Bundle Audit Committee (Open) 7 June 2022

Agenda attachments

ITEM 0 Agenda Audit Committee Open 7 June 2022 TM.docx

0 OPENING ITEMS

1.1 09:30 - Chair's Welcome, Apologies and confirmation of quorum

2 09:33 - Declarations of Interest

Members are reminded that they should declare any personal or business interests which they have in any matter or item to be considered at the meeting which may influence, or may be perceived to influence their judgement, including interests relating to the receipt of any gifts or hospitality received. Declarations should included as a minimum, personal direct and indirect financial interests, and normally also include such interests in the case of close family members. Any declaration must be made before the matter is considered or as soon as the Member becomes aware that a declaration is required.

3 09:34 - Minutes

To confirm as a correct record the Minutes of the Committee

ITEM 3 Audit Committee OPEN Minutes 3 March 2022 CT and TM.doc

4 09:36 - Action Log

ITEM 4 Action Log.docx

4.1 ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION

5 09:40 - Annual Accounts 2021/22

ITEM 5 2021-22 Annual Accounts Report Executive Summary -AC 07 June 22.docx

ITEM 5.1 Appendix 1 - Annual Accounts 2021-22.pdf

6 10:10 - 2021/22 Annual Report

ITEM 6 Annual Report 2021-22 for Audit Committee.docx

ITEM 6.1 2021-22 Annual Report Final for Audit Committee.docx

ITEM 6.2 Annual Report and Accounts Highlight (pre-design).docx

7 10:40 - Internal Audit reports

7.1 Head of Internal Audit Annual Report and Opinion
7.2 Risk management & assurance
7.3 Network and Information Systems (NIS) Directive
7.4 Respiratory protective equipment
7.5 Service reconfiguration
7.6 Waste management
7.7 Follow up review
7.8 Organisational culture – a learning organisation

ITEM 7.1 AA HIA Annual Report and Opinion 21-22 WAST_Final.pdf

ITEM 7.2 WAST 2122-01_Risk Management Assurance_Final Internal Audit Report_for Trust issue.pdf

ITEM 7.3 WAST_2122-005_NIS Directive_Internal Audit Report (Final).pdf

ITEM 7.4 WAST_2122-21_RPE_Final Internal Audit Report_for Trust issue.pdf

ITEM 7.5 WAST_2122-008_Service Reconfiguration_Final Internal Audit Report client issue.pdf

ITEM 7.6 WAST Waste Management Final Report.pdf

ITEM 7.7 WAST_2122-022_Follow Up_Final Internal Audit Report_for Trust issue.pdf

ITEM 7.8 WAST_2122-19_Learning Organisation_Final Internal Audit Report for client issue.pdf

8 11:10 - Audit Wales reports

8.1 Audit Wales Update Report
8.2 Final Audit of Accounts
8.3 Emergency Services Collaborative Report
8..4 Audit Plan 2022

ITEM 8.1 WAST Audit Committee update 07062022.pdf

ITEM 8.2 Final Audit of Accounts ISA 260 - WAST - 2021-22.pdf

ITEM 8.3 Emergency-services-Joint-Working-2022.pdf

ITEM 8.4 AUDIT WALES Audit Plan 2022.pdf

8.1	11:30 - COMFORT BREAK
9	11:40 - Risk Management and Board Assurance Framework
	ITEM 9 Executive Summary Risk Management Report AC 070622.docx
10	11:55 - Audit Tracker
	Audit Tracker circulated separately by e mail
	ITEM 10 Executive Summary AC - Internal Audit Report 070622.docx
11	12:05 - Losses and Special Payments – Payments for the Period FROM 1st April 2021 TO 31st March 2022 & 1st April 2022 TO 30th April 2022
	ITEM 11 Executive Summary SBAR Losses and Special Payments - AC 7 June 2022.docx
	ITEM 11.1 Annex 1 - Losses Special and Payments 2021-22 M1-12.pdf
	ITEM 11.2 Annex 2 - Losses Special and Payments 2022-23 M1.pdf
	ITEM 11 Executive Summary SBAR Losses and Special Payments - AC 7 June 2022.docx
	ITEM 11.1 Annex 1 - Losses Special and Payments 2021-22 M1-12.pdf
	ITEM 11.2 Annex 2 - Losses Special and Payments 2022-23 M1.pdf
11.1	CLOSING ITEMS
12	Key messages for Board
13	Any other business
14	Date and time of next meeting 15 September at 09:30

Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru Welsh Ambulance Services NHS Trust

AGENDA
MEETING OF THE AUDIT COMMITTEE
Held in public on 7 June 2022 from 09:30 to 12:30
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	Information	Martin Turner	Verbal	
3.	Minutes of last meeting	Approval	Martin Turner	Paper	
4.	Action Log	Review	Martin Turner	Paper	
ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION					
5.	Annual Accounts 2021/22	Approval	Chris Turley	Paper	30 Mins
6.	Annual Report 2021/22	Approval	Trish Mills	Paper	30 Mins
7.	7.1 Head of Internal Audit Annual Report and Opinion 7.2 Risk management & assurance 7.3 Network and Information Systems (NIS) Directive 7.4 Respiratory protective equipment 7.5 Service reconfiguration 7.6 Waste management 7.7 Follow up review 7.8 Organisational culture – a learning organisation	Assurance	Osian Lloyd	Paper	30 Mins
8.	8.1 Audit Wales Update Report 8.2 Final Audit of Accounts 8.3 Emergency Services Collaborative Report 8.4 Audit Plan 2022	Assurance	Dave Thomas Fflur Jones	Paper	20 Mins
COMFORT BREAK 10 Mins					
9.	Risk Management and Board Assurance Framework	Assurance Approval	Trish Mills	Paper	15 Mins
10.	Audit Tracker	Assurance	Julie Boalch	Paper	10 Mins
11.	Losses and Special Payments – Payments for the Period 1st April 2021 To 31st March 2022 & 1st April 2022 To 30th April 2022	Assurance	Chris Turley	Paper	15 Mins
CLOSING ITEMS					
12.	Key messages for Board	Information	Martin Turner	Verbal	5
13.	Any other business	Discussion	Martin Turner	Verbal	
14.	Date and time of next meeting	Information	Martin Turner	Verbal	

No.	Agenda Item	Purpose	Lead	Format	Time
	15 September at 09:30				

Lead Presenters

Name of Lead	Position of Lead
Martin Turner	Non Executive Director
Chris Turley	Director of Finance and Corporate Resources
Osian Lloyd	Internal Audit
Julie Boalch	Head of Risk/Deputy Board Secretary
Trish Mills	Board Secretary
Simon Cookson	Internal Audit
Fflur Jones Dave Thomas	Audit Wales

WELSH AMBULANCE SERVICES NHS TRUST

UNCONFIRMED MINUTES OF THE OPEN MEETING OF THE AUDIT COMMITTEE OF THE WELSH AMBULANCE SERVICES NHS TRUST HELD ON THURSDAY 3 March 2022 VIA TEAMS

PRESENT :

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

IN ATTENDANCE :

Julie Boalch	Head of Risk and Deputy Board Secretary
Judith Bryce	Assistant Director of Operations
Simon Cookson	Internal Audit NWSSP
David Butler	Internal Audit NWSSP
Fflur Jones	Audit Wales
Jill Gill	Financial Accountant
Dr Catherine Goodwin	Organisational Culture & Workplace Wellbeing Lead
Andy Haywood	Director of Digital Services
Wendy Herbert	Interim Executive Director of Quality and Nursing
Navin Kalia	Deputy Director of Finance and Corporate Resources
Osian Lloyd	Deputy Head of Internal Audit NWSSP
Trish Mills	Board Secretary
Jeff Prescott	Corporate Governance Officer
Duncan Robertson	Interim Assistant Director of Research, Audit and Service Improvement
Chris Turley	Executive Director of Finance and Corporate Resources
Carl Window	Counter Fraud Manager

APOLOGIES:

Joga Singh	Non Executive Director

13/22 PROCEDURAL MATTERS

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

Declarations of Interest

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

Minutes

The Minutes of the open and closed sessions of the Audit Committee meeting held on 2 December 2021 were confirmed as a correct record.

Action Log

The Committee considered the action log:

Action 27/21 – Internal Audit Reports, deferring of reviews. Updates were given on the Internal Audit reviews that were requested for deferment. Trade Union Release Time, Health and Safety, Decarbonisation and the Savings Plan. Agreed for this action to be closed.

Action 28/21 – Audit Wales Reports, Taking Care of the Carers Audit Review – Update was on the agenda, action Closed.

Action 31/21a - A process to outline the use of the Trust Seal be developed. Item is on agenda, action closed.

Action 31/21b - Produce a list showing recent use of the Trust Seal, details were attached to the action log, action closed.

Action 34/21 – Loses and Special Payments. Review the reporting process. Item on agenda, action closed.

Action 36/21 – 2022/2023 Annual Filings timetable – Dates to be published. Item on agenda, action closed.

