bar one) could be administered by all clinicians. Enhancement to the recording mechanisms of this data is recommended. **Limited** assurance has therefore been determined.

Audit objective 4: Management information relating to the appropriate use of analgesia and its efficacy is regularly monitored, and themes / trends are identified.

2.23 The Trust reports on care bundle compliance to the Clinical Intelligence Assurance Group (CIAG) for the following five clinical indicators (CI):

- Hypoglycaemia
- Neck of Femur (NOF)
- ST Elevation Myocardial Infractions (STEMI)
- Stroke
- Return of Spontaneous Circulation (ROSC) at Hospital

Management confirmed that, historically, the information has been derived from validated data (including manual audit of non-compliant cases) to determine overall compliance. However, since the introduction of the new ePCR system from March 2022, the information consists of raw (unvalidated) data. **(See MA2)**

2.24 A review of the data contained in the CI reports noted that only the NOF and STEMI indicators report on pain scores (noting compliance is for one or more scores recorded) and compliance with administration of analgesia. As noted in objective 3, reports into compliance figures for other clinical codes are not currently undertaken. **(See MA2).** There are no themes / trends reported either, however, we do acknowledge that the clinical team will be reviewing the format of reporting to ensure good clinical practice is captured and reported.

2.25 The Clinical Audit and Effectiveness department informed us that they undertake general pain score reviews within the Trust, however the last audit undertaken in the subject was a follow up review in 2019. There is the expectation that pain scores are recorded twice – pre and post analgesia; however management confirmed that if only one has been recorded, this will still be recorded as compliant. A review of the pain score compliance levels from this review highlighted a 83.9% compliance rate for one or more pain scores recorded, an increase on the 77% recorded in 2016, but still short of the 100% expected level..

2.26 The team have informed us that they are in the process of undertaking deep dives into the clinical indicators to ensure information coming through from the ePCR system is accurate. The team supplied us with reports on recently undertaken reviews into ePCR Clinical Data Assurance for NOF and STEMI, noting that there is a discrepancy between information manually reviewed to the raw data extracted from ePCR system. Due to these discrepancies, only STEMI compliance rates are reported to QuEST, with May's pain score compliance reported at 73%.

Conclusion:

2.27 Management information on the appropriate use and efficacy of pain management, reporting to the CIAG, is only in relation to STEMI and NOF. There is no other reporting to ensure the management of other clinical code areas is appropriate and compliant with guidance; and there is no analysis of

themes/trends included in the reports either. Therefore, we have determined **limited** assurance.

Audit objective 5: There are appropriate governance and reporting arrangements in place.

2.28 As per para 2.11 the Ambulance Practice Steering Group receives monthly Medicines Management Assurance reports for which the pain management focus is in relation to the compliance levels for the three EMS PGDs (see Objective 2). Review of the terms of reference for the Group confirms the reporting lines to the Quality Patient Experience & Safety (QuEST) Committee, via the Clinical and Quality Governance Group (CQGG).

2.29 As per para 2.17, the Clinical Intelligence Assurance Group receives monthly updates on the Trusts Clinical Indicators, highlighting the bundle compliance rates for five clinical codes. This includes pain scores and administration of analgesia for NOF & STEMI only, noting that only STEMI compliance rates are reported to QuEST currently due the discrepancy between information manually reviewed to the raw data extracted from ePCR system. Review of the terms of reference for this group confirms reporting into the QuEST Committee via the CQGG.

2.30 A review of the QuEST papers for 2022/23 failed to note any reporting on PGDs compliance rates. In respect of the Clinical Indicators, at the November 2022 meeting, it was reported that *'The Trust is unable to fully report on the performance of all clinical indicators whilst work continues to link ePCR with the CAD and quality assure metrics.'* However, it was noted that three of the four meetings did report on STEMI, Stroke and ROSC at Hospital care bundles compliance.

2.31 Review of the February 2023 meeting minutes noted that the proposed changes to the terms of reference for the Committee includes *'a quarterly 'spotlight' on clinical indicators via the CQGG to provide more focus on clinical care'*

Conclusion:

2.32 Ambulance Service Indicators and Medicine Management assurance reports are issued regularly to the CIAG and APSG respectively. Both groups have clear reporting lines to the QuEST Committee, via the Clinical Quality Governance Group, to escalate issues when required. However, it is noted that the Trust is currently reporting what they can to Committee with the caveat of the infancy of ePCR, but enhancement of assurance reporting in respect of pain management is required. **Reasonable** assurance, therefore, has been determined.

Appendix A: Management Action Plan

Matter arising 1: Patient Group Directions (Operation)	Impact
The Trust currently reports on the compliance levels of three EMS Patient Group Directions on a regular basis; and it is noted that these are not administered as an analgesia. Based on Appendix 3 and 4 of the Medicines Management Policy, it was identified that the Trust have a further 19 PGDs in place relating to Advanced Paramedic Practitioners (APP), 3 PGDs relating to enhanced analgesia and 4 PGDs in place for Occupational Health staff. Whilst review of compliance for these is undertaken by the Head of Medicines Management, there is no formal reporting of compliance levels with APP PGDs. At the date of reporting, compliance rates varied between 32% and 81% across the Trust, with 13 not achieving the 75% target (refer to Appendix C for full details of compliance rates across localities). It is also recognised that only four of the APP PGDs are for analgesia with one reaching the compliance level (Ibuprofen) and the remaining three (codeine-phosphate; diazepam and paracetamol) achieving a 52% compliance rate (which has increased to 62%, 62% and 54% respectively at the date of reporting) Each PGD is given a three-year cycle for review. At present, 12 of the PGDs have surpassed their review date (7 APP PGDs, 3 enhanced analgesia PGDs and 2 EMS paramedic PGDs). Of these, two are in relation to analgesia – Ibuprofen: circa 12 months; and Ketamine, circa 3 months.	Potential risk of: • Controlled drugs are not being managed / used safely resulting in patient harm

Recommendations	Priority
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. 1.2 The Trust should ensure all PGDs follow the Medicines Management policy, with a review undertaken every three years as a minimum.	**High**

Management response	Target Date	Responsible Officer
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.	July 2023	Head of Medicines Management

1.2	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.	30 September 2023	Head of Medicines Management
	We will prepare and agree a prioritisation plan, to manage the expired status backlog which will be presented to APSG and through to CQGG.	30 September 2023	Head of Medicines Management
	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	30 March 2024	Assistant Director of Clinical Development

Matter arising 2: Lack of oversight for pain scoring and administration of analgesia (Operation)	Impact
To undertake sample testing during the review, to confirm completeness of pain score recording and effectiveness of analgesia administered, we requested the data for a number of clinical codes within the Trust. However, due to the infancy of the ePCR system management advised that it would be difficult to extract the required data in a timely manner. Noting that NOF and STEMI pathways are currently subject to regular reporting through the clinical indicators, this data had to be used. Data for children, however, was extracted for our use. This limitation to data reduced the scope of testing to be performed to assess the compliance with guidance for completion of the ePCR records and the recorded effectiveness of the pain relief administered. It was also noted that the data extracted from ePCR is raw (unvalidated) data when, previously, the compliance data was determined manually from validated data. There are no themes / trends reported either, however, we do acknowledge that the clinical team will be reviewing the format of reporting to ensure good clinical practice is captured and reported.	Potential risk of: • Lack of oversight of incidents / issues relating to pain management within the Trust

Recommendations	Priority
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.	**High**

Management response	Target Date	Responsible Officer
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.	30 Dec 2023	Assistant Director of Clinical Development

Matter arising 3: Administration of Analgesia (Operation)	Impact
From review of the ePCR records provided, we were unable to identify the Trust member administering the analgesia. Management advised that any Trust member can complete the form, even if their grade is below that required to administer the analgesia, with the assumption it would have been the most senior member of staff responsible for administering the analgesia. However, in the event of any patient recourse, this does not provide the required assurances as to the qualifications / experience of the actual member of staff providing the pain relief.	Potential risk of: • Controlled drugs are not being managed / used safely resulting in patient harm

Recommendations	Priority
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.	**Medium**

Management response	Target Date	Responsible Officer
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.	30 September 2023	Assistant Director of Clinical Development Health Board Clinical Lead (ePCR)

Appendix B: Administration of Pain Management: results of testing

Audit ref	Callout category	Pain Score 1	Pain Score 2	Analgesia Administered	Pain levels reduced
1	Child	9	9	Entonox	X
2	Child	10	2	Entonox	✓
3	Child	Not taken – patient too young	N/A	Morphine Sulphate	Recorded that patient became more settled following analgesia
4	Child	9	9	Entonox	X
		9	Not taken	Paracetamol	Unknown
		9	Not taken	Ibuprofen **Note 1**	Unknown
5	Child	8	6	Paracetamol	✓
6	NOF	Not taken	Not taken	Paracetamol	Unknown
		9	8	Morphine Sulphate	✓
		8	5	Morphine Sulphate	✓
		5	4	Morphine Sulphate	✓
7	NOF	7	4	Paracetamol	✓
8	NOF	-	-	No analgesia administered **Note 2**	-
9	NOF	Not taken	Not taken	Paracetamol	Unknown
		Not taken	Not taken	Entonox	Unknown
		9	8	Morphine Sulphate	✓
		7	6	Morphine Sulphate	✓
		7	Not taken	Paracetamol	Unknown
10	NOF	10	10	Paracetamol	X
		10	7	Morphine Sulphate	✓

Audit ref	Callout category	Pain Score 1	Pain Score 2	Analgesia Administered	Pain levels reduced
11	STEMI	6	Not taken	Paracetamol	Unknown
12	STEMI	6	1	Morphine Sulphate	✓
13	STEMI	6	4	Paracetamol	✓
14	STEMI	Not taken	Not taken	Morphine Sulphate	Unknown
15	STEMI	-	-	No analgesia administered **Note 3**	-

Note 1 Within our sample, this is the only analgesia that needs to be administered by an Advanced Paramedic Practitioner. From review of the ePCR form, we were unable to determine if this had been administered appropriately.

Note 2 As per ePCR form, patient took own pain relief prior to paramedic's arrival, stated no pain on crews' arrival

Note 3 As per ePCR form, patient stated they were not in pain, no analgesia administered

Appendix C: Advanced Paramedic Practitioner PGD Compliance Rate

PGD	Central and West		South East		North		Total	
Amoxicillin	83.87%		4%		10.71%		**32.86%**	
Cetirizine Hydrochloride	100%		60.87%		82.14%		**81%**	
Clarithromycin	54.84%		34.78%		53.57%		**47.73%**	
Co-Amoxiclav	83.87%		0%		14.29%		**32.72%**	
Codeine Phosphate (A)	48.38%	50%	52.17%	78.95%	57.14%	58.33%	**52.56%**	**62.42%**
Diazepam (A)	45.16%	46.67%	56.52%	68.42%	57.14%	70.83%	**52.85%**	**61.97%**
Doxycycline	54.84%		30.43%		57.14%		**47.47%**	
Flucloxacillin	83.87%		0%		10.71%		**31.53%**	
Fluorescein Sodium 1%	100%		56.52%		85.71%		**80.74%**	
Ibuprofen (A)	96.77%	96.67%	47.83%	78.95%	82.14%	83.33%	**75.58%**	**86.31%**
Loperamide Hydrochloride	100%		52.17%		85.71%		**77.85%**	
Nitrofurantoin	54.84%		30.43%		50%		**45.09%**	
Oral Rehydration Salts	100%		47.83%		82.14%		**76.66%**	
Paracetamol (A)	45.16%	46.67%	56.52%	47.37%	57.14%	66.67%	**52.94%**	**53.57%**
Penicillin 'V	83.87%		0%		7.14%		**30.34%**	
Prednisolone	100%		52.17%		85.71%		**79.29%**	
Prochlorperazine	100%		52.17%		82.14%		**78.10%**	
Tetracaine Hydrochloride	45.16%		39.13%		50%		**44.76%**	
Trimethoprim	54.84%		30.43%		57.14%		**29.52%**	
Salbutamol MDI	100%		34.78%		60.71%		**65.16%**	

A: PGD is in respect of an analgesia and additional information has been provided regarding compliance rates both at the date of fieldwork (May 2023); and at the date of reporting (June 2023).

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.
 **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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IM&T Infrastructure
Final Internal Audit Report
June 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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Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services NHS Trust

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Review reference:	WAST-2223-06
Report status:	Final
Fieldwork commencement:	13th March 2023
Fieldwork completion:	27th March 2023
Debrief meeting:	11th April 2023
Draft report issued:	26th April 2023
Management response received:	11th May 2023
Final report issued:	5th June 2023
Auditors:	Osian Lloyd Head of Internal Audit Martyn Lewis Senior IM&T Manager John Cundy Senior Auditor
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Distribution:	Aled Williams (Welsh Ambulance Service NHS Trust - Head of ICT)
Committee:	Audit Committee

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

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

Executive Summary

Purpose

The overall objective of the audit was to Provide assurance over the Management and operation of the WAST IM&T Infrastructure.

Overview

We have issued reasonable assurance on this area.

There is a record of infrastructure assets, although we note that switches are not included. The infrastructure and network are subject to active monitoring, with alerts being triggered to enable actions to be undertaken to fix identified issues.

Infrastructure equipment is kept up to date, although we note the presence of some older equipment. Servers are patched appropriately and there is a dual site replication process to enable resilience.

The key management actions are:

- Ensuring the accuracy of the asset register.
- Formalising the alert management process.
- Ensuring all switches are recorded
- Ensuring the services to be provided within the back-up site are appropriately prioritised.

Report Opinion

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

Assurance summary[1]

Objectives		Assurance
1	Infrastructure maintenance and support	Reasonable
2	Network stability and capacity	Reasonable

[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	ICT asset register	1	Operation	Medium
3	Alert management	1&2	Operation	Medium
4	Recording of switches on asset register and security patching	1	Operation	High
6	Back-up capacity	2	Operation	Medium

1. Introduction

1.1 The term 'infrastructure' in an Information and Communication Technology (ICT) context refers to an organisation's collection of hardware, software, networks, data centres, facilities and related equipment used to develop, test, operate, monitor, manage and/or support information technology services. This review also considers people to be part of the organisation's infrastructure as without competent well-qualified people in charge of running and maintaining the ICT infrastructure, its capabilities are artificially limited.

1.2 The risks considered as part of this audit are:

- Information Management and Technology (IM&T) infrastructure and network do not meet the needs of the Welsh Ambulance Services NHS Trust ('the Trust' or 'WAST'); and
- Unavailability of critical systems and data loss, which could lead to the Trust being unable to deliver digital health services for an extended period of time, as well as significantly increasing the cost of recovery efforts.

1.3 Cyber security and back-up testing are important parts of network management. The Trust has a cyber security response plan which is being subject to its own audit undertaken at the same time as this review. That audit includes an objective on the Trust's back-up restoration testing arrangements. Therefore, these aspects of have been excluded from the scope of this audit.

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
Operating Effectiveness	1	3	1	5
Total	1	3	2	6

2.2 All matters arising and the related recommendations and management actions are detailed in **Appendix A**

Objective 1: The IT infrastructure is maintained, with appropriate planning, governance, support and risk management in place.

Asset Recording

2.3 A complete and accurate asset register is a necessary control in the effective maintenance and operation of any network. The WAST ICT asset register is kept and maintained in the configuration management database (CMDB) on

Servicepoint. We were advised that there is confidence that it has a high level of accuracy, though it is acknowledged that there has been no 'stocktake' since 2016.

2.4 WAST use the Lansweeper IT asset management software to record equipment that logs onto the network. We also considered whether the Trust could configure the CMDB and the Lansweeper software to enable automated comparison between them as part of regular asset tracking controls. Review of the data supplied from Lansweeper provided highlighted that there is no obvious or easy way to reconcile between the two systems as names and identifiers do not correlate. The CMDB names assets using a 6-digit number, Lansweeper contains information such as make, model and serial number. **See Matter Arising 1.**

Support Provision

2.5 Appropriate supplier contract management arrangements are necessary to ensure services are being delivered and received as per contractual terms. The WAST ICT Department have developed a contract management Standard Operating Procedure (SOP), which defines the actions required at each stage of the supplier contract management process, from formation to expiry. We noted the SOP document seen was not yet formally signed-off. There is a simple register of contracts with supporting documents stored on a SharePoint site in a consistent folder structure. **See Matter Arising 2.**

2.6 The testing of contract management arrangements is not within the scope of this review, however we note that a separate review is included within the 2023/2024 Internal Audit Plan.

2.7 Servers and storage hardware are all still in vendor support and there is third party assistance to upgrade these bi-annually.

Monitoring

2.8 We note that WAST use the Paessler PRTG software to monitor the 'health' of its infrastructure equipment. This covers required areas including system and individual server capacity levels and is an appropriate utility for this task. It is in use in other health organisations across the globe. It presents information in a visual dashboard style and highlights areas where capacities are being reached.

2.9 The monitoring system also produces alerts to report unexpected events or process failures. At present these alerts are issued to the relevant staff involved in network operations and maintenance. We note that there is no defined SOP for responding to the alerts in terms of prioritising, clearing and reporting on them.

2.10 The lack of a structured process could introduce the risk of delay/failure to address possible faults in a timely manner. The lack of a comprehensive process to ensure alerts are prioritised and that all of them are cleared, or clear themselves reduces the value of the alert utility. **See Matter Arising 3**

Risk Management

2.11 We have reviewed a copy of the ICT risk register downloaded from the Digital Health and Care Wales (DHCW) mandated Datix system, which includes risks relating to old equipment and software. We are satisfied that the ICT risks are

being managed in line with WAST policy. There is clear evidence of regular risk review and escalation / de-escalation of risks between local and corporate level as deemed appropriate.

Patching and Updating

2.12 In order to maintain the infrastructure at optimum operational efficiency planned maintenance and upgrades are necessary. WAST ICT use a simple spreadsheet-based calendar 'ICT Planner 2023'. It lists the scheduling of planned key events, including upgrades or resilience testing, and has a list of events which are not yet scheduled. It is a simple and effective method for the scheduling of key events.

2.13 The approach to security and patching is slightly different for each of the network and equipment elements. All are risk assessed based on a number of criteria such as location, exposure to external access, ease of access etc., to enable the Trust to prioritise investments made in equipment replacement. Items defined as higher risk are subject to prioritised patching to ensure protection. The patching process is defined within formal procedure documents.

2.14 We note that various operating system versions are in use on servers, including some dating as far back as 2008 and 2012 on some of the core systems, and are therefore more likely to contain security vulnerabilities. These are primarily in a secure network (VRF) where there is no internet access. We further note that WAST plan to replace these in the next financial year at a cost of over £1m, with a business case in development to seek Welsh Government support for this equipment. As legacy applications are being switched off they are decommissioning the older servers that support them.

2.15 The infrastructure also includes a number of switches which are used to connect devices on the network. We understand that some of these are old, out of support and contain security vulnerabilities. We also note that switches are not recorded on the asset register, and at the time of the audit there was no record of switches in use. In addition, switches are not subject to patching as a routine process. **See Matter Arising 4**

2.16 Server patching is assessed and is a more scheduled process, especially if a reboot is required to manage downtime etc; this is necessary to ensure availability as WAST is operational 24/7. On the networking front, core equipment such as firewalls, wireless-local area network controllers are in vendor support and patched to the latest versions which improves security and performance. All devices are actively monitored by PRTG, and in addition there is continuous monitoring for suspicious activity across the network. The funding bid mentioned in 2.12 will include elements of networking equipment replacement.

2.17 The Trust PC/Laptops have been on a five-year replacement cycle, but due to covid and subsequent equipment shortages this has increased to six years. The operating systems are all at Windows 10 minimum with regular patching undertaken on user devices. Testing of Windows 11 is planned for the new financial year; but there are still some legacy applications (7 digipens) that are on Windows 7. The Trust are aware of this equipment and the need to decommission, as such we have not raised a matter at this time.

Conclusion:

2.18 WAST is totally dependent on its network infrastructure and takes appropriate steps to keep it operational and effective. Although we have raised some actions on system alert handling, asset register accuracy, contract management arrangements and routine patching of switches, we still consider **Reasonable** assurance is appropriate for this objective.

Objective 2: The use of the network is managed to ensure stability and capacity is appropriate for the organisation.

2.19 The WAST Emergency Medical Services (999) network has three Clinical Contact Centres, the 111 network has eight. All of these utilise the BT provided Public Sector Broadband Aggregation (PSBA) scheme. All centres have dual exchange connectivity, to automatically reconnect to calls if equipment fail partway through. Each centre uses 'CISCO Unified Contact Centre Enterprise' software, which is also used by the UK National Ambulance Centre.

2.20 WAST is one of 13 UK ambulance services that are interconnected. Calls failover or switch between WAST contact centres according to set response times. If all WAST centres are busy the call will be routed to the 'least busy' centre nationally. All 999 and 111 calls are answered, there is no 'busy please try later' option.

2.21 We understand that the PSBA has 'failed' once, during the 2022 world cup when every school in Wales watched the Welsh national team's matches which caused the network to become full. This in turn impacted on the effectiveness of the PSBA's operation, including call handling. As yet there is no Welsh Government report on the incident, however to provide additional resilience should a similar event reoccur, WAST has acquired a 'Limited Implementation Virgin Point to Point link' which provides alternative call options should the PSBA have a capacity issue in the future.

2.22 WAST telephony have a real-time monitoring facility and can poll the equipment at the BT end of the line to confirm that it is operational. There are four technicians providing telephone network support within WAST, with a requirement that all network engineers are CISCO certified.

2.23 The Trust uses the 'SolarWinds CatTool', a network automation tool designed to manage configurations on network devices such as routers, switches, and firewalls. This software takes a daily configuration back-up of every item of equipment, which is then compared to the previous back-up and all changes are reported by the system. SolarWinds alerts are sent to the engineers however, as noted above, there is no documented process for prioritising and clearing them. **See Matter Arising 3**

2.24 The network and capacity is continuously monitored by the PRTG software as per paragraph 2.7. The amount of space used in each server is constantly updated, and alerts are generated when a server reaches a set percentage of its capacity. The network structure and operating system facilitate the easy addition of more servers/disk space if they are needed.

2.25 Stability, or availability to users, is reliant on replication which is a common industry standard used by most large organisations globally at this time. For example, where there are two networks running simultaneously in parallel, any data entered on any part of one network is immediately duplicated on the other.

2.26 Therefore, there are always two systems, usually in two different locations. The system is set up so that if there is an issue on one system, all affected users automatically failover (switch) to the other. System monitoring arrangements ensure these are recorded and alerts are issued according to their pre-determined conditions.

2.27 Systems that are deemed critical for the Trust, including the Computer Automated Despatch (CAD) system, are hosted at the main data centre at Vantage Point House. Resilience is provided through a live server running the software and a separate, linked reporting server that runs live monitoring and reporting without impacting the live service. The reporting server is also the first failover system, meaning that if there is a problem with the live server then the service switches automatically to the reporting server.

2.28 The Trust has a second site, located in Newport, which also has a replicated copy of the live and reporting servers for disaster recovery purposes. We have been advised that failover to this facility is not completely automated. **See Matter Arising 5**

2.29 Non-critical systems are hosted/stored on the Nutanix software. The decision on which Trust systems are critical was taken several years ago; there is a lot more data and systems in use now. The main data centre has seven physical servers hosting 120 virtual ones. The back-up centre has four servers but we were informed that not all non-critical services can be restored at this site. **See Matter Arising 6**

Conclusion:

2.30 The work to keep networks stable, operational, and available is never-ending; there will always be a need for continuous monitoring, updating, maintenance, contingency planning and review. We are satisfied that the WAST ICT Department recognise the importance of their systems and are managing them accordingly. Although there are matters arising under this objective, we consider **Reasonable assurance** is appropriate at this time.

Appendix A: Management Action Plan

Matter Arising 1: ICT asset register (Operation)	Impact
The WAST ICT asset register is kept and maintained in the configuration management database (CMDB) on Servicepoint. Although we understand that WAST have confidence in the accuracy of their asset register they cannot be fully confident it is 100% accurate. It is also acknowledged that there has been no 'stocktake' since 2016. We also considered whether the Trust could configure the CMDB and the Lansweeper software to enable automated comparison between them as part of regular asset tracking controls. We were informed by management that this would not be practical to implement due to variations in identifiers, and were advised that staff are able to cross reference some asset types such as PCs, laptops and monitors.	Potential risk of: • Loss of assets

Recommendations		Priority
1.1	WAST should schedule a physical stocktake to ensure the asset register is 100% accurate.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
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.	April 2024	Head of ICT

Matter Arising 2: Contract management SOP (Operation)			Impact
The WAST ICT Department have developed a contract management Standard Operating Procedure (SOP) document. However, it is not signed off and approved by an appropriate authority.			Potential risk of: • Inappropriate contract management arrangements leading to the Trust not achieving value for money.
Recommendations			**Priority**
2	The contract management SOP should be appropriately reviewed and authorised and communicated to relevant staff.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
2	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 2023	Contract Manager

Matter Arising 3: Alert management (Operation)	Impact
There are several distinct teams involved in infrastructure support and alert monitoring. The PRTG Alerts are distributed to all team members, though not all alerts are relevant to all those informed. There is no formal documented process for reviewing, prioritising and clearing alerts, which reduces the value of this utility.	Potential risk of: • Lack of prioritisation • Delays to fault rectification.

Recommendations		Priority
3	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.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
3	Agreed, will look to formalise the process and provide some ownership to the defined process	Dec 2023	ICT Service Delivery Manager

Matter Arising 4: Recording of switches on asset register and security patching (Operation)	Impact
The network infrastructure includes a number of switches which are used to connect devices to the network. We understand that some of these are old, out of support and contain security vulnerabilities. We also note that switches are not recorded on the asset register, and at the time of the audit there was no record of switches in use. In addition, switches are not subject to patching as a routine process.	Potential risk of: • Loss of service

Recommendations		Priority
4.1	Switches should be identified within the asset register.	**High**
4.2	A process for patching of unpatched switches or other network components should be established.	
4.3	A mechanism to deal with/isolate equipment that cannot be brought up to the required security specification should be defined.	

Agreed Management Action		Target Date	Responsible Officer
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.	March 2024	Network & Telecoms Manager
4.2	We will look to develop a risk based patching procedure for network switches and devices	March 2024	Network & Telecoms Manager
4.3	This will be included in the above patching procedure	March 2024	Network & Telecoms Manager

Matter Arising 5: Disaster recovery site activation (Design)			Impact
The disaster recovery site at Newport is not 'failed over' to automatically. In the event of an incident occurring resulting in the site being needed, this could result in avoidable delay whilst the systems are switched.			Potential risk of: • Avoidable loss of critical services
Recommendations			**Priority**
5	Consideration should be given to how long the switch to the disaster recovery site will take and if automation is a practical option.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
5	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 2023	Head of ICT

Matter Arising 6: Back-up capacity (Operation)			Impact
The capacity of the backup server site is less than the main site and not all services can be restored to run there. The criticality of the services on the systems has not been reviewed for several years. There have been significant changes since it was done, and system importance criticality decided.			Potential risk of: • Loss of service
Recommendations			**Priority**
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.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
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	Marc 2024	Head of ICT

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

Archwilio Cymru
Audit Wales

Audit Committee Update – Welsh Ambulance Service NHS Trust

Date issued: July 2023

Document reference: 3687A2023

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

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

Audit Wales is the non-statutory collective name for the Auditor General for Wales and the Wales Audit Office, which are separate legal entities each with their own legal functions as described above. Audit Wales is not a legal entity and itself does not have any functions.

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

Contents

Audit Committee update:

Audit Committee Update

About this document

1 This document provides the Audit Committee with an update on current and planned Audit Wales work.

2 Accounts and performance audit work are set out in this update, and information is also provided on the Auditor General's wider programme of national value for money examinations and the work of our Good Practice Exchange (GPX).

Accounts audit update

Exhibit 1 summarises the status of our key accounts audit work.

Exhibit 1 – Accounts audit work

Area of work	Current status
2021-22 Audit of the Charitable Funds' Financial Statements	The Charity's annual report and accounts were approved by the Board of Trustees on 16 February 2023 and were certified by the Auditor General for Wales on 17 February 2023.
Audit of the 2022-23 Financial Statements	Audit work is complete, with our closing 'Audit of Accounts Report' issued alongside this paper. The accounts will be 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 in Autumn 2023
Workforce planning	An assessment of workforce risks that NHS bodies are experiencing currently and are likely to experience in the future. The review will examine how local and national workforce planning activities are being taken forward to manage those risks and address short-, medium- and longer-term workforce needs	Fieldwork nearing completion, anticipated to report to next Audit Committee
Structured Assessment 2023 - core	This work will review the following core areas: • Board and committee cohesion and effectiveness;	Fieldwork starting July 2023. Anticipated to report to November Audit Committee

Topic	Focus of the work	Current status and Audit Committee consideration
	• Corporate systems of assurance; • Corporate planning arrangements; and • 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 digital	This work will examine digital arrangements, with a particular focus on how NHS bodies are investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency.	Early scoping. Fieldwork to commence during the autumn of 2023.
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 late 2023.

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 two Good Practice Exchange (GPX) events since we last reported to the Committee in March 2023: In June 2023 we ran a workshop under the title 'Together we can – creating the conditions to empower our communities to thrive' following the publication of our Together we can – community resilience and self-reliance report. In May 2023 we ran workshops titled 'A Wales of Vibrant Culture and Thriving Welsh Language.'

6 The next Good Practice Exchange events will be on the theme of 'Digital Strategy'. The events will be held in Cardiff on 21 September 2023 and in north Wales on 27 September 2023. Further details of future events are available on the GPX website.

NHS-related national studies and related products

7 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.

8 **Exhibit 4** provides information on the NHS-related or relevant national studies published during the past six months. It also includes all-Wales summaries of work undertaken locally in the NHS.

Exhibit 4 – NHS-related or relevant studies and all-Wales summary reports

Title	Publication date
Digital Inclusion in Wales Key questions for public bodies	March 2023
Orthopaedic Services in Wales – Tackling the Waiting List Backlog	March 2023
Poverty in Wales data tool	November 2022
Time for Change – Poverty in Wales	November 2022

Additional information

9 **Exhibit 5** provides information on corporate documents published by Audit Wales since the last committee update.

10 This includes the Audit Wales Forward Work Programme. This forward programme of performance audit work is shaped by stakeholder engagement activity and our Picture of Public Services analysis. It sits alongside our annual audit of accounts at over 800 public bodies in Wales.

It is focussed on four themes:

- tackling inequality
- responding to the climate and nature emergency
- service resilience and access
- well managed public services

Exhibit 5 – Audit Wales corporate documents

Title	Publication Date
Our Work Programme for 2023-2026	May 2023
Annual Report and Accounts 2022-2023	June 2023

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

Archwilio Cymru
Audit Wales

Welsh Ambulance Services NHS Trust – Detailed Audit Plan 2023

Audit year: 2023

Date issued: June 2023

Document reference: 3630A2023

This document has been prepared as part of work performed in accordance with statutory functions. Further information can be found in our Statement of Responsibilities.

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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.

About Audit Wales

Our aims and ambitions

Assure

the people of Wales that public money is well managed

Explain

how public money is being used to meet people's needs

Inspire

and empower the Welsh public sector to improve

Fully exploit our unique perspective, expertise and depth of insight

Strengthen our position as an authoritative, trusted and independent voice

Increase our visibility, influence and relevance

Be a model organisation for the public sector in Wales and beyond

Contents

Introduction

I have now largely completed my planning work.

This Detailed Audit Plan specifies my statutory responsibilities as your external auditor and to fulfil my obligations under the Code of Audit Practice.

It sets out the work my team intends undertaking to address the audit risks identified and other key areas of focus during 2023.

It also sets out my estimated audit fee, details of my audit team and key dates for delivering my audit team's activities and planned outputs.

Adrian Crompton
Auditor General for Wales

Audit of financial statements

I am required to issue a report on your financial statements which includes an opinion on their 'truth and fairness' and the regularity of income and expenditure. and the proper preparation of key elements of your Remuneration and Staff Report. I lay them before the Senedd together with any report that I make on them. I will also report by exception on a number of matters which are set out in more detail in our Statement of Responsibilities.

I do not seek to obtain absolute assurance on the truth and fairness of the financial statements and related notes but adopt a concept of materiality. My aim is to identify material misstatements, that is, those that might result in a reader of the accounts being misled. The levels at which I judge such misstatements to be material is set out later in this plan.

I am also required to certify a return to the Welsh Government which provides information about the Trust to support preparation of the Whole of Government Accounts.

There have been no limitations imposed on me in planning the scope of this audit.

Performance audit work

I must satisfy myself that the Trust has made proper arrangements for securing economy, efficiency, and effectiveness in its use of resources. I do this by undertaking an appropriate programme of performance audit work each year.

My work programme is informed by specific issues and risks facing the Trust and the wider NHS in Wales. I have also taken account of the work that is being undertaken or planned by other external review bodies and by internal audit.

The majority of my performance audit work is conducted using INTOSAI auditing standards. The International Organisation of Supreme Audit Institutions is a global umbrella organisation for the performance audit community. It is a non-governmental organisation with special consultative status with the Economic and Social Council (ECOSOC) of the United Nations

Your audit at a glance

My financial statements audit will concentrate on your risks and other areas of focus

My audit planning has identified the following risks:

Significant financial statement risks

- Management override
- Financial duty to break-even over three years

Other areas of audit focus

- A new accounting standard, IFRS16, on leases
- Quinquennial valuation of the estate
- Investment in capital expenditure
- Completeness of disposals
- Clinical negligence and personal injury claims

My performance audit will include:

- Structured Assessment
- Structured Assessment deep dive on digital investment
- Local report – Follow up Review of Quality Governance Arrangements

Financial statements materiality

Materiality £2.963m

Materiality	£2.963m
Reporting threshold	£148k

My aim is to identify and correct material misstatements, that is, those that might cause the user of the accounts into being misled.

Materiality based on the draft financial statements is calculated using:

- 2022-23 gross expenditure of £296.3m
- Materiality percentage of 1%

I report to those charged with governance any misstatements above a trivial level (set at 5% of materiality).

Areas of specific interest

There are some areas of the accounts that may be of more importance to the user of the accounts and we have set a lower materiality level for these:

- Remuneration of senior officers and Non-Executive directors as per the banding category within the Remuneration Report
- Related party transactions with senior officers and Non-Executive directors £10,000

Significant financial statements risks

Significant risks are identified risks of material misstatement for which the assessment of inherent risk is close to the upper end of the spectrum of inherent risk or those which are to be treated as a significant risk in accordance with the requirements of other ISAs. The ISAs require us to focus more attention on these significant risks.

Exhibit 1: significant financial statement risks

Significant risk	Our planned response
The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.32-33].	The audit team will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for bias; and • evaluate the rationale for any significant transactions outside the normal course of business.
There is a risk that you will fail to meet your first financial duty to break even over a three-year period. You have reported a year-end surplus of £62,000. This, combined with the outturns for 2020-21 and 2021-22, shows a three-year surplus of £207,000. Your current financial pressures increase the risk that management judgements and estimates could be biased in an effort to achieve the financial duty. There is also a risk of material misstatement due to fraud in expenditure recognition and as such is treated as a significant risk [PN 10]. This risk is focused on transactions before and after the year end, and key year-end balances, relating to non-pay expenditure with bodies outside of NHS Wales and Welsh Government.	The audit team will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for bias; • perform detailed testing on a sample of key transactions before and after the year end to ensure they are accounted for in the correct accounting period; and • perform detailed testing on a sample of key year end balances to ensure they are appropriate and complete.

Other areas of focus

I set out other identified risks of material misstatement which, whilst not determined to be significant risks as above, I would like to bring to your attention.

Exhibit 2: other areas of focus

Audit risk	Our planned response
A new accounting standard, IFRS16 Leases, has been adopted by the FReM for 2022-23. IFRS16 will significantly change how most leased assets are accounted for as leased assets will need to be recognised as assets and liabilities in the Statement of Financial Position. There are also significant additional disclosure requirements specific to leased assets that will need to be reflected in the financial statements.	My audit team will: • consider the completeness of the lease portfolios identified by the Trust needing to be included in IFRS16 calculations. • review a sample of calculated asset and liability values and ensure that these have been accounted for and disclosed in accordance with the Manual for Accounts. • ensure that all material disclosures have been made.
The quinquennial valuation of the NHS estate took place as at 1 April 2022. There is a risk that assets are not valued on appropriate bases and that movements in the carrying values of assets are not appropriately accounted for and disclosed. Given the current economic climate, there is a further risk that the carrying values of assets have changed during 2022-23 and that 1 April 2022 valuations are materially misstated at the balance sheet date.	My audit team will: • consider the appropriateness of the work of the Valuation Office Agency as a management expert. • test the appropriateness of asset valuation bases. • review a sample of movements in carrying values to ensure that movements have been correctly accounted for and disclosed, in accordance with the Manual for Accounts. • consider whether the carrying value of assets at 1 April 2022 remains materially appropriate or whether additional in-year adjustments are required due to the impact of current economic conditions.
There is significant investment in capital projects and a risk that capital	My audit team will:

expenditure classified as Assets Under Construction is materially mis-stated: • Capital expenditure up to month 11 was reported at £12.5m, increasing to £29.1m up to month 12. • At the year end, there are balances of £25.5m classified as Assets Under Construction, with vehicles under construction held by third parties. • There is an element of judgement needed when determining the amount of costs to be capitalised on each project and the valuation of these assets at the end of the year.	• understand the reasons for the peak in capital expenditure in month 12 and assess impact on audit approach. • detailed testing on a sample of additions and capital accruals. • for vehicles under construction by third parties, review the contractual terms and assess whether the criteria for recognising the assets have been met. • review and challenge whether any assets under construction require impairment.
Last year there were issues with the completeness of asset disposals within the financial statements. Assets no longer in use were removed from Property, Plant and Equipment and Intangibles.	My audit team will: • review your arrangements for capturing disposals. • perform detailed testing to ensure asset disposals are complete.
A key source of estimation uncertainty relates to the provision for clinical negligence and personal injury claims. The subjective nature of these provisions and associated judgments give risk to increased risk.	My audit team will: • perform detailed testing on a sample of claims. • Evaluate the reasonableness of key assumptions and judgments. • Consider the work of Legal and Risk Services and the NHS Business Services Authority as a management expert.

Financial statements audit timetable

I set out below key dates for delivery of my accounts audit work and planned outputs.

Exhibit 3: key dates for delivery of planned outputs

Planned output	Work undertaken	Report finalised
2023 Outline Audit Plan	February 2023	Presented to March 2023 Audit Committee
2023 Detailed Audit Plan	April to May 2023	May 2023
Audit of financial statements work: • Audit of Financial Statements Report • Opinion on the Financial Statements	May to July 2023	July 2023

Planned performance audit work

I set out below details of my performance audit work and key dates for delivery of planned outputs.

Exhibit 4: key dates for delivery of planned outputs

Theme	Approach	Timescales
Structured Assessment - core	Structured assessment will continue to form the basis of the work my audit teams do at each NHS body to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. My 2023 structured assessment work will review the following core areas: • Board and committee cohesion and effectiveness; • Corporate systems of assurance; • Corporate planning arrangements; and • Corporate financial planning and management arrangements. My structured assessment work will also include a review of the arrangements that are in place to track progress against previous audit recommendations. This allows the audit team to obtain assurance that the necessary progress is being made in addressing areas for improvement identified in previous audit work. It also enables us to more explicitly measure the impact our work is having.	Fieldwork to commence between June and August 2023 with reporting by the end of October 2023.
Structured Assessment - deep dive review of investment in digital	In addition to the core structured assessment work described above, my audit teams will also review certain arrangements at NHS bodies in more depth.	Fieldwork to commence during the autumn of 2023 and reporting by April 2024.

Theme	Approach	Timescales
	This year, my audit teams will examine digital arrangements, with a particular focus on how NHS bodies are investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency.	
Local project work – Follow up Review of Quality Governance Arrangements	My audit team will review progress since our Quality Governance report was issued in 2022. My audit team will analyse progress in responding to recommendations issued in order to make improvements to quality governance arrangements within the Trust.	Fieldwork to commence September 2023 and reporting by December 2023.

Fee and audit team

In January 2023 I published the fee scheme for the 2023-24 year as approved by the Senedd Finance Committee. My fee rates for 2023-24 have increased by 4.8% for inflationary pressures. In addition, my financial audit fee has a further increase of 10.2% for the impact of the revised auditing standard ISA 315 on my financial audit approach. More details of the revised auditing standard and what it means for the audit I undertake is set out in **Appendix 1**. I have increased my performance audit fee by a total of 22.3% to reflect both the inflationary pressure mentioned above and the overall risks that the organisation is facing. This will bring the Trust's performance audit fee more in line with other trusts in NHS Wales and enable my team to undertake an appropriately targeted programme of local performance audit work.

I estimate your total audit fee will be £188,424.

Planning will be ongoing, and changes to my programme of audit work, and therefore my fee, may be required if any key new risks emerge or if the level of work is higher than envisaged. I shall make no changes without first discussing them with the Director of Finance and Corporate Resources.

Our financial audit fee is based on the following assumptions:

- The agreed audit deliverables (via inflo) sets out the expected working paper requirements to support the financial statements.
- Appropriate officials will be available during the audit.
- No matters of significance, other than as summarised in this plan, are identified during the audit.

Exhibit 5: breakdown of audit fee

Audit area	Proposed fee for 2023 (£)[1]	Actual fee for 2022 (£)
Audit of Financial Statements	**107,609**	**93,686**
Performance audit work:		
• Structured Assessment	62,811	66,066
• Local Project – Follow Up Review of Quality Governance Arrangements	18,004	-
Performance work total	**80,815**	**66,066**
Total fee	**188,424**	**159,752**

[1] The fees shown in this document are exclusive of VAT, which is not charged to you. They also exclude the audit fee for the Charitable Funds account.

The main members of my team, together with their contact details, are summarised in **Exhibit 6**.

Exhibit 6: my local audit team

Name	Role	Contact number	E-mail address
Dave Thomas	Engagement Director (Performance Audit)	02920 320604 / 07798 503064	Dave.Thomas@audit.wales
Gareth Lucey	Audit Director (Financial Audit)	029 2082 9398	Gareth.Lucey@audit.wales
Alison Butler	Audit Manager (Financial Audit)	02920 320665 / 07807 839460	Alison.Butler@audit.wales
Andrew Doughton	Audit Manager (Performance Audit)	07812 094642	Andrew.Doughton@audit.waes
Erin Pollard	Audit Lead (Financial Audit)	02920 829371	Erin.Pollard@audit.wales
Fflur Jones	Audit Lead (Performance Audit)	07773 193627	Fflur.Jones@audit.wales

I can confirm that my team members are all independent of the Trust and your officers. However, there is one potential issue to bring to your attention. The Financial Audit Manager's husband is the Director of Finance and Corporate Services at NHS Wales Shared Services Partnership. We have put arrangements in place to ensure any actual of perceived conflicts of interest are addressed.

Audit quality

Our commitment to audit quality in Audit Wales is absolute. We believe that audit quality is about getting things right first time.

We use a three lines of assurance model to demonstrate how we achieve this. We have established an Audit Quality Committee to co-ordinate and oversee those arrangements. We subject our work to independent scrutiny by QAD* and our Chair, acts as a link to our Board on audit quality. For more information see our Audit Quality Report 2022.

Our People

The first line of assurance is formed by our staff and management who are individually and collectively responsible for achieving the standards of audit quality to which we aspire.

- Selection of right team
- Use of specialists
- Supervisions and review

Arrangements for achieving audit quality

The second line of assurance is formed by the policies, tools, learning & development, guidance, and leadership we provide to our staff to support them in achieving those standards of audit quality.

- Audit platform
- Ethics
- Guidance
- Culture
- Learning and development
- Leadership
- Technical support

Independent assurance

The third line of assurance is formed by those activities that provide independent assurance over the effectiveness of the first two lines of assurance.

- EQCRs
- Themed reviews
- Cold reviews
- Root cause analysis
- Peer review
- Audit Quality Committee
- External monitoring

* QAD is the quality monitoring arm of ICAEW.

Appendix 1

The key changes to ISA315 and the potential impact on your organisation

Key change	Potential impact on your organisation
More detailed and extensive risk identification and assessment procedures	Your finance team and others in your organisation may receive a greater number of enquiries from our audit teams at the planning stage of the audit. Requests for information may include: • information on your organisation's business model and how it integrates the use of information technology (IT); • information about your organisation's risk assessment process and how your organisation monitors the system of internal control; • more detailed information on how transactions are initiated, recorded, processed, and reported. This may include access to supporting documentation such as policy and procedure manuals; and • more detailed discussions with your organisation to support the audit team's assessment of inherent risk.
Obtaining an enhanced understanding of your organisation's environment, particularly in relation to IT	Your organisation may receive more enquiries to assist the audit team in understanding the IT environment. This may include information on: • IT applications relevant to financial reporting; • the supporting IT infrastructure (e.g. the network, databases); • IT processes (e.g. managing program changes, IT operations); and • the IT personnel involved in the IT processes. Audit teams may need to test the general IT controls and this may require obtaining more detailed audit evidence on the operation of IT controls within your organisation. On some audits, our audit teams may involve IT audit specialists to assist with their work. Our IT auditors may need to engage with members of your IT team who have not previously been involved in the audit process.

Key change	Potential impact on your organisation
Enhanced requirements relating to exercising professional scepticism	Our audit teams may make additional inquiries if they identify information which appears to contradict what they have already learned in the audit.
Risk assessments are scalable depending on the nature and complexity of the audited body	The audit team's expectations regarding the formality of your organisation's policies, procedures, processes, and systems will depend on the complexity of your organisation.
Audit teams may make greater use of technology in the performance of their audit	Our audit teams may make use of automated tools and techniques such as data analytics when performing their audit. Our teams may request different information or information in a different format from previous audits so that they can perform their audit procedures.

Through our Good Practice work we share emerging practice and insights from our audit work in support of our objectives to assure, to explain and to inspire.

Our newsletter provides you with regular updates on our public service audit work, good practice and events, which can be tailored to your preferences.

For more information about our Good Practice work click here.

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

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Our work programme for 2023-2026

Our work programme for 2023-2026

About our work programme

1 Our Audit Wales strategy for 2022-2027 includes a focus on the development and delivery of a 'strategic, dynamic and high-quality audit programme', as well as a 'targeted and impactful approach to communications and influencing'.

2 In spring 2022, we consulted on our work programme. Informed by responses to that consultation, and our 2021 Picture of Public Services analysis, we have been shaping an indicative medium-term programme of performance audit work that sits alongside our annual audit of accounts at over 800 public bodies in Wales. By identifying a clearer medium-term horizon and drawing together different parts of our overall work programme, we aim to enhance our overall research and development, and the timeliness and impact of our audit work.

3 Our audit programme for 2023-2026 will be focused on four themes:

Tackling inequality

Responding to the climate and nature emergency

Service resilience and access

Well-managed public services

About this paper

4 We have prepared this paper in advance of work to develop our website and the information it holds about our work programme to improve our engagement with the public and other stakeholders about our work.

5 The paper focuses on our national value for money examinations and studies. This programme of work includes value for money examinations, local government studies, and the preparation of summary reports of the findings from local audit work across multiple NHS, central government and/or local government bodies. It also includes examinations undertaken in response to issues of public concern identified through our audit work or raised with the Auditor General through correspondence. Our work will include consideration of how the sustainable development principle and its 'five ways of working' are being applied.

6 The topics identified below as work in progress at 1 April 2023, or to start during 2023-24, mirror Appendix 2 of our Annual Plan 2023-24. Plans for other outputs may emerge as our work programme evolves at both a national and local level, including follow up work and local audit work already planned as part of previous years' programmes.

7 In addition, our local audit plans will include other new work at individual bodies to be progressed during 2023-24:

- For principal councils: local reviews include coverage waste and recycling, planning services, the Welsh Housing Quality Standard, performance management and reporting, counter fraud and whistleblowing, transformation programmes, roads and transport, arrangements to support application of the sustainable development principle, corporate governance, scrutiny, and safeguarding.

- For NHS bodies: as an extension to our annual structured assessment work across all bodies we will undertake a deeper dive into digital developments. While planning arrangements for local bespoke projects are still ongoing, emerging areas of focus at individual bodies include follow up of previous audit recommendations in areas such as primary care, quality governance, clinical coding and outpatient services, use of strategic assistance funding in escalated organisations, and the robustness of operational governance arrangements.

- For Fire and Rescue Authorities: our local audit programme will include consideration of approaches to targeting fire prevention work.

- For National Park Authorities: our local audit programme will include consideration of arrangements for ensuring under-represented groups are encouraged and supported to visit.

8 We have also listed below indicative topics that we have identified for possible national work to start during 2024-25 and 2025-26, some of which we would expect to then flow into 2026-27. These indicative plans will be revisited as part of our annual planning cycle and taking accounts of any emerging areas of interest / concern and ongoing risk assessment.

National value for money examinations and studies 2023-2026

Work in progress at 1 April 2023

NHS quality governance	A summary of how NHS bodies' quality governance arrangements are supporting good quality and safe care, building on local audit work.
Corporate Joint Committees (CJCs)	Whether CJCs are making good progress in developing their arrangements to meet their statutory obligations and the Welsh Government's aim of strengthening regional collaboration.
Managing assets and workforce in local government	How councils' strategic approaches to workforce and asset management are supporting their ability to transform, adapt, and maintain service delivery in the short and longer term.
Maximising EU funding	Progress in maximising drawdown of EU funds under the Structural Funds Programme and Rural Development Programme by the end of December 2023.
Net zero (pan-UK overview)	An overview of policy and delivery arrangements across different parts of the UK, and in partnership with other UK audit bodies.
Unscheduled care	A whole system review, undertaken in phases, that will examine the effectiveness of hospital discharge arrangements, management of unscheduled care demand and the effectiveness of national leadership arrangements.

Covering teacher's absence	Developments since our November 2020 report on this topic, and a March 2021 report by the Senedd Petitions Committee.
NHS workforce	NHS bodies' approaches to workforce planning and drawing together key data.
Planning for sustainable development – brownfield regeneration	Action local councils are taking to support and encourage vacant non-domestic properties and vacant brownfield sites being repurposed into homes or for other uses.
Building safety	How responsible public bodies are discharging their statutory responsibilities to ensure buildings in Wales are safe, against the backdrop of the UK Building Safety Act 2022.
Ukrainian refugee services	How the Welsh Government, working with its partners, has responded to support Ukrainian refugees in Wales.
Governance/oversight of National Park Authorities	Whether authorities have effective governance arrangements that support good outcomes for citizens.
Digital strategy in local government	Councils' strategic approach to digital, including application of the sustainable development principle and arrangements for securing value-for-money.

Use of performance information in local government	Whether councils' use of performance data enables senior leaders to understand the service-user perspective and the outcomes of their activities to effectively manage performance.
Cancer services	Examining different stages of the patient pathway and building on local audit work at Public Health Wales around the recovery of screening services.
Affordable housing	Arrangements to deliver the Welsh Government's target and realise wider benefits, progress to date and risks to delivery, and application of the sustainable development principle.
Active travel	Delivery of Welsh Government objectives and how associated funding is being managed and deployed.

Other work that we intend to start during 2023-24

Capital planning and programme management	A programme of work, covering the Welsh Government's overall approach to capital and infrastructure, local audit work on capital planning and work on specific capital programmes, including possible further work on the Welsh Government's investment programme for schools and colleges following on from our report in 2017.
Challenges for the cultural sector	Covering Amgueddfa Cymru (Museum Wales), the National Library of Wales, Sport Wales, and the Arts Council of Wales to examine how they are applying the sustainable development principle when taking steps to meet their well-being objectives.
Homelessness	Examining how services are working together to progress the response to homelessness, informed in part by our previous work on people sleeping rough, and in the context of the Welsh Government's 2021-2026 homelessness action plan.
Addressing biodiversity decline	A high-level look at how audited bodies are responding to the biodiversity and resilience of ecosystems duty under the Environment (Wales) Act 2016. Also, a more focused review to examine action that Natural Resources Wales is taking around terrestrial, freshwater and/or marine protected sites.

Rebalancing care and support	A programme of work looking at different aspects of the Welsh Government's Rebalancing Care and Support agenda and associated funding streams, including the Health and Social Care Regional Integration Fund and the Health and Social Care Integration and Rebalancing Capital Fund.
Tackling NHS waiting lists	Local audit work across health boards following on from our national overview report on the planned care backlog in May 2022.
Access to education for children with Additional Learning Needs.	Considering costs associated with the Welsh Government's transformation programme and challenges around its implementation.
Further and higher education funding and oversight – Commission for Tertiary Education and Research	Early work to look at the application of the sustainable development principle by the newly created Commission as it becomes fully operational from 1 April 2024. This could include reflecting more broadly on financial and other challenges for the sectors, picking up from our October 2021 Picture of Higher and Further Education report.
Governance of Fire and Rescue Authorities	Considering whether authorities have effective governance arrangements that support good outcomes for citizens (applying a similar approach to our current work at National Park Authorities – see above).

The senior public service	Building on other work that we have been undertaking on public service workforce issues, this review would focus on issues around senior leadership, potentially encompassing issues including pay and secondments, performance management, departures, succession planning, and leadership development.
Financial sustainability in local government	Local audit work across the 22 principal councils to revisit local government finances and approaches to financial sustainability, also considering application of the sustainable development principle. This work would build on themes in our national summary report in September 2021.
Commissioning and contract management in local government	Local audit work to consider how principal councils' arrangements for commissioning, and subsequent contract management where a client-contractor model is chosen, apply value-for-money considerations and the sustainable development principle.

Indicative topics for work to start in 2024-25 or 2025-26

Narrowing educational attainment gaps	Picking up from issues summarised in our October 2021 Picture of Schools report, this work could examine variation across Wales and good practice, as well as the impact of funding associated with deprivation.
Public health challenges	Examining key public health challenges of our time, with a possible focus on tackling obesity or planning for future health pandemics.
Post Brexit economic developments	Exploring potentially the Welsh Government's support – financial and other – for sectors most impacted by Brexit, such as ports and export-led companies.
The socio-economic duty	Building on our September 2022 report on Equality Impact Assessment, to consider how public bodies are integrating the socio-economic duty under the Equality Act 2010 into their decision-making processes since it came into force in March 2021.
Health inequalities	Linked to work on public health challenges, considering the issues which effect equality of access to services and the wider impact on individuals, communities and our health and social care systems.
Foundational economy	Examining the impact of Welsh Government policy and support around the foundational economy and its provision of basic goods and services that society relies upon.

Net zero follow up	Following up on issues relevant to our July 2022 report on public sector readiness for net zero carbon by 2030. This work is likely to focus in more detail on specific areas of concern, such as the robustness of public bodies' net zero reporting arrangements.
National Transport Delivery Plan	Building on our current work on Active Travel to look at other key areas of delivery for Llwybr Newydd: the Wales transport strategy 2021.
Decarbonising housing	Examining progress in decarbonising housing across different tenures and the delivery and impact of related Welsh Government funding.
Adult mental health services	Considering issues of demand for and access to mental health services, including potentially community mental health support.
Primary care – dentistry	Looking at progress with the national strategic approach and various initiatives to improve access, as well as the dental contract and its impact on NHS dental provision in Wales.
The National Fraud Initiative (NFI) 2022-23	Reporting in autumn 2024 on the results of the latest NFI exercise 2022-23.

Partnership governance	Building potentially on evidence from other work and/or following up on our October 2019 review of Public Services Boards, this review could reflect on the partnership working landscape in Wales, with a possible good practice focus.
Applying the sustainable development principle	Reporting by May 2025 on findings from our examinations of how public bodies prescribed under the Well-being of Future Generations (Wales) Act 2015 are applying the sustainable development principle.
Delivering the Digital Strategy for Wales	Following on from other work, including our March 2023 report on digital inclusion, work that we have undertaken on cyber resilience, and other local audit work, this review would examine issues relevant to the six 'missions' that the Welsh Government has set out in the Digital Strategy for Wales.
Public sector workforce challenges	Drawing together findings from other relevant work supported, potentially, by some additional data analysis to consider challenges around workforce planning and management across Welsh public services.
Public procurement	A pan-public sector review examining developments in the public procurement landscape including, potentially, early consideration of the implementation of new duties proposed by the Welsh Government in its Social Partnership and Public Procurement (Wales) Bill.
Picture of public services	An update to our 2021 Picture of Public Services analysis and ahead of the end of the current Auditor General's term of office in summer 2026.

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AGENDA ITEM No	**8**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**5**

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

MEETING	Audit Committee
DATE	25th July 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 were presented to the Trust Board on 25th May 2023 and are updated as at 6th July 2023. The high rated 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 and the mitigating actions identified and taken to ensure risks achieve their target score.

5. Updates made in respect of actions, controls and assurances are highlighted in blue on the BAF.

RECOMMENDATION:

6. 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 inclusion of the Civil Contingencies Risk on the Corporate Risk Register at a score of 15 as presented to Trust Board in May 2023.
   (c) Note the increase in score of Risk 424 from 12 to 16.

(d) Note the increase in score of Risk 163 from 12 to 16.
(e) Note the closure of Risk 245 from the Corporate Risk Register.
(f) Note the closure of Risk 557 from the Corporate Risk Register.
(g) Note the update on the Risk Management Transformation Programme.
(h) Receive the Guidance on Interpreting the Board Assurance Framework.

KEY ISSUES/IMPLICATIONS
The key issues and implications are set out in the Executive Summary above.

REPORT APPROVAL ROUTE
Each of the Principal Risks have been or are due to be considered by the following Committees, as relevant to their remit, during the forthcoming reporting period: ADLT (26 June 2023) EMT (5 July 2023) Charity Committee (5 July 2023) Finance & Performance Committee (17 July 2023) Quality, Safety & Patient Experience (10 August 2023) People & Culture Committee (17 August 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 Annex 5 – Guidance on Interpreting the Board Assurance Framework

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

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

SITUATION

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

2. A summary of the Trust's 17 principal risks on the Corporate Risk Register (CRR) as at 6 July 2023 is detailed in Annex 1; each of the high rated risks have been fully and formally reviewed in line with the review schedule.

BACKGROUND

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

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

ASSESSMENT

5. The summary of the Trust's 17 principal risks is set out in Annex 1 with the full risk detail including controls, assurances, gaps and mitigating actions contained within the Board Assurance Framework (BAF) in Annex 2.

6. The EMT has approved the Principal Risk activity described in this paper and considered the full review of each risk undertaken throughout June 2023 by Risk Owners and the ADLT.

<u>Principal Risks</u>

7. The principal risks were presented to the Trust Board on 25th May 2023 and are updated as at 6th July 2023. The high rated risks have been reviewed during this reporting period in line with the agreed review schedule detailed at Annex 3.

Focus has been given to each of the risk ratings and the mitigating actions identified and taken to ensure that risks achieve their target score. This is in addition to the regular review of controls, assurances, and any gaps.

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

9. All current mitigating actions within WAST's control have been completed or superseded in relation to Risk 223. The Trust will continue to challenge itself that all possible mitigations are in place or planned, this includes considering a potential breakdown of risk score by Health Board. Additionally, the Board will continue to receive an update against the Avoidable Harm paper and action plan at each meeting.

10. A deep dive in relation to Risk 224 took place at the Quality & Nursing Directorate meeting and it was agreed that the score should remain at 25 given recent cases of patients deteriorating outside of Emergency Departments.

11. In relation to Risk 201, while it is acknowledged that the rating for this risk remains high and has been static for some time given the current status, the Trust is not in a position to de-escalate it. Members should note that this risk is reviewed by the People and Culture Committee at each meeting. Any concerns are escalated through the Alert, Advise and Assure (AAA) report and during discussion at each Board meeting. The risk rating will be kept under regular review and will be de-escalated as soon as is appropriate and practicable.

12. Risk 160 - Whilst good progress is being made to reduce sickness absence, a decision was made in May 2023 to keep the risk rating under review. Profiling seasonal impacts of illness and historical data during the next 4 months will enable us to make an informed decision as to whether to reduce the risk.

13. The risk score has increased on Risk 424 from 12 (3x4) to 16 (4x4) given the level of risk the organisation is experiencing in the current financial climate and with no further recurrent funding agreed to deliver the Trust's transformational plans. This score is aligned to the Trust's financial Risk 139.

14. Risk 558 - Whilst there is significant work in this area, there remains a considerable risk to the health and wellbeing of the workplace. Handover delays remain high which leads to regular shift overruns. There are pilots in place to understand whether a different approach can be introduced; however, this need to be evaluated before reducing the risk. Staff will shortly be surveyed using our new staff survey tool which will give the Trust further insight and some data to

measure how people are feeling. External pressures such as the cost of living crisis will likely increase the pressure our people are feeling.

15. Risk 163 - Whilst the national pay dispute has ended for the majority of Trade Unions (RCN potential action is currently paused) relationships with Trade Union Partners need to be approached sensitively. There are a range of issues that require engagement and partnership working, alongside the full implementation of all aspects of the WAST annex. On this basis, the score has increased from 12 (3x4) to 16 (4x4).

16. Risk 199 – The risk score is to remain the same as not all actions have been implemented and have been delayed during the operational pressures. Once the remainder of the actions have been completed then the score will be reduced. This will be reviewed in the next reporting period.

17. All original actions are now complete in relation to Risk 260; however, a review of the recent Cyber Resilience Unit (CRU) assessment is to be undertaken to identify any further actions. On this basis the score remains the same given continued activity by cyber actors due to wider world events. There is a general heightened alert for government and public sector bodies although no specific threat has been identified against NHS bodies.

18. Risk 543 – The majority of mitigating actions complete on Risk 543 and so the score remains unchanged as further reviews of the CE assessor and CRU reports are required to identify any further actions that need to be undertaken.