RESOLVED: That

(1) the Minutes of the Audit Committee's open and closed sessions held on 2 December 2021 were confirmed as a correct record;

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

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

14/22 COMMITTEE EFFECTIVENESS REVIEW 2021/22

1. Trish Mills reminded the Committee that as detailed in the Trust's Standing Orders and the Committee's Terms of Reference, it was obligatory for Board Committees to evaluate their effectiveness and report findings to the Board annually.

2. The Committee effectiveness review included a review of its terms of reference (TOR) and the gleaning of information from questionnaires sent to members and core attendees.

3. In respect of the TOR, Trish Mills outlined several proposed amendments which in the main were minor. The Committee's attention was drawn to the areas of clinical audit and information governance and information security. Both these areas were contained in the NHS wales Audit Handbook model TOR as Audit Committee roles, however it was agreed that these currently appropriately sit within the Quality, Patient Experience and Safety Committee TOR, with that Committee providing assurance to the Audit Committee on clinical audit in particular and to the Board on all matters in its remit.

4. Furthermore, the Committee were alerted to the proposed Committee membership changes which would strengthen executive representation at the Committee by adding the Executive Directors of Quality and Nursing and Workforce and Organisational Development.

5. In terms of the questionnaires, the Committee noted that 11 had been distributed with 4 being responded to. Details of the responses were contained within the report.

Comments:

1. The Chair commented that the Accountable Officer (Chief Executive) was not a member but would receive an invite. Simon Cookson explained that this varied across health boards, in most cases the Chef Executive attended at least one a year. Following a discussion, it was agreed that paragraph 4.6 of the TOR be amended to state that the Chief Executive **will** be invited to attend annually as opposed to should be invited.

2. Members held a discussion which considered how other Board Committees demonstrated the governance procedures they have undertaken and how it was escalated for assurance purposes. Trish Mills explained that the reviews of all committees will go to the Board, and that the second stage of effectiveness will include the development of cycles of business for the committees. This, together with clear TORs would provide the audit committee and the board with an overview of the governance arrangements. It was suggested that the alert information contained in other committee highlight reports be provided for the Audit Committee's attention as part of a regular update.

RESOLVED: That the Committee

(1) Reviewed and approved changes to the Terms of Reference subject to the minor amendment described above;

(2) Considered the issues raised in both the participants' questionnaire and the NHS Wales Audit Committee Handbook self-assessment;

(3) Set priorities for the Committee for 2022/23; and

(4) It was noted that the Committee Annual report would be circulated to Members prior to submission of the Board in May 2022 for comment.

15/22 GOVERNANCE PRACTICE NOTES

Trish Mills outlined several practice notes which were being presented to the Committee for approval. The practice notes were intended to provide guidance on the application of

the Standing Orders. Details of the practice were as follows:

1. Trust Seal Governance Practice Note: A proforma was to be used when requests for the use of the seal were made and this was included in the practice note. The Governance Team were working with the Estates Team to develop a forward view of the leases and other land related documents that may require the Trust Seal so that approvals can be scheduled in advance to take place in person where possible. Furthermore the Governance Team will record the use of the seal on an electronic register from 1 April 2022.

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

3. Chair's Action Governance Practice Note: This practice note provided for a streamlined approach to Chair's Actions by way of email in the majority of cases. It also provided for the ways in which they were ratified in public session of the Board thereafter.

Comments:

In respect of the practice note related to Private Board and Committee Business, which provided that minutes of the Remuneration Committee would be provided to the private session of the Trust Board unless there were sensitivities in the minutes that precluded this, clarity was sought in terms of whether all Board members would have sight of Remuneration Committee Minutes. Trish Mills explained that the Remuneration Committee Terms of Reference were being amended in order that all Non Executive Directors would be Members therefore they would see the Minutes. However there may be occasions where the Minutes would have sensitive details concerning the Executive and where sanctioned by the Chair of the Remuneration Committee it would not be appropriate for them to be disclosed.

RESOLVED: That the Audit Committee approved the Governance Practice Notes for the Trust Seal, Private Board and Committee Business, and Chair's Action.

16/22 INTERNAL AUDIT REPORTS

Progress report

1. Simon Cookson introduced the progress report and advised the Committee that all the audits in progress were due to close on time.

2. He added that the cooperation with Trust Executive Directors was very positive in respect of completing the audit reports and expected that the end of year report would be a positive opinion.

3. The formal deferment of the audit review on the savings plan for 2022/23 was requested and approved by the Committee.

Internal Audit Plan 2022/23

Osian Lloyd updated the Committee on the Internal Audit plan for 2022/23 which set out the programme of work proposed for next year. He added that it contained the internal audit charter which defined the overarching purpose and authority for internal audit. The report also considered areas of risk and the Trust's response to them. The plan was kept under review and remained flexible subject to the varying situations. A note of thanks was recorded for Julie Boalch in her work and the assistance provided to Internal Audit.

Comments:

A question arose in respect of timings of audits, especially in regards to ambulance immediate release response requests, Osian Lloyd advised that there was opportunity to be flexible on timings and outlined the mechanism involved in setting the deadlines. For this particular area the timings were agreed with the Director of Operations and the Medical Director.

Internal Audit Reviews

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

1. Information Management – Reasonable Assurance. The purpose of this review was to assess 999 calls and the availability of patient discharges through 'Consult and Close' and how it was analysed to inform patient safety and quality improvement. There were 2 medium priority findings raised; greater use of the referral data in the incident records should be made and that the current analysis of the 'can't send' responses was extended to include other incident responses. This should be routinely analysed, monitored and reported.

2. Digital Governance - Reasonable Assurance. The purpose of this review was to provide assurance that the Trust's governance of digital services was appropriate to provide oversight and deliver the digital strategic objectives. The key matters that arose was the requirement to develop a strategic outline programme which would describe how the digital strategy would be implemented and the required resourcing, to define the key timescales of delivery and to establish the structures in order to link in with operations.

3. Recruitment Practices, Equality, Diversity and Inclusion (EDI) – Reasonable Assurance. The Purpose of the report was to provide assurance that arrangements were in place to ensure that applicants from a diverse range of backgrounds were encouraged and supported in the recruitment process. There were 4 medium priority findings raised and related to; improve the link with the Patient Experience and Community Involvement Team and the strategic equality objectives, more analysis was required on the effectiveness of initiatives to attract new staff, further work was required on the progress of candidates and the Terms of Reference for the EDI steering group require updating. Paul Hollard added that these issues would be monitored through the People and Culture Committee.

4. Non Emergency Patient Transfer Services - Transfer of Operations, Benefits Realisation. Limited Assurance. The purpose of this review was to provide assurance that benefits realised reflected those identified at the start of the transfer

of works project. It was important to note that the findings related to the capturing, reporting and monitoring of the benefits realised. Paul Hollard added it was imperative to be clear that the audit review did not concern the transfer process, it referred to the benefits realisation plan. Judith Bryce advised the Committee that several discussions had been held with Audit colleagues and management were content with the findings

5. Cardiff Make Ready Depot (MRD) – Reasonable Assurance. David Butler explained that the purpose of this review was to evaluate the processes and procedures implemented by the Trust in order to support the management and delivery of the Cardiff MRD scheme. The Audit revealed that whilst some of the works costs had increased significantly the overall project would be delivered within the funding envelope. Whilst there had been an 18 week delay to the project, it was noted that 10 of these were attributed to the pandemic. The key priorities of note were; the need to conclude on the assessment of any project delays, to formally review performance of the project and that any remaining recommendations were to be considered as part of the formal post project evaluation. Chris Turley added that notwithstanding the pandemic, delivery of the project had been remarkable, albeit there had been a delay. He commented there were still some snagging issues with the building and that some operational staff would be moving in within the next couple of weeks.

RESOLVED: That the

(1) Internal Audit Plan for 2022/23 was approved;

(2) Internal Audit Charter was approved; and

(3) The associated Internal Audit resource requirements and Key Performance Indicators were noted.

17/22 RESPONSE TO AUDIT WALES REPORT AND CHECKLIST: TAKING CARE OF THE CARERS

Catherine Goodwin informed the Committee that the report provided an outline to the Trust's responses in respect of the audit undertaken on Taking Care of the Carers. Several recommendations had emanated from the report and these were:

1. Retaining a strong focus on staff wellbeing
2. Consider workforce issues in recovery plans
3. Evaluating the effectiveness and impact of the staff wellbeing offer
4. Enhancing collaborative approaches to supporting staff wellbeing
5. Providing continued assurance to boards and committees
6. Building on local and national staff engagement arrangements

Comments:

Trish Mills added that the above recommendations would be included in the Trust's audit

tracker.

RESOLVED: That the Committee noted the update:

18/22 AUDIT WALES UPDATE AND ANNUAL REPORT

The update was given by Fflur Jones who briefed the Committee on the audit work either completed or scheduled for the upcoming year. Some of the scheduled work included areas from the 2020/21 structured assessment and the quality governance review. Members noted that the work on unscheduled care, which had been paused during 2021, had resumed.
In terms of the annual report, Fflur Jones gave an overview of the contents and drew the Committee's attention to work undertaken on Test, Trace and Protect and financial audit work. She asked that a note of thanks be recorded to those in the Trust that had assisted in its compilation.