19. Risk 594 – The risk score remains at 15 following review. While the Health Boards have responded to the original letter sent from the Chief Executive highlighting this risk the responses have provided limited assurance. To this end the Trust is working with the Welsh Government NHS Executive to provide further assurances that the response from Health Boards is sufficient to reduce this risk. A Mass Casualty Exercise is being arranged for October 2023 to test the response and this will provide a further opportunity to review this risk and score at that time.

20. Risks 100 and 283 are not due for review until August 2023.

<u>Closure and De-Escalation of Risks</u>

21. As a result of reviewing the risk ratings and mitigating actions two risks have been closed from the CRR as described below.

22. Risk 557 was recommended by the Executive Risk Owner for closure from the CRR which was approved by the EMT given the risk has been mitigated due to the acceptance of the pay award by the majority of Trade Unions.

23. **Risk 557** - Potential impact on services as a result of Industrial Action

IF *trade unions take industrial action in response to the national pay award*

THEN *this is likely to disrupt our ability to provide a safe, efficient and good quality service in the 6 core areas the business*

RESULTING IN *potential harm to patients, adverse effect to patient outcomes, increase in SAIs/concerns/coroners cases, negative media reports, and impact on the Trust's corporate reputation.*

24. Additionally, The Executive Risk Owner and ADLT recommended that Risk 245 be de-escalated from the CRR as this has achieved the target score of 8 (2x4) having reduced from 16 (4x4). The EMT approved the de-escalation.

25. **Risk** 245 - Failure to have sufficient capacity at an alternative site for EMS Clinical Contact Centres (CCCs) which could cause a breach of Statutory Business Continuity regulations.

IF *CCCs are unable to accommodate additional core functions and do not have alternative site arrangements in place in the event of a business continuity incident*

THEN *there is a risk that EMS CCCs cannot utilise other CCC's space, accommodation and facilities*

RESULTING IN *potential patient harm and a breach of the requirements of the Civil Contingencies Act (2004) and Contingency Planning Regulations (2005)*

26. The rationale is that the Control Room Solution implementation is complete across all 3 Emergency Medical Services (EMS) Clinical Contact Centres (CCCs) which has increased dispatch capability in all areas and the risk has reduced from 16 (4x4) and reached the target score of 8 (2x4). The remaining risk in relation to the ability to accommodate call handling functionality will be managed at a directorate level and reviewed when the telephony capacity in the new Vantage Point House resilient suite is identified. The risk of not being able to meet civil contingencies has now significantly reduced.

<u>New Corporate Risks</u>

27. One new risk was assessed and approved for inclusion on the CRR as follows:

28. **NEW Civil Contingencies Risk** (scoring 15) - *The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death*

IF *a major incident or mass casualty incident is declared*

THEN *there is a risk that the Trust cannot provide its pre-determined attendance as set out in the Incident Response Plan and provide an effective, timely or safe response to patients*

RESULTING IN *catastrophic harm (death) and a breach of the Trust's legal obligation as a Category 1 responder under the Civil Contingency Act 2004*

29. This was reported to Trust Board in May 2023.

Further Review of Risks

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

    a. Risks to the reputation of the Trust's Charity and Trustees due to late filing of accounts.
    b. Charity governance.
    c. Integrated technical planning capability and capacity.
    d. Capacity to handle volume of complex concerns and requests i.e. Putting Things Right Team.
    e. 111 Symptom Checkers
    f. Decarbonisation programme
    g. Salus implementation

Risk Management Transformation Programme

31. 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.

32. 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.

33. This programme is overseen by the Audit Committee.

RECOMMENDED

34. 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 inclusion of the Civil Contingencies Risk on the Corporate Risk Register at a score of 15 as presented to Trust Board in May 2023.
    c) Note the increase in score of Risk 424 from 12 to 16.
    d) Note the increase in score of Risk 163 from 12 to 16.
    e) Note the closure of Risk 245 from the Corporate Risk Register.
    f) Note the closure of Risk 557 from the Corporate Risk Register.
    g) Note the update on the Risk Management Transformation Programme.
    h) Receive the Guidance on Interpreting the Board Assurance Framework.

Annex 1 – Corporate Risk Register Summary

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
223 QuEST	The Trust's inability to reach patients in the community causing patient harm and death	**IF** significant internal and external system pressures continue **THEN** there is a risk of an inability and/or a delay in ambulances reaching patients in the community **RESULTING IN** patient harm and death	Director of Operations	**25 (5x5)** →
224 QuEST	Significant handover delays outside A&E departments impacts on access to definitive care being delayed and affects the trust's ability to provide a safe and effective service	**IF** patients are significantly delayed in ambulances outside A&E departments **THEN** there is a risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised **RESULTING IN** patients potentially coming to harm and a poor patient experience	Director of Quality & Nursing	**25 (5x5)** →
160 PCC	High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service	**IF** there are high levels of absence **THEN** there is a risk that there is a reduced resource capacity **RESULTING IN** an inability to deliver services which adversely impacts on quality, safety and patient/staff experience	Director of Workforce & Organisational Development	**20 (5x4)** →
201 PCC	Damage to Trust reputation following a loss of stakeholder confidence	**IF** the stability of the Trust deteriorates to a level where service delivery fails to meet patient safety, national standards and contractual obligations	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)** ↑ **12**

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.		**(3x4)**
245 FPC **CLOSED**	Failure to have sufficient capacity at an alternative site for EMS Clinical Contact Centres (CCCs) which could cause a breach of Statutory Business Continuity regulations	**IF** CCCs are unable to accommodate additional core functions and do not have alternative site arrangements in place in the event of a business continuity incident **THEN** there is a risk that EMS CCCs cannot utilise other CCC's space, accommodation and facilities **RESULTING IN** potential patient harm and a breach of the requirements of the Civil Contingencies Act (2004) and Contingency Planning Regulations (2005)	Director of Operations	**8 (2x4)** ⬇ **16 (4x4)**
424 FPC	Prioritisation or Availability of Resources to Deliver the Trust's IMTP	**IF** resources are not forthcoming within the funding envelope available to WAST (link to risk 139) **THEN** there is a risk that there is insufficient capacity to deliver the IMTP **RESULTING IN** delay or non-delivery of IMTP deliverables which will adversely impact on the Trust's ability to deliver its	Director of Strategy Planning and Performance	**16 (4x4)** ⬆ **12 (3x4)**

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		strategic objectives and improvement in patient safety and staff wellbeing		
458 FPC	A confirmed commitment from EASC and/or Welsh Government is required in relation to funding for recurrent costs of commissioning	**IF** sufficient recurrent funding is not forthcoming there is a risk that the Trust will be committed to additional expenditure through delivery of the IMTP and in year developments which are only recognised by commissioners on a cost recovery basis **THEN** there is a risk that the Trust may not be able to deliver services and there will be a lack of funding certainty when making recurrent cost commitments. Any potential 'exit strategies' from developed services could be challenging and harmful to patients. **RESULTING IN** patients not receiving services, the Trust not achieving financial balance and a potential failure to meet statutory obligations causing reputational damage.	Director of Finance & Corporate Resources	**16 (4x4)** →
557 PCC **CLOSED**	Potential impact on services as a result of Industrial Action	**IF** trade unions take industrial action in response to the national pay award **THEN** this is likely to disrupt our ability to provide a safe, efficient and good quality service in the 6 core areas the business **RESULTING IN** potential harm to patients, adverse effect to patient outcomes, increase in SAIs/concerns/coroners cases,	Director of Workforce & Organisational Development	**16 (4x4)** →

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

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

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
	levels of patient safety and experience	**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		
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 – Board Assurance Framework

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	26/06/2023	TREND	25 (5x5)
		Date of Next Review:	25/07/2023	➡	

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

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

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

Risk Commentary Q4 2022/23

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

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

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

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

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1. Regional Escalation Protocol	1. Daily conference calls to agree RE levels in conjunction with Health Boards
2. Immediate release protocol	2. The Immediate Release Protocol is a Nationally agreed NHS Wales protocol. Refusals by Health Boards are Datixed by WAST and compliance report shared weekly with the Health Board Chief Operating Officers (COOs)
3. Resource Escalation Action Plan (REAP)	3. Weekly review by Senior Operations team with assessment of action compliance. The Senior Leadership Team convenes every Tuesday as the Weekly Performance Meeting to review performance and demand data, and review/assign REAP Levels as appropriate. Dynamic escalation via Strategic Command structure.
4. 24/7 Operational Delivery Unit (ODU)	4. Shift reports from ODU & ODU Dashboard received by Exec, SOT and On-Call Team at start/end. Provides operational oversight with dynamic CSP review and system escalation as required.
5. Gold/Strategic, Silver/Tactical and Bronze/Operational 24 hour/ 7 day per week system to manage escalation plans	5. Same as 5 - Shift reports from ODU & ODU Dashboard received by Exec, SOT and On-Call Team at start/end. Provides operational oversight with dynamic CSP review and system escalation as required.
6. Limited Alternative Care Pathways in place	6. Limited Assurance - Health Informatics reports, APP dashboard monitors, reports on app use by Consultant Connect, APP development and expansion, and bids for additional prescribing APPs.
7. Consult and Close (previously Hear and Treat)	7. Monitoring CSD rates through AQIs. Consult and Close volumes form part of EMS CCC weekly reports to SLT. Regular reporting of incident volumes to Operational Review Groups. Summary level information about Consult and Close volumes, targets, trends and recontact rates reported to TB and sub-committees. Metrics relating to Ambulance Quality Indicators (AQI) published on a quarterly basis by EASC. Bi-monthly EASC Provider reports. Consult and Close performance reported in Joint Executive Team meeting every 6 months with Welsh Government. NWSSP Information Management Internal Audit report February 2022 (External Assurance). Consult and Close rate has increased from 12% to circa 15% March 2023.

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	26/06/2023	TREND	25 (5x5)
		Date of Next Review:	25/07/2023		

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

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

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	26/06/2023	TREND	25 (5x5)
		Date of Next Review:	25/07/2023		

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

iii) WAST – Transfer of Care Brief

GAPS IN CONTROLS	GAPS IN ASSURANCE
1. Acknowledgement and acceptance of risk by Health Boards and balancing the risks across the whole system	**1. Improvement in handover delays across Cardiff and Vale and more latterly across AB have led to improved handovers at Eds. This has now been sustained for some months across C&V in a phased programme of improvement with no delays in excess of 2 hours. Programme of improvement underway in AB, commencing at 4hour tolerance with a plan to reduce over time. In other Health Boards, there remains little or no controls, with variation in both handovers and risk levels across Health Boards**
2. Blockages in system e.g. internal capacity within Health Boards which affect patient flow	
3. Covid capacity streaming	
4. Transition Plan/Inverted Triangle – bid for transition plan has been put in and is now subject to funding	
5. Local delivery units mirroring WAST ODU	
6. Handover delays link to risk 224	
7.	
8. During industrial action days, Health Boards demonstrated compliance with reducing handover delays in order to maximise WAST resources. Despite a reduced volume of conveyance as a result of the industrial action, there is however a demonstration that reduced handover delays are achievable, and this therefore warrants a triangulation of data.	
9. There is an ambition that no handover should exceed 4 hours and for lost hours to handover to be reduced by 25% but given the track record over last 6 months there is a low confidence in attaining this.	
10. Outputs from the NHS System Reset – it is a closer collaboration to address some of the system blockages and reduce system pressures. This is the aspiration	
11.	
12. Handover Improvement Plans agreed between WAST and Health Boards	12. Handover Improvement Plans have been replaced by Integrated Commissioning Action Plans (ICAPS) and are subject to review with EASC; However, it is noted that previous plans did not demonstrate sufficient improvement in reducing handover delays
18. National Transfer & Discharge Model	18. National Transfer & Discharge model is yet to be determined. A task and finish has been established to progress this piece of work
21. Mental Health Practitioners	21. Mental Health Practitioners – not yet implemented but part of the Care Closer to Home workstream
Please note that the gaps listed are not WAST's and are therefore outside of the control of WAST	

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
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 Workforce & OD	30.07.23 Checkpoint	Offers to 22 in July 2023. 13.33 FTE uplift. Continue to seek opportunities for funding APPs to improve service delivery.

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	26/06/2023	TREND	25 (5x5)
		Date of Next Review:	25/07/2023		

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

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:	27/06/2023	TREND	25 (5x5)
		Date of Next Review:	27/07/2023	→	

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

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

Risk Commentary Q4 2022/23

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 due to handover of care delays. There were over **2,000** +4 hour patient handovers in **April 2023**; the target being 0 from September 2022 **has now moved to the end of 2023/24.** Currently < 0.0**14**% of the Trust's demand is going into Same Day Emergency Care currently is <0.025% (modelling 4%). 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. **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).**

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) ***by*** *revised to March 2023/24.*
c) Alternative capacity equivalent to 1,000 beds project (LHB CEOs)
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 is currently in pilot phase and an evaluation is to be undertaken in quarter 1 2023/24 by EASC. 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 monitors, reports on app use by Consultant Connect and shared at local and corporate meetings regarding patient safety and handover of care position across NHS Wales and NHS England.
4. WAST Clinical Notice in place - Escalating a clinical concern with a deteriorating patient outside the Emergency Department (11.02.2021). National Early Warning Score (NEWS) trigger of 5 or above for escalation to hospital clinicians. NEWS data available via EPCR (electronic patient care record).	4. NEWS data now available via ePCR and escalation system in place 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:	27/06/2023	TREND	25 (5x5)
		Date of Next Review:	27/07/2023		

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

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

5. Workstreams put in place to meet requirements of *Right care, right place, first time Six Goals for Urgent and Emergency Care A policy handbook 2021–2026.* Goal 4 incorporates the reduction of handover of care delays through collective system partnership. WAST membership at system workshops supported by Commissioners looking at handover of care delays which includes the implementation of the Fit2Sit programme and handover of care checklist pan NHS Wales. Learning from NWAS shared that indicates up to 20% of ambulance arrivals may be suitable for Fit 2 Sit Additionally, the Emergency Ambulance Services Committee (EASC) have stated that no delay should exceed 4 hours.	5. Monthly Integrated Quality and Performance Report
6. Hospital Ambulance Liaison Officer (HALO) (Some Health Boards).	6.
7. Regional Escalation Protocol and Resource Escalation Action Plan (REAP). Proactive and forward-looking weekly review of predicted capacity and forecast demand. Deployment of predetermined actions dependant on assessed level of pressure. Consideration of any bespoke response/actions plans in the light of what is expected in the coming week. WAST has updated the REAP in advance of winter, including revised triggers (higher) for handover lost hours.	7. The Senior Leadership Team convenes every Tuesday as the Weekly Performance Meeting to review performance and demand data, and review/assign REAP Levels as appropriate. Dynamic escalation is via the Strategic Command structure.
8. Staff from WAST, Health Boards and third sector organisations assisting to meet patient's Fundamentals of Care as best they can in the circumstances.	8. Confirmed through Healthcare Inspectorate Wales (HIW) workshops and Health & Care Standards self-assessment process.
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 (**April 2023 overall 75%** - **Safeguarding and dementia over 90%.**
13. Clinical audit programme in place.	13. Clinical audit programme in place (dynamic document) with oversight from the Clinical Quality Governance Group and QuEST.
14. Workshop set up by the Deputy Chief Ambulance Commissioner to respond to the findings in the Health Care Inspectorate Wales (HIW) Report *Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover* (undertaken 2021). WAST has senior representation at this meeting. – assurance is that HIW approve and sign off WAST elements and Health Board elements of recommendations.	14. Workshop set up by the Deputy Chief Ambulance Commissioner to respond to the findings in the Health Care Inspectorate Wales (HIW) Report Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover (undertaken 2021). WAST has senior representation at this meeting. A collective response from WAST and Health Boards is being overseen by EASC.
15. Escalation of patient safety concerns by Trust Board: featured in provider reports to the Emergency Ambulance Committee (EASC); been the subject of Accountable Officer correspondence to the NHS Wales Chief Executive; numerous escalations to professional peer groups initiated by WAST Directors; and coverage at Joint Executive Meetings with Welsh Government. Evidence submission to Senedd Health and Social Care Committee. Written evidence submitted during Q4 21/22 to the committee to assist their inquiry into Hospital Discharge and its impact on patient flow through hospitals Report published in June 2022 containing 25 recommendations with recommendation six specifically WAST related stating "The Welsh Government should explain how the targets outlined in the Minister for Health and Social Service's statement of 19 May 2022 on urgent and emergency care and the Six Goals Programme to eradicate ambulance patient handover delays of more than four hours and reduce the average ambulance time lost per arrival by 25 per cent (from the October 2021 level) have been set. It should also confirm the target dates for the achievement of these targets."	15. Monthly Integrated Quality and Performance Report, CEO Reports to Trust Board including 'Actions to Mitigate Avoidable Patient Harm Report' (last presented to Trust Board May 2023 and Board sub-committee oversight and escalation through 'Alert, Advise and Assure' reports.
16. Implementation of Duty of Quality, Duty of Candour and new Quality Standards requirements in April 2023.	16. Welsh Government Road Map in place (soft launch) with milestones for organisations – baseline assessment and monthly updates (RAG ratings) in place with Trust Board oversight. The current internal assessment

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:	27/06/2023	TREND	25 (5x5)
		Date of Next Review:	27/07/2023	→	

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

	overall as of February 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) and Joint Executive Team (JET) meeting Welsh Government (I&E).
	2. Healthcare Inspectorate Wales (HIW) 'Review of Patient Safety, Privacy, Dignity and Experience whilst waiting in Ambulances during Delayed Handover' Report and system wide improvement plan with working group in place with WAST senior representation. Oversight by HIW and 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 30 (as of 07.03.2023) overdue nationally reportable incident investigations.
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. **23,082** hours were lost in **April 2023 with 2021 +4 hour patient handovers in April 2023.**
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

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

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:	27/06/2023	TREND	25 (5x5)
		Date of Next Review:	27/07/2023		

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

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 dashboards.
3. Continued Health Board interactions – my next patient (boarding), patient safety team dialogue – proactive conversations with Health Board Directors of Quality & Nursing.	Executive Director of Quality & Nursing	• Monthly and as required.	• Monthly meetings continue to be held and networking through EDoNS.
4. Recruit and train more Advanced Paramedic Practitioners – Value Based Healthcare Fund bid for up to 50 WTE	Director of Paramedicine	• Q4 2023/24	• Bid not successful. However, Trust decision to proceed with 18 MSC places. 10 started in September (North) with the balance (eight) on target for March 2023 start. • 22 trainee APPs expected to complete training in Jun-23. • EMT has agreed to offer places to these 22 trainee APPs funded from a reduction in technician posts 1/2s i.e. internal movement. • The Trust has recently submitted a bid to increase AHPs in Primary and Community Care (WG fund) for more APPs.
5. Overnight falls service extension	Executive Director of Quality & Nursing	• June 2023	• Night Car Scheme extension agreed to 31 March 2023 (2 regional resources) • Aim to achieve 60% utilisation of Falls Assistant resources, by December 2022 and achieve consistent utilisation of 60% + through Jan-Mar 2023. Good progress has been made on this. • Falls level 1 and 2 impact evaluation report completed - presenting to Clinical Quality Governance Group (CQGG) 18 Jan-2023.
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. • Key policies updated and approved. • Participation in the All Wales Duty of Candour implementation group by Patient Safety Team – monthly. • **Quality Management System workshop to be held 12 June 2023.**
7. Virtual Ward **now Connected Support Cymru**	Executive Director of Quality & Nursing	• Q2 2023/24	• **Commencing Test of Change deployments with SJAC – two vehicles at present have been utilised, 2 to follow.** • **Arrangements – CSD selecting cases for SJAC to respond and take patient observation. To date, the small number of cases have negated any EA attendance to the scene.** • **Funding – CASC have awarded SJAC a direct commission for circa 20 weeks provision.** • **Small Business Research Initiative – has 'kicked off' phase one, with a virtual warding technology platform in development for the pre-hospital/community used (within WAST).**
8. Organisational change process of Putting Things Right Team (PTR) to enable increased capacity across all functions to manage increasing complexity and demands.	Executive Director of Quality & Nursing	• Q2 2023/24	• Informal consultation phase **commenced** May 2023.
9. Connect with All Wales Tissue Viability Network to explore strengthening the current investigations into harm from pressure damage across the whole patient pathway.	**Assistant Director Quality & Nursing**	• **Q2 2023/24**	
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.**

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:	27/06/2023	TREND	25 (5x5)
		Date of Next Review:	27/07/2023	➡	

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

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 Workforce & Organisational Development	Completed	• Strong focus from Executives with detailed updates to EMT every two weeks. • Year-end position is +85 FTEs, with a vacancy factor of just 1%, rather than the often used 5%, which would produce a figure of -88 FTEs rather than the estimated - 15 FTEs. • Further non recurrent funding has been secured for 2023/24
5. Transition Plan	Chief Executive Officer	Completed	• Action complete, but the Trust will continue to undertake strategic and technical workforce planning in support of the Trust's ambition e.g. inverting the triangle etc.
6. Consideration of additional WAST schemes to support overall risk mitigation through winter	Director of Operations	Completed	• Winter ended. Focus now on forecasting and modelling for the summer, but Trust not aiming to produce specific Summer Plan (the Trust did during the pandemic linked to travel restrictions). • The Trust needs to determine whether there is value in producing a specific winter plan, particularly, within the context of the financial constraints NHS Wales is not operating in.
7. National 111 awareness campaign	Director of Partnerships and Engagement Director of Digital	Completed	• The national awareness campaign was undertaken as planned and ended in March 2023. An evaluation will be provided to the 111 Board.

Risk ID 160	High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service	Date of Review:	13/07/2023	TREND	20 (5x4)
		Date of Next Review:	13/08/2023	➡	

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 Workforce & Organisational Development	ASSURANCE COMMITTEE	People and Culture Committee

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. Managing Attendance at Work Policy/Procedures in place	1. (a) Policy reviews to ensure policies and procedures are fit for purpose (b) Audits by People Services on sickness
2. Respect and Resolution Policy- 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- 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 pulse survey tool will provide data on overall engagement and wellbeing**
18. Stress risk assessments- identify measures that can be taken to address issues	18. **Reference to the assessments during attendance management line manager training and to the TUS**
19. Sickness statistics are reported to SLT, SOT, People & Culture Committee, Trust Board and the CASC	19. Sickness forms part of Workforce Scorecard to People & Culture Committee
20. External agency support e.g. St John Ambulance, Fire and Rescue- if needed at times of increased pressure	20. **Standard procedures in place to access additional resource capacity**
21. Monthly reviews of colleagues on Alternative duties	21. Action plans arising from meetings with colleagues implemented through monthly diarised meetings
22. Manager guidance on managing Alternative duties	22. **Evidence of managers guidance in place and referenced in attendance management training**
23. Fortnightly report on absence to EMT and report to every meeting of People & Culture Committee	23. Minuted meetings and action logs for EMT & People & Culture Committee
24. Sickness audits for localities- provides additional level of detail	24. Audits carried out and actions taken forward
25. Additional support for areas with higher than average absence – emphasis is on understanding reasons and developing action plans	25. Dedicated meetings taking place and support from people services for areas with higher than average absence with local plans in place to address specific issues

Risk ID 160	High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service	Date of Review:	13/07/2023	TREND	20 (5x4)
		Date of Next Review:	13/08/2023	➡	

IF	THEN	RESULTING IN		Likelihood	Consequence	Score
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	Inherent	4	4	16
			Current	5	4	20
			Target	3	4	12

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
	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 Workforce & OD	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 Workforce & OD	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 Workforce & OD	31.07.22 Complete	Training produced and rolled out. Now BAU
5. Roll out platform for raising concerns (in relation to Freedom to Speak Up Arrangements)	Freedom to Speak Up Arrangements Task & Finish Group Ownership moving to DWOD	Extended from 31.07.22 to 31.03.23. Extended to 31.05.23 **Extended to 31.08.23**	Exetended 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.**
6. Strengthen Freedom to Speak Up Arrangements policy and advice	Assistant Director of **Inclusion, Culture and Wellbeing**	**31.05.23** **Extended to 31/08/23**	**Deadline extended to coincide with launch of new platform, although Guardians are in place and weekly review meetings taking place. They are receiving the highly confidential Datix**

Risk ID 160	High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service	Date of Review:	13/07/2023	TREND	20 (5x4)
		Date of Next Review:	13/08/2023		

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

			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.**
7. Create a Manager and Staff training plan for Freedom to Speak Up Arrangements	Assistant Director **Inclusion, Culture and Wellbeing**	**31.05.23 extended to 30/9/23**	Ongoing – extended until 30/9/23 to enable soft launch with feedback and policy and advice to be shared. Training plan will be produced with an emphasis on making the platform and use of freedom to speak up as simple and accessible as possible. **SharePoint page constructed and comms plan being finalised following refresher demos to key stakeholders.** **Head of Culture and OD in post from August to further this work.**
8. Accountability meetings with senior ops managers	Deputy Director of Workforce & OD	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 Workforce & OD	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	Complete – group started 17.10.22 and will meet quarterly.
12. Review of top 100 cases by the team on a monthly basis	Deputy Director of Workforce and OD	Commenced and ongoing – review 30.06.23 **BAU**	Underway and **now** BAU

Risk ID 201	Damage to Trust reputation following a loss of stakeholder confidence	Date of Review:	19/06/2023	TREND	20 (4x5)
		Date of Next Review:	19/07/2023	➡	

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

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

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

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

Risk Commentary Q4 2022/23

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

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

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

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

Risk ID 201	Damage to Trust reputation following a loss of stakeholder confidence	Date of Review:	19/06/2023	TREND	20 (4x5)
		Date of Next Review:	19/07/2023	➡	

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

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

Risk ID 139	Failure to deliver our Statutory Financial Duties in accordance with Legislation	Date of Review:	20/06/2023	TREND	16 (4x4)
		Date of Next Review:	20/07/2023		

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

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

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

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

CONTROLS	**ASSURANCES**
	Internal Management (1st Line of Assurance)
1. Financial governance and reporting structures in place	1. Risk is reviewed quarterly at F&P and a report is submitted bi-monthly to Trust Board
2. Financial policies and procedures in place	2.
3. Budget management meetings	3. Diarised dates for budget management meetings
4. Regular financial reporting to ADLT, EFG, EMT, FPC and Trust Board in place	4. Diarised dates for EFG and FPC and monthly reports
5. Welsh government reporting	5.
6. Monthly review of savings targets	6. ADLT monthly review
7. Regular review monitoring and challenge via WAST and CASC quality and delivery meeting with commissioners.	7.
8. Monthly ICMB (Internal Capital Monitoring Board) meetings to monitor and review progress against capital programme and engagement with WG and capital leads.	8. Diarised dates for ICMB meetings with regular monthly report
9. PSPP monthly reporting and regular engagement with P2P colleagues and periodic Trust Wide communications	9. Regular PSPP communications (Trust wide) on Siren
10. Forecasting of revenue and capital budgets	10. (a) Monthly monitoring returns to ADLT, EFG, EMT and FPC (b) Reliance on available intelligence to inform future forecasting.
11. Business cases and benefits realisation (both revenue and capital)	11. Business cases – scrutiny and approval at senior management team which are submitted to ADLT, EMT, FPC prior to Trust Board for approval as appropriate according to value.
	External Assurances Management (1st Line of Assurance)
	5. Monthly Monitoring Returns to Welsh Government
	7. EASC management meetings. Monthly meetings with EASC and DAG for NEPTS.
	8. Bi-monthly Capital CRL meetings with Trust and WG capital leads
	9. Regular P2P meetings diarised (bi-monthly)
	10. Monthly monitoring returns into Welsh Government
	Independent Assurances (3rd Line of Assurance)
	1-10 Internal audit reviews covering
	1-10 External audit reviews
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
• Lack of formalised service contracts between Commissioner and WAST as a commissioned body	None identified.