Comments:

Members expressed their frustration in respect of the amount of time being taken to complete the unscheduled care review and the lack of timescale to completion. Fflur Jones agreed to update the Committee on progress going forward.

RESOLVED: That

(1) the Committee received the reports noting that the Board would receive the annual report under consent items at its next meeting; and

(2) the audit plan would be circulated to Members prior to the next Committee meeting.

19/22 2021/2022 ANNUAL REPORT TIMELINE

1. Trish Mills reported that a Task and Finish Group had been established to ensure that the Trust met the Annual Report 2021-22 reporting requirements as set out in the Manual for Accounts published by Welsh Government and was aligned with the timetable for the Trust's annual accounts.

2. A timetable for the production of the Annual Report had been developed and was brought to the attention of the Committee. Due to the scheduling of Trust Board and Committee meetings, it was proposed that the Draft Annual Report will be circulated by e mail for review by Members.

RESOLVED: That the Committee approved;

(1) The Annual Report 2021-22 Timetable; and

(2) Circulation of the following reports by email for review:

a. Sign off Draft Remuneration Report Lead to the Remuneration Committee;
b. Sign off of Draft Annual Report to Audit Committee

20/22 2021/2022 ANNUAL ACCOUNTS UPDATE

1. The Committee were given an update by Chris Turley which included any planning undertaken, the progress made and any issues arising with the preparation of the 2021/22 annual accounts.

2. The Committee were also provided with the details of the timetable and key dates in relation to the 2021/22 year end accounts.

Comments:

In relation to any instances of actual, suspected or alleged fraud within NWSSP and BCULHB fraud it was queried why BCULHB was not included within the management response. It was agreed that BCULHB would be included within the response

RESOLVED: That the Committee

(1) Noted the contents of the report;

(2) Considered and approved the response points within Annex 2 of the report subject to the additional reference of BCULHB within the management response; and

(3) A note of thanks was recorded for all those involved in the work, notably, Navin Kalia, Jill Gill and Julie Boalch.

21/22 AUDIT TRACKER

Julie Boalch presented the report and drew attention to the following key points:

1. All of the recommendations had been closely scrutinised by the relevant responsible officers; paying particular attention to any overdue recommendations.

2. At the time of issuing the report there were 83 internal audit recommendations, of which 15 had been added to the tracker since the last Audit Committee meeting as a result of 3 audit reports presented in December 2021.

3. In respect of the 83 recommendations, 31 were overdue with 4 of them marked as high priority and were from the 2020/21 clinical contact centres performance report and these were due to be completed between April and July 2022.

4. A further recommendation related to the Trust's Risk Appetite Statement from the Risk Management and Assurance review which formed part of the Risk Transformation programme currently underway. This would not be completed until approximately March 2023.

Comments:

In terms of the overdue recommendations, were there any high risks or was the Trust

content they could be contained? Julie Boalch explained that the 2 recommendations relating to the information systems security were being addressed by external consultants. In relation to the remaining 2, raising concerns and risk management and assurance, work was continuing and progressing on both.

RESOLVED: That Members receivedand discuss the contents of the report and:

(1) Noted the activity since the last Audit Committee in December 2021; and

(2) Considered the Trust's proposals to address each recommendation.

22/22 RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK

1. Trish Mills advised the Committee that the purpose of the report was to give an update in relation to the Trust's Corporate Risks and Board Assurance Framework (BAF). A particular focus was on the work that was currently underway rearticulating and strengthening the Trust's highest scoring risks.

2. Furthermore the Committee was asked to approve a request to pause reporting on the BAF for 3 months. This would enable work on a transitional BAF that would provide for updated and rearticulated risks, particularly the highest scoring risks, together with a review of the controls in place and assurances against each control which would enable the actions to address any gaps to be clear. The Committee was assured that the Board and all Committees would, in the meantime, continue to receive regular updates on the Corporate Risk Register (CRR) which contained the Trust's key risks.

3. A new risk had been added to the CRR, number 458, a confirmed commitment from the Emergency Ambulance Services Committee (EASC) and/or Welsh Government required regarding funding for recurrent costs of commissioning. Chris Turley added that this risk was likely to change in terms of the score, currently a 12. The Committee recognised that the Finance and Performance Committee was monitoring this particular risk.

4. Trish Mills made reference to the work underway to review other corporate risks which included:

    c. Risk 163 - *Maintaining Effective and Strong Trade Union Partnerships* which had increased in score from 9 to 12
    d. There was a title change to risk 139, the new title was described as *Failure to deliver our Statutory Financial Duties in accordance with legislation*
    e. Risk 109, *Resource availability (revenue) to deliver the organisation's IMTP* was recommended for closure noting that this element of the risk was included under risk 458.

Comments:

1. The Committee welcomed the report and supported the pausing of BAF reporting, recognising that the key corporate risks would continue to be monitored and managed during this period.

2. Members discussed in further detail regarding the reporting of the high risks in more detail to the Board. Trish Mills explained that the transitional BAF will incorporate the high rated risks and will detail the actions to mitigate them. The relevant Committees would also be scrutinising and challenging these risks; the actions to monitor the risks would be carried out through the Executive Management Team.

RESOLVED: Members received assurances on the contents of the report and considered and approved:

(1) The request to pause reporting of the Board Assurance Framework for 3 months.
(2) The change in title of Risk 139.
(3) The closure of Risk 109 from the Corporate Register.
(4) The escalation of Risk 163 to the Corporate Register.
(5) The inclusion of Risk 458 on the Corporate Register

23/22 LOSSES AND SPECIAL PAYMENTS – PAYMENTS FOR THE PERIOD 1 April 2021 – 31 January 2022

Chris Turley gave an overview of the report explaining that future reports be developed to contain further narrative of any themes and trends resulting from losses and payments.

RESOLVED: That the Losses and Special Payments report for the period was received.

24/22 LOSSES AND SPECIAL PAYMENTS DEEP DIVE INTO PERSONAL INJURY CLAIMS

1. Wendy Herbert reminded the Committee this was the last of the four deep dives that had been undertaken provide details of losses and special payments relating to personal injury claims.

2. The report illustrated details of all personal injury claims (38) registered during the calendar years of 2020 and 2021. The number of cases received during 2020 totalled 23 and in 2021 the figure was 15, a marked reduction.

3. In respect of the 3 claims received by patients in 2021 these related to the Non emergency Patient Transport Service.

4. Of the 21 Claims received by staff in 2020, the majority were from Emergency Medical Service (EMS) staff and in 2021 of the 12 claims received, again the majority were from EMS staff.

5. The deep dive has identified that there has been some evidence of prior learning and improvement. This was borne out by the fact that claims from previous years involving staff tripping over cables had dramatically reduced.

6. In terms of themes from this deep dive it was noted that these included needle stick issues and claims relating to Covid, stress and assault.

7. As a resulting of these claims the Trust has gained significant learning; which have included; use of equipment including PPE, introduction of quarterly station inspections, introduction of Trauma Risk Management and 24 hour access to occupational assistance.

8. There have been several high cost claims which have exceeded £100k and these included work related stress and falling from a vehicle.

9. In some cases where it has been possible to avoid solicitor costs and rely on the Trust's small claims team to manage claims, the Trust has saved in the region of £300k - £360k.

Comments:

1. Following a question in terms of Welsh Risk Pool (WRP) legal assistance, Wendy Herbert explained there was a cost to the Trust which varied for each case; in particular the high cost claims, WRP used private solicitors for support.

2. In terms of patient Non Emergency Transport Services, was it possible to distinct if the claims related to the Trust's internal service or external providers. Wendy explained this was possible and advised that for the 3 claims relating to patient transport, 2 were in house and 1 involved a St John provider.

RESOLVED: That the Committee considered the report.

25/22 KEY MESSAGES FOR BOARD

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

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

26/22 ANY OTHER BUSINESS

This was the last Audit Committee meeting that Emrys Davies would be attending and the Chair thanked him for his contribution to the Committee. The thanks were reciprocated by Emrys.

Date of Next Meeting: 7 June 2022

Ref	Date	Agenda Item	Action Note	Responsible	Due Date	Progress/Comment	Status
14/22	3 March 2022	Committee Terms of Reference	Amend paragraph 4.6 to read Chief Executive **will** be invited to attend annually.	Trish Mills	7 June 2022	Update for 7 June 2022	Complete

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

2021/22 ANNUAL ACCOUNTS

MEETING	Audit Committee
DATE	7 June 2022
EXECUTIVE	Director of Finance & Corporate Resources
AUTHOR	Jill Gill, Head of Financial Accounting
CONTACT	Chris Turley chris.turley2@wales.nhs.uk

EXECUTIVE SUMMARY

The Trust submitted its unaudited Draft Annual Accounts for 2021/22 to the Welsh Government, on 29th April 2022, in line with the agreed timetable.

The accounts for the year ended 31 March 2022 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 2021/22 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 £0.260 million for the year, of this £0.185m related to a donated asset resulting in an adjusted surplus of £0.075m being reported as the financial duty;
b) Met its financial duty to break even over the 3 years 2019/2020 to 2021/2022;
c) Expended Capital Investment funds of £27.942 million, thereby utilising 100% of the Trust's Capital Expenditure Limit;
d) Achieved Public Sector Payments Policy (PSPP) of 97.2% within 30 days against the 95% target.

The requirement to achieve the administrative External Financing Target was again suspended for 2021/22.

REPORT APPROVAL ROUTE
An update on the financial performance of the Trust as at Month 12 2021/22 and therefore the draft 2021/22 year end position (subject to audit) was provided to both the Finance & Performance Committee on 16th May 2022 and Trust Board on 26th May 2022. The audited Annual Accounts are to be presented to Trust Board for their approval on 13th June 2022. The final approved and audited Annual Accounts are due to be submitted to Welsh Government by 15th June 2022 together with the Trust's Annual Report, as a single unified document in line with the agreed timetable.

REPORT APPENDICES
Appendix 1 – Annual Accounts 2021/22

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

2021/22 ANNUAL ACCOUNTS REPORT

SITUATION

1. The Trust submitted it's unaudited 2021/22 Draft Accounts on 29th April 2022 to the Welsh Government, in line with the agreed timetable.

BACKGROUND

2. The accounts for the year ended 31 March 2022 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 £0.260 million for the year; of this £0.185m related to a donated asset resulting in an adjusted surplus of £0.075m being reported as the financial duty;

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 2019/20 to 2021/22 as shown below.

Annual Financial Performance	2019-20 £000	2020-21 £000	2021-22 £000	**2019-20 to 2021-22 Financial Duty £000**
Retained Surplus	45	70	260	**375**
Less Donated Asset/Grant Funded Revenue Adjustment	0	0	(185)	**(185)**
Adjusted Surplus/(Deficit)	**45**	**70**	**75**	**190**

c) External Financing Limit (EFL); Due to the continuing circumstances as a result of the COVID-19 pandemic, the requirement to achieve the administrative External Financing Target has again been suspended for 2021/22.

d) Expended Capital Investment funds of £27.942 million, thereby utilising 100% of the Trust's Welsh Government set Capital Expenditure Limit; and

e) Achieved Public Sector Payments Policy (PSPP) of 97.2% 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, including omissions, however one uncorrected misstatement has been identified and reported within the auditors ISA 260 report. Given the way this one has arisen, this will be the same across all NHS Wales organisations. This arose due to a very late update received by WG from the District Valuer in March 2022 advising that the indexation for property had risen during quarter 4 to 113 from 111. The WG issued an instruction to all health bodies on 31st March 2022 **not** to apply this increase, as the overall effect was not material. If the increase had been applied for the Trust for the whole of 2022, the effect would have been to revalue upwards the value of property by a net amount of c£0.3m (the opposite account entry would have been to revaluation reserve) and this in turn would have increased depreciation by £0.004m. This increase in depreciation would have received ring-fenced funding from the WG, resulting in an overall neutral effect on revenue.

7. Whilst it is disappointing that such an uncorrected misstatement has had to be reported through from AW in this way, as noted above this was down to a specific instruction by WG to all NHS Wales organisations on how this late indexation notification was to be treated in the draft accounts and will therefore apply to all HBs and Trusts in Wales. Due to the timing of this being requested by AW and the immateriality of it in terms of the overall Trust position, this will not now be adjusted in the final accounts. Again, as we understand it, this is consistent with the approach being taken by all other NHS Wales organisations

8. 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 2021/22 financial statements, citing that they provide a true and fair view of the Trust's finances in the 2021/22 financial year.

9. The audited accounts are due to be presented to Trust Board for their approval on 13th June 2022.

10. The final approved and audited annual accounts and accountability report are then due to be submitted to Welsh Government by 15th June 2022 as one single unified document in line with the agreed timetable.

RECOMMENDED: That the Trust's Annual Accounts for 2021/22 be recommended for formal approval by the Trust Board.

Welsh Ambulance Services NHS Trust

Foreword

These accounts for the period ended 31 March 2022 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 4000 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 100 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, which is an amalgamation of NHS Direct Wales (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 2022

	Note	2021-22 £000	2020-21 £000
Revenue from patient care activities	3	261,570	232,768
Other operating revenue	4	14,889	8,988
Operating expenses	5.1	(276,398)	(241,847)
Operating (deficit)/surplus		61	(91)
Investment revenue	6	14	5
Other gains and losses	7	129	175
Finance costs	8	56	(19)
Consolidated Total			
Retained surplus	2.1.1	260	70
Other Comprehensive Income			
Items that will not be reclassified to net operating costs:			
Net gain/(loss) on revaluation of property, plant and equipment		1,016	522
Net gain/(loss) on revaluation of intangible assets		0	0
Net gain/(loss) on revaluation of financial assets		0	0
Movements in other reserves		0	0
Net gain/(loss) on revaluation of PPE and Intangible assets held for sale		0	0
Impairments and reversals		(96)	(643)
Transfers between reserves		0	0
Reclassification adjustment on disposal of available for sale financial assets		0	0
Sub total		920	(121)
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		920	(121)
Total comprehensive income for the year		1,180	(51)

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

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2022

		Note	31 March 2022	31 March 2021
			£000	£000
Non-current assets	Property, plant and equipment	**13**	**95,594**	89,390
	Intangible assets	**14**	**3,231**	3,463
	Trade and other receivables	**17.1**	**790**	2,278
	Other financial assets	**18**	**0**	0
	Total non-current assets		**99,615**	95,131
Current assets	Inventories	**16.1**	**1,826**	1,628
	Trade and other receivables	**17.1**	**17,148**	14,481
	Other financial assets	**18**	**0**	0
	Cash and cash equivalents	**19**	**18,708**	18,468
			37,682	34,577
	Non-current assets held for sale	**13.2**	**130**	130
	Total current assets		**37,812**	34,707
Total assets			**137,427**	129,838
Current liabilities	Trade and other payables	**20**	**(35,752)**	(28,521)
	Borrowings	**21**	**(1,364)**	(1,616)
	Other financial liabilities	**22**	**0**	0
	Provisions	**23**	**(4,402)**	(6,949)
	Total current liabilities		**(41,518)**	(37,086)
Net current assets/(liabilities)			**(3,706)**	(2,379)
Total assets less current liabilities			**95,909**	92,752
Non-current liabilities	Trade and other payables	**20**	**0**	0
	Borrowings	**21**	**0**	(1,059)
	Other financial liabilities	**22**	**0**	0
	Provisions	**23**	**(10,058)**	(11,887)
	Total non-current liabilities		**(10,058)**	(12,946)
Total assets employed			**85,851**	79,806
Financed by Taxpayers' equity:				
	Public dividend capital		**81,219**	76,354
	Retained earnings		**(5,701)**	(5,961)
	Revaluation reserve		**10,333**	9,413
	Other reserves		**0**	0
	Total taxpayers' equity		**85,851**	79,806

The financial statements were approved by the Board on 13th June 2022 and signed on behalf of the Board by:

Chief Executive : Jason Killens……

Date: 13th June 2022

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 as at 31 March 2021	**76,354**	**(5,961)**	**9,413**	**79,806**
Adjustment	**0**	**0**	0	**0**
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 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**
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 CHANGES IN TAXPAYERS' EQUITY

2020-21	Public Dividend Capital £000	Retained earnings £000	Revaluation reserve £000	Total £000
Changes in taxpayers' equity for 2020-21				
Balance at 31 March 2020	76,309	(6,209)	9,712	79,812
Adjustment	0	0	0	0
Balance at 1 April 2020	76,309	(6,209)	9,712	79,812
Retained surplus/(deficit) for the year		70		70
Net gain/(loss) on revaluation of property, plant and equipment		0	522	522
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	(643)	(643)
Other reserve movement		0	0	0
Transfers between reserves		178	(178)	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	248	(299)	(51)
New Public Dividend Capital received	835			835
Public Dividend Capital repaid in year	(790)			(790)
Public Dividend Capital extinguished/written off	0			0
Other movements in PDC in year	0			0
Balance at 31 March 2021	76,354	(5,961)	9,413	79,806

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

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2022

	Note	2021-22 £000	2020-21 £000
Operating surplus/(deficit)	SOCI	61	(91)
Movements in working capital	30	(593)	(450)
Other cash flow adjustments	31	25,662	20,659
Provisions utilised		(6,963)	(2,504)
Interest paid		(44)	(19)
Net cash inflow (outflow) from operating activities		18,123	17,595
Cash flows from investing activities			
Interest received		14	5
(Payments) for property, plant and equipment		(21,339)	(22,259)
Proceeds from disposal of property, plant and equipment		158	291
(Payments) for intangible assets		(270)	171
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		(21,437)	(21,792)
Net cash inflow (outflow) before financing		(3,314)	(4,197)
Cash flows from financing activities			
Public Dividend Capital received		9,530	835
Public Dividend Capital repaid		(4,665)	(790)
Loans received from Welsh Government		0	0
Other loans received		0	0
Loans repaid to Welsh Government		0	0
Other loans repaid		0	0
Other capital receipts		0	0
Capital elements of finance leases and on-SOFP PFI		(1,311)	(1,962)
Cash transferred (to)/from other NHS Wales bodies		0	0
Net cash inflow (outflow) from financing activities		3,554	(1,917)
Net increase (decrease) in cash and cash equivalents		240	(6,114)
Cash [and] cash equivalents at the beginning of the financial year	19	18,468	24,582
Cash [and] cash equivalents at the end of the financial year	19	18,708	18,468

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 2021-2022 Manual for Accounts. The accounting policies contained in that manual follow the 2021-2022 Financial Reporting Manual (FReM), in accordance with international accounting standards in conformity with the requirements of the Companies Act 2006 except for IFRS 16 Leases, which is deferred until 1 April 2022; 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 Note 37.1 'Other Information' on page 74 of 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 2017-2018 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 the 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

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

1.11.1 The NHS Wales organisation as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are recognised in calculating the NHS Trust's surplus/deficit charged.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term. Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.11.2 The NHS Wales organisation as lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the NHS Wales organisation net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the NHS Wales organisation's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

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 2021-22, 2020-21 and 2019-2020.