Risk ID 139	Failure to deliver our Statutory Financial Duties in accordance with Legislation	Date of Review:	20/06/2023	TREND	16 (4x4)
		Date of Next Review:	20/07/2023		

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

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

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

Risk ID 163	Maintaining Effective & Strong Trade Union Partnerships	Date of Review:	23/06/2023	TREND	16 (4x4)
		Date of Next Review:	23/09/2023	⬆	

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

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

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

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

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

Actions to reduce risk score or address gaps in controls and assurances	**Action Owner**	**By When/Milestone**	**Progress Notes:**
1. Develop an action plan from the recommendations of the ACAS report	Deputy Director of Workforce & Organisational Development	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 Workforce & Organisational Development	Completed 12/01/23	WASPT re-established. Third meeting scheduled T&F group undertaking work on the engagement model below WASPT through SLT and SOT is in progress with TU engagement. TU cell stood down.
3. Proposed externally facilitated mediation session(s) building on the IPA workshops and specifically to address the thorny issue of what happens when we fail to agree	Deputy Director of Workforce & Organisational Development	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

Risk ID 163	Maintaining Effective & Strong Trade Union Partnerships			Date of Review:	23/06/2023	TREND	16 (4x4)
				Date of Next Review:	23/09/2023		

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

4. Minutes of formal Partnership Forum should be reported to PCC or Board in future (return to BAU).	Deputy Director of Workforce & Organisational Development	Completed 12/01/23	WASPT feeding into PCC
5. Establish formal meeting structures below WASPT	Deputy Director of Workforce and Organisational Development	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, People and Culture**	30/08/23	

Risk ID 424	Resource availability (capital) to deliver the organisation's Integrated Medium-Term Plan (IMTP)	Date of Review:	23/06/2023	TREND	16 (4x4)
		Date of Next Review:	23/09/2023	⬆	

IF resources are not forthcoming within the funding envelope available to WAST (link to risk 139)	**THEN** there is a risk that there is insufficient capacity to deliver the IMTP	**RESULTING IN** delay or non-delivery of IMTP deliverables which will adversely impact on the Trust's ability to deliver its strategic objectives and improvement in patient safety and staff wellbeing		Likelihood	Consequence	Score
			Inherent	4	4	16
			Current	4	4	16
			Target	1	4	4

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

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

CONTROLS	**ASSURANCES**
	Internal **Management (1st Line of Assurance)**
1. Prioritisation of IMTP deliverables	1. Prioritisation detailed in IMTP and reviewed and agreed at Strategic Transformation Board
2. Financial policy and procedures	2.
3. Governance and reporting structures e.g. Strategic Transformation Board (STB)	3. IMTP sets out delivery structures and meeting minutes are available
4. Assurance meetings with Welsh Government and Commissioners	4. Agendas, minutes and slide decks available
5. Transformation Support Office (TSO) which supports the major delivery programmes	5. Paper on TSO to Strategic Transformation Board
6. Project and programme management framework	6. PowerPoint pack detailing PPM
7. Regular engagement with key stakeholders	7. Stakeholder Engagement Framework
8. Financial Sustainability Programme – savings and income work streams	**8. FSP programme highlight reports**
	Independent Assurance (3rd Line of Assurance) 2. Subject to Internal Audit

GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Project and programme management (PPM) framework to be reviewed	1. PPM needs to be reviewed and approved through STB
~~2. Head of Transformation vacancy~~	2. Benefits have not been fully linked to benefits realisation
3. Lack of a commercial contractual relationship with Commissioners (link to risk 458)	

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

Risk ID 458	A confirmed commitment from EASC and/or Welsh Government is required in relation to funding of recurrent costs of commissioning services to deliver the IMTP and/or any additional services	Date of Review:	20/06/2023	TREND	16 (4x4)
		Date of Next Review:	20/07/2023	➡	

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

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

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

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. A formal approach to service change to be developed providing secure recurrent funding with commissioners.	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.
3. 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:	23/06/2023	TREND	15 (3x5)
		Date of Next Review:	23/07/2023	➡	

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

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

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

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

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1 Systematic review and assessment of Health and Safety arrangements and Governance (All NHS Wales Health & Safety Management System - HSMS).	1. Assessment criteria set for health and safety management system (HSMS) All Wales system). HSMS approved at ADLT in 2022. ADLT members sponsorship for all 11 management principles.
1. Health & Safety Governance and reporting arrangements – National Health, Safety and Welfare Committee. Reporting into People and Culture Committee. (PCC)	2. Trusts Legislative Compliance Register in place. Assessments to be reviewed in ADLT in April 2023. Monthly, Quarterly and Annual H&S performance reports to ADLT and H&S National Health, Safety and Welfare Committee. Quarterly performance reports to ADLT, EMT, PCC. Reports published on H&S webpage. H&S climate cultural survey developed to determine perception of Trust position against Bradley Curve.
2. Provision of dedicated health and safety expertise and advice to meet the requirements of the Management of Health and Safety at Work Regulations 1999, - Regulation 7 'Health and Safety Assistance'.	H&S Policy approved in 2018. Following landing of business case, Policy reviewed **and commences substantial consultation process on 30.06.23 -Q1 20232.** Violence and Aggression Policy in place. Risk Assessment Procedure, Display Screen Equipment Procedure, Workplace Premise Audits inspection Procedure in place. Control of Substances Hazardous to Health (COSHH), New and Expectant Mothers Risk Assessment Procedure approved at ADLT in **February 2023.** Lifting Operations Lifting Equipment / Provision and Use of Workplace Equipment (PUWER) combined Procedure in draft with an expectation of **commencing the approval process** approval during **Q2-Q3** 2023. Lone Worker Procedure ongoing - expectation of second draft Q2 2023. Trust wide Hazard register in place. **Reviewed by** ADLT in Q**1** 2023 and approved in Q1 2023. 3.
3. Health & Safety Policy and Corporate level Procedures.	4. H&S Policy approved in 2018. Following landing of business case, Policy review underway Q4 2022-Q1 2023. Violence and Aggression Policy, Risk Assessment Procedure, Display Screen Equipment Procedure, Workplace Premise Audits inspection Procedure in place. Control of Substances Hazardous to Health (COSHH), New and Expectant Mothers Risk Assessment Procedure approved at ADLT in February 2023. Dangerous Substances Explosive Atmospheres (DSEAR) Procedure, Lifting Operations Lifting Equipment / Provision and Use of Workplace Equipment (PUWER) combined Procedure in draft with an expectation of commencing the approval process approval during Q1 2023. Lone Worker Procedure ongoing - expectation of second draft Q1 2023. Trust wide Hazard register framework in place. Reviewed by ADLT in Q1 2023 with expectation of approval Q1 2023.
4. Mandatory Health and Safety training for all staff on ESR. Induction training in place for all new operational staff.	5. Quarterly statistics provided by ESR support team and incorporated into Health and Safety quarterly and annual Performance reports. Induction training compliance held on ESR
5. 2 year rolling programme of scheduled H&S premise audits.	6. Inspections are being undertaken in line with schedule. ~~Ongoing.~~ **Live action.**
6. Risk assessments (including local risk assessments, Covid 19, Workplace Risk Assessments, risk assessments covering EMS and NEPTs activities, operations risk assessments).	7. Workplace risk assessments are undertaken by local management teams, reviewed by H&S team and previously monitored by BCRT. These are being monitored by local operations mangers. Other operational risk assessments and SOPs are held on dedicated Share-point sections. Performance metrics in place.
7. Working Safely Strategic Programme Board (STB) to provide oversight of the Working Safely Action plan. Dynamic Delivery Action Group to continue to undertake actions on the Working Safely Action Plan.	8. Working Safely Action Plan has been agreed and this is being held to account by Strategic Transformation Board. Deliverables are being monitored through the Dynamic Delivery Group meeting. Terms of reference for Dynamic Delivery Group are approved.
8. Rolling programme of IOSH Managing Safely- for Managers- scheduled training programme in place.	9. Attendance and competency figures provided in a quarterly report to ADLT, National Health, Safety and Welfare Committee and People and Culture Committee.

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:	23/06/2023	TREND	15 (3x5)
		Date of Next Review:	23/07/2023	➡	

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

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

9. IOSH Leading Safely for Directors and Senior Managers training in place.	10. Attendance and figures provided in monthly report to ADLT. Personal safety commitments are being monitored on a quarterly basis
10. Board Development Day covering Health & Safety Management and Culture Awareness training undertaken in April 2022.	11. Diarised meeting.
11. Health and Safety Management System recognised document approval routes for health and safety documentation.	12. Approved and minuted at ADLT meeting in 2022.
12. IOSH Leading Safely training delivered to majority of Board and Executive Team on 26 July 2022.	13. Compliance metrics held on H&S team database.
13. IOSH Leading Safely additional sessions for new Board /EMT members and ADLT to be scheduled for 2023.	14.
14. Leading Safely, Safety Positive conversations training to be delivered to Board and EMT **to be rescheduled from** June 2023.	15.
15.	16. Internal Audit to be undertaken in Q1 23/24 (controls 1– 10) **(External Independent Assurance (3rd Line of Assurance)**
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1.	**1.** Baseline audit for HSMS not to be commenced till Q1-Q2 2023 (***being addressed in Action 1)***
2. Subgroups of National H&S and Welfare Committee currently under review. **(being addressed in Action 2)**	2. H&S Climate Cultural survey to be rolled out once political pressures (IA) reduce**.** Expectation of roll out Q1-Q2 2023/24 (***being addressed in Action 3)***
3.	3.
4. The Health and Safety Policy and some procedures are due to be reviewed by the end of Q4 2022 in Q1 2022 (***being addressed in Action 4***)	4. (a) Review of H&S Policy ~~is due by the end of Q1 2023~~ **has been undertaken. Policy to commence consultation process 30.06.23**. (***being addressed in Action 4)*** (b) Workforce Transformational change has influenced some content within H&S policy (***being addressed in Action 4)***
5. Poor uptake in statutory and mandatory H&S training ***(being addressed as part of Actions 5)***	5.
6.	6. Two-year Schedule for H&S inspections and visits commenced September 2022. Compliance metrics, themes and trends are to be included within Monthly and Quarterly and Annual Performance Reports. ***(being addressed as part of Actions 6)***
7.	7. (a) Current copies of risk assessments and SOPs are not available at all stations. ***(being addressed as part of Actions 7)*** (b) Lack of clarification over many SOPs are required until HSMS baseline audit has been completed. ***(being addressed as part of Actions 7)***
8. Operational pressures and Industrial Action on service impacting on Working Safely Programme delivery **(being addressed in Action 8)**	8.
9. Staff availability to attend training ***(being addressed in Action 5)***	9. Work ongoing to determine how many Managers require IOSH Manging Safely. ***(being addressed in Action 9).*** A H&S Training needs analysis has been developed and incorporated into the H&S Policy.
10. Effective learning from events to be documented ***(being addressed in Action 8)***	10. Currently there is no structured monitoring process in place to ensure attendance on the IOSH Leading Safely course. ***(being addressed in Action 5)***
11.	11.
12.	12.
13.	13.
14.	14.
15.	15.
16.	16.

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:	23/06/2023	TREND	15 (3x5)
		Date of Next Review:	23/07/2023		

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

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

17.

17.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Meetings to be scheduled to undertake baseline assessment and feedback to EMT.	Head of Health and Safety	~~Q1-Q2 2023~~ **Q2-Q3 2023**	
2. Meetings to be held with TU partners and AD/Head of H&S to agree arrangements for sub-groups.	Head of Health and Safety	Q1 2023	ToR Developed and presented at National HSW Committee in Q2 2022. Further discussions requested a Charter arrangement. Draft Charter developed and presented in National HSW committee in Q3 2022. Further discussions requested by TU partners. Following discussions held with OD in April 2023 to provide consideration of integrating subgroups into WASTP, **23.06.23- H&S to be incorporated into WASTP sub-groups LPF.**
3. Assessment to be undertaken in Q1 2023 of political pressure to determine viability of conducting culture survey	Head of Health and Safety	~~Q1-Q2 2023~~ **Q2-Q3 2023**	**Political pressures still present. Survey to be rolled out once eased. Watching brief.**
4. H&S Policy Group meeting to be established and draft policy to be created	Head of Health and Safety	Q1 2023	Initial meeting held in December 2022 first draft to be presented at Policy Group Meeting in January 2023 for comments from key stakeholders. Challenges with attendance due to IA. Expectation of draft Policy being presented at Policy Group to propose full consultation in May 2023. **Policy presented at Policy Group in June 23 and commences substantial consultation process on 30.06.23.**
5. IT solution being investigated to collate data from inspections to enable trending and monitoring of actions generated	Deputy Head of Health and Safety	Q4 2023	The audit proforma has been migrated onto MS Forms to allow for improved data collection. Meeting held with I.T. provider in Q4 2022 provide consideration for the development of utilisation of Power B.I systems. **Ongoing.**
6. H&S advisors will liaise with local management teams to identify risk assessments and SOP's in place and ensure visibility on SharePoint	Deputy Head of Health and safety	Q2-Q3 2023	Ongoing action. Assessment against the HSMS Principle 3- Compliance Assurance will assist in determining what RA/SOPS are required.
7. Priority Elements of Working Safely Action Plan to be identified and programme schedule presented to STB to ensure sufficient support from Operational Teams. Migrate into Annual Health and Safety Improvement Plan.	Head of Health and Safety	Q2 2023	Priority actions for 2023-24 identified as Culture, Manual Handling, Violence and Aggression, Incident investigation training. 05.04.23 Development of Health and Safety Improvement Plan underway.
8. Review of number of line managers within the Trust to put in place a suitable schedule to roll out appropriate H&S training as determined within the training needs analysis within the H&S Policy.	Deputy Head of Health and Safety	Q2 2023	Interim schedule in place to address known line managers. **Further work required with other Directorates to allow for performance metrics to be generated.**
Completed Actions	**Action Owner**	**When /Milestone**	**Progress Notes:**
1. Delivery of the Working Safely Action Plan (WSAP) (Priority top 25)	Head of Health & Safety	31.09.22 Partially completed. Long term action.	Pump and Prime phase commenced 01.09.21. Closure report for PPP presented to EMT during Q3 2022/23. Working Safely Programme to continue being monitored by STB. Four priorities determined for 2023/24- Violence & Aggression, Culture, Manual Handling and Incident Investigation.
2. IOSH Leading Safely training to be delivered to Exec Team and Board (forms part of WSAP)	Head of Health & Safety	31.12.22 Partially completed.	Training delivered to Board and Executive team on 26.07.22. IA and operational pressures impacted on availability to attend during Q4 2022.Further sessions to be scheduled for Q1 2023/4- Q2 2023/24 for new members.
3. WAST Leading Safely Behavioural Audit training to Exec Team and Board (forms part of WSAP)	Head of Health & Safety	31.12.22 Scheduled	Initially scheduled for BDD - February 2023. Rescheduled to June 2023.
4. H&S team workforce review (accompanying Business Case forms part of this) (this forms part of WSAP)	Head of Health & Safety	31.03.22 Completed	Completed- Workforce review fully implemented 03.10.22
5. Culture survey to all members of staff (forms part of WSAP)	Head of Health & Safety	30.09.22 Partially completed	Survey developed and to be presented at National H&S Committee on 02.11.22 and SOT in December for feedback. Decision made during Q3 2022/23 to postpone survey unit political pressures ease. Expectation of roll out Q4 2023-Q1 2023/24. Political unease impacted on the roll out of the survey roll out. Expectation that survey will be rolled out during Q1-Q2 2023/4

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:	23/06/2023	TREND	15 (3x5)
		Date of Next Review:	23/07/2023	➡	

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

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

6. A compliance register that describes the requirements of the various Health & Safety legislation that the Trust needs to comply with (part of WSAP)	Deputy Head of H&S	30.06.22 Completed	Compliance Register framework developed Q2 2022.
7. An initial assessment will provide assurance on how we are complying with the legislation.	Deputy Head of H&S	Partially completed. Assurance - 01.06.22 Rolling programme of assessments – 31.12.22	Assessments undertaken. Some outstanding estates assessments scheduled January 2023. Compliance register presented to ADLT members on 04.04.23 for feedback/agreement of assessments undertaken.
8. Quarterly report on training compliance to be presented to ADLT for actioning within respective Directorates	Head of Health and Safety	Q3 2022 - Complete	Report is a standard section of Quarterly H&S Performance report to ADLT

Risk ID 260	Significant and Sustained Cyber Attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems	Date of Review:	25/06/2023	TREND	15 (3x5)
		Date of Next Review:	25/07/2023		

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

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

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

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:	25/06/2023	TREND	15 (3x5)
		Date of Next Review:	25/07/2023		

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

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

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

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

Risk ID 543	Major disruptive incident resulting in a loss of critical IT systems	Date of Review:	25/06/2023	TREND	15 (3x5)
		Date of Next Review:	25/07/2023		

IF there is an unexpected or uncontrolled event e.g. flood, fire, security incident, power failure, network failure in WAST, NHS Wales or interdependent systems	THEN there is a risk of a loss of critical IT systems	RESULTING IN a partial or total interruption in WAST's ability to deliver essential services, loss or theft of personal/patient data and patient harm or loss of life		Likelihood	Consequence	Score
			Inherent	4	5	20
			Current	3	5	15
			Target	2	5	10

IMTP Deliverable Numbers: TBC

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

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

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

Risk ID 558	**Deterioration of staff health and wellbeing in the face of continued system pressures as a consequence of workplace experiences**	**Date of Review:**	**23/06/2023**	**TREND**	**15 (3x5)**
		Date of Next Review:	**23/07/2023**		

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

IMTP Deliverable Numbers: TBC

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

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.
	External - Independent Assurance - Audit Wales – Taking Care of the Carers report in October 2021

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

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

Risk ID 558	**Deterioration of staff health and wellbeing in the face of continued system pressures as a consequence of workplace experiences**	**Date of Review:**	**23/06/2023**	**TREND**	**15 (3x5)**
		Date of Next Review:	**23/07/2023**		

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

1. Restart the Health and Wellbeing Steering Group (link to risk 160)	Assistant Director Inclusion, Culture and Wellbeing	Completed	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.
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 WOD	30.06.23	Software has been procured. Planning for rollout ~~has started~~ **is underway. First survey delivery in July 2023.**

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

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

IMTP Deliverable Numbers: TBC

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

CONTROLS	**ASSURANCES**
	Internal **Management (1st Line of Assurance)**
1. Immediate release protocol	1. The Immediate Release Protocol is a Nationally agreed NHS Wales protocol. Refusals by Health Boards are Datixed by WAST and compliance report provided weekly to the DG for Health & Social Services.
2. Resource Escalation Action Plan (REAP)	2. The Senior Leadership Team convenes every Tuesday as the Weekly Performance Meeting to review performance and demand data, and review/assign REAP Levels as appropriate. Dynamic escalation via Strategic Command structure.
3. Regional Escalation Protocol	3. Daily conference calls to agree RES levels in conjunction with Health Boards
4. Incident Response Plan	4. The Incident Response Plan has been ratified via EMT
5. Mutual Aid arrangement with NARU	5. AACE National Policy on mutual aid in place
6. Clinical Safety Plan	6. CSP adopted by EMT and operational; reviewed annually by SLT
7. Operational Delivery Unit 24/7 cover	7. Shift reports from ODU & ODU Dashboard received by Exec, SOT and On-Call Team at start/end of shift
8. In hours and Out of hours command cover	8. Civil Contingency requirement as set out in the Command Policy and Incident Response Plan
9. Notification and Escalation Procedure	9. Published procedure in operation, reviewed 3 yearly by SLT
10. Continued escalation of risk to partners and stakeholders	10. Referenced by the Executive Director of Operations in correspondence sent to health board Chief Operating Officers dated 30 March 2023. It was further emphasises at the face to face COO Peer Group meeting on 14 April 2023.
	External Independent Assurance N/A
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
Despite the controls listed, the single most limiting factor in providing a pre-determined response in line with the Incident Response Plan is the lost capacity due to hospital handover delays. In this area, WAST has no control. – link to CRR 223 on CRR.	The Trust is not assured that Hospital sites have plans in place that are trained and tested to release ambulances effectively and immediately in the event of an incident declaration.
	Following two incidents (Pembroke Dock Ferry fire on 11th February 2023 and the Swansea gas explosion on 13 March 2023), The Trust is not assured by the effectiveness of assurances given by Health Boards (responses provided following correspondence from WAST CEO – formal returns received from LHBs except BCU). Despite these two incidents being lower level incident declarations where the pre-determined attendance was met, the experience does not add confidence to the ability to release all resources from hospitals which would support assurance.

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

Risk ID 100	Failure to persuade EASC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience	Date of Review:	05/05/2023	TREND	12 (3x4)
		Date of Next Review:	03/08/2023		

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

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

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

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

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

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Agree and influence EASC/Health Boards that sufficient funding to be provided to WAST	CEO WAST	02/08/23 Checkpoint Date	30.09.22 Additional £3m provided for +100 FTEs into Response by 23/01/23. 12/01/23 Recurrent funding for the +100 not secure. 02.05.23 Recurrent funding still not secure.
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.
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.
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 ofNCCU to undertake.
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.

Risk ID 283	Failure to implement the EMS Operational Transformation Programme	Date of Review:	02/05/2023	TREND	12 (3x4)
		Date of Next Review:	03/08/2023	→	

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

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

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

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

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

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

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

Risk ID 283	Failure to implement the EMS Operational Transformation Programme			Date of Review:	02/05/2023	TREND	12 (3x4)
				Date of Next Review:	03/08/2023		

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

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. 02.025.23 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.
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.

IMTP Deliverable Key

No.	IMTP Deliverable
1	We will recover our systems of working and implement new ways of working developed during the pandemic as we learn to live with COVID-19
2	We will engage with a range of stakeholders, developing genuine Pan-Wales representation on partnership structures and delivering strong political and media relationships across the spectrum
3	We will develop and deliver a collaborative programme of work to design and implement new models within EMS (Inverting the Triangles)
4	We will work with partners to promote and expand use of 111 across Wales
5	We will increase the capacity and capability of the clinical teams for 111 and 999 callers, increasing clinical information available to them and we will create one integrated national team
6	We will work with partners to increase the number of seamless 24/7 pathways from the 111 clinical team to appropriate face to face consultations
7	We will take steps to continuously improve the safety and quality of the service and provide an improved patient experience
8	We will increase accessibility, content and user experience of the 111 Digital front end, which can offer increasingly personalised advice
9	We will increase and balance response capacity and capability across urban and rural area of Wales
10	We will increase skill levels and resources (information, equipment and technology) available to clinicians on scene to allow them to most effectively assess and treat patients
11	We will work with partners to increase number of seamless 24/7 referral pathways as alternatives to ED conveyance and improve hospital handover
12	We will take steps to continuously improve the safety and quality of the service and provide an improved patient experience
13	We will develop and deliver an improvement plan for NEPTS and increase capacity where required to meet demand
14	We will develop and implement with partners an-All Wales transfer and discharge service
15	We will continue to deliver against our Transport Solutions Programme to embed as a business-as-usual approach to service delivery
16	We will take steps to continuously improve the safety and quality of the service and provide an improved patient experience
17	We will improve resource availability, tackling absence and recruitment challenges to deliver improved performance
18	We will effectively manage risk, governance and compliance to promote and protect colleague and patient safety, and ensure a safe, productive and fair work environment
19	We will purposefully shape our future People and Culture Strategy to equip our people to thrive in a changing environment
20	We will foster a culture of belonging and wellbeing where our people can engage, feel supported and represented
21	We will improve access to, and availability of services via the 111 Wales website and other digital channels (NHS Wales app)
22	Improved signposting to the most appropriate service
23	Improved digital tools and services to empower our teams to do their best
24	We will use modern technology to reduce repeat tasks and improve processes
25	Standardised information architecture and common approach to data and analytics across the organisation
26	We will deliver greater insights to WAST and NHS Wales, through improved data sharing, analytics and visualisation
27	Improved resilience, flexibility and interoperability for the 999-call platform
28	We will provide an improved financial plan to support our ambitions
29	Finalise our organisational position on achieving University Trust Status (UTS) in collaboration with WG, embracing a culture of learning, research and innovation
30	We will deliver the Estates Strategic Outline Plan
31	We will implement the Environmental and Sustainability Strategy
32	Deliver the Fleet SOP
33	We will secure and implement Quality Management and control systems
No.	**IMTP Deliverable**
34	We will transform the way we work and engage with people
35	We will revisit and implement the Public Health Plan
36	We will implement the Clinical Strategy to support developments across our service ambitions
37	We will deliver a values-based approach
38	We will deliver strong risk management processes and embed a Trust-wide risk culture that embeds the principles of good governance

Welsh Ambulance Services NHS Trust

Guidance on Interpreting the Board Assurance Framework

Version 1.1 April 2023

Board Assurance Framework

The Board Assurance Framework (BAF) provides assurance to the Board on the Trust's delivery of its strategic aims, outlined in its 3 Year Integrated Medium Term Plan (IMTP) and through its risk management framework.

An element of the Trust's Risk Transformation Programme was to develop a transitional BAF that focussed the Board on the key risks that might compromise the achievement of those strategic aims.

The BAF currently draws its principal risks from the Corporate Risk Register and maps them to the Integrated Medium-Term Plan deliverables and therefore, by extension, are the Trust's strategic risks.

As the Trust's risk maturity advances the current BAF template will be used to capture risks to the strategic objectives and will be cross-referenced to the principal corporate risks.

The BAF aligns principal risks, drawn from the Corporate Risk Register, the key controls, and the assurances on those controls. Gaps are identified where key controls and assurances are insufficient to mitigate the risk and subsequent actions are identified. The Board should monitor these actions as intended to close the gaps and mitigate the risks.

COMPONENTS OF THE BAF

Elements for the Board to consider when scrutinising the BAF:

1. REVIEW DATE

Risks scored high (15-25) are reviewed monthly, medium risks (8-12) are reviewed quarterly, and low risks (1-6) are reviewed every 6 months.

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

The Board should consider whether the risk has been reviewed on time and in accordance with the governance routes agreed by the Audit Committee.

2. RISK ARTICULATION

An *If, Then, Resulting In* approach is used to provide a more detailed description of the risk. The Board should consider whether the cause and effect of the risk clear.

3. SCORING

The risk score uses the likelihood x consequence mechanism. A guide on how likelihood and consequence scores are arrived at to gauge if the score is appropriate is included in the tables in annex 1.

4. CONTROLS

A control is a measure that is already in place to mitigate a risk. Controls may change or be added to through regular updates. The Board will need to assure itself that these controls are effective to manage the principal risks.

5. ASSURANCE

Assurance provides confidence, evidence, and certainty that controls are effective. The Board should look at the control and the assurance related to that specific control to judge its effectiveness in managing the risk. As the BAF matures future iterations could include an assurance rating to support the assessment of effectiveness of controls.

6. GAPS

A gap in control or assurance occurs when either of these elements do not exist or that they do not effectively mitigate the risk. It may be that the control is not operating effectively to mitigate the risk. The Board should consider whether gaps are comprehensive with what is known in the current environment and whether the BAF supports the identification of the gaps or weaknesses in controls.

7. ACTIONS

An action is something which is intended to be done and which will limit the impact of a risk in the future. It may reduce the likelihood of the risk occurring at all. Once complete an action may become a new control. The Board should consider whether there is an associated action for each gap; are those actions on track according to their dates; and will these actions support the reduction of the risk when completed and become controls.

RISK SCORING MATRIX

Annex 1

Consequence:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
Safety & Well-being - Patients/ Staff/Public	Minimal injury requiring no/minimal intervention or treatment. No time off work. Physical injury to self/others that requires no treatment or first aid. Minimum psychological impact requiring no support. Low vulnerability to abuse or exploitation - needs no intervention. Category 1 pressure ulcer.	Minor injury or illness, requiring minor intervention. Requires time off work for >3 days Increased hospital stay 1-3 days. Slight physical injury to self/others that may require first aid. Emotional distress requiring minimal intervention. Increased vulnerability to abuse or exploitation, low level intervention. Category 2 pressure ulcer.	Moderate injury/professional intervention Requires time off work 4-14 days. Increased hospital stay 4-15 days. RIDDOR/Agency reportable incident. Impacts on a small number of patients. Physical injury to self/others requiring medical treatment. Psychological distress requiring formal intervention by MH professionals. Vulnerability to abuse or exploitation requiring increased intervention. Category 3 pressure ulcer.	Major injury leading to long-term disability. Requires time off work >14 days. Increased hospital stay >15 days. RIDDOR Reportable. Regulation 4 Specified Injuries to Workers. Patient mismanagement, long-term effects. Significant physical harm to self or others. Significant psychological distress needing specialist intervention. Vulnerability to abuse or exploitation requiring high levels of intervention. Category 4 pressure ulcer.	Incident leading to death. RIDDOR Reportable. Multiple permanent injuries or irreversible health effects. An event which impacts on a large number of patients.
Quality/ Complaints/ Assurance/ Patient Outcomes	Peripheral element of treatment or service suboptimal. Informal complaint/inquiry.	Overall treatment/service suboptimal. Formal complaint (Stage 1). Local resolution. Single failure of internal standards. Minor implications for patient safety. Reduced performance.	Treatment/service has significantly reduced effectiveness. Formal complaint (Stage 2). Escalation. Local resolution (poss. independent review). Repeated failure of internal standards. Major patient safety implications.	Non-compliance with national standards with significant risk to patients. Multiple complaints/independent review. Low achievement of performance/delivery requirements. Critical report.	Totally unacceptable level or quality of treatment/service. Gross failure of patient safety. Inquest/ombudsman/inquiry. Gross failure to meet national standards/requirements.
Workforce/ Organisational Development/ Staffing/ Competence	Short-term low staffing level that temporarily reduces service quality (< 1 day).	Low staffing level that reduces the service quality.	Late delivery of key objective/service due to lack of staff. Unsafe staffing level (>1 day)/competence. Low staff morale. Poor staff attendance for mandatory/key professional training.	Uncertain delivery of key objective/ service due to lack/loss of staff. Unsafe staffing level (>5 days)/competence. Very low staff morale. Significant numbers of staff not attending mandatory/key professional training.	Non-delivery of key objective/service due to loss of several key staff. Ongoing unsafe staffing levels or competence/skill mix. No staff attending mandatory/professional training.
Statutory Duty, Regulation, Mandatory Requirements	No or minimal impact or breach of guidance/statutory duty.	Breach of statutory legislation. Reduced performance levels if unresolved.	Single breach in statutory duty. Challenging external recommendations/improvement notice.	Enforcement action. Multiple breaches in statutory duty. Improvement notices. Low achievement of performance/ delivery requirements. Critical report.	Multiple breaches in statutory duty. Zero performance rating. Prosecution. Severely critical report. Total system change needed.
Adverse Publicity or Reputation	Rumours. Low level negative social media. Potential for public concern.	ocal media coverage - short-term reduction in public confidence/trust. hort-term negative social media. Public expectations not met.	Local media coverage - long-term reduction in public confidence & trust. Prolonged negative social media. Reported in local media.	National media coverage <3 days, service well below reasonable public expectation. Prolonged negative social media, reported in national media, long-term reduction in public confidence & trust. Increased scrutiny: inspectorates, regulatory bodies and WG.	National/social media coverage >3 days, service well below reasonable public expectation. Extensive, prolonged social media. MP/MS questions in House/Senedd. Total loss of public confidence/trust. Escalation of scrutiny status by WG.

Consequence:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
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

AGENDA ITEM No	**9**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**2**

AUDIT REPORT

MEETING	Audit Committee
DATE	25 July 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 audit recommendation tracker is in place for the purpose of tracking progress across the Trust to ensure that recommendations contained in internal and external audit review reports are actioned in a timely manner.

2. There are 143 internal audit recommendations on the tracker. 52 are overdue from their agreed completion dates and revised completion dates have been assigned aligned to progress updates and plans to address the recommendations.

3. There are several significantly overdue recommendations from 2019/20 and 2020/21 and advice has been sought from the Head of Internal Audit regarding these historic recommendations resulting in a number of them being closed. They are marked as complete with the last column providing the reasons for doing so particularly where further reviews are due to take place and where actions have been subsumed into detailed work plans or superseded.

4. Specifically, advice has been sought from Internal Audit to close recommendation 245 in relation to risk appetite statements. This recommendation is superseded by an updated recommendation included in the 2022/23 Risk Management review which is before this Committee meeting. This was agreed by Internal Audit as an appropriate way forward given the development of risk appetite statements is also included in the risk management transformation programme and monitored by the Strategic Transformation Board.

5. Recommendations 320a and 320b that relate to Information Security review have now been closed from the tracker with Internal Audit's agreement given the ICT Asset Management Policy is navigating the Trust's approval processes and that the RFID solution pilot is in place and forms part of ongoing work

programme. Additionally, a further audit review has been undertaken on IM&T Infrastructure and the report contains recommendations within it that relate to a similar theme.

6. Recommendation 385 relating to 111 Service Governance Arrangements has now been closed with Internal Audit's agreement as it forms part of the ongoing SALUS programme which was approved; however, it should be noted that this is on the assumption that baseline performance data for the 111 service has now been captured in order to help determine whether the expected benefits are being realised, and that this will be monitored via the Salus Programme. A further advisory review is in the audit programme on the 111 service which may or may not touch on this specific area – the details of the scope are yet to be defined.

7. Recommendations 382 and Rec 383 relating to CCC Performance Management review and CCC coaching and the training of 111 staff are proposed for closure from the tracker given the passage of time and the organisation has moved on. Advice will be sought from Internal Audit on closure of these recommendations.

8. Several recommendations relating to the Information Management Hear and Treat review have not had a recent update review. A meeting has been arranged with Internal Audit and the Medical & Clinical Directorate team to consider these more closely and to discuss the possibility of closing several of these given that the organisation has moved on and there are priority and capacity issues. There is a potential to reframe others to bring them up to 2023; however, the Trust needs to be realistic about whether these recommendations add value at this time given current work programmes already in place.

9. Recommendation 504 relating to the Waste Management review will be transferred to the Head of Workforce Development and Education and into the People and Culture directorate for reporting and monitoring.

10. Further consideration will be given to the longest overdue recommendations with a view to mapping some of these against future audit plans and the possibility of closing any that would be subject to a further or similar review. This approach will be considered more widely in partnership with Internal Audit and Audit Wales ahead of the Audit Committee in September 2023.