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 NHS Wales organisations 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 Wales 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 organisation 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.

All claims for losses and special payments are provided for, where the probability of settlement of an individual claim is over 49%. 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 6-49%, 25% of the defence costs are provided for with the remaining liabilities being disclosed as a contingent liability.

1.22 Pooled budget

The NHS Wales organisation has not entered into pooled budgets with Local Authorities.

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 organisations, 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	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 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 16 Leases is to be effective from 1 April 2022.

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 2021-2022 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 the corporate trustee of the Welsh Ambulance Services NHS Trust Charitable Fund it is therefore considered for accounting standards compliance to have control of the Welsh Ambulance Services NHS Trust Charitable Fund as a subsidiary.

The determination of control is an accounting standard test of control and there has been no change to the operation of the Welsh Ambulance Services NHS Trust Charitable Fund or its independence in its management of charitable funds.

However the organisation has with the agreement of the Welsh Government adopted the IAS 27(10) exemption to consolidate. Welsh Government as the ultimate parent of the NHS Wales organisations will disclose the Charitable Accounts in the Welsh Government Consolidated Accounts. Details of the transactions with the charity are included in the related parties notes.

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			**2019-20 to 2021-22 Financial duty**
	2019-20 £000	2020-21 £000	2021-22 £000	**£000**
Retained surplus	45	70	260	**375**
Less Donated asset / grant funded revenue	0	0	(185)	**(185)**
Adjusted surplus/ (Deficit)	45	70	75	**190**

The Welsh Ambulance Services NHS Trust has met its financial duty to break even over the 3 years 2019-2020 to 2021-2022.

2.1.2 Integrated Medium Term Plan (IMTP)

Due to the pandemic, the process for the 2020-23 integrated plan was paused in spring 2020 temporary planning arrangement were implemented

As a result the extant planning duty for 2021-22 remains the requirement to submit and have approved a 2019-22 integrated plan, as set out in the NHS Wales Planning Framework 2019-22.

The Welsh Ambulance Services NHS Trust submitted a 2019-22 integrated plan in accordance with the planning framework.

The Minister for Health and Social Services extant approval.

Status	**Approved**
Date	18/04/2019

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

Due to circumstances that arose as a result of the COVID-19 pandemic, the requirement to achieve the External Financing Target has been suspended for 2021-22. It is expected to be reintroduced for 2022-23.

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:

	2021-22	2020-21
Total number of non-NHS bills paid	**49,800**	**48,451**
Total number of non-NHS bills paid within target	**48,400**	**47,079**
Percentage of non-NHS bills paid within target	**97.2%**	**97.2%**

The Trust has met the target.

3. Revenue from patient care activities	2021-22	2020-21
	£000	£000
Local health boards	**41,034**	35,433
Services Committees (WHSSC & EASC)	**185,589**	172,180
Welsh NHS Trusts	**745**	751
Welsh Special Health Authorities	**0**	0
Foundation Trusts	**0**	0
Other NHS England bodies	**136**	127
Other NHS Bodies	**0**	0
Local Authorities	**0**	2
Welsh Government	**29,908**	21,658
Welsh Government - Hosted Bodies	**0**	0
Non NHS:		
Private patient income	**0**	4
Overseas patients (non-reciprocal)	**0**	0
Injury Costs Recovery (ICR) Scheme	**193**	194
Other revenue from activities	**3,965**	2,419
Total	**261,570**	232,768
Welsh Government Covid 19	**12,810**	13,811

Included within Non NHS: Other revenue from activities £3.965m above is £1.796m from Department of Health & Social Care and £1.781m from Health Security Agency , total £3.577m.This relates to funding provided for Covid 19 Mobile Testing Units (MTU), (2020/21 £2.354m).

Injury Cost Recovery (ICR) Scheme income:

	2021-22	2020-21
	%	%
To reflect expected rates of collection ICR income is subject to a provision for impairment of:	23.76	22.43

4. Other operating revenue	2021-22	2020-21
	£000	£000
Income generation	**0**	0
Patient transport services	**0**	0
Education, training and research	**1,329**	685
Charitable and other contributions to expenditure	**0**	0
Receipt of Covid Items free of charge from other NHS Wales Organisations	**0**	1,946
Receipt of Covid Items free of charge from other organisations	**0**	0
Receipt of donations for capital acquisitions	**185**	0
Receipt of government grants for capital acquisitions	**0**	0
Non-patient care services to other bodies	**0**	0
Rental revenue from finance leases	**0**	127
Rental revenue from operating leases	**141**	0
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	**79**	128
Business unit	**0**	0
Scheme Pays Reimbursement Notional	**0**	0
Other	**13,155**	6,102
Total	**14,889**	8,988
Total Patient Care and Operating Revenue	**276,459**	**241,756**
Other revenue comprises:		
Personal injury benefit scheme (PIBS)	**132**	**921**
Air Ambulance paramedic funding	**0**	**0**
Hazardous Area Response Team (HART)	**2,570**	**2,457**
Other minor services income	**4,317**	**2,086**
Funding for impairments (as funds flow monies)	**6,136**	**638**
Total	**13,155**	6,102

5. Operating expenses	**2021-22**	2020-21
5.1 Operating expenses	**£000**	£000
Local Health Boards	**131**	228
Welsh NHS Trusts	**914**	837
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	**12,599**	8,694
Welsh Government	**374**	312
Other NHS Trusts	**0**	0
Directors' costs	**1,835**	1,625
Operational Staff costs	**189,878**	172,004
Single lead employer Staff Trainee Cost	**0**	0
Collaborative Bank Staff Cost	**0**	0
Supplies and services - clinical	**6,801**	7,228
Supplies and services - general	**2,336**	3,245
Consultancy Services	**878**	434
Establishment	**4,373**	3,544
Transport	**16,995**	13,462
Premises	**12,216**	9,207
Impairments and Reversals of Receivables	**0**	0
Depreciation	**15,190**	13,707
Amortisation	**1,750**	1,821
Impairments and reversals of property, plant and equipment	**6,135**	638
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	**163**	150
Other auditors' remuneration	**0**	0
Losses, special payments and irrecoverable debts	**843**	1,409
Research and development	**0**	0
Other operating expenses	**2,987**	3,302
Total	**276,398**	241,847

On 1st April 2019 employer pension contributions increased by 6.3%. Welsh Government funded this by making payment directly to the NHS Pensions Agency on the Trust's behalf. Further detail is provided in note 37.1.

5. Operating expenses (continued)
5.2 Losses, special payments and irrecoverable debts:

Charges to operating expenses **Increase/(decrease) in provision for future payments:**	**2021-22** **£000**	2020-21 £000
Clinical negligence;-		
Secondary care	**310**	2,237
Primary care	**0**	0
Redress Secondary Care	**262**	330
Redress Primary Care	**0**	0
Personal injury	**(688)**	1,563
All other losses and special payments	**0**	0
Defence legal fees and other administrative costs	**171**	274
Structured Settlements Welsh Risk Pool	**0**	0
Gross increase/(decrease) in provision for future payments	**55**	4,404
Contribution to Welsh Risk Pool	**0**	0
Premium for other insurance arrangements	**0**	0
Irrecoverable debts	**37**	(28)
Less: income received/ due from Welsh Risk Pool	**751**	(2,967)
Total charge	**843**	1,409

Personal injury includes £0.126m in respect of permanent injury benefits (2020-21 £0.915m). This expenditure includes a charge of £0.099m 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 2021-22.