11. The Audit Tracker will be revised during the next quarter, and a recommendation made at the September 2023 Audit Committee meeting which will include a revised process for tracking recommendations and a new tracking format.

12. For information, Internal Audit have produced a Gantt chart in relation to the 2023/24 Internal Audit plan and reviews that illustrates the work that will be completed over a period of time and the time planned to complete the work. This

is included as Appendix 2. An overarching timeline is being developed that enables the Trust to plan for when audits are complete and time for management and Director to review, prepare management responses and circulate the reports through governance processes for sign off.

13. **The Committee is asked to note the update and:**
    a) **Consider the audit activity since the last Audit Committee.**
    b) **Consider the proposals to address each recommendation particularly arrangements for the closure of historic recommendations.**

KEY ISSUES/IMPLICATIONS
As set out above.
REPORT APPROVAL ROUTE
Audit Tracker reviewed by: ADLT – 30th June 2023 EMT – 6th July 2023

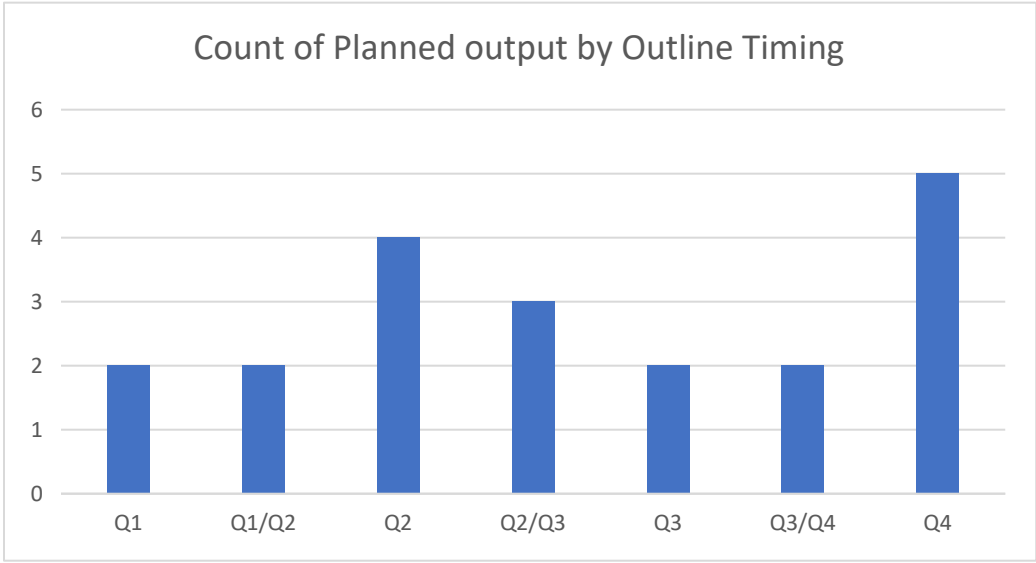
REPORT APPENDICIES
Appendix 1 – Audit Tracker (Circulated separately) Appendix 2 – Internal Audit Gantt chart – 2023/24 audit reviews

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

Planned output	Executive Lead	Outline Timing	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Senior Paramedic Role	Director of Paramedicine	Q1												
Records management	Interim Director of Digital	Q1												
Decarbonisation	Director of Finance and Corporate Services / Executive Team	Q1/Q2												
Serious Adverse Incidents Joint Investigation Framework	Director of Quality and Nursing	Q1/Q2												
111 service commissioning arrangements (advisory)	Director of Planning and Performance	Q2												
Seatbelt action plan	Director of Operations	Q2												
Technical resilience	Interim Director of Digital	Q2												
Estates Assurance: Estate	Director of Finance and	Q2												
Strategy Development	Director of Planning and Performance	Q2/Q3												
Retention of staff	Director of Workforce & OD	Q2/Q3												
Disciplinary case management - Compassionate leadership	Director of Workforce & OD	Q2/Q3												
Clinical Handover	Director of Paramedicine / Director of Quality and Nursing / Director of Operations	Q3												
ICT contract management	Interim Director of Digital	Q3												
Delivery of Major Change Programmes	Director of Planning & Performance & Director of Finance and Corporate Resources	Q3/Q4												
Integrated Quality Performance and Management Framework	Director of Planning and Performance / Director of Quality & Nursing	Q3/Q4												
Risk Management & Assurance	Board Secretary	Q4												
Clinical Audit	Director of Paramedicine	Q4												
Volunteers Governance	Director of Operations / Board Secretary	Q4												
Capital Assurance: Vehicle Replacement Programme	Director of Finance and Corporate Services	Q4												
Follow Up Action Tracker	Board Secretary / Executive Team	Q4												

Executive Lead	Audit ref as per plan	Planned output	Outline Timing	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Board Secretary	1	Risk Management & Assurance	Q4												
	11	Volunteers Governance (in conjunction with Director of Operations)	Q4												
	20	Follow Up Action Tracker	Q4												
Director of Finance and Corporate Services	2	Decarbonisation	Q1/Q2												
	3	Delivery of Major Change Programmes (in conjunction with Director of Planning & Performance)	Q3/Q4												
	18	Estates Assurance: Estate Condition	Q2												
	19	Capital Assurance: Vehicle Replacement Programme	Q4												
Director of Operations	8	Clinical Handover (in conjunction with Director of Paramedicine / Director of Quality & Nursing)	Q3												
	11	Volunteers Governance (in conjunction with Board Secretary)	Q4												
	12	Seatbelt action plan	Q2												
Director of Paramedicine	8	Clinical Handover (in conjunction with Director of Operations and Director of Quality & Nursing)	Q3												
	9	Senior Paramedic Role	Q1												
	10	Clinical Audit	Q4												
Director of Planning and Performance	3	Delivery of Major Change Programmes (in conjunction with Director of Finance & Corporate Services)	Q3/Q4												
	4	111 service commissioning arrangements (advisory)	Q2												
	5	Integrated Quality Performance and Management Framework (in conjunction with Director of Quality & Nursing)	Q3/Q4												
	6	Strategy Development	Q2/Q3												
Director of Quality and Nursing	5	Integrated Quality Performance and Management Framework (in conjunction with Director of Planning & Performance)	Q3/Q4												
	7	Serious Adverse Incidents Joint Investigation Framework	Q1/Q2												
	8	Clinical Handover (in conjunction with Director of Paramedicine and Director of Operations	Q3												
Interim Director of Digital	13	Records management	Q1												
	14	Technical resilience	Q2												
	15	ICT contract management	Q3												
Director of Workforce & OD	16	Retention of staff	Q2/Q3												
	17	Disciplinary case management - Compassionate leadership	Q2/Q3												

Outline Timing	Count of Planned output
Q1	2
Q1/Q2	2
Q2	4
Q2/Q3	3
Q3	2
Q3/Q4	2
Q4	5



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

TRUST POLICY REPORT

MEETING	Audit Committee
DATE	25 July 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.

2. 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 means that most policies have now past their review date; however, it is important to note that these remain our extant policies, they are in use and have not expired. The majority of policies will only require minor changes during the review process as they have already been through robust governance.

3. 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; Members 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.

4. It is, of course, good practice to review, improve and update our policies in a timely manner and a policy prioritisation exercise is underway to fully assess the Trust's position and outline a priority programme of work to bring the organisation's key policies up to date during 2023/24 and schedule a further work plan over 2024-2026.

5. By way of additional assurance, the Trust's internal controls and policies are tested by the Audit Wales Structured Assessment and through the Internal Audit annual audit plan, both of which are aligned to areas of identified risk within the Trust. Additionally, there is a robust programme of risk management in place that will identify any specific areas that need to be addressed outside of the standard process for the review of policies.

6. The Corporate Governance Team hold a policy risk on the Directorate Register which will be reassessed given the that the Trust has several policies that are past their review date. This risk is partially mitigated given that these are the Trust's extant policies and will be further mitigated as any required amendments are made, and these are brought through the policy governance process.

7. The Trust's policy governance process is being refreshed in partnership with Trade Union colleagues and includes the review of the Policy on Policies and the process for other documents such as Standard Operating Procedures. It is expected that proposals will be submitted to the Executive Management Team (EMT) for endorsement in late August 2023 and a report submitted to Audit Committee and Trust Board in December 2023 for approval.

8. The EMT agreed proposals to consider extending the current review dates for several non-critical policies that have already been through a robust review process and this will be included in the report for Audit Committee and Trust Board in December 2023 which will also include an overview of the process in selecting these non-critical policies for extension and the 3 year policy work plan for approval.

RECOMMENDATION:

9. **Members are asked to:**
   - **a) Consider the contents of the report and the programme of work in development to mitigate risk and bring policies in line with appropriate review dates.**
   - **b) Provide a view on any of the policies within Committee's remit that should be included on the priority work plan.**

KEY ISSUES/IMPLICATIONS
10. The key issues are set out in the Executive Summary above.
REPORT APPROVAL ROUTE
11. The report and associated policy tracker were considered by: • Policy Group – 20th June 2023 • ADLT – 26th June 2023 • EMT – 28th June 2023

REPORT ANNEXES
SBAR Report 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)	NA
Health Improvement	NA	Socio Economic Duty	NA
Health and Safety	NA	TU Partner Consultation	NA

SITUATION

1. This paper provides an update to the Committee on the status of Trust Policies as of 20th June 2023 along with proposals to bring them up to date.

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 has maintained a policy tracker contained at Annex 1. 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. The tracker describes the status of all policies and lists those which have been identified as a priority for review to date by working with Directors and their teams as well as reviewing Committee Terms of Reference and cycles of business.

7. In terms of a breakdown of the numbers; the Trust holds 93 polices and, for the reasons set out in this paper, only 13 of those are within their review date – this equates to 14% overall.

8. Additionally, there are 19 all Wales NHS Policies that the Trust has adopted from the NHS Employers Unit and only 1 of these is within its review date - equating to 5%. These figures and policy reviews are out of the Trust's control as the programme of policy review work sits with NHS Wales. The Trust has received a review schedule from the NHS

Employers Unit and whilst 5 policies are under review, all NHS Wales employment policies remain extant.

9. There are 13 new policies which have been identified for development along with 2 new policies expected from the NHS Employers Unit. This brings the total number of policies on the policy tracker to 127.

10. There were 49 policies that became due for review during the pandemic; however, there are a number that fell due just before and just after this which will naturally have been postponed given the response to the pandemic.

11. The policy prioritisation exercise which is underway will fully assess the Trust's position and outline a priority work plan to review the organisation's key policies during 2023/24 and schedule a further work plan over 2024-2026.

Policy Work Plan

12. Colleagues have reviewed their directorate lists within the tracker to support the development of a priority schedule and workplan for 2023/24. The Corporate Governance Team will continue to work across the Trust to develop a 3 year work plan to ensure the necessary work is undertaken to enable the Trust to maintain a suite of up to date policies.

13. There is an additional piece of work to be done to review policies in terms of their status and whether these are better suited as Standard Operating Procedures rather than Policy. This will be drawn out in the revised policy governance process.

14. Key Policies identified for priority review in 2023/24 so far are described below; however, this is not a definitive list and others will be included as the work programme is fully established by the Policy Group in August 2023. The list consists of those policies that sit under the Audit Committee's remit as well as specific policies that sit within Safeguarding and Health & Safety for example. The EMT reviewed this draft list at its meeting on 28th June 2023.

    1. Assessment, Failure Referral and Appeals Policy
    2. CCTV Policy
    3. Children in Special Circumstances Policy
    4. Counter Fraud, Corruption and Bribery Policy
    5. Data Protection Policy
    6. Driving at Work Policy
    7. Education Programme Policy
    8. Environmental, Estates and Facilities Policy
    9. Equality Policy

10. Fire Safety Policy
11. Flexible Working Policy
12. Health and Safety Policy
13. Home Working Policy
14. HR Starting Policy
15. Information Governance Policy
16. NHS Wales Raising Concerns Policy
17. Occupational Health Policy
18. People Development Policy
19. Policy for the Development and Review of Policies
20. Recruitment and Selection Policy
21. Relocation Expenses Policy
22. Risk Management Policy (new)
23. Safeguarding Children and Adults Policy
24. Staff Immunisation Policy
25. Violence and Aggression Policy

15. It is worthy of note that several policies are already at various stages of the review and development process, as described in the list below, and have been included on the Policy Group Agenda in recent months.

    1. Information Security Policy
    2. Waste Management Policy (New)
    3. Management of High Intensity Service Users (Previous Frequent Caller)
    4. Medicines Management Policy
    5. Infection Prevention and Control Policy
    6. Premises and Vehicle Cleaning Policy
    7. NHS Pay Progression Policy
    8. NHS Wales Lease Car/Pool Car Policy
    9. NHS Wales Executive National Policy on Patient Safety Incident Reporting and Management
    10. Clinical Supervision Policy (New)
    11. Management of Medical Devices Policy
    12. Standards of Business Conduct Policy

16. The EMT agreed proposals to consider extending the current review dates for several non-critical policies that have already been through a robust review process. An extension could be between 6-12 months to support a manageable work plan over the next 3 years and could be applied to policies that fell due just before, during and just after the pandemic period. Work is underway to carry out an assessment of which policies this extension could be applied to facilitate a manageable work plan.

17. A workshop is in the early planning stages and due to be held on the 19th September 2023 to launch the revised policy governance process, which is currently under review, along with a series of communications to support colleagues to undertake the review of existing policies or develop new policies.

RECOMMENDED

18. **Members are asked to:**
    a) **Consider the contents of the report and the programme of work in development to mitigate risk and bring policies in line with appropriate review dates.**
    b) **Provide a view on any of the policies within Committee's remit that should be included on the priority work plan.**

Policy Title	Priority Number 1 High 10 Low	Directorate	Policy Lead	Policy Type	Issue Date	Review Date	Date Review due to Commence (within 3 months)	Comments
~~Gifts and Hospitality and Declaration of Interest Policy~~ Standards of Business Conduct Policy	1	CORPORATE GOVERNANCE	Trish Mills	Corporate	04/09/18	04/09/21	04/06/21	In the process now
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
Risk Management Policy	1	CORPORATE GOVERNANCE	Julie Boalch	Corporate	01/02/13	01/01/14	01/10/13	Under review
Data Protection Policy	1	DIGITAL	Aled Williams (DPO)	Corporate	15/12/16	15/12/19	15/09/19	Working with Kelly on a timeline for review
Environmental, Estates and Facilities Policy	1	FINANCE & CORPORATE RESOURCES	Susan Woodham	Corporate	16/07/14	16/02/17	16/11/16	
Management of Medical Devices Policy	1	MEDICAL & CLINICAL	Jon Wilson	Corporate	22/05/18	22/07/18	22/04/18	Out to consultation. Back at PG 29 Aug, QuEST 9 Nov
Professional Regulation Policy	1	MEDICAL & CLINICAL	Greg Lloyd	Employment	10/01/19	10/01/21	10/10/20	
Health and Safety Policy	1	QS&PE	Nicola White	Corporate	28/11/17	28/11/20	28/08/20	In process now
Infection Prevention & Control Policy	1	QS&PE	Louise Coulson	Clinical	08/09/20	22/05/21	08/02/21	In process now
Premises and Vehicle Cleanliness Policy	1	QS&PE	Louise Coulson	Clinical	26/11/19	26/11/21	26/08/21	In process now
CCTV Policy	2	DIGITAL	Kelly Holding	Corporate	25/04/19	25/04/21	25/01/21	
Information Security Policy	2	DIGITAL	James Rowlands	Corporate	25/04/19	25/04/22	25/01/22	Currently in review (Feb 2023)
Non Medical Prescribing Policy	2	MEDICAL & CLINICAL	Kerry Robertshaw	Clinical	25/02/20	25/02/23	25/11/22	
Alternatives to Conveyance Policy	3	MEDICAL & CLINICAL	Bryn Thomas	Clinical	01/11/10	01/11/11	01/08/11	
Consent to Examination and Treatment Policy	3	MEDICAL & CLINICAL	Bryn Thomas	Clinical	25/02/20	25/02/21	25/11/20	
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
Dispatch Cross Reference (DCR) Table Policy	4	MEDICAL & CLINICAL	Grayham McLean	Corporate	23/02/21	23/02/24	23/11/23	
Data Quality Policy	5	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
Management of ~~Frequent Callers~~ High Intensity Users Policy	5	MEDICAL & CLINICAL	Sarah Woods	Clinical	04/09/18	04/09/21	04/06/21	T&F group reviewing changes and then back to PG
Medicines Management Policy	5	MEDICAL & CLINICAL	Chris Moore	Clinical	25/02/20	25/02/23	25/11/22	In process now
Information Governance Policy	6	DIGITAL	Kelly Holding	Corporate	25/10/18	25/10/21	25/07/21	
Information Sharing Policy	6	DIGITAL	Kelly Holding	Corporate	New	New	#VALUE!	
Counter Fraud, Corruption and Bribary Policy	6	FINANCE & CORPORATE RESOURCES	Carl Window	Corporate	24/05/18	24/05/21	24/02/21	scheduled within 2023 work plan
Management of Controlled Drugs Policy	6	MEDICAL & CLINICAL	Chris Moore	Clinical	27/07/21	27/07/24	27/04/24	In process now
Access to Personal Information Policy	7	DIGITAL	Judith Birkett	Corporate	25/04/19	25/04/21	25/01/21	
Forensic / Digital Evidence Policy	7	DIGITAL	Aled Williams / James Rowlands	Corporate	New	New	#VALUE!	Not yet written - no systems in place yet for forensics
Patient Clinical Record Policy	7	MEDICAL & CLINICAL	Kevin Webb	Clinical	New	New	#VALUE!	
Access Control Policy	8	DIGITAL	Kelly Holding	Corporate	25/10/18	25/04/20	25/01/20	
Records Management Policy	8	DIGITAL	Judith Birkett	Corporate	25/10/18	25/10/21	25/07/21	Needs updating to latest GDPR references
Vehicle Disposal Policy	8	FINANCE & CORPORATE RESOURCES	Gavin Lane	Corporate	11/03/21	11/03/24	11/12/23	
Information Classification Policy	9	DIGITAL	Aled Williams	Corporate	No dates	No dates	#VALUE!	
Mobile Computing Policy	9	DIGITAL	Aled Williams / James Rowlands	Corporate	No dates	No dates	#VALUE!	Drafted - but most remote working aspects now covered under Info Security Policy
Trust Mobile Phone Policy	9	DIGITAL	Aled Williams / Tony Raine	Corporate	01/11/09	01/11/12	01/08/12	Possibly obsolete

Fuel Card Policy	9	FINANCE & CORPORATE RESOURCES	Gavin Lane	Corporate	25/04/19	25/04/21	25/01/21	
Confidentiality and Code of Conduct	10	DIGITAL	Kelly Holding	Corporate	23/02/21	23/02/24	23/11/23	
Information Risk Policy	10	DIGITAL	Kelly Holding	Corporate	23/02/21	23/02/24	23/11/23	
Tyres and Wheels	10	FINANCE & CORPORATE RESOURCES	Gavin Lane	Corporate	16/07/19	16/07/20	16/04/20	
NHS Wales Lease Car Policy	10	FINANCE & CORPORATE RESOURCES	Angie Evans	Corporate	30/10/19	30/10/22	30/07/22	New All-Wales policy only recently provided and approved by AC in Nov 22 - would assume no review
Charitable Funds Investment Policy	10	FINANCE & CORPORATE RESOURCES	Jill Gill	Corporate	13/02/20	13/02/23	13/11/22	This policy was approved at policy group in June and will go to the July CFC meeting
Purchase Card Policy	10	FINANCE & CORPORATE RESOURCES	Jill Gill	Corporate	New	New	#VALUE!	Purchase card process in place on a trial basis which will help to inform the final purchase card policy
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
Overpayments Policy	N/A	FINANCE & CORPORATE RESOURCES	NWSSP / Jill Gill	Corporate	New	New	#VALUE!	All Wales Overpayments Policy review group has been set up with a second meeeting taking place on
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
NHS Wales Research and Development Policy NHS Wales	See comments	MEDICAL & CLINICAL	Nigel Rees	Corporate	10/05/18	10/05/21	10/02/21	
Intellecutal Rights Policy	x	MEDICAL & CLINICAL	Nigel Rees	Clinical	01/01/17	01/11/18	01/08/18	Will be superseded by all Wales Policy
NHS Wales Do Not Attempt CPR for Adults in Wales	x	MEDICAL & CLINICAL	Dr Paul Buss	Clinical	30/10/18	NRS	#VALUE!	
Decontamination of Medical Devices Policy (SOP)	x	QS&PE	Louise Coulson	Clinical	New	New	#VALUE!	IPC owned SOP, not Clinical Directroate policy
Vehicle Telematics Policy		FINANCE & CORPORATE RESOURCES	Gavin Lane	Corporate	10/05/18	10/05/21	10/02/21	
Business Continuity Management Policy		OPERATIONS	TBC	Corporate	24/10/19	24/10/22	24/07/22	
Command Policy		OPERATIONS	Clare Langshaw	Corporate	25/04/23	25/04/26	25/01/26	In process now
~~Emergency Operations Demand Management Policy~~ superseded by Clinical Safety Plan		OPERATIONS	Kate Blackmore	Corporate	19/11/20	19/05/21	19/02/21	
High Risk Record Policy		OPERATIONS	Katie Blackmore	Corporate	16/07/20	16/07/23	16/04/23	
MPDS QA Policy		OPERATIONS	TBC	Clinical	10/01/19	10/01/21	10/10/20	
Quality Assurance Framework for the Clinical Desk		OPERATIONS	TBC	Clinical	01/06/15	NRS	#VALUE!	
Adverse Incident/Hazard Reporting Policy		QS&PE	Jane Palin	Clinical	25/04/23	25/04/26	25/01/26	
Children in Special Circumstances Policy & Procedure		QS&PE	Fiona Davies	Clinical	28/11/17	28/11/20	28/08/20	
Domestic Abuse, Gender Based Violence and Sexual Violence “Ask and Act” Policy		QS&PE	Rhiannon Thomas	Clinical	26/11/19	26/11/21	26/08/21	
Infection Prevention & Control: Sharps Policy		QS&PE	Louise Coulson	Clinical	01/12/20	01/12/23	01/09/23	
Lone Worker Policy		QS&PE	Nicola White	Employment	No dates	No dates	#VALUE!	
Management of Allegations Policy: When an allegation or concern is raised about an Employee or Volunteer		QS&PE	Nikki Harvey	Corporate	27/02/18	27/02/21	27/11/20	
Management of Compensation Claims Policy		QS&PE	Trish Gaskell	Corporate	26/02/19	26/02/21	26/11/20	
Mental Capacity Policy		QS&PE	Steve Clarke	Employment	New	New	#VALUE!	
NHS Wales ANTT Policy		QS&PE	Louise Coulson	Employment - All Wales	25/02/20	25/07/21	25/04/21	
NMC Revalidation and Registration		QS&PE	Helen Rees	Employment - All Wales	04/09/18	04/09/21	04/06/21	
Organisational Learning and Promoting Improvements in Patient Safety Policy and Procedure		QS&PE	TBC	Clinical	01/11/13	01/11/14	01/08/14	
Policy for the Development, Review and Approval of NHS Direct Wales/111Clinical Decision Support Software Changes		QS&PE	Helen Rees	Corporate	New	New	#VALUE!	
Putting Things Right Policy		QS&PE	Jane Palin	Corporate	25/04/23	25/04/26	25/01/26	
Safeguarding Children and Adults at Risk of Harm Policy This policy has merged with the Protection of Vulnerable Adults Policy		QS&PE	Nikki Harvey	Corporate	28/11/17	27/11/20	28/07/20	

Safer Handling Policy		QS&PE	Mike Jones	Employment	01/12/20	01/12/23	01/09/23	
Violence & Agression Policy		QS&PE	Nicola White	Employment	04/02/21	04/02/24	04/11/23	

AGENDA ITEM No	**11**
OPEN or CLOSED	**Open**
No of ANNEXES	**1**

Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru Welsh Ambulance Services NHS Trust

STANDARDS OF BUSINESS CONDUCT POLICY AND INTERNAL AUDIT UPDATE

MEETING	Audit Committee
DATE	25 July 2023
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Trish Mills, Board Secretary
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. The limited assurance internal audit on standards of business conduct received in December 2022 recommended that a revised policy be developed. That draft policy is at Annex 1 for endorsement by Committee before its presentation to the Trust Board for approval on 27 July.

2. The policy has undergone a wholesale revision and details of the material changes are set out in the SBAR. An All-Wales approach to standards of business conduct is being developed, however the policy has been drafted on best practice principles and has been reviewed and endorsed by the Policy Group and the Executive Management Team. A focused campaign of stakeholder consultation has assisted in the presentation of a well-rounded policy to the Committee.

3. All internal audit recommendations have been addressed with one management response being extended to April 2024 (see paragraph 4(d)) and one due in August. The extension relates to the holding centrally and publishing publicly of the declarations of decision makers.

4. 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 issue with gifts is most prevalent.

5. Electronic declarations, repository and reporting solutions are being investigated to make the process of declaring simpler for staff and to provide assurance on breadth and depth for the Committee.

6. The Register of interests is available on the Trust website and is linked to all Board and Committee agenda. As indicated above, declarations for decision makers will be centrally held and published from April 2024.

RECOMMENDATION:

7. The Audit Committee is asked to note the update on the standards of business conduct internal audit, endorse the policy for approval by the Trust Board and note the next steps for the Corporate Governance Team.

KEY ISSUES/IMPLICATIONS
Key issues/implications are set out above.
REPORT APPROVAL ROUTE
Policy Group – 25 April and 20 June 2023 Executive Management Team – 14 June 2023

REPORT APPENDICIES
Annex 1 – Draft Standards of Business Conduct Policy

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	NA
Environmental/Sustainability	NA	Legal Implications	Yes
Estate	NA	Patient Safety/Safeguarding	NA
Ethical Matters	Yes	Risks (Inc. Reputational)	NA
Health Improvement	NA	Socio Economic Duty	NA
Health and Safety	NA	TU Partner Consultation	Yes

STANDARDS OF BUSINESS CONDUCT POLICY AND INTERNAL AUDIT UPDATE

SITUATION

1. The purpose of this paper is to provide the Committee with an update on the Standards of Business Conduct Internal Audit and the resultant revised policy for endorsement ahead of its approval by the Board on 27 July.

BACKGROUND

2. The current policy is the 'Gifts, Hospitality Interests: Commercial Sponsorship and Fundraising Policy' which was approved on 13 September 2018 and was due for review in September 2021.

3. A limited assurance internal audit on Standards of Business Conduct was received in December 2022 and reviewed by the Audit Committee on 2 March 2023.

ASSESSMENT

Internal Audit

4. The internal audit made the following recommendations:

(a) The Trust should review and update the Gifts and Hospitality Policy for ratification by the Audit Committee.
The target date for this was 6 June, however the Audit Committee was moved from that date due to the change in the audit schedule therefore the policy is presented to this meeting on 25 July. This recommendation will thereafter be closed.

(b) 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.
A communications plan has been developed with communications colleagues which includes the initial communication on the policy on Siren, coupled with periodic messaging on declaring interests – particularly annually, as well as reminders regarding gifts and hospitality throughout the year, particularly during festive or religious holiday.
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.
This recommendation is proposed to be closed.

(c) Evidence to demonstrate the verification process undertaken as part of the annual eligibility checks should be retained centrally.

This related to Board Member annual eligibility checks (fit and proper). A confidential folder for the Board has been established in SharePoint and checks related to disqualified director search; insolvency and bankruptcy search; and Charity Commission searches are retained.

This recommendation is closed.

(d) Management should determine and implement a solution to ensure the completeness and accuracy of declarations of interest, including nil returns.

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 Trust should look to implement a centrally maintained register which includes the DOIs of all 'high risk' staff and decision makers, not limiting the register exclusively to Board members.

The report highlighted that whilst Board member declarations were centrally held, others were not and there was no process in place for the Corporate Governance Team to check that all declarations were made. This is somewhat of a maturity journey for the Trust and will require us to make the best use of an electronic repository such as ESR. The accepted management response was initially to target a cohort of 'decision makers' for completion of declarations and hold them centrally. The policy at Annex 1 includes decision makers and their declarations will be held centrally. This was initially planned to be in place following the approval of the policy (i.e. from 30 June 2023) however declarations were recently received from the Assistant Directors Leadership Team (ADLT) in particular in March 2023 as part of the annual review and therefore we are proposing that declarations for the decision makers listed in the policy will commence from March 2024 so as not to duplicate efforts. 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.

It is recommended that completion of the recommendations related to decision makers is extended to April 2024.

(e) The Trust should also ensure mitigating actions to manage conflicts of interest arising from declarations are captured and arrangements put in place to monitor their implementation.

The management response indicated that these will be captured where possible i.e. on declaration of secondary employment. However, it is not always possible or appropriate to add in a mitigating action, as a conflict does not automatically arise out of an interest held by a staff member. We addressed this by making that clear in the policy and setting out how conflicts can be managed when they arise (sections 8 and 9).
This recommendation is therefore closed.

(f) The Trust should enhance the gifts and hospitality register to ensure appropriate detail is captured.
This has been done and the recommendation is closed. The new register is now published on the website and was reported to Audit Committee in April 2023.
This recommendation is therefore closed.

(g) Management should remind all staff of the requirements of the Gifts and Hospitality policy, and that completed [gifts and hospitality] forms should be submitted to Corporate Governance in a timely manner for review.
This recommendation is not due until August 2023 and will be incorporated into the communications plan above.

(h) Management should return incomplete forms to ensure all required information is captured.
All declarations of gifts and hospitality are now reviewed by the Board Secretary before being placed on the register.
This recommendation is therefore closed.

Standards of Business Conduct Policy

5. The policy at Annex 1 is a wholesale review of the extant policy. There is currently not an All-Wales policy approach however the direction of travel is for a policy similar to this (largely based on the NHS England policy) to be adopted. Major changes include:

(a) The determination of a cohort of decision makers whose declarations will be centrally held by the Corporate Governance Team and added to the register of interests to be published publicly.
(b) Clarity on what constitutes an interest, where it may come into conflict and how to manage conflicts when they arise.
(c) Clarity on family member connections and where their interests may need to be declared.
(d) Options when a gift has been received and cannot be refused or the donor cannot be found.

(e) More particularity around hospitality including from contractors and suppliers.
(f) A wider range of conduct inclusions such as political activity, social media, confidentiality, gambling, lending, borrowing, trading on WAST premises, insolvency/CCJs, arrest or conviction.
(g) Publication and reporting schedule.
(h) Addition of research related interests.

6. Monitoring of the policy will be by way of:

(a) Register of Interests publicly available on the Trust website;
(b) Register of Interests reported to the Audit Committee annually;
(c) Register of Gifts, Hospitality and Sponsorship reported to the Audit Committee annually;
(d) Training programme available to new staff and annual refreshers.

RECOMMENDATION

7. The Audit Committee is asked to note the update on the standards of business conduct internal audit and endorse the policy for approval by the Trust Board.

NEXT STEPS

8. The process of collecting and adding interests and receiving declarations of gifts, hospitality etc. is ongoing throughout the year and cyclical for the more formal collection of declarations in March. There are however maturity elements to this area of work which will form part of the Corporate Governance Team's Local Directorate Plan and include:

(a) Development of a suitable electronic collection platform and repository. Whilst ESR has some functionality for this its capabilities for reporting, reminders etc are being further explored.
(b) Converting the Word declaration forms to a more accessible format.
(c) Rolling out communications throughout the year, particularly at festive and religious holidays where gifts may be more prevalent.
(d) Contact the cohort of decision makers in Q3 to obtain their declarations of interest and add to the centrally held register.
(e) Explore opportunities for training on the policy and declarations generally on the statutory and mandatory training platform.

Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services
NHS Trust

GIG CYMRU NHS WALES

Standards of Business Conduct Policy

Policy Number:	035	**Version No:**	3.0	**Supersedes:**	V2.2 2018
Date of Approval:	TBC	**Review Date:**	2 years following approval	**Impact Assessments Completed:**	EqIA Welsh Language
Classification of Document:	Corporate	**Policy**		**Approved by:**	Trust Board
Brief Summary of Document:	The Standards of Business Conduct policy describes the standards and public service values which underpin the work of the Welsh Ambulance Services NHS Trust (WAST). In particular it sets out the specific arrangements for the appropriate declarations of interest, and the acceptance/refusal of offers of gifts, hospitality and sponsorship.				
Scope:	This policy applies to WAST Non-Executive Directors and employees. For the purpose of this policy the term 'employees' encompasses individuals who are not direct employees of WAST and includes consultants, agency workers, specialist contractors, those who have an honorary contract with WAST, secondees who carry out work for WAST but are not directly employed by it, NHS Wales trainees on placement with WAST, jointly appointed staff and volunteers.				
To be read in conjunction with:	Nolan Principles Code of Conduct for NHS Managers UK Corporate Governance Code Standards for members of NHS boards and CCG governing bodies in England Working Time Policy				
Owning Committee	Audit Committee				
Policy Lead: **Trade Union Lead:**	Trish Mills Damon Turner	**Job Title:**	Board Secretary Trade Union Representative		
Executive Director:	Trish Mills	**Job Title:**	Board Secretary		

Version Control Sheet

Version	Date	Author	Summary of Changes
2.0	31/10/17	Carl Window	Updated counter fraud legislation references
2.0	19/11/17	Julie Boalch	Transposed to new template
2.0	13/02/18	Keith Cox	Updated narrative
2.1	08/03/18	Julie Boalch	Formatting
2.2	17/04/18	Keith Cox	Comments post consultation
3.0	Mar 23	Trish Mills	This is a wholesale review of the current policy therefore this version does not have tracked changes. Changes include: • Includes 'decision makers' category. • Centrally held and published 'decision makers' interests. • Breaches and publication section added. • Included patents and IP. • Defined who is in scope. • Publication and reporting schedule. • Included sponsored posts. • Range of conduct inclusions such as political activity, social media, confidentiality, gambling, lending, borrowing, trading on WAST premises, insolvency/CCJs, arrest or conviction. • Clarity on interest categories and examples. • Options where gifts have been received and cannot be refused or donor found. • More particularity around hospitality including from contractors or suppliers. • Included family member connections in policy (previously was in form).

Version	Date	Author	Summary of Changes
			• Clear indication that all staff must provide declaration, even if nil declaration. • Detail on how to manage conflicts. • Crossover to standing orders and terms and conditions clearer. • Clarity on legacies. • Provides for gifts to be channelled to charity.
Keywords	Declaration of interest Gifts Hospitality Sponsorship Conflict of interest		

Impact Assessment Reviews

Area	Date of Review	Name of Reviewer
Training	N/A	N/A
Counter Fraud	March 2023	Carl Window
Information Governance	8 June 2023	Kelly Holding
Records Management	8 June 2023	Kelly Holding
EqIA / Welsh Language	13 April 2023	Melfyn Hughes/Alex Payne
Estates	N/A	N/A
Environment	N/A	N/A
ESMCP	N/A	N/A

Task and Finish Group Members

Name	Job Title
NOT APPLICABLE	

Policy Approval Route

Meeting Title	Meeting Date	Purpose/Outcome
Policy Group	25 April 2023 20 June 2023	Initial review Final review after consultation
Executive Management Team	14 June 2023	Review
Audit Committee	25 July 2023	Endorse
Trust Board	28 July 2023	Approve

Disclaimer
If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Corporate Governance Manager

Contents

1. Introduction

1.1 The Standards of Business Conduct policy describes the standards and public service values which underpin the work of the Welsh Ambulance Services NHS Trust (WAST).

1.2 It is a long and well-established principle that public-sector organisations must be impartial and honest in their business and that their staff must act with integrity. As a publicly funded organisation, we have a duty to set and maintain the highest standards of conduct and integrity. We expect the highest standards of corporate behaviour and responsibility from Board members and all employees in accordance with our WAST behaviours.

1.3 The "Seven Principles of Public Life", or the "Nolan Principles" form the basis of the Standards of Behaviour requirements for WAST staff and Board Members. These are:

Selflessness – Individuals should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or friends.

Integrity – Individuals should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

Objectivity – In carrying out public business, including making public appointments, awarding contracts, recommending individuals for rewards and benefits, choices should be made on merit.

Accountability – Individuals are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate for their position.

Openness – Individuals should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands it.

Honesty – Individuals have a duty to declare any private interests relating to their duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership – Individuals should promote and support these principles by leadership and example.

2. Policy Statement

2.1 The Trust is committed to ensuring that its staff practice the highest standards of conduct and behaviour. This policy sets out those expectations and provides supporting guidance so that all staff are informed and supported in delivering that aim.

2.2 This Policy re-states and builds on the provisions of the Trust's Standing Orders. It re-emphasises the commitment of the Trust to ensure that it operates to the highest standards, sets out key roles and responsibilities and the arrangements for ensuring that declarations can be made.

3. Scope

3.1 This policy applies to WAST Non-Executive Directors, employees and workers. For the purpose of this policy this encompasses individuals who are not direct employees of WAST and includes consultants, bank workers, agency workers, specialist contractors, those who have an honorary contract with WAST, secondees who carry out work for WAST but are not directly employed by the Trust, NHS Wales trainees on placement with WAST, jointly appointed staff and volunteers. This policy is relevant to all those persons and for ease of reference they are called 'staff' or 'staff member' in this policy.

Decision Making Officers

3.2 Some staff are more likely than others to have a decision-making role or influence on the use of public money because of the requirements of their role. In the context of this policy, the officers listed below are referred to as 'decision making officers', however additions may be made to this list from time to time:

(a) Board members (including Non-Executive Directors and Executive Directors);

(b) Executive Management Team (EMT);

(c) Assistant Directors Leadership Team (ADLT);

(d) Board and Committee attendees (per Committee terms of reference); and

(e) Staff on Band 8 and above not in the above.

3.3 Declarations made by decision making officers will be published in accordance with paragraph 9.21 from March 2024.

4. Aim

4.1 The aim of this policy is to ensure that arrangements are in place to support staff to act in a manner that upholds WAST's standards of behaviour as well as setting out specific arrangements for the appropriate declarations of interest and dealings with gifts, hospitality, and sponsorship.

5. Objectives

5.1 As well as promoting the standards of business conduct expected of public bodies, this policy aims to protect our organisation and staff from any suggestion of corruption, partiality, or dishonesty. It does this by providing a clear framework through which WAST can give guidance and assurance that staff conduct themselves with honesty, integrity, and probity. The policy should be read in conjunction with all relevant organisational policies, terms and conditions of employment/engagement, and related documents which are set out in the cover sheet.

6. Failure to Comply with Policy

6.1 Failure to comply with the requirements set out in this policy and any accompanying procedures may result in action being taken in accordance with the Trust's Disciplinary Policy and Procedure.

6.2 Where the failure to comply relates to an individual that is not a direct employee of the Trust, action may be taken in accordance with the relevant engagement procedures (e.g. termination of a secondment agreement).

6.3 Any financial or other irregularities or impropriety which involve evidence or suspicion of fraud, bribery, or corruption by any staff, will be reported to NHS Counter Fraud Authority or the Trust's Local Counter Fraud Specialists in accordance with its Standing Financial Instructions and the Counter Fraud and Corruption Policy, with a view to an appropriate investigation being conducted and potential prosecution being sought if deemed appropriate.

7. Raising Concerns and Breaches

7.1 This policy may be breached innocently, accidentally, or because of deliberate actions. Staff should speak up about any genuine concerns they have in relation to compliance with this policy. These can be raised directly with their own line manager, another senior manager or with the Board Secretary. Alternatively, staff can use the Trust's confidential third party platform for raising concerns.

7.2 All reported concerns will be treated with the appropriate confidentiality and investigated in line with WAST policies and procedures.

7.3 The Board Secretary will take a report on breaches and responses to the Audit and Assurance Committee and the Board on an annual basis.

8. What are Conflicts of Interest?

8.1 A conflict of interest is a set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of carrying out their role is, or could be, impaired or influenced by another interest they hold.

8.2 A conflict of interest may be:

(a) Actual: there is a relevant and material conflict *now* between one or more interests of the member of staff;
or
(b) Potential: there is the possibility of a material conflict *in the future* between one or more interests of a staff member.

8.3 Staff are expected to act at all times with the utmost integrity and objectivity and in the best interests of the organisation in performing their duties, and to avoid situations where there may be a potential conflict of interest. Staff must not use their position for personal advantage or seek to gain preferential treatment.

8.4 Staff are required to declare any actual or potential interests which may be perceived as conflicting with that overriding requirement.

9. Declarations of Interest

9.1 Staff are required to declare interests to ensure that, should they be involved in discussions or decisions that bring that interest into conflict with their role at the Trust, that can be managed appropriately. It also promotes transparency and the highest standards of business conduct. The fact that a staff member has declared an interest, whether that is ownership of a consultancy, a directorship, or a position of authority in a charity, does not assume it will in fact cause a conflict to arise at any stage.

9.2 Where a staff member does not hold any interests as set out in this policy, they must in any event return a 'nil declaration'. The form for declaring interests is at Annex 1 and enables staff to make this declarations simply and quickly.

9.3 Conflicts can occur because of interests held by the staff member, as well as interests held by a close family member, business partner, close friend, or associate. If staff are aware of material interests (or could reasonably be expected to know about these) then these should be declared. In this context, close family members are defined as:

(a) spouse or civil partner;

(b) any other person with whom the individual cohabits;

(c) children or stepchildren;

(d) spouse/partners' children or stepchildren;

(e) parents;

(f) grandparents; and

(g) siblings.

9.4 Staff may hold interests for which they cannot see any potential conflict. However, caution is always advisable because others may see it differently and may *perceive* an interest. It is important to exercise judgement and to declare such interests where there is otherwise a risk of suggestion of improper conduct. Where there is potential for interests to be relevant and material to the organisation, the interest must be declared. If in doubt, declare and/or seek advice from the Board Secretary on the materiality of the interest you hold.

Categories of Interests Which Could Cause a Conflict

9.5 Interests can arise in a number of different contexts. A material interest is one which a reasonable person would take into account when making a decision regarding the use of taxpayers' money because the interest has relevance to that decision and may attract a benefit to the staff member. In this context, a benefit may be a financial gain or avoidance of a loss.

9.6 Interests can generally be considered in the following categories, although the examples are not exhaustive:

(a) Financial interests

This is where an individual may get direct financial benefit from the consequences of a decision they are involved in making. Some example of financial interests you should therefore declare are as follows:

(i) Directorships, including Non-Executive Directorships held in private companies or public limited companies;

(ii) Ownership or part-ownership of private companies, businesses, or consultancies likely or possibly seeking to do business with the NHS;

(iii) Shareholdings and ownership interests in any publicly listed, private or not for profit company, business, partnership, or consultancy which are doing or might reasonably be expected to do business with the NHS. This includes shareholdings, debentures, or rights where the total nominal value is £5,000 or one hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less;

(iv) Secondary employment (or in the case of a Non-Executive Director who is in employment, the details of that employment);

(v) Other commercial interests relating to a decision to be taken by the Trust;

(vi) Being in receipt of a grant or sponsored research;

(vii) Being in receipt of an honoraria.

(b) Non-financial professional interests

This is where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or status or promoting their professional career. Some examples of what you should therefore declare are set out below:

(i) An advocate for a particular group of patients;

(ii) A clinician with a special interest;

(iii) An active member of a particular specialist body;

(iv) An advisor for a WAST regulator (e.g., HIW).

(c) Non-financial personal interests

This is where an individual may benefit personally in ways that are not directly linked to their professional career and do not give rise to a direct financial benefit, because

of decisions that they are involved in making in their professional career. Some examples of what you should therefore declare are set out below:

(i) A position of authority in another NHS organisation, commercial, charity trustee, voluntary, professional, statutory, or other body which could be seen to influence their role;

(ii) A position on an advisory group or other paid or unpaid decision-making forum that could influence how the NHS spends taxpayers' money;

(iii) Any connection with a private, public, voluntary, or other organisation contracting or likely to contract for NHS services;

(iv) Membership of a lobbying or pressure group with an interest in health and care;

(v) Membership of an organisation which might lead to conflict or might be perceived to do so.

(d) Indirect interests

This is where an individual has a close association (see paragraph 9.3) with an individual who has a financial interest, a non-financial professional interest or a non-financial personal interest who would stand to benefit from a decision the staff is involved in making. It could also include an staff member's involvement in the recruitment or management of close family members and relatives.

(e) Loyalty interests

As part of their role, staff may need to build strong relationships with colleagues across the NHS and in other sectors. These relationships can be hard to define. They are unlikely to be directed by any formal process or managed via any contractual means, however these 'loyalty' interests can influence decision making.

Declaring Interests

9.7 Staff must declare any relevant and material interests on the form at Annex 1. Declarations should be made as soon as is reasonably practicable, and within 28 days after the interest arises.

9.8 Staff are required to make their declarations interests as follows:

Officer Category	Frequency of Mode of Declaration
(a) Members of the Trust Board	• On appointment • Annually in March • In formal meetings where an interest is material • In relation to individual procurement exercises or contracts • When potential conflicts are identified Declarations will be held centrally by the Board Secretary and placed on a register of declarations of interest.
(b) Decision Making Officers	• On appointment • Annually in March • In formal meetings where an interest is material • In relation to individual procurement exercises or contracts • When potential conflicts are identified • When moving to a new role Declarations will be held centrally by the Board Secretary from March 2024 and placed on a register of declarations of interest. The Board Secretary will provide line managers of decision makers with copies of centrally held declarations.
(c) All other staff	• On appointment • Annually (even if a nil declaration is made) • When potential conflicts are identified • When moving to a new role Declarations are held by line managers and will be made available for inspection on request by the Board Secretary, Internal Audit and Audit Wales

9.9 If staff are in any doubt as to whether they have an interest or whether it is declarable, they should consult their line manager or the Board Secretary.

Register of Declared Interests

9.10 The register of interests is maintained by the Board Secretary who will formally record the declared interests of all staff. Interests will remain on the register for six months after they have expired at which point it will be removed from the register. Records will be kept in line with the Trust's retention policy. There may be occasions when a staff member declares an interest which the Board Secretary later agrees is not material. In such an instance the declaration will be recorded but not published.

Publication of Declarations

9.21 The register of interests of decision making officers will be published on the WAST website and updated where new interests arise. The register of interests of Board members and those attending Committees will be published with the Board and Committee papers at each meeting.

9.22 In exceptional circumstances, where the public disclosure of information could give rise to a real risk of harm or is prohibited by law, an individual's name and/or other information may be redacted from the publicly available register. Where a staff member believes that substantial damage or distress may be caused to them or somebody else by the publication of information about them, they may make a request in writing to the Board Secretary. A confidential, un-redacted version of the register will be held securely by the Board Secretary.

9.23 Staff should be aware that external organisations, e.g., Association of British Pharmaceutical Industries (ABPI), may also publish information relating to commercial sponsorship or other payments. The Trust will review such publications to ensure that appropriate internal declarations have been made in accordance with this policy and will take appropriate action where they have not.

Managing Conflicts of Interest - General

9.24 All declarations of interest must be reviewed by the appropriate line manager, and in the case of decision makers by the Board Secretary, with consideration given to any actions required to mitigate the conflict in the individual circumstances. However, it is not always possible to identify mitigations at the time of declaration. These are often more appropriately made where the staff member's interests conflicts with their role, for example where they are required to make or be involved in a decision. In such cases it may be necessary for the line manager to consider a range of possible actions which may include:

(a) Deciding that no action is warranted;

(b) Restricting the staff member's involvement in discussions and excluding them from decision making;

(c) Removing the staff member from the whole decision-making process;

(d) Removing the staff member's responsibility for an entire area of work; or

(e) Removing the staff member from their role altogether if the conflict is so significant that they are unable to operate effectively in the role.

9.25 An audit trail of the actions taken must be maintained by the line manager. The Board Secretary can provide advice on mitigations.

Managing Conflicts of Interest – In Meetings

9.26 All formal meetings, including of the Board and its Committees, must have a standing agenda item at the beginning of each meeting to determine whether there are any conflict of interest to declare in relation to the business to be transacted at the meeting. The Standing Orders and all Committee terms of reference will incorporate this requirement. Any new interests declared at the meeting should be included in the relevant register of interest by the Board Secretary as soon as practicable after the meeting.

9.27 In the event that the chair of the meeting has a conflict of interest, the vice chair is responsible for deciding the appropriate course of action to manage conflicts of interests. If the vice chair is also conflicted, then the remaining non-conflicted voting members of the meeting should unanimously agree how to manage the conflict(s).

9.28 When a member of the meeting (including the chair or vice chair) has a conflict of interest in relation to one or more items of business to be transacted at the meeting, the chair (or vice chair or remaining non-conflicted members where relevant as described above) must decide how to manage the conflict. The appropriate course of action will depend on the particular circumstances, but could include one or more of the following:

(a) Where the chair has a conflict of interest, deciding that the vice chair (or another non-conflicted member of the meeting if the vice chair is also conflicted) should chair all or part of the meeting;

(b) Requiring the individual who has a conflict of interest (including the chair or vice chair if necessary) not to attend the meeting;

(c) Ensuring that the individual does not receive the supporting papers or minutes of the meeting which relate to the matter(s) which give rise to the conflict;

(d) Requiring the individual to leave the discussion while the relevant matter(s) are being discussed and when any decisions are being taken in relation to those matter(s);

(e) Allowing the individual to participate in some or all of the discussion when the relevant matter(s) are being discussed but requiring them to leave the meeting when any decisions are being taken in relation to those matter(s);

(f) Noting the interest and ensuring that all attendees are aware of the nature and extent of the interest but allowing the individual to remain and participate in both the discussion and in any decisions. This is only likely to be an appropriate course of action where it is decided that the declared interest in either not material or not relevant to the matter(s) under discussion;

(g) Conflicts of interest arising at a Board meeting must be managed in accordance with the requirements of the Standing Orders.

9.29 In all cases a quorum must be present for the discussion and decision.

9.30 All decisions under a conflict of interest must be recorded by the meeting secretariat and clearly reported in the minutes of the meeting. The minutes will include:

(a) Who has the interest;

(b) The nature and extent of the conflict;

(c) An outline of the discussion;

(d) The actions taken to manage the conflict; and

(e) Evidence that the conflict was managed as intended.

9.31 To support chairs in their role, the secretariat will provide access to details of any conflicts which have already been made by members of the group.

10. Patents and Intellectual Property

10.1 An All Wales Policy on Intellectual Property is in development and will be the primary policy statement for this area once approved. In the meantime, however, staff are to be guided by the following.

10.2 Staff should declare patents and other intellectual property rights they hold (either individually or by virtue of their association with a commercial or other organisation) relating to goods and services which are, or might reasonably be expected to be, procured, or used by the NHS.

10.3 Any patents, designs, trademarks or copyright resulting from the work (e.g. research) of a staff member carried out as part of their employment shall be the Intellectual Property of WAST.

10.4 Where the undertaking of external work, gaining patent or copyright or the involvement in innovative work, benefits or enhances our reputation or results in financial gain, consideration will be given to rewarding staff subject to any relevant guidance for the management of Intellectual Property in the NHS issued by the Department of Health and Social Services

10.5 Staff must seek prior permission through their line manager before entering into any agreement with bodies regarding product development where this impacts on normal working time or uses WAST equipment and/or resources.

10.6 Where holding of patents and other intellectual property rights give rise to a conflict of interest, then this must be declared.

11. Procurement

11.1 Conflicts of interest need to be managed appropriately through the whole procurement process. At the outset of any process, the relevant interests of individuals involved should be identified and clear arrangements put in place to manage any conflicts. This includes consideration as to which stages of the process a conflicted individual should not participate in, and in some circumstances, whether the individual should be involved in the process at all.

11.2 The Procurement Department (provided by the NHS Wales Shared Services Partnership) will seek to have staff working on a project with the Procurement Department complete a declaration of interest to ensure that there is no opportunity for conflicts to arise.

12. Gifts

12.1 A gift is an item of personal value, given by a third party e.g., a patient or a supplier. This includes prizes in draws and raffles at sponsored events/conferences.

12.2 All staff must ensure that they are not placed in a position that risks, or appears to risk, compromising their role or the organisation's public and statutory duties or reputation. Staff should always refuse gifts or other benefits which might reasonably be seen to compromise their personal judgement or integrity.

12.3 The Bribery Act 2010 makes it a criminal offence to give or offer a bribe, or to request, offer to receive, or accept a bribe. The Act reformed the criminal law of bribery, making it easier to tackle this offence proactively in both the public and private sectors. It introduced a corporate offence which means that commercial organisations, including NHS bodies, will be exposed to criminal liability, punishable by an unlimited fine, for failing to prevent bribery.

12.4 Staff should not ask for or accept gifts, gratuities, or honoraria from any individual or organisation that may be capable of being construed as being able to influence any decision or cast doubt on the integrity of such decisions. Staff are reminded that it may be considered to be a breach of the organisation Disciplinary Policy to solicit gifts. It may also be illegal, under the Bribery Act 2010, and staff that are found to have done so may face disciplinary action and prosecution.

12.5 Individuals offering gifts must be advised by the intended recipient that there is a requirement to declare and report such offers.

Gifts of cash or cash equivalents

12.6 Under no circumstances should staff accept a personal gift of cash or cash equivalents (e.g., tokens, vouchers, gift cards, lottery tickets or betting slips) regardless of the value.

12.7 Such gifts should be politely refused; however, the donor may be informed that should they wish to, they may make a donation to the WAST charity. If that is the case, the donor should be directed to the charity's financial accountant or by contacting the Board Secretary on amb_corporategovernance@wales.nhs.uk.

12.8 Where cash is left by an unknown donor that may also be deposited to the WAST charity.

Gifts from patients, families, service users, foreign dignitaries, etc., (not suppliers or contractors – see below)

12.9 Personal gifts of cash may not be accepted. However, as set out in paragraph 12.7 the donor may be directed to the WAST charity.

12.10 The acceptance and declaration of gifts is dependent upon their value. A common sense approach should be applied to the valuing of gifts, using the actual amount if known, or an estimate that a reasonable person would make as to its value.

12.11 Gifts valued up to £25:

(a) Staff may accept gifts up to the value of £25 from patients/service users/relatives as a mark of their appreciation for the care that has been provided. This can include items such as chocolates, flowers, cards.

(b) There is no requirement to declare such gifts, However multiple gifts from the same source over a 12 month period should be declared where the cumulative value exceeds £25.

12.12 Gifts valued at over £25:

(a) Where a gift is offered that is likely to be over £25 in value it should be politely declined.

(b) In some cases, the gift may have been delivered and it may be difficult to return it or it may be felt that the bearer may be offended by the refusal. Under such circumstances the gift can be accepted, with the options for its use being agreed with the line manager and communicated to the donor:

- Share the gift with all staff;
- Raffle the gift for charity;
- Donate the gift to charity; or
- Make a donation to charity and keep the gift.

(c) The gift must be declared via the form at Annex 2 and instructions set out on that form followed. A clear reason should be recorded as to why it was considered permissible to accept the gift, alongside the way it was used, actual or estimated value and include line manager approval.

12.13 If there is any doubt about the appropriateness of accepting a gift, staff should either politely decline or consult their line manager or the Board Secretary.

Gifts from suppliers, contractors, customers etc.

12.14 Gifts from suppliers or contractors the NHS does business with, or is likely to do business with, or customers, should be declined, whatever the value. An exception to this is low

cost branded promotional aids (such as calendars and pens) which may be accepted where they are valued at under £6 in total.

12.15 Gifts to a team or directorate of low value such as confectionary (up to £25) intended to be shared by the team or directorate may also be accepted. Gifts accepted from suppliers in accordance with this provision must be declared via the form at Annex 2 and instructions set out on that form followed. A clear reason should be recorded as to why it was considered permissible to accept the gift, alongside the actual or estimated value and include line manager approval.

12.16 Gifts from suppliers, contractors or customers that have been declined in line with this policy should be declared via the form at Annex 2 and instructions set out on that form followed. This will allow WAST to monitor when such organisations are inappropriately offering gifts or potential inducements.

Legacy in a Will

12.17 On occasions staff are left bequests in a service user's will which they become aware of before the service user is deceased or because they have been informed by the deceased service user's legal representative. In such circumstances the member of staff must immediately inform their manager. It should be borne in mind that staff cannot benefit from a bequest by virtue of their position as a Trust staff, undertaking their duties. If a member of staff receives a bequest they should contact the Board Secretary.

Gifts from Dignitaries/Overseas Organisations

12.18 There may be occasions when visits are made by dignitaries or overseas organisations who consider it cultural custom and practice to exchange gifts. In such cases staff should seek guidance from the Board Secretary and declare these gifts. A decision will then be jointly made as to the most appropriate way to manage the gift. This will depend on the nature of the gift culture and may include decisions to keep and display in public, donate to an internal user group, auction for charity, etc.

Publication

12.19 The register of gifts, hospitality and sponsorship will be published on the WAST website following its presentation to the Audit Committee annually.

13. Hospitality

13.1 Hospitality is where there is an offer of food, non-alcoholic drink, accommodation, entertainment or entry into an event or function by a third party, regardless of whether provided during or outside normal working hours.

13.2 Hospitality must only be accepted when there is a legitimate business reason and it is proportionate to the nature and purpose of the event.

13.3 Staff should exercise discretion in accepting offers of hospitality in case it would, or might appear to place them under any obligation to the individual or organisation making the offer; compromise their professional judgement and impartiality; or otherwise, be improper.

13.4 Hospitality should only be accepted on a one-off basis and should not take the form of regular events. It is very important that receiving hospitality does not influence, or is perceived to potentially influence, any decision making or behaviours.

13.5 Hospitality might be offered during working visits but may also be offered where:

(a) There is a genuine need to impart information, or represent WAST at stakeholder or community events which have an association with WAST;

(b) Staff are being invited to receive an award or prize in connection with the work of the organisation or their role within it;

(c) Staff are invited to a Society or Institute dinner or function which is to be funded by a commercial organisation and where there is a genuine benefit to the professional standing of the individual or WAST.

These types of hospitality must be authorised prior to their acceptance by the Director by completing the form at Annex 2 and instructions set out on that form followed.

13.6 Individual offering hospitality must be advised by the intended recipient that there is a requirement to declare and report such offers.

Hospitality from suppliers or contractors

13.7 Staff in contact with current or potential suppliers or contractors should be particularly mindful of accepting any hospitality that might later be misconstrued as impacting on strict independence and impartiality.

13.8 Offers can be accepted if modest and reasonable but must be declared and approved by the line manager.

Meals and refreshments

13.9 Meals and refreshments (food and non-alcoholic drinks) which are equivalent to that offered in similar circumstances by NHS Wales can be accepted and need not be reported (unless it is offered by a supplier or contract – see paragraph 13.8).

13.10 Meals and refreshments offered of a value between £15 and £50 may be accepted and must be declared, indicating whether it has been accepted or declined, via the form at Annex 2 and instructions set out on that form followed.

13.11 Offers over a value of £50 should be refused unless (in exceptional circumstances) Director approval is given in advance of acceptance. A clear reason should be recorded on the declaration as to why it was permissible to accept hospitality of this value.

13.12 A common sense approach should be applied to the valuing of meals and refreshments, using an actual amount, if known, or an estimate.

Travel and accommodation

13.13 Modest offers to pay some or all the travel and accommodation costs related to attendance at events may be accepted but must be declared. Offers which go beyond the type which would be funded by WAST must have Director approval in advance. A clear reason should be recorded on the declaration as to why it was permissible to accept travel and accommodation of this type.

13.14 Examples of travel and accommodation which would not normally be funded might include:

(a) offers of business or first-class travel and accommodation (including domestic travel);

(b) offers of foreign travel and accommodation;

(c) A holiday or weekend/overnight break;

(d) Offers of hotel accommodation when this is not associated with a sponsored source or conference;

(e) Use of a company flat or hotel suite.

13.15 Where a meeting is funded by the pharmaceutical industry, this must be disclosed in the papers relating to the meeting and in any published minutes or actions. The Department or Directorate organising or hosting the event must ensure that the funding has been

approved in line with the requirements set out in the Commercial Sponsorship section of this policy.

Register of Gifts and Hospitality

13.16 The register of gifts and hospitality is maintained by the Board Secretary who will formally record the declarations of all staff. The register is reported to the Audit Committee annually and available for public inspection.

14. Sponsorship

Sponsored Posts

14.1 Staff who are considering entering into an agreement regarding the external sponsorship of a post within NHS Wales must seek formal approval. Staff will be required to demonstrate acceptance of a sponsored post is transparent and does not stifle competition.

14.2 Rolling sponsorship of posts should be avoided unless appropriate checkpoints are put in place to review and confirm the appropriateness of the arrangements continuing.

14.3 There should be written confirmation that the sponsorship arrangements will have no effect on any commissioning or other management decisions over the duration of the sponsorship and auditing arrangements should be established to ensure that this is the case. These written arrangements should set out the circumstances under which we may exit the sponsorship arrangements if conflicts of interest arise which cannot be mitigated.

14.4 Holders of sponsored posts must not promote or favour the sponsor's specific products or organisation and information about alternative suppliers must be provided.

14.5 Sponsors must not have any influence over the duties of the post or have any preferential access to services, materials or intellectual property related to or developed in connection with the sponsored post.

Sponsored events

14.6 Sponsorship of events, including courses, conferences, and meetings, by external bodies should only be approved if it can be demonstrated that the event will result in clear

benefits for WAST. Sponsored events require the approval of the relevant Director in advance.

14.7 Sponsorship should not in any way compromise decisions or be dependent on the purchase or supply of goods or services.

14.8 Sponsors should not have any influence over the content of an event, meeting, seminar, publication, or training event.

14.9 WAST will not endorse individual companies or their products or services because of the sponsorship.

14.10 During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection (or other) legislation. As a general rule, information which is not in the public domain should not be supplied and no information should be supplied to a company for its commercial gain.