	2021-22 **£**	2020-21 £
Permanent injury included within personal injury:	**125,783**	914,891

6. Investment revenue	2021-22	2020-21
Rental revenue :	**£000**	£000
PFI finance lease revenue:		
Planned	**0**	0
Contingent	**0**	0
Other finance lease revenue	**0**	0
Interest revenue:		
Bank accounts	**14**	5
Other loans and receivables	**0**	0
Impaired financial assets	**0**	0
Other financial assets	**0**	0
Total	**14**	5

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7. Other gains and losses	2021-22	2020-21
	£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	**129**	175
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	**129**	175

8. Finance costs	2021-22	2020-21
	£000	£000
Interest on loans and overdrafts	**0**	0
Interest on obligations under finance leases	**44**	68
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	**44**	68
Provisions unwinding of discount	**(100)**	(49)
Periodical Payment Order unwinding of discount	**0**	0
Other finance costs	**0**	0
Total	**(56)**	**19**

9. Operating leases

9.1 Trust as lessee

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

Payments recognised as an expense	**2021-22**	2020-21
	£000	£000
Minimum lease payments	**2,027**	1,969
Contingent rents	**0**	0
Sub-lease payments	**0**	0
Total	**2,027**	1,969

Total future minimum lease payments	**2021-22**	2020-21
Payable:	**£000**	£000
Not later than one year	**1,842**	1,637
Between one and five years	**4,167**	2,303
After 5 years	**1,798**	1,802
Total	**7,807**	5,742

Total future sublease payments expected to be received	**0**	0

9. Operating leases (continued)

9.2 Trust as lessor

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

Rental Revenue

Receipts recognised as income	**2021-22**	2020-21
	£000	£000
Rent	**0**	0
Contingent rent	**0**	0
Other	**143**	121
Total rental revenue	**143**	121

Total future minimum lease payments	**2021-22**	2020-21
Receivable:	**£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	2021-22 £000	2020-21 £000
	£000	£000	£000	£000	£000	£000	£000
Salaries and wages	**157,003**	**494**	**1,754**	**0**	**0**	**159,251**	145,090
Social security costs	**15,091**	**0**	**0**	**0**	**0**	**15,091**	12,857
Employer contributions to NHS Pensions Scheme	**17,902**	**0**	**0**	**0**	**0**	**17,902**	15,903
Other pension costs	**6**	**0**	**0**	**0**	**0**	**6**	2
Other post-employment benefits	**0**	**0**	**0**	**0**	**0**	**0**	0
Termination benefits	**292**	**0**	**0**	**0**	**0**	**292**	306
Total	**190,294**	**494**	**1,754**	**0**	**0**	**192,542**	174,158

Of the total above:		
Charged to capital	**956**	652
Charged to revenue	**191,586**	173,506
Total	**192,542**	174,158

Net movement in accrued employee benefits (untaken staff leave total accrual included in note above)	**673**	1,466
The net movement in accrued employee benefits footnote above includes Covid 19 Net movement in accrued employee ber	**673**	1,466

10.2 Average number of employees	Permanently Employed	Staff on Inward Secondment	Agency Staff	Specialist Trainee (SLE)	Other Staff	2021-22 Total	2020-21 Total
	Number	Number	Number	Number	Number	Number	Number
Administrative, clerical and board members	**557**	**9**	**15**	**0**	**0**	**581**	558
Medical and dental	**1**	**0**	**0**	**0**	**0**	**1**	1
Nursing, midwifery registered	**207**	**0**	**0**	**0**	**0**	**207**	170
Professional, scientific and technical staff	**2**	**0**	**0**	**0**	**0**	**2**	1
Additional Clinical Services	**2,058**	**0**	**6**	**0**	**0**	**2,064**	1,755
Allied Health Professions	**1,052**	**0**	**0**	**0**	**0**	**1,052**	1,106
Healthcare scientists	**0**	**0**	**0**	**0**	**0**	**0**	0
Estates and Ancillary	**62**	**0**	**0**	**0**	**0**	**62**	62
Students	**0**	**0**	**0**	**0**	**0**	**0**	0
Total	**3,939**	**9**	**21**	**0**	**0**	**3,969**	3,653

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

10.3. Retirements due to ill-health	2021-22	2020-21
Number	**5**	3
Estimated additional pension costs £	**348,066**	150,929

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)	2021-22 Number of compulsory redundancies Whole numbers only	2021-22 Number of other departures Whole numbers only	2021-22 Total number of exit packages Whole numbers only	2021-22 Number of departures where special payments have been made Whole numbers only	2020-21 Total number of exit packages Whole numbers only
less than £10,000	**0**	**0**	**0**	**0**	0
£10,000 to £25,000	**0**	**1**	**1**	**0**	0
£25,000 to £50,000	**0**	**3**	**3**	**0**	2
£50,000 to £100,000	**0**	**2**	**2**	**0**	1
£100,000 to £150,000	**0**	**0**	**0**	**0**	0
£150,000 to £200,000	**0**	**0**	**0**	**0**	1
more than £200,000	**0**	**0**	**0**	**0**	0
Total	**0**	**6**	**6**	**0**	**4**

Exit packages cost band (including any special payment element)	2021-22 Cost of compulsory redundancies £	2021-22 Cost of other departures £	2021-22 Total cost of exit packages £	2021-22 Cost of special element included in exit packages £	2020-21 Total cost of exit packages £
less than £10,000	**0**	**0**	**0**	**0**	0
£10,000 to £25,000	**0**	**22,191**	**22,191**	**0**	0
£25,000 to £50,000	**0**	**131,053**	**131,053**	**0**	63,551
£50,000 to £100,000	**0**	**138,628**	**138,628**	**0**	66,417
£100,000 to £150,000	**0**	**0**	**0**	**0**	0
£150,000 to £200,000	**0**	**0**	**0**	**0**	176,244
more than £200,000	**0**	**0**	**0**	**0**	0
Total	**0**	**291,872**	**291,872**	**0**	**306,212**

Exit costs paid in year of departure	Total paid in year 2021-22 £	Total paid in year 2020-21 £
Exit costs paid in year	**171,637**	239,796
Total	**171,637**	**239,796**

Redundancy, voluntary early release, and other departure costs have been paid in accordance with the provisions of the relevant schemes / legislation. Where the Trust has agreed early retirements or compulsory redundancies, 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 (see note 10.3 for details of ill health retirement costs).

The disclosure reports the number and value of exit packages agreed in the year in line with the Welsh Government manual for accounts. The costs disclosed above exclude costs relating to Payments in Lieu of Notice (PILON).

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. The 2021-22 financial year is the first year disclosures in respect of the 25th percentile pay ratio and 75th percentile pay ratio are required.

	2021-22	**2021-22**	**2021-22**	2020-21	2020-21	2020-21
	£000	**£000**	**£000**	£000	£000	£000
Total pay and benefits	**Chief Executive**	**Employee**	**Ratio**	Chief Executive	Employee	Ratio
25th percentile pay ratio	**162,500**	**24,565**	**6.62:1**	167,500	22,945	7.3:1
Median pay	**162,500**	**31,805**	**5.11:1**	167,500	30,523	5.49:1
75th percentile pay ratio	**162,500**	**44,814**	**3.63:1**	167,500	42,287	3.96:1
Salary component of total pay and benefits						
25th percentile pay ratio	**167,500**	**21,777**	**7.69:1**	167,500	21,142	7.92:1
Median pay	**167,500**	**24,882**	**6.73:1**	167,500	24,157	6.93:1
75th percentile pay ratio	**167,500**	**39,027**	**4.29:1**	167,500	33,779	4.96:1

Total pay and benefits	**Highest Paid Director ***	**Employee**	**Ratio**	Highest Paid Director *	Employee	Ratio
25th percentile pay ratio	**162,500**	**24,565**	**6.62:1**	167,500	22,945	7.3:1
Median pay	**162,500**	**31,806**	**5.11:1**	167,500	30,523	5.49:1
75th percentile pay ratio	**162,500**	**44,814**	**3.63:1**	167,500	42,287	3.96:1
Salary component of total pay and benefits						
25th percentile pay ratio	**167,500**	**21,777**	**7.69:1**	167,500	21,142	7.92:1
Median pay	**167,500**	**24,882**	**6.73:1**	167,500	24,157	6.93:1
75th percentile pay ratio	**167,500**	**39,027**	**4.29:1**	167,500	33,779	4.96:1

In 2021-22, 0 (2020-21, 0) employees received remuneration in excess of the highest-paid director.

Remuneration for all staff ranged from £18,576 to £167,500 (2020-21, £18,185 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

NHS and social care financial recognition scheme bonus of £735 payment to reward eligible NHS staff has not been included in the NHS Remuneration Report calculations. This bonus payment is not a contractual payment, but a one off payment to reward eligible staff for their commitment and tireless efforts in the most challenging circumstances.

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.

Following the change of presentation of the disclosure note, a new methodology has been implemented resulting in a different report having to be utilised, this has resulted in the median pay for 2020-21 increasing by £1,510 from the figure disclosed in the 2020-21 accounts. The reason behind this increase is that the new report takes their gross salary as at 31st March 2022 whereas the previous report calculated their cumulative gross pay.

10.6.2 Percentage Changes	**2020-21 to 2021-22**	2019-20 to 2020-21
% Change from previous financial year in respect of Chief Executive	**%**	%
Salary and allowances	**-3.0**	3.1
Performance pay and bonuses	**0**	0
% Change from previous financial year in respect of highest paid director		
Salary and allowances	**-3.0**	3.1
Performance pay and bonuses	**0**	0
Average % Change from previous financial year in respect of employees taken as a whole		
Salary and allowances	**3.6**	4.7
Performance pay and bonuses	**0**	0

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 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 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.

11. Pensions (continued)

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 2016 funding valuation also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports.

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 £50,000 for the 2021-2022 tax year (2020-2021 £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.

	2021-22 Number	**2021-22 £000**	2020-21 Number	2020-21 £000
NHS				
Total bills paid in year	**995**	**7,609**	889	7,578
Total bills paid within target	**923**	**6,848**	806	6,937
Percentage of bills paid within target	**92.8%**	**90.0%**	90.7%	91.5%
Non-NHS				
Total bills paid in year	**49,800**	**124,384**	48,451	106,133
Total bills paid within target	**48,400**	**122,353**	47,079	104,195
Percentage of bills paid within target	**97.2%**	**98.4%**	97.2%	98.2%
Total				
Total bills paid in year	**50,795**	**131,993**	49,340	113,711
Total bills paid within target	**49,323**	**129,201**	47,885	111,132
Percentage of bills paid within target	**97.1%**	**97.9%**	97.1%	97.7%

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

	2021-22 £	2020-21 £
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 :

2021-22	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
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	0	0	0	0	0
At 31 March 2022	9,043	28,879	0	23,262	24,382	76,496	38,676	1,880	202,618
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	0	0	0	0	0
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	18,418	51,679	31,280	1,466	107,024
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

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. Trusts 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.

A chartered surveyor was used during the 2021/22 financial year to value an asset that became operational during the year.

13. Property, plant and equipment :

2020-21	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 2020	8,772	20,649	0	22,100	20,959	67,473	32,423	1,833	174,209
Indexation	0	585	0	0	0	0	0	0	585
Additions - purchased	0	170	0	13,192	5	1,388	661	1	15,417
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	835	0	0	0	0	835
Reclassifications	0	715	0	(18,945)	1,633	13,798	2,709	14	(76)
Revaluation	(153)	(490)	0	0	0	0	0	0	(643)
Reversal of impairments	0	0	0	0	0	0	0	0	0
Impairments	(21)	(560)	0	0	0	0	(62)	0	(643)
Reclassified as held for sale	0	0	0	0	0	(4,260)	0	0	(4,260)
Disposals other than by sale	0	0	0	0	0	0	0	0	0
At 31 March 2021	8,598	21,069	0	17,182	22,597	78,399	35,731	1,848	185,424
Depreciation									
At 1 April 2020	0	2,165	0	0	14,170	44,154	24,953	1,087	86,529
Indexation	0	63	0	0	0	0	0	0	63
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	0	0	0	0	0	(5)	0	(5)
Reclassified as held for sale	0	0	0	0	0	(4,260)	0	0	(4,260)
Disposals other than by sale	0	0	0	0	0	0	0	0	0
Charged during the year	0	877	0	0	2,033	7,441	3,165	191	13,707
At 31 March 2021	0	3,105	0	0	16,203	47,335	28,113	1,278	96,034
Net book value									
At 1 April 2020	8,772	18,484	0	22,100	6,789	23,319	7,470	746	87,680
Net book value									
At 31 March 2021	8,598	17,964	0	17,182	6,394	31,064	7,618	570	89,390
Net book value at 31 March 2021 comprises :									
Purchased	8,598	17,964	0	17,182	6,394	31,064	7,618	570	89,390
Donated	0	0	0	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0	0	0	0
At 31 March 2021	8,598	17,964	0	17,182	6,394	31,064	7,618	570	89,390
Asset Financing:									
Owned	8,598	17,964	0	17,182	6,394	31,064	4,968	570	86,740
Held on finance lease	0	0	0	0	0	0	2,650	0	2,650
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 2021	8,598	17,964	0	17,182	6,394	31,064	7,618	570	89,390

The net book value of land, buildings and dwellings at 31 March 2021 comprises :

	£000
Freehold	23,688
Long Leasehold	2,874
Short Leasehold	0
Total	26,562

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. LHB s 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 NHS Trust received the following donated assets during the year:

EMS Fully Equipped Ambulance	£0.185 million

ii) Valuations
The Trust's 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. A chartered surveyor was used during the 2021/22 financial year to value an asset that became operational during the year.

The Trust 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 six to eight years.
Buildings are depreciated on useful lives as determined by the Valuation Office Agency.

iv) Compensation and Write downs
£6.136 million was received from the Welsh Assembly Government in respect of compensation for assets impaired during the year. This is included in the income statement.

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

vi) Assets Held for Sale or sold in the period.
Assets becoming classified as held for sale are shown in Note 13.2. Those sold in the period are detailed below.

Gain/(Loss) on Sale

		Gain/(Loss) on sale
Asset description	**Reason for sale**	**£000**
Vehicles	No longer serviceable	**113**
Equipment	No longer serviceable	**16**
		129

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 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	**0**	**0**	**0**	**0**	**0**	**0**
Balance c/f 31 March 2022	**130**	**0**	**0**	**0**	**0**	**130**
Balance b/f 1 April 2020	246	0	0	0	0	246
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	(116)	0	0	0	0	(116)
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	0	0	0	0	0	0
Balance c/f 31 March 2021	130	0	0	0	0	130

As at 31st March 2022, one property is included within this category.

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 is now anticipated to take place during the financial year 2022/23.

Within Note 13 there is £4.227m of Transport equipment and £0.118m of Plant & Machinery that is reclassified as held for sale. These relate wholly to fully depreciated vehicles and equipment which are then sold at auction.The gain on sale of these assets within the year is included in full within Note 13 (vi) (£0.129m).

14. Intangible assets

	Computer software purchased	Computer software internally developed	Licenses and trade-marks	Patents	Development expenditure internally generated	Total
Cost or valuation	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
At 1 April 2021	**11,570**	**0**	**4,589**	**0**	**0**	**16,159**
Revaluation		**0**			**0**	**0**
Reclassifications	**788**	**0**	**602**	**0**	**0**	**1,390**
Reversal of impairments	**0**	**0**	**0**	**0**	**0**	**0**
Impairments	**0**	**0**	**0**	**0**	**0**	**0**
Additions						
- purchased	**128**	**0**	**0**	**0**	**0**	**128**
- internally generated	**0**	**0**	**0**	**0**	**0**	**0**
- donated	**0**	**0**	**0**	**0**	**0**	**0**
- government granted	**0**	**0**	**0**	**0**	**0**	**0**
Reclassified as held for sale	**0**	**0**	**0**	**0**	**0**	**0**
Transfers from/(into) other NHS bodies	**0**	**0**	**0**	**0**	**0**	**0**
Disposals other than by sale	**0**	**0**	**0**	**0**	**0**	**0**
At 31 March 2022	**12,486**	**0**	**5,191**	**0**	**0**	**17,677**
Amortisation						
At 1 April 2021	**9,448**	**0**	**3,248**	**0**	**0**	**12,696**
Revaluation		**0**			**0**	**0**
Reclassifications	**0**	**0**	**0**	**0**	**0**	**0**
Reversal of impairments	**0**	**0**	**0**	**0**	**0**	**0**
Impairments	**0**	**0**	**0**	**0**	**0**	**0**
Charged during the year	**1,036**	**0**	**714**	**0**	**0**	**1,750**
Reclassified as held for sale	**0**	**0**	**0**	**0**	**0**	**0**
Transfers from/(into) other NHS bodies	**0**	**0**	**0**	**0**	**0**	**0**
Disposals other than by sale	**0**	**0**	**0**	**0**	**0**	**0**
Accumulated amortisation at 31 March 2022	**10,484**	**0**	**3,962**	**0**	**0**	**14,446**
Net book value At 1 April 2021	**2,122**	**0**	**1,341**	**0**	**0**	**3,463**
Net book value At 31 March 2022	**2,002**	**0**	**1,229**	**0**	**0**	**3,231**
Net book value						
Purchased	**2,002**	**0**	**1,229**	**0**	**0**	**3,231**
Donated	**0**	**0**	**0**	**0**	**0**	**0**
Government granted	**0**	**0**	**0**	**0**	**0**	**0**
Internally Generated	**0**	**0**	**0**	**0**	**0**	**0**
At 31 March 2022	**2,002**	**0**	**1,229**	**0**	**0**	**3,231**

14. Intangible assets

	Computer software purchased	Computer software internally developed	Licenses and trade-marks	Patents	Development expenditure internally generated	Total
Cost or valuation	£000	£000	£000	£000	£000	£000
At 1 April 2020	11,419	0	4,589	0	0	16,008
Revaluation		0			0	0
Reclassifications	76	0	0	0	0	76
Reversal of impairments	0	0	0	0	0	0
Impairments	0	0	0	0	0	0
Additions						
- purchased	75	0	0	0	0	75
- internally generated	0	0	0	0	0	0
- donated	0	0	0	0	0	0
- government granted	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0
Transfers from/(into) other NHS bodies	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0
At 31 March 2021	11,570	0	4,589	0	0	16,159
Amortisation						
At 1 April 2020	8,352	0	2,523	0	0	10,875
Revaluation		0			0	0
Reclassifications	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0
Impairments	0	0	0	0	0	0
Charged during the year	1,096	0	725	0	0	1,821
Reclassified as held for sale	0	0	0	0	0	0
Transfers from/(into) other NHS bodies	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0
Accumulated amortisation at 31 March 2021	9,448	0	3,248	0	0	12,696
Net book value At 1 April 2020	3,067	0	2,066	0	0	5,133
Net book value At 31 March 2021	2,122	0	1,341	0	0	3,463
Net book value						
Purchased	2,122	0	1,341	0	0	3,463
Donated	0	0	0	0	0	0
Government granted	0	0	0	0	0	0
Internally Generated	0	0	0	0	0	0
At 31 March 2021	2,122	0	1,341	0	0	3,463

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.