14.11 At WAST's discretion, sponsors or their representatives may attend or take part in the event, but they should not have a dominant influence over the content or the main purpose of the event.

14.12 The involvement of a sponsor in an event should always be clearly identified in the interests of transparency.

14.13 All pharmaceutical companies entering into sponsorship agreements must comply with the Code of Practice for the Pharmaceutical Industry.

Sponsored research

14.14 Funding sources for research purposes must be transparent. Any proposed research must go through the relevant approvals process.

14.15 There must be a written protocol and written contract and the sponsoring organisation, which specifies the nature of the services to be provided and the payment for those services. Where the contract includes provision of people this, and accompanying arrangements, must be clearly articulated.

14.16 The study must not constitute an inducement to commission any service.

Declaring sponsorship

14.17 Should there be any doubt about the appropriateness of accepting sponsorship, staff should seek advice from their line manager or the Board Secretary.

14.18 Declarations should include the value of the sponsorship. A common-sense approach should be applied to valuing the sponsorship if there is not a contractual value specified, for example a room and refreshments being provided for an event.

14.19 Sponsorship secured through, contracted by, paid directly to, or managed through a third party, such as exhibitors at our events sold through a third party or a sponsor paying for catering directly to an event venue should be declared.

14.20 Declarations should be made via the form at Annex 2 within 28 day of when the sponsorship was agreed rather than the date or the event. In exceptional circumstances where there are multiple sponsorship arrangements, the sponsorship may be declared within 28 days of the event taking place provided that this is agreed in advance by the relevant Director.

14.21 Declarations made in accordance with the policy will be published on the WAST website. In exceptional circumstances the value of the sponsorship may be published in bands where there are multiple sponsors of an event. A complete register will be held by the Board Secretary.

14.22 The register of sponsorship is maintained by the Board Secretary who will formally record the declarations of all staff.

15. Miscellaneous Payments and Honoraria

15.1 Staff may be invited to give presentations at conferences, provide responses to surveys or attend professional meetings where a one off payment or honoraria is offered. The activity should be reported using a Gifts, Hospitality, Sponsorship and Honoraria Form and it should be authorised by the appropriate Director.

Honoraria received for work undertaken during working hours

15.2 When appropriate authorisation has been granted to permit a staff member to be involved in activity outside their normal contract during working hours, any honoraria paid must be received back to the Trust revenue budget to reimburse the Trust for the staff member's time.

15.3 To avoid personal tax implications, staff are urged to request the Honoraria is paid directly to the Trust. This is then seen as reimbursement to the Trust to cover the loss of

the staff member's time, and not honoraria. This money will then be transferred into the Trust revenue budget. The staff member who has undertaken the work must not be the budget holder for the budget receiving the funds in lieu of the honorarium due to a conflict of interest.

15.4 If the staff member receives the honoraria directly and then reimburses the Trust, the staff member remains liable for the payment of both tax and National Insurance Contributions (NIC), regardless of the final destination of the honoraria.

Honoraria received for work undertaken in an individual's own time (out of normal working hours or on authorised annual leave)

15.5 Staff are personally liable for the payment of both tax and NICs on any honoraria payments received. Following their first honoraria declaration staff will be asked to sign a declaration statement confirming that they understand their responsibilities and this will be held on file by the Board Secretary.

15.6 If the staff member wishes to suggest a donation may be made to the Trust's Charitable Funds in lieu of an honoraria, this must be received into the Charity's general fund and it is then for the Charity to determine how the donated funds should be used. The basic principle being that the staff member giving their own time should have no influence over how the donation is then used and therefore lessens the risk of this being interpreted as being of any benefit to them as 'income' in any sense.

15.7 In cases of doubt, staff should seek advice from the Board Secretary and should report any case where an offer of sponsorship or honoraria is pressed which might be open to objection. Instances where honoraria has been offered and declined should still be declared on the Gifts, Hospitality, Honoraria and Sponsorship Declaration Form.

16. Secondary Employment (and Clinical Private Practice)

16.1 All staff (depending on the details of their contract as regards secondary employment and private practice) are required to seek approval from their line manager if they are engaged in or wish to engage in secondary employment in addition to their work with WAST. This approval should be sought even if the staff member is temporarily absent from work e.g., through sickness, maternity leave, or secondment.

16.2 Secondary employment or private practice must neither conflict with nor be detrimental to the WAST work of the staff member in question. Examples of secondary employment or private practice which may give rise to a conflict of interest includes, but is not limited to:

(a) employment with another NHS body;

(b) working two roles internally for WAST;

(c) employment with another organisation which might be in a position to supply goods/services to the NHS in Wales; and

(d) self-employment, including private practice, in a capacity which might conflict with the work of the NHS in Wales or which might be in a position to supply goods/services to NHS in Wales.

16.3 Where a risk of conflict of interest is identified, these should be managed in accordance with the guidance provided at paragraph 9.24. WAST reserves the right to refuse permission where it reasonably believes a conflict will arise or that approval would be detrimental to the work of the staff member in question.

16.4 In undertaking any secondary employment, staff should have regard to section 'Trading on Official NHS Premises' at paragraph 19.12.

16.5 WAST may have legitimate reasons within employment law for knowing about secondary employment of staff, even where this does not give rise to the risk of a conflict of interest. Nothing in this policy prevents such enquiries being made.

Declaring secondary employment and private practice

16.6 All staff must declare any relevant secondary employment or private practice on appointment, and when any new employment arises, in accordance with the guidance above. Declarations should be made by via the form at Annex 1 and instructions set out on that form followed.

16.7 The register of secondary employment and private practice is maintained by the Board Secretary who will formally record the declarations of all staff for the public record.

17. Charitable Collections

Charitable Collections Individual

17.1 Whilst WAST supports staff who wish to undertake charitable collections amongst immediate colleagues, no reference or implication should be drawn to suggest that WAST is supporting the charity. Permission is not required for informal collections

amongst immediate colleagues on an occasion like retirement, marriage, birthday or a new job.

Charitable Collections - Organisational

17.2 Charitable collections which reference WAST must be authorised and documented by the appropriate Director in advance and reported to the Board Secretary.

18. Political Activity

18.1 Any political activity should not identify an individual as a staff member of WAST. Conferences or functions run by a party-political organisation should not be attended in an official capacity, except with prior written permission from the Director of Partnerships and Engagement.

19. Personal Conduct

Corporate Responsibility

19.1 All staff have a responsibility to respect and promote the corporate or collective decision of WAST, even though this may conflict with their personal views. Staff may comment as they wish as individuals however, if they decide to do so, they should make it clear that they are expressing their personal view and not the view of WAST.

19.2 When speaking as a staff member of WAST, whether to the media, in a public forum or in a private or informal discussion, staff should ensure that they reflect the current policies or view of the organisation.

19.3 For any public forum or media interview, approval should be sought in advance. In the case of the Board, approval is from the Chairman and/or Chief Executive with advice from the Head of Communications. In the case of all other staff, the Head of Communications will provide the approval. Where this is not practicable, they should report their action to the Chairman (for Board members) and Head of Communications for all others as soon as possible.

19.4 All staff must ensure their comments are well considered, sensible, well informed, made in good faith, in the public interest and without malice and that they enhance the reputation and status of WAST.

19.5 Staff must follow the guidance for communication with the media; disciplinary action may be taken if this is not followed.

Use of Social Media

19.6 Staff should be aware that social networking websites are public forums and should not assume that their entries will remain private. Staff communicating via social media must comply with the relevant organisational social media and associated policies. staff must not conduct themselves in a way that brings WAST into disrepute, or disclose information that is confidential to WAST, its staff or patients.

Confidentiality

19.7 Staff must, at all times, operate in accordance with the UK General Data Protection Regulation and Data Protection Act 2018, and maintain the confidentiality of information of any type, including but not restricted to patient information; personal information relating to staff; commercial information. This duty of confidence remains after staff (however employed) leave WAST.

19.8 For the avoidance of doubt, this does not prevent the disclosure or information where there is a lawful basis for doing so (e.g., consent). Staff should refer to the suite of WAST Information Governance and Corporate Information Technology policies for detailed information.

Gambling

19.9 No staff member may bet or gamble when on duty or on WAST premises, with the exception of small lottery syndicates or sweepstakes related to national events such as the World Cup or Grand National among immediate colleagues within the same offices where no profits are made or the lottery is wholly for purposes that are not for private or commercial gain.

Lending and borrowing

19.10 The lending or borrowing of money between staff should be avoided, whether informally or as a business, particularly where the amounts are significant.

19.11 It is a particularly serious breach of discipline for any staff member to use their position to place pressure on someone in a lower pay band, a business contact, or a member of the public to loan them money.

Trading on WAST Premises

19.12 Trading on official premises is prohibited, whether for personal gain or on behalf of others. This includes but is not limited to flyers advertising services/products in common areas, or catalogues in common areas.

19.13 Canvassing within the office by, or on behalf of, outside bodies or firms (including non-WAST interests of staff or their relatives) is also prohibited.

19.14 Trading does not include small tea or refreshment arrangements solely for staff.

Individual Voluntary Arrangements, County Court Judgment (CCJ), Bankruptcy/Insolvency

19.15 Any staff member who becomes bankrupt, insolvent, has active County or High Court Judgment, or has made an individual voluntary arrangement with an organisation must inform their line manager and the Workforce and Organizational Development Directorate as soon as possible. Staff who are bankrupt or insolvent cannot be employed, or otherwise engaged, in posts that involve duties which might permit the misappropriation of public funds or involve the approval of orders or handling of money.

Arrest or Conviction

19.16 A staff member who is arrested, subject to continuing criminal proceedings, or convicted of any criminal offence must inform their line manager and the Workforce and Organisational Development Directorate as soon as is practicably possible.

20. Annual Eligibility Reviews

20.1 Board Members will, on appointment and annually, declare that they are eligible to hold the office of Board Member. These declarations extend to members of the Executive Management Team who are not voting members of the Board and to Trade Union Representatives on the Board.

20.2 All Board members' tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements, so far as they are applicable, as specified in the Membership Regulations. Any member must inform the Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on their

eligibility to hold office. The Chair will advise the Minister of Health and Social Services in writing of any such cases immediately.

20.3 The Board Secretary will undertake annual due diligence checks at the same time as receiving the eligibility declarations. These will include disqualified director and trustee searches, and bankruptcy and insolvency searches. In addition, the Board Secretary will ensure that all members have a DBS on file and have had or are undergoing their annual appraisal.

20.4 Completion of annual eligibility reviews will be reported to the Audit Committee.

21. Roles and Responsibilities

21.1 The Chief Executive is the Accountable Officer with overall responsibility for ensuring that the Trust operates efficiently, economically and with probity. The Chief Executive will ensure a policy framework is set and that arrangements are in place to support the delivery of that framework.

21.2 The Chair will:

(a) Ensure that Non-Executive Directors Board are aware of the requirements contained within this Policy;

(b) Lead by example and ensure that they personally declare any relevant interest or the offer of gifts, hospitality, or sponsorship;

(c) Approve (or not) the acceptance of gifts, hospitality and sponsorship that have been offered to Non-Executive Directors prior to the event.

21.3 The Director of Finance and Corporate Resources is responsible for ensuring appropriate monitoring arrangements are established to ensure that purchasing decisions are not being influenced by a sponsorship agreement.

21.4 The Board Secretary will:

(a) Ensure that the appropriate forms and paperwork for declaring an interest are available on the intranet;

(b) Review the content of declarations of interest made by decision makers on receipt;

(c) Review the contents of declarations of gifts, hospitality and sponsorship made and the advice subsequently provided by Line Managers to ensure that the recommended action is compliant with Trust policy. The Board Secretary will liaise directly with the relevant Line Manager in instances where this is not considered to be the case;

(d) Advise staff on all aspects of this policy;

(e) Ensure arrangements are in place to prompt staff to complete a Declaration of Interest Form on initial employment with WAST and at periodic intervals thereafter;

(f) Ensure that a Register of Interests and a Register of Gifts, Hospitality and Sponsorship is established and maintained as a formal record of interests declared by staff;

(g) Published those registers on the WAST Website in accordance with the requirements of the organisation's Freedom of Information Publication Scheme;

(h) Report the content of those registers and the effectiveness of the arrangements in place to the Audit Committee at agreed intervals, including any breaches of this policy.

21.5 Directors will:

(a) Lead by example and ensure that they personally declare any interests the subject of this policy;

(b) Approve (or not) the acceptance of gifts, hospitality and sponsorship that have been offered within their Directorate prior to the event;

(c) Ensure that they review the contents of the Register of Declarations on an annual basis to assist with the verification of the information contained within it.

21.6 Line Managers will:

(a) Ensure that staff are aware of the requirements of this policy and the implications for their work, particularly at annual PADR discussions;

(b) Support individuals in their declaration applications, seeking advice from other managers or from the Board Secretary if required;

(c) Ensure any declarations of interest are managed in accordance with this policy.

21.7 All staff will:

(a) Ensure they are aware of and are compliant with the requirements of this policy, consulting their line manager or appropriate senior manager if they require clarification;

(b) Declare to WAST any relevant interests, gifts, hospitality, and sponsorship;

(c) Obtain permission from their line manager/Director before accepting gifts, hospitality, or sponsorship;

(d) Verbally declare any relevant interest when a potential for conflict arises e.g., at Board and Committee meetings, during procurement process etc;

(e) Observe the Standing Orders, Standing Financial Instructions and procurement policies and procedures of the Trust.

21.8 An annual training package to raise awareness and understanding of this policy will be included in the WAST training for all staff. All decision making officers will be required to submit an annual attestation that all appropriate declarations required by the policy have been submitted.

22. Impact Assessments

22.1 Equality Impact Assessment

An Equality Impact Assessment initial screening was undertaken on this policy and it was assessed not to be significant from the perspective of the application of the Equality Act 2010, and that no negative impact on the protected characteristics within the legislation were identified. A full Equality Impact Assessment was not required.

22.2 Welsh Language Assessment

The Equality Impact Assessment took account of Welsh Language and it was found to be neutral/no impact.

22.3 Environmental Impact Assessment

This policy will put the relevant requirements in place (such as waste management plan, reduction of CO_2 emissions & reduction of carbon footprint) in order to ensure that the Welsh Ambulance Services NHS Trust ongoing commitment to reduce its impact on the environment is maintained and to become a more sustainable organisation in line with Trust policy and Environmental Governance System.

23. Counter Fraud

The Welsh Ambulance Services NHS Trust is committed to taking all necessary steps to counter fraud, bribery, and corruption within the Trust. Staff should report suspected incidents of fraud and corruption to the Trust Local Counter Fraud Specialist, who will be happy to discuss any issues or concerns. Alternatively, staff may contact the confidential NHS Counter Fraud Authority, Fraud and Corruption Reporting line on 0800 028 40 60; or the on-line reporting facility https://cfa.nhs.uk/reportfraud Fraud investigations may lead to disciplinary action and / or prosecution and civil recovery procedures.

24. Records Management

The Welsh Ambulance NHS Services Trust (WAST) recognises the importance of sound records management arrangements for both clinical and corporate records. The Trusts' records are its corporate memory, providing evidence of actions and decisions and representing a vital asset to support daily functions and operations. Records support policy formation and managerial decision-making, protect the interests of the Trust and the rights of patients, staff and members of the public.

25. Information Governance

Information Governance (IG) is an overarching term used to describe all aspects of information management. The Trust and its staff shall ensure that they provide satisfactory assurance to stakeholders as to how the organisation fulfils its statutory and organisational responsibilities in relation to the management of information. It will enable management and staff to make correct decisions, work effectively and comply with relevant legislation and the organisations aims and objectives.

The IG framework ensures that it sets out the high level principles for confidentiality, integrity and availability of information to promote and build a level of consistency across the Trust.

26. Health and Safety

The health, safety and well-being of staff, volunteers and Contractors who work for the Welsh Ambulance is of paramount importance.

The Management of Health and Safety at Work Regulations 1999 require the Trust to make a suitable and sufficient assessment of the risks to the health and safety of its employees to which they are exposed whilst they are at work and the risks to the health and safety of anyone else affected by the activities of the Trust.

27. Audit and monitoring

Monitoring for compliance with this policy will be by way of:

(a) Register of Interests publicly available on the Trust website
(b) Register of Interests reported to the Audit Committee annually

(c) Register of Gifts, Hospitality and Sponsorship reported to the Audit Committee annually

28. References

Not applicable

29. Appendices

Annex 1 – Declaration of Interests
Annex 2 – Declaration of Gifts, Hospitality and Sponsorship

ANNEX 1 - This form should be downloaded separately from the Trust's Intranet here.

DECLARATION OF INTERESTS FORM

Please review the Standards of Business Conduct Policy for details of interests which may be relevant and material and therefore subject to declaration. The policy can be found on the Trust's Intranet here.

All staff should make a declaration - even where it is a 'nil' declaration i.e., you do not have any interests to declare.

For 'decision making officers' as defined in the policy, this form is reviewed by the Board Secretary and provided to your line manager for their review. It is placed on the Register of Interests which is maintained by the Board Secretary, provided to the Audit Committee annually, and published on the Trust's website.

Full Name	
Position	
Directorate	
Employee Number	
Line Manager's Name and Position	

Section A: Nil Declaration:

I do not hold any of the interests set out below, and have nothing to declare:	☐

If you have completed Section A go straight to sign off section C

Section B: Interests to Declare:

Refer to the policy for full details but note that you will not automatically be conflicted just because you hold some of the interests set out below. A conflict may arise where you interests do not align to decisions you are making, or where there is a perception that they do not align. In those circumstances a mitigation plan will be put in place.

Interest Declared that relate to you	Details of Interest including the full name of any organisations/companies/directorships	Date When Interest Commenced
Financial Interest This is where you may get direct financial benefit from the consequences of a decision you are involved in making. This may include but is not limited to: • Directorships, including Non-Executive Directorships held in private companies or public limited companies; • Ownership or part-ownership of private companies, businesses, or consultancies likely or possibly seeking to do business with the NHS • Shareholdings and ownership interests in any publicly listed, private or not for profit company, business, partnership, or consultancy which are doing or might reasonably be expected to do business with the NHS		

Interest Declared that relate to you	Details of Interest including the full name of any organisations/companies/directorships	Date When Interest Commenced
• Secondary employment (or in the case of a Non-Executive Director who is in employment, the details of that employment) • Other commercial interests relating to a decision to be taken by the Trust • Being in receipt of a grant or sponsored research • Being in receipt of an honoraria		
Non-Financial Professional Interest This is where you may obtain a non-financial professional benefit from the consequences of a decision you are involved in making, such as increasing your professional reputation or status or promoting your professional career. This may include but is not limited to where you are: • An advocate for a particular group of patients • A clinician with a special interest • An active member of a particular specialist body • An advisor for a WAST regulator (e.g., HIW)		
Non-financial personal interests This is where you may benefit personally because of decisions that you are involved in making. This may include but is not limited to where you are in:		

Interest Declared that relate to you	Details of Interest including the full name of any organisations/companies/directorships	Date When Interest Commenced
• A position of authority in another NHS organisation, commercial, charity, voluntary, professional, statutory, or other body which could be seen to influence your role • A position on an advisory group or other paid or unpaid decision-making forum that could influence how the NHS spends taxpayers' money • Any connection with a private, public, voluntary, or other organisation contracting or likely to contract for NHS services • Membership of a lobbying or pressure group with an interest in health and care • Membership of an organisation which might lead to conflict, or might be perceived to do so		
Indirect interests This is where you have a close association with an individual (relative/friend/business associate) who has a financial interest, a non-financial professional interest or a non-financial personal interest who would stand to benefit from a decision the officers is involved in making. If you are aware of material interests, or could reasonably be expected to know about these, then they should be declared.	*Include here the details of the interest of the individual(s) with whom you have a close association and their relevant interests.*	

Interest Declared that relate to you	Details of Interest including the full name of any organisations/companies/directorships	Date When Interest Commenced
Loyalty interests As part of you role you may need to build strong relationships with colleagues across the NHS and in other sectors. These relationships can be hard to define. They are unlikely to be directed by any formal process or managed via any contractual means, however these 'loyalty' interests can influence decision making.		

Section C: Declaration

I declare that the information I have given on this form is correct and complete and that I will not create a conflict of interest between my NHS employment and an external body/organisation or my personal interests. I understand that if I knowingly provide false information or fail to disclose relevant information, this may result in disciplinary action and I may be liable to prosecution and/or civil proceedings. I consent to the disclosure of information on this form to review by the Trust's Auditors and understand the form may be reviewed for the purpose of fraud prevention and detection by NHS Counter Fraud Specialists. I agree to submit further notices in order to bring up to date information given in this notice and will declare any interest I acquire after the date of this notice. I agree to publication of my interests on the public record on the Trust website.

Signature of person making this declaration	
Date of Signature	

As line manager of the person making this declaration I confirm that I have reviewed the declaration. I do not consider that the interests declared (if any) present an immediate conflict and will manage any conflicts that may arise from time to time in accordance with the Standards of Business Conduct Policy

Signature of line manager	
Date of Signature	

The Line Manager is required to retain these declarations for inspection on request by members of the Executive Team, Internal/External Audit or the Counter Fraud Officer.

ANNEX 2 - This form should be downloaded separately from the Trust's Intranet here.

DECLARATION OF GIFTS, HOSPITALITY, AND SPONSORSHIP

Extracts of the gifts, hospitality, and sponsorship section of the Standards of Business Conduct Policy are set out below for context and ease of reference, however staff are requested to review the Policy before completing this form. The policy can be found on the Trust's Intranet here.

Complete the relevant section of this form for declaration of receipt or offer of a gift, hospitality (including travel and accommodation) or sponsorship.

This form must be authorised by your line manager or Director and reviewed and held centrally by the Board Secretary. Your declaration will be placed on the Register of Interests which is maintained by the Board Secretary, provided to the Audit Committee annually, and published on the Trust's website. The Board Secretary can be contacted for advice on the Policy and this form directly or via amb_corporategovernance@wales.nhs.uk.

Full Name	
Position	
Directorate	
Employee Number	
Signature	
Date	

A declaration must be made even where a gift or hospitality has been declined.

1. GIFTS

Staff must not be placed in a position that risks, or appears to risk, compromising their role or the organisation's public and statutory duties or reputation. Staff should always refuse gifts or other benefits which might reasonably be seen to compromise their personal judgement or integrity.

Staff may accept gifts up to the value of £25 from patients/service users/relatives as a mark of their appreciation for the care that has been provided. These may be items such as chocolates, flowers etc. **There is no requirement to declare these gifts unless** the gift is from a supplier, or multiple gifts from the same source over 12 months have a cumulative value over £25.

Cash or cash equivalents (tokens, gift cards, vouchers etc) **of any value must not be accepted**. Where cash has been left by a donor who cannot be traced it may be deposited to the WAST Charity.

Gifts over £25 should be declined, but where that is not possible the gift **must be declared on this form.** In some cases, the gift may have been delivered and it may be difficult to return it or it may be felt that the bearer may be offended by the refusal. Under such circumstances the gift can be accepted, with the options for its use being agreed with the line manager in line with section 12 of the Policy.

Gifts from suppliers or contracts should be declined whatever the value, other than low cost branded promotional items such as calendars and pens. Any gifts from suppliers, regardless of the value **must be declared on this form**. Likewise, any offers of gifts *declined* from suppliers or contracts must be declared.

Where a gift is required to be declared in line with the Policy, the following information is required. Your line manager or the Board Secretary can provide advice.

Details of gift including date it was offered	
Estimated value of gift	
Name of donor if known	
Was the gift refused?	
Where gift could not be refused, why it was considered suitable to accept the gift	
How the gift was used	

2. HOSPITALITY

Hospitality is where there is an offer of food, non-alcoholic drink, accommodation, entertainment or entry into an event or function by a third party, regardless of whether provided during or outside normal working hours.

Hospitality must only be accepted when there is a legitimate business reason and it is proportionate to the nature and purpose of the event.

Staff should exercise discretion in accepting offers of hospitality in case it would or might appear to place them under any obligation to the individual or organisation making the offer; compromise their professional judgement and impartiality; or otherwise, be improper. This is particularly important when it is offered by current or potential suppliers or contractors.

Meals and refreshments which are equivalent to that offered in similar circumstances by NHS Wales can be accepted and need not be declared. This may arise for example as part of a conference.

Meals and refreshments offered of a value between £15 and £50 may be accepted and must be declared. This may be signed off by your line manager.

Offers over a value of £50 should be refused unless (in exceptional circumstances) **Director approval** is given in advance of acceptance. A clear reason should be recorded on the declaration as to why it was permissible to accept hospitality of this value.

Modest offers to pay some or all the **travel and accommodation** costs related to attendance at events may be accepted but must be declared.

Details of hospitality including date	
Estimated value of hospitality. Where the value is over £50 provide reason why accepted.	
Name of provider of hospitality	
Is the provider of the hospitality a current or potential supplier or contract	Yes ☐ No ☐ Not known ☐

3. SPONSORSHIP

Sponsorship of events, including courses, conferences, and meetings, by external bodies should only be approved if it can be demonstrated that the event will result in clear benefits for WAST. Sponsored events require the approval of the relevant Director in advance.

Sponsorship of a post and of research are dealt with in more detail in the Policy at section 14.

Details of sponsorship including date	
Estimated value of sponsorship	

4. LINE MANAGER/DIRECTOR DECLARATIONS

(a) I have reviewed this declaration and consider the action taken by the individual are appropriate.

Full Name	
Position	
Signature	
Date	

or

(b) I have reviewed this declaration and consider the action taken by the individual is not appropriate and I have advised the individual accordingly as set out below.

Reasons for considering offer not appropriate	
Full Name	
Position	
Signature	
Date	

Once completed and signed this form must be sent to the Board Secretary directly or via amb_corporategovernance@wales.nhs.uk.

AGENDA ITEM No	**12**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**1**

LOSSES AND SPECIAL PAYMENTS - PAYMENTS FOR THE PERIOD FROM 1ST APRIL 2022 TO 31st MARCH 2023 & 1st APRIL 2023 TO 31 MAY 2023

MEETING	Audit Committee
DATE	25 July 2023
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 during the year to 31st March 2023 (**Annex 1**) and the months of April and May 2023 (**Annex 2**).

KEY ISSUES/IMPLICATIONS

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

- period 1st April 2022 to 31st March 2023 - £0.380m
- two months to 31st May 2023 - (£0.041m) - Net reimbursements

REPORT APPROVAL ROUTE

Audit Committee 25th July 2023 – no action required for information under SFI's only.

REPORT APPENDICES

Annex 1 – Summary and details of payments made for the twelve months to 31st March 2023

Annex 2 – Summary and details of payments made for the two months to 31st May 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 MARCH 2023 & 1st APRIL 2023 TO 31 MAY 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 twelve months from 1st April 2022 to 31st March 2023 (**Annex 1**) and two months to 31st May 2023 (**Annex 2**).

ASSESSMENT

3. Total net Losses and Special Payments made during the period 1st April 2022 to 31st March 2023 amounted to £0.380 million and the two months to 31st May 2023 amounted to (£0.041) of net reimbursements.

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 twelve months to 31st March 2023 payments made exceeded reimbursements received by £0.380m.

5. During March you will note the total damages paid amounted to £1.027m and this was for 11 payments. Three of these eleven payments amounting to £1,014m were in respect of damages for clinical negligence claims and costs on accounts paid in respect of a patient, and year-end creditors that Welsh Risk Pool (WRP) requested to be added for damages.

6. During March you will also note claimant's solicitors' costs incurred of £0.225m, these also relate to the same medical negligence case referred to above

RECOMMENDED

7. That the Losses and Special Payments Report for this period be received.

Welsh Ambulance Services NHS Trust
Losses and Special Payments

Annex 1

Summary of payments for the twelve months to 31st March 2023:

	£
April 2022	£109,893.12
May 2022	£141,037.72
June 2022	-£121,785.57
July 2022	£104,081.28
August 2022	-£242,461.55
September 2022	£31,524.41
October 2022	£80,621.95
November 2022	£97,829.14
December 2022	-£1,170,608.84
January 2023	£49,830.39
February 2023	£19,718.23
March 2023	£1,279,962.58
	£379,642.86

Losses and Special Payments Breakdown:

Payment Type	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
	£	£	£	£	£	£	£	£	£	£	£	£	
Claimants Solicitor Costs	40,455.00	40,731.00	83,866.00	23,200.00	233,182.00	5,000.00	38,656.00	23,100.00	0.00	5,328.96	0.00	225000	£718,518.96
Counsel fees	10,825.00	5,339.00	2,827.50	17,195.63	9,050.00	1,150.00	6,077.08	9,912.50	3,656.26	5,675.00	5650	8677.5	£86,035.47
CRU	0	29,816.83	3,686.00	1,312.00	0	3,791.00	33,858.00	-27,374.38	688.00	0.00	-891	-3946	£40,940.45
Damages	12,875.00	23,200.00	42,374.31	21,095.87	17,600.00	0	39,000.00	0.00	-950.00	5,000.00	23500	1026860	£1,210,555.18
Defence Costs	4,061.02	2,318.90	2,368.87	4,012.20	221.79	4,510.46	532.10	4,295.61	464.08	3,516.50	5580.62	1964.8	£33,846.95
Expert Witness	15,024.00	10,140.75	6,587.50	7,740.00	2,400.00	2,856.25	1,350.00	5,880.00	2,900.00	4,680.03	4335	9922.71	£73,816.24
Vehicle Repairs	12,155.60	29,491.24	5,156.51	29,525.58	6,786.46	14,216.70	36,038.77	12,015.41	6,663.66	14,849.90	12658.88	11483.57	£191,042.28
WRP Refund	0.00	0	-268,652.26	0	-518,151.70	0	-74,890.00	70,000.00	-1,184,030.84	10,780.00	-31115.27	0.00	-£1,996,060.07
Property Repairs	14,497.50	0	0	0	6,449.90	0	0	0	0	0	0	0	£20,947.40
Court Refund	0.00	0	0	0	0	0	0	0	0	0	0	0	£0.00
Total	**£109,893.12**	**£141,037.72**	**-£121,785.57**	**£104,081.28**	**-£242,461.55**	**£31,524.41**	**£80,621.95**	**£97,829.14**	**-£1,170,608.84**	**£49,830.39**	**£19,718.23**	**£1,279,962.58**	**£379,642.86**

Welsh Ambulance Services NHS Trust

Losses and Special Payments

Summary of payments for the twelve months to 31st March 2023:

Key

MN Medical Negligence
PI Personal Injury
DP Damage To Property

	£	
PI cases < £1,000	4,110.72	8 CASES
DP cases < £1,000	18,911.15	49 CASES
23RT4MN0014	8.61	
23RT4MN0006	39.42	
23RT4MN0001	80.36	
23RT4MN0009	130.58	
22RT4MN0013	206.64	
23RT4MN0005	455.69	
23RT4GN0012	1,000.00	
23RT4GN0025	1,000.00	
21RT4MN0013	1,000.00	
22RT4MN0011	1,050.00	
22RT4DP0097	1,113.36	
22RT4EG0005	1,200.00	
22RT4DP0091	1,213.84	
23RT4MN0008	1,275.00	
18RT4MN0023	1,287.00	
22RT4MN0017	1,320.00	
22RT4DP0042	1,382.04	
22RT4MN0001	1,442.72	
23RT4DP0010	1,449.49	
23RT4GN0016	1,500.00	
22RT4DP0099	1,500.40	
20RT4MN0008	1,508.00	
22RT4DP0102	1,520.13	
23RT4DP0063	1,544.29	
21RT4GN0014	1,600.00	
21RT4PI0035	1,625.00	
22RT4MN0003	1,650.00	
23RT4DP0002	1,651.41	
23RT4DP0003	1,659.37	
23RT4DP0037	1,794.00	
23RT4DP0007	1,827.40	
23RT4DP0015	1,907.45	
23RT4DP0011	1,948.86	
23RT4DP0049	1,962.74	
23RT4DP0061	1,970.61	
22RT4PI0040	2,000.00	
23RT4DP0062	2,009.24	
22RT4GN0011	2,020.00	
23RT4DP0008	2,053.80	
23RT4MN0002	2,070.00	
23RT4DP0043	2,073.64	
23RT4DP0001	2,157.23	
23RT4DP0016	2,310.44	
23RT4DP0020	2,315.47	
22RT4DP0094	2,320.14	
22RT4DP0085	2,369.84	
23RT4DP0017	2,376.89	
22RT4DP0075	2,434.68	
23RT4MN0011	2,450.00	
23RT4DP0072	2,457.88	
23RT4PI0006	2,510.00	
23RT4DP0055	2,634.13	
23RT4DP0058	2,690.69	
23RT4DP0019	2,700.43	
23RT4PI0001	2,702.70	
23RT4GN0032	2,760.00	
23RT4DP0070	2,831.58	
23RT4DP0074	2,864.35	
23RT4DP0060	2,919.01	
19RT4PI0061	2,930.00	
23RT4DP0069	2,955.76	
23RT4MN0012	2,980.00	
19RT4MN0008	3,021.00	
23RT4DP0051	3,032.28	
22RT4DP0086	3,053.20	
22RT4DP0090	3,108.94	
22RT4GN0014	3,400.00	
23RT4DP0005	3,437.50	
22RT4MN0018	3,520.09	
22RT4DP0057	3,522.90	
22RT4PI0036	3,560.00	
22RT4GN0004	3,670.00	
23RT4DP0053	3,698.63	
22RT4PI0043	3,900.00	
23RT4DP0024	3,921.48	
22RT4DP0101	4,421.27	
23RT4DP0039	4,665.00	
23RT4DP0050	4,796.15	
23RT4DP0056	5,020.79	
22RT4DP0013	5,208.00	
23RT4DP0042	5,372.44	
23RT4DP0018	5,440.85	
21RT4GN0011	5,750.00	
20RT4PI0028	5,942.00	
22RT4PI0016	6,100.00	
18RT4MN0012	6,140.00	
20RT4PI0035	6,645.00	
23RT4DP0038	6,665.13	
23RT4DP0012	6,865.40	
21RT4MN0009	7,022.50	
23RT4DP0014	7,049.48	
22RT4PI0026	7,151.00	
22RT4PI0008	7,207.00	
22RT4MN0002	7,534.48	
19RT4DP0079	7,964.82	
19RT4PI0037	8,082.71	
23RT4DP0032	8,083.42	
23RT4DP0013	8,612.22	
21RT4PI0009	9,132.00	
21RT4DP0086	10,387.33	
22RT4PI0038	11,239.29	
22RT4MN0012	11,769.50	
19RT4PI0049	12,325.00	
23RT4DP0033	12,659.74	
21RT4PI0022	12,991.00	
19RT4PI0060	13,376.00	
20RT4PI0007	19,825.33	
22RT4PI0018	20,328.96	
22RT4DP0080	20,947.40	
18RT4MN0001	25,035.00	
20RT4PI0025	26,508.45	
21RT4PI0001	38,820.25	
20RT4PI0008	42,867.96	
20RT4MN0010	48,985.20	
20RT4MN0019	63,365.00	
17RT4MN0007	70,510.00	
21RT4PI0017	72,967.00	
18RT4MN0005	117,719.00	
19RT4PI0008	123,871.63	
16RT4MN0009	155,500.00	
18RT4MN0016	209,013.75	
20RT4MN0011	884,363.28	
17RT4MN0007	-603,244.01	WRP REFUND
18RT4MN0005	-536,929.00	WRP REFUND
20RT4MN0010	-289,685.20	WRP REFUND
18RT4MN0023	-222,013.50	WRP REFUND
18RT4PI0060	-202,886.25	WRP REFUND
19RT4PI0053	-56,834.01	WRP REFUND
20RT4PI0025	-28,380.83	WRP REFUND
20RT4MN0006	-7,682.00	WRP REFUND
20RT4PI0001	-6,371.50	WRP REFUND
20RT4PI0012	-5,021.98	WRP REFUND
21RT4GN0008	-5,000.00	WRP REFUND
19RT4PI0048	-3,426.00	WRP REFUND
21RT4GN0014	-2,560.00	WRP REFUND
18RT4MN0001	-1,830.00	WRP REFUND
22RT4GN0014	-1,800.00	WRP REFUND
22RT4GN0004	-1,750.00	WRP REFUND
22RT4GN0007	-1,750.00	WRP REFUND
19RT4PI0059	-1,430.79	WRP REFUND
21RT4GN0016	-1,250.00	WRP REFUND
22RT4GN0008	-500.00	WRP REFUND
22RT4GN0011	-500.00	WRP REFUND
22RT4GN0017	-350.00	WRP REFUND
Total	**379,642.86**	

Feb-23

Case Reference	Details	Amount (£)
18RT4MN0016	Expert witness	450.00
18RT4MN0016	Counsel fees	1,300.00
19RT4PI0037	Counsel fees	1,125.00
19RT4PI0048	WRP Refund	- 3,426.00
19RT4PI0059	WRP Refund	- 1,430.79
20RT4MN0008	Defence Costs	108.00
20RT4PI0001	WRP Refund	- 6,371.50
20RT4PI0004	Defence Costs	1.42
20RT4PI0008	Counsel fees	2,325.00
20RT4PI0012	WRP Refund	- 5,021.98
20RT4PI0042	WRP Refund	- 14,865.00
21RT4DP0046	Vehicle repairs	- 94.58
21RT4EG0001	CRU	- 891.00
22RT4DP0013	Defence Costs	463.10
22RT4DP0013	Defence Costs	251.90
22RT4DP0013	Defence Costs	651.20
22RT4GN0019	Defence Costs	- 50.00
22RT4MN0012	Expert witness	495.00
22RT4MN0012	Defence Costs	108.00
22RT4MN0017	Expert witness	1,320.00
22RT4PI0016	Damages	5,000.00
22RT4PI0018	Damages	15,000.00
22RT4PI0043	Counsel fees	900.00
22RT4PI0043	Damages	3,000.00
23RT4DP0042	Vehicle Repairs	4,020.00
23RT4DP0053	Vehicle Repairs	3,209.32
23RT4DP0061	Vehicle Repairs	1,970.61
23RT4DP0062	Vehicle Repairs	2,009.24
23RT4DP0063	Vehicle Repairs	1,544.29
23RT4DP0064	Vehicle repairs	1,663.50
23RT4DP0064	Vehicle repairs	- 1,663.50
23RT4DP0065	Vehicle repairs	163.33
23RT4DP0065	Vehicle repairs	- 163.33
23RT4DP0066	Vehicle Repairs	1,186.73
23RT4DP0066	Vehicle Repairs	- 1,186.73
23RT4EG0016	Defence Costs	603.90
23RT4GN0021	Damages	500.00
23RT4GN0032	Defence costs	2,760.00
23RT4MN0002	Expert witness	2,070.00
23RT4PI0001	Defence Costs	683.10
Totals		**19,718.23**

Mar-23

Case Reference	Details	Amount (£)
16RT4MN0009	Damages	150,000.00
18RT4MN0016	Counsel fees	590.00
18RT4MN0016	Damages	200,000.00
19RT4PI0037	Expert witness	2,407.71
19RT4PI0037	Expert witness	2,250.00
20RT4MN0008	Counsel fees	1,400.00
20RT4MN0011	Counsel fees	2,175.00
20RT4MN0011	Counsel fees	1,275.00
20RT4MN0011	Counsel fees	112.50
20RT4MN0011	Counsel fees	25.00
20RT4MN0011	Claimants Solicitor Costs	112,500.00
20RT4MN0011	Damages	663,750.00
20RT4MN0011	Claimants Solicitor Costs	87,500.00
20RT4MN0019	CRU	- 2,388.00
20RT4PI0008	Damages	10,000.00
20RT4PI0008	Claimants Solicitor Costs	25,000.00
21RT4EG0003	CRU	- 725.00
21RT4GN0007	CRU	- 833.00
21RT4PI0035	Defence Costs	625.00
22RT4DP0013	Defence Costs	256.30
22RT4DP0013	Defence Costs	630.30
22RT4MN0001	Expert witness	150.00
22RT4MN0001	Expert witness	225.00
22RT4MN0003	Counsel fees	1,650.00
22RT4MN0012	Expert witness	390.00
22RT4MN0018	Expert witness	3,500.00
22RT4PI0011	Counsel fees	850.00
22RT4PI0046	Counsel fees	600.00
23RT4DP0050	Vehicle Repairs	300.00
23RT4DP0067	Vehicle repairs	86.70
23RT4DP0067	Vehicle repairs	- 86.70
23RT4DP0068	Damages	360.00
23RT4DP0069	Vehicle Repairs	2,955.76
23RT4DP0070	Vehicle Repairs	2,831.58
23RT4DP0071	Vehicle Repairs	74.00
23RT4DP0072	Vehicle Repairs	2,457.88
23RT4DP0073	Vehicle Repairs	283.50
23RT4DP0073	Vehicle Repairs	- 283.50
23RT4DP0074	Vehicle Repairs	2,864.35
23RT4DP0075	Vehicle repairs	97.58
23RT4DP0075	Vehicle repairs	- 97.58
23RT4EG0016	Defence Costs	166.10
23RT4GN0010	Damages	200.00
23RT4GN0012	Damages	1,000.00
23RT4GN0018	Damages	250.00
23RT4GN0019	Damages	250.00
23RT4GN0025	Damages	1,000.00
23RT4GN0034	Damages	50.00
23RT4MN0012	Expert witness	1,000.00
23RT4PI0001	Defence Costs	287.10
Totals		**1,279,962.58**

Welsh Ambulance Services NHS Trust
Losses and Special Payments

Annex 1

Summary of payments for the two month to 31st May 2023:

	£
April 2023	-£69,261.75
May 2023	28,671.21
June 2023	
July 2023	
August 2023	
September 2023	
October 2023	
November 2023	
December 2023	
January 2024	
February 2024	
March 2024	
	-£40,590.54

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	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	£14,371.50
Counsel fees	8,912.79	2,123.91	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	£11,036.70
CRU	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
Damages	8,448.00	14,200.45	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	£22,648.45
Defence Costs	3,713.72	521.58	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	£4,235.30
Expert Witness	4,680.00	2,319.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	£6,999.00
Vehicle Repairs	3,520.77	4,506.27	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	£8,027.04
WRP Refund	-107,908.53	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-£107,908.53
Property Repairs	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
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**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**-£40,590.54**

Welsh Ambulance Services NHS Trust
Losses and Special Payments

Summary of payments for the two months to 31st May 2023:

Key

MN Medical Negligence
PI Personal Injury
DP Damage To Property

	£	
PI cases < £1,000	2,310.20	4 CASES
DP cases < £1,000	4,342.68	16 CASES
23RT4PI0003	8,616.00	
23RT4EG0018	5,175.29	
20RT4PI0025	5,155.50	
21RT4PI0017	5,000.00	
23RT4EG0017	3,575.00	
24RT4PI0001	2,587.95	
21RT4GN0011	2,448.00	
24RT4DP0003	1,784.17	
23RT4EG0019	1,650.00	
23RT4DP0079	1,627.94	
22RT4GN0031	1,600.00	
24RT4DP0001	1,322.35	
19RT4PI0037	1,000.00	
21RT4MN0011	11,562.50	
22RT4MN0013	1,430.00	
22RT4MN0001	1,362.91	
22RT4MN0011	1,300.00	
22RT4MN0018	1,300.00	
23RT4MN0012	855.00	
22RT4MN0003	600.00	
20RT4MN0011	390.00	
20RT4MN0008	260.00	
22RT4MN0012	62.50	
19RT4PI0008	- 107,908.53	WRP Refund
Total	**- 40,590.54**	

Apr-23

Case Reference	Details	Amount (£)
19RT4PI0008	WRP Refund	- 107,908.53
19RT4PI0037	Counsel fees	625.00
20RT4MN0008	Expert Witness	260.00
20RT4MN0011	Expert Witness	390.00
20RT4PI0025	Claimants Solicitor Costs	588.00
20RT4PI0025	Claimants Solicitor Costs	4,567.50
21RT4GN0011	Damages	2,448.00
21RT4PI0006	Counsel fees	900.00
22RT4GN0031	Claimants Solicitor Costs	1,600.00
22RT4MN0011	Expert Witness	1,300.00
22RT4MN0012	Counsel fees	62.50
22RT4MN0013	Expert Witness	1,430.00
22RT4MN0018	Expert Witness	1,300.00
23RT4DP0058	Vehicle Repairs	684.90
23RT4DP0069	Vehicle Repairs	43.81
23RT4DP0079	Vehicle Repairs	1,627.94
23RT4DP0080	Vehicle Repairs	240.00
23RT4DP0081	Vehicle Repairs	106.50
23RT4DP0082	Vehicle Repairs	817.62
23RT4EG0009	Defence Costs	69.36
23RT4EG0017	Defence Costs	3,575.00
23RT4EG0018	Counsel fees	5,175.29
23RT4EG0019	Counsel fees	1,650.00
23RT4EG0020	Defence Costs	69.36
23RT4EG0021	Counsel fees	500.00
23RT4PI0003	Claimants Solicitor Costs	2,616.00
23RT4PI0003	Damages	6,000.00
Totals		**- 69,261.75**

May-23

Case Reference	Details	Amount (£)
19RT4PI0037	Counsel fees	375.00
20RT4PI0037	Counsel fees	625.00
21RT4MN0011	Damages	11,562.50
21RT4PI0017	Claimants Solicitor Costs	5,000.00
22RT4GN0034	Defence Costs	92.44
22RT4MN0001	Expert witness	864.00
22RT4MN0001	Counsel fees	498.91
22RT4MN0003	Expert witness	600.00
22RT4PI0006	Counsel fees	625.00
23RT4MN0012	Expert witness	855.00
23RT4PI0018	Defence Costs	160.20
24RT4DP0001	Vehicle Repairs	1,322.35
24RT4DP0002	Vehicle Repairs	699.75
24RT4DP0003	Vehicle Repairs	1,784.17
24RT4DP0004	Vehicle Repairs	310.00
24RT4DP0005	Vehicle Repairs	390.00
24RT4EG0001	Defence Costs	39.42
24RT4EG0002	Defence Costs	65.93
24RT4EG0003	Defence Costs	163.59
24RT4GN0001	Damages	50.00
24RT4PI0001	Damages	2,587.95
Totals		**28,671.21**

QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE
HIGHLIGHT REPORT TO AUDIT COMMITTEE

This report provides the Audit Committee with key escalation and discussion point at the last Committee meeting.

Audit Committee Meeting Date	25 July 2023
Committee Meeting Date	11 May 2023
Chair	Bethan Evans

KEY ESCALATION AND DISCUSSION POINTS
ALERT (Alert the Board to areas of escalation)
1. No alerts for the Audit Committee.
ADVISE (Detail any areas of on-going monitoring, approvals, or new developments to be communicated)
2. No areas to advise for the Audit Committee.
ASSURE (Detail here any areas of assurance the Committee has received)
3. The Committee's terms of reference at paragraph 3.16 provides that it will: *Approve the annual clinical audit plan that meets the standards set for the NHS in Wales; review the outcomes of **clinical audits** in line with the clinical audit plan and provide assurance to the Audit Committee in this respect.* 4. 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 at this meeting. 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. This supports recommendations in the Audit Wales Clinical Governance Review 2022. The Committee will monitor the plan and outcomes on a quarterly basis.
RISKS
N/A

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

COMMITTEE CYCLE OF BUSINESS 2023-24

MEETING	Audit Committee
DATE	25 July 2023
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Trish Mills, Board Secretary
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. Updating of the cycle of business for this committee is the final step in the 2022/23 effectiveness reviews that were conducted in Q4. Amendments to the Committee's terms of reference agreed in Q4 have been incorporated into this updated cycle of business.

2. The cycle has been developed with correlation to the duties in the terms of reference. This will allow members to review the appropriateness of the proposed reports and their frequency.

3. The cycle for the Committee is a maturing document and the areas related to whistleblowing processes and arrangements, and near miss reporting are developing. The People and Culture Committee has oversight of the Speaking Up Safely Framework and its implementation is one of the Committee's priorities for 2023/24. The Quality, Patient Experience and Safety Committee (QUEST) receives patient safety reporting which is predominantly based on the significant and catastrophic harm with moderate harm and near misses incorporated into thematic content. A more explicit near miss reporting will be developed, however there is limited capacity in the team to do so this year given the need to deal with the core requirements of national reportable incidents, Coroner requests and the Duty of Candour.

4. The Audit Committee is requested to note that cycles of business are now complete for all Board Committees and are being utilised for planning, agenda setting and monitoring.

RECOMMENDATION:

5. The Committee is asked to:

(a) Review and approve the 2023-24 cycle of business at Annex 1; and

(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.

KEY ISSUES/IMPLICATIONS

6. There are some areas of the cycle where reporting remains to be developed including the near miss report and the whistleblower report. Work will continue with the relevant directors on these areas over the coming months.

REPORT APPROVAL ROUTE

N/A

REPORT APPENDICIES

Annex 1: Cycle of business 2023/24

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

CYCLE OF BUSINESS 2023/24

SITUATION

7. The purpose of this paper is to provide the Committee with the updated cycle of business as the final step in the 2023/24 effectiveness review process.

BACKGROUND

8. The Committee carried out its effectiveness review in Quarter 4 2022/23. This included a review of its terms of reference, amendments to which were approved by the Committee in April 2023.

9. The final step in the effectiveness review process is the development a cycle of business for the Committee.

ASSESSMENT

Cycle of Business

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

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

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

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

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

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

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

    10.7. removes the ad hoc elements of agenda setting.

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

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

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

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

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

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

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

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

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

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

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

13.9. the Committee receives and reviews key Trust Annual Reports e.g., Trust Annual Report, Infection Control Annual Quality Statement; Annual Governance Statement and make recommendations to the Board for their adoption; and

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

14. The cycle for the Committee is a maturing document and the areas remaining to be developed include:

14.1. Whistleblowing processes and arrangements (3.1(i)): Staff can currently raise concerns through the traditional routes of line management and escalation set out in the All Wales Procedure for Raising Concerns, and through the sensitive issues function in Datix. A new Speaking Up Safely framework is in development by the Director of People and Culture with oversight of the implementation with the People and Culture Committee in 2023/24. The whistleblowing process and arrangements for special investigations will come to Audit Committee. It is proposed that regular verbal updates from the Chair of the People and Culture Committee are provided on progress in the interim.

14.2. The National Audit Office survey that was completed during the 2022/23 effectiveness review recommends this Committee reviews information on near misses to help determine whether the systems in place are sufficiently robust to mitigate future risk events. It is proposed that this is a report directed by QUEST with the mechanics of that to be developed further in the Patient Safety Report.

RECOMMENDATION

15. The Committee is asked to:

(a) Review and approve the 2023-24 cycle of business at Annex 1; and

(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.

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										
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	Relevant directors to be in attendance for limited assurance reviews
Audit Wales										
Audit Plan	EMT and Board	Annually						Audit Wales	Review	SFI 3.4.1 AC must ensure cost efficient external audit service is delivered; SFI 3.4.3 AC to review plan and associated costs. Noted to Board
Update report	N/A	Quartlery						Audit Wales	Assurance	
Annual Audit Report	EMT and Board	Annually						Audit Wales	Assurance	Audit report for calendar year. Copy to Board in AAA
Structured Assessment	EMT and Board	Annually						Audit Wales	Assurance	May also be presented at other times depending upon audit plan
Losses & Special Payments/Single Tender Waivers										
Quarterly lossess and special payments report	N/A	Quarterly						EDOF	Approval	See Note 1
Tender update report and single tender waiver request	N/A	Quarterly						EDOF	Assurance	Closed session
Counter fraud										
Counter fraud update report	N/A	Quarterly						EDOF	Assurance	Closed session. See Note 7
Standing Orders & Standing Financial Instructions										
Standing Orders & Standing Financial Instructions	EMT and Board	Annually						BS	Endorsement	Amendments to standing orders, standing financial instructions, scheme of reservation and delegation and associated schedules
Breach of Standing Orders & Standing Fin. Instructions	EMT	Ad Hoc						BS	Discussion/Assurance	
Governance Practice Notes	EMT	Annually						BS	Approval	Annual review of practice notes related to SOs and SFIs
Whistleblower, Declarations, Gifts & Hospitality										
Annual report on declarations of interest	EMT	Annually						BS	Assurance	Audit committee to provide report to Board on adequacy of arrangements for DOI annually
Report on gifts and hospitality	EMT	Annually						BS	Assurance	
Whistleblower report	TBC	TBC						BS	TBC	See Note 2
Other										
Near Miss Report	QUEST	Annually						TBC	Assurance	See Note 3
Policy										
Policy report	EMT	Annually						BS	Assurance	Position on policies including those outstanding for review etc. See Note 4
Policies	Policy Group	Ad Hoc						BS	Approval	Policies within the purview of this Committee - see Note 6
Financial procedures	TBC	Ad Hoc						EDOF	Approval	SFI 1.1.3 all financial procedures must be approved by the EDOF and Audit Committee
Risk Management										
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						Committee Chair	Various	
Committee effectiveness reviews and annual reports	All Committees	Annually						BS	Approval	This includes the annual report and amendments to TORs for all Board Committees and WASPT
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	
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

Losses and special payments	Whilst SFIs provide for approval of these, the payments are in effect already made when they are presented to the AC. All payments are made within SFI delegated limits. Further work with DOFs and Finance Academy at the next version of the SFIs to look at whether ACs should retrospectively approve such payments.
Whistleblowing	Staff can currently raise concerns through the traditional routes of line management and escalation set out in the All Wales Procedure for Raising Concerns, and through the sensitive issues function in Datix. A new Speaking Up Safely framework is in development by the Director of People and Culture with oversight of the implementation with the People and Culture Committee in 2023/24. The whistleblowing process and arrangements for special investigations to come to Audit Committee. Propose regular verbal updates from the Chair of the People and Culture Committee in the interim.
Near Miss Report	NAO effectiveness review outcomes recommends AC reviews information on 'near misses' to help determine whether the systems in place are sufficiently robust to mitigate future risk events. Propose this is a report directed by QUEST
Policy report	Each Committee has included in their cycles of business a report on the policies in their remit and their currency. An overarching report is being developed for this Committee's oversight.
Committee annual reports	Timing to be reviewed when setting 23/24 committee dates to ensure alignment with committee effectiveness reviews
TOR 3.2 (a) The Committee will support the Board with regard to its responsivities for governance by reviewing: the policies for ensuring compliance with relevant regulatory, legal and code of conduct and accountability requirements.	Key corporate policies include - Counter Fraud Policy - Charitable Funds Investment Policy - Standards of Business Conduct - Whistleblowing Policy - Public Sector Payment Policy (All Wales) - Risk Policy - Data Protection Policy - Health & Safety Policy - Information Governance Policy - Information Risk Policy - Information Security Policy
Local Counter Fraud	Local Counter Fraud Specialists (LCFSs) are responsible for developing the anti-fraud, bribery and corruption culture within their respective health service areas and for investigating fraud cases within their own local health trusts and boards. The Welsh ministers and the NHS Counter Fraud Authority (NHSCFA) have entered into a service agreement under section 83 of the Government of Wales Act 2006, to ensure that appropriate provision is in place to tackle all matters connected to Fraud, Bribery and Corruption. It is the role of the LCFS to ensure regular engagement and reporting to senior members surrounding the work completed within this field, with the audit committee being recognised as an appropriate recipient to the status and developments of the service. Service strands of hold to account, prevent and deter, inform and involve, and strategic governance
Cycle of Business	The cycle has been developed to align with the duties for the Committee set out in the terms of reference. Of note, paragraph 3.5 of the terms of reference requires the Committee's programme of work to be designed to provide assurance that: a.there is an effective internal audit function that meets the standards set for the provision of internal audit in the NHS in Wales and provides appropriate independent assurance to the Board and the Accountable Officer through the Committee; b.there is an effective counter fraud service that meets the standards set for the provision of counter fraud in the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Committee and ensure all reported fraud concerns and ongoing investigations are notified to the Committee; c.there are effective arrangements in place to secure active, ongoing assurance from management with regard to their responsibilities and accountabilities, whether directly to the Board and the Accountable Officer or through the work of the Board's committees; d.the work carried out by key sources of external assurance, in particular, but not limited to the Trust's external auditors, is appropriately planned and co-ordinated and that the results of external assurance activity complements and informs (but does not replace) internal assurance activity; e.the work carried out by the whole range of external review bodies is brought to the attention of the Board, and that the organisation is aware of the need to comply with related standards and recommendations of these review bodies, and the risks of failing to comply; f.the systems for financial reporting to the Board, including those of budgetary control, are effective; g.the results of audit and assurance work specific to the Trust, and the implications of the findings of wider audit and assurance activity relevant to the Trust's operations, are appropriately considered and acted upon to secure the ongoing development and improvement of the organisations' governance arrangements; h.progress is monitored against the requirement of the Auditors' Management Letter; i.the Committee receives and reviews key Trust Annual Reports e.g., Trust Annual Report, Infection Control Annual Quality Statement; Annual Governance Statement and make recommendations to the Board for their adoption; and j.the Committee reviews the content of the Corporate Risk Register and obtain assurance that control measures are in place to mitigate all identified risks.

AGENDA ITEM No	**15**
OPEN or CLOSED	**Open**
No of APPENDIX	**1**

Committee Priorities 2023/24

MEETING	Audit Committee
DATE	25 July 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. Progress is steady with nothing to escalate.

RECOMMENDATION

2. The Committee is asked to note the update.

KEY ISSUES/IMPLICATIONS

No issues to raise.

REPORT APPROVAL ROUTE

Not applicable

REPORT APPENDICES

None

REPORT CHECKLIST

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

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

COMMITTEE PRIORITIES 2023/24

SITUATION

3. This report updates the Committee on progress against the priorities it set for 2023/24.

BACKGROUND

4. 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 priority which is set out below, was agreed by the Trust Board in May 2023 and will be tracked quarterly.

ASSESSMENT

5. 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 are in the process of being updated for the induction of the new Vice Chair. It is proposed that this is completed and any lessons learned from the onboarding of the Vice Chair and the programme brought to the November Committee.

RECOMMENDATION

6. The Committee is asked to note the update.

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	25 May 2023
Committee Meeting Date	20 April 2023
Chair	Martin Turner

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

1. No alerts were generated from this meeting.

ADVISE

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

2. The Committee held its **annual effectiveness review**. Responses to the National Audit Office questionnaires were reviewed and changes agreed to terms of reference and operating arrangements. The Committee's annual report and revised terms of reference were approved and are recommended to the Board for approval.

3. A **non-compliance with the Standing Orders** was noted related to the availability of Board papers ten calendar days before a Board meeting. It was noted that whilst the Trust could make continued improvements on uploads to papers to ensure they are at least seven days ahead of Board meeting, the timeliness of data and information was key and a ten day period would potentially provide outdated information, particularly when factoring in governance processes ahead of that time. It was noted that there are discussions with Board Secretaries and Welsh Government on changes to the Standing Orders in this respect. Timeliness of papers will be a focus for the Board Secretariat for 2023/24.

ASSURE

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

4. The Committee reviewed the **effectiveness of the Board Committees** by way of receipt of their annual reports and amendments to their terms of reference. The changes to the operating arrangements for specific Committees and those applicable to all were discussed and the Board Secretary will ensure the changes are incorporated into the cycles of business for the upcoming meetings and that priorities set by the Committees are regularly monitored. The Committee endorsed the annual reports and terms of reference and recommends them to the Board for their approval. It was noted that the upcoming Board development sessions were focusing on strategy and governance, however it was felt that the prominence of the former at the Board and the latter at the Audit Committee could be increased.

5. The revisions to the **Standing Orders** were noted and are before the Board for approval at the May meeting. They are minor given that the Welsh Government *model Standing Orders and Standing Financial Instructions* have not been amended in 2022/23. Changes before the Committee therefore related to updates to the roles in the tables of delegations to officers and reflect amendments to the terms of reference for Committees. The Governance Practice Notes which provide guidance on the application of the Standing Orders as they relate to Chair's actions, decisions made in private session, and application of the Trust Seal were reviewed and renewed for a further twelve months.

6. The Committee reviewed the self-assessment against **2017 Governance Code** and noted that there were no areas where the Trust did not comply. The Accountability Report in the 2022/23 Annual Report will not our compliance with the Code. A self-assessment against the **Governance, Leadership and Accountability elements of the Health and Care Standards** was also reviewed. There were some areas of partial compliance which the Committee were assured were being addressed. The Committee noted that the Health and Care Standards are being revised with the introduction of the Health and Care (Quality and Engagement) (Wales) Act 2020.

7. The **Register of Interests** was received and will be published on the Trust website and form part of the pack of papers for each Board and Committee meeting. Further enhancements to the Register will be made following the approval of the Standards of Business Conduct Policy which will be reviewed by the Audit Committee in July.

8. The **Register of Gifts and Hospitality** was also received and will be publicly available on the Trust website.

9. The members reflections included:

    - Papers were of good quality and easy to read;
    - Attendance and contributions at the meeting was excellent; and
    - Helpful to look at one themed area (i.e. governance) in more detail and this was welcomed

RISK MANAGEMENT

The Committee is responsible for the review of the risk management framework and is not assigned individual risks for oversight.

This meeting did not review any items of risk management as it was a standalone meeting for the purpose of Committee effectiveness reviews and other yearend governance issues.

COMMITTEE AGENDA FOR MEETING		
Audit Committee Effectiveness Review 2023/24	Board Committees Effectiveness Reviews 2023/24	Review of Standing Orders and Governance Practice Notes
Self-assessment against Governance Code 2017 and Governance Health and Care Standards	Register of Interests Register of Gifts, Hospitality and Sponsorship	

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					
Liam Williams	Duncan Robertson				
Angie Lewis					
Osian Lloyd (IA rep)					
Audit Wales rep					
Paul Seppman					
Damon Turner					
Trish Mills					
Carl Window					

	Attended
	Deputy attended
	Apologies received
	No longer member