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

15. Impairments

Impairments in the period arose from:	2021-22 Property, plant & equipment £000	2021-22 Intangible assets £000	2020-21 Property, plant & equipment £000	2020-21 Intangible assets £000
Loss or damage from normal operations	**0**	**0**	0	0
Abandonment of assets in the course of construction	**0**	**0**	0	0
Over specification of assets (Gold Plating)	**0**	**0**	0	0
Loss as a result of a catastrophe	**0**	**0**	0	0
Unforeseen obsolescence	**0**	**0**	0	0
Changes in market price	**0**	**0**	0	0
Other	**6,135**	**0**	638	0
Reversal of impairment	**0**	**0**	0	0
Impairments charged to operating expenses	**6,135**	**0**	638	0
Analysis of impairments :				
Operating expenses in Statement of Comprehensive Income	**6,135**	**0**	638	0
Revaluation reserve	**96**	**0**	643	0
Total	**6,231**	**0**	1,281	0

Included within the above total of £6.231m are the following items:-

- a review undertaken in connection with expenditure incurred on Trust buildings identified that a total impairment of £1.458m was required as there were instances where the value of the buildings had not been enhanced. Of this amount, £1.362m was charged to operating expenses.

- the remaining £4.773m relates to the amount spent on Cardiff MRD over and above the valuation received once the works to the property were complete. All of this amount was charged to operating expenses.

16. Inventories

16.1 Inventories

	31 March 2022 £000	31 March 2021 £000
Drugs	**120**	121
Consumables	**1,439**	1,265
Energy	**0**	0
Work in progress	**0**	0
Other	**267**	242
Total	**1,826**	1,628
Of which held at net realisable value:	**0**	0

16.2 Inventories recognised in expenses

	31 March 2022 £000	31 March 2021 £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 2022	31 March 2021
Current	**£000**	£000
Welsh Government	**2,437**	4,777
WHSSC & EASC	**2,509**	1,453
Welsh Health Boards	**2,077**	1,837
Welsh NHS Trusts	**192**	158
Welsh Special Health Authorities	**8**	19
Non - Welsh Trusts	**15**	0
Other NHS	**24**	6
2019-20 Scheme Pays - Welsh Government Reimbursement	**0**	0
Welsh Risk Pool Claim reimbursement:-		0
NHS Wales Secondary Health Sector	**4,198**	4,268
NHS Wales Primary Sector FLS Reimbursement	**0**	0
NHS Wales Redress	**0**	0
Other	**0**	0
Local Authorities	**1**	36
Capital debtors- Tangible	**0**	0
Capital debtors- Intangible	**0**	0
Other debtors	**4,560**	1,063
Provision for impairment of trade receivables	**(291)**	(259)
Pension Prepayments		
NHS Pensions Agency	**0**	0
NEST	**0**	0
Other prepayments	**1,418**	1,123
Accrued income	**0**	0
Sub-total	**17,148**	14,481
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	**0**	0
NHS Wales Secondary Health Sector	**406**	1,831
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	**384**	447
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	**790**	2,278
Total trade and other receivables	**17,938**	16,759

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

Other debtors includes £0.669m re Compensation Recovery Unit (2020-21 £0.731m).

17.2 Receivables past their due date but not impaired

	31 March 2022	31 March 2021
	£000	£000
By up to 3 months	1,342	854
By 3 to 6 months	1	0
By more than 6 months	0	0
Balance at end of financial year	**1,343**	854

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

	31 March 2022	31 March 2021
	£000	£000
Balance at 1 April	(259)	(290)
Transfer to other NHS Wales body	0	0
Provision utilised (Amount written off during the year)	5	3
Provision written back during the year no longer required	0	0
(Increase)/Decrease in provision during year	(37)	28
ECL/Bad debts recovered during year	0	0
Balance at end of financial year	**(291)**	(259)

17.4 Receivables VAT

	31 March 2022	31 March 2021
	£000	£000
Trade receivables	38	16
Other	0	0
Total	**38**	**16**

18. Other financial assets

	31 March 2022 £000	31 March 2021 £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)		
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)		
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 2022	31 March 2021
	£000	£000
Opening Balance	**18,468**	24,582
Net change in year	**240**	(6,114)
Closing Balance	**18,708**	18,468
Made up of:		
Cash with Government Banking Service (GBS)	**18,644**	18,424
Cash with Commercial banks	**60**	39
Cash in hand	**4**	5
Total cash	**18,708**	18,468
Current investments	**0**	0
Cash and cash equivalents as in SoFP	**18,708**	18,468
Bank overdraft - GBS	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash & cash equivalents as in Statement of Cash Flows	**18,708**	18,468

In response to the IAS 7 requirement for additional disclosure, the changes in liabilities arising for financing activities are:

Lease Liabilities £1.311m reduction.

The movement relates to cash, no comparative information is required by IAS 7 in 2021-22.

20. Trade and other payables at the SoFP Date	31 March 2022	31 March 2021
Current	**£000**	£000
Welsh Government	**0**	313
WHSSC & EASC	**442**	12
Welsh Health Boards	**248**	266
Welsh NHS Trusts	**219**	241
Welsh Special Health Authorities	**35**	325
Other NHS	**95**	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	**1,589**	1,454
National Insurance contributions payable to HMRC	**2,192**	1,997
Non-NHS trade payables - revenue	**3,883**	1,938
Local Authorities	**8**	155
Capital payables-Tangible	**10,063**	3,374
Capital payables- Intangible	**104**	246
Overdraft	**0**	0
Rentals due under operating leases	**0**	0
Obligations due under finance leases and HP contracts	**0**	0
Imputed finance lease element of on SoFP PFI contracts	**0**	0
Pensions: staff	**2,450**	2,190
Non NHS Accruals	**13,931**	15,780
Deferred Income:		
Deferred income brought forward	**230**	207
Deferred income additions	**263**	23
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
PFI - Payments on account	**0**	0
Sub-total	**35,752**	28,521

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, £2.429m relates to the NHS Pension scheme (2020-21 £2.167m) and £0.021m to the NEST pension scheme (2020-21 £0.022m).

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

Non-current	31 March 2022 £000	31 March 2021 £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
Obligations due under finance leases and HP contracts	**0**	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	**35,752**	28,521

21. Borrowings	31 March 2022	31 March 2021
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**	1,616
Other	**0**	0
Total	**1,364**	1,616
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**	1,059
Other	**0**	0
Total	**0**	1,059

A finance lease contract was entered into with Airwave during 2007-08 in respect of the National Ambulance Radio Re-procurement Project. During the financial year 2019-20, the Airwave finance lease was extended to November 2022 due to the national replacement scheme being delayed. This is the only finance lease liability included within the above.

21.2 Loan advance/strategic assistance funding

	31 March 2022	31 March 2021
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.

22. Other financial liabilities

	31 March 2022	31 March 2021
Current	**£000**	£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

	31 March 2022	31 March 2021
Non-current	**£000**	£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

2021-22

Current	At 1 April 2021	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 2022
	£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

Expected timing of cash flows:

	In year to 31 March 2023	Between 01-Apr-23 to 31 March 2027	Thereafter	Totals
	£000	£000	£000	£000
Clinical negligence:-				
Secondary Care	1,350	348	0	1,698
Primary Care	0	0	0	0
Redress Secondary Care	194	12	0	206
Redress Primary Care	0	0	0	0
Personal injury	1,560	1,911	7,660	11,131
All other losses and special payments	0	0	0	0
Defence legal fees and other administration	298	71	0	369
Structured Settlements - WRPS	0	0	0	0
Pensions - former directors	0	0	0	0
Pensions - other staff	15	50	6	71
2019-20 Scheme Pays - Reimbursement	0	0	0	0
Restructuring	0	0	0	0
Other	985	0	0	985
Total	4,402	2,392	7,666	14,460

"Other" provisions £0.985m (2020-21 £2.228m) relates to a provision of £0.599m in respect of an evaluation of recent employment legislation and case law affecting the calculation of annual leave payments for employees working in the NHS and £0.386m for dilapidation of leasehold premises.

23. Provisions (continued)

2020-21

	At 1 April 2020	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 2021
Current										
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Clinical negligence:-										
Secondary Care	1,977	0	0	0	0	1,690	(863)	(93)	0	2,711
Primary Care	0	0	0	0	0	0	0	0	0	0
Redress Secondary Care	0	0	0	0	0	485	(172)	(155)	0	158
Redress Primary Care	0	0	0	0	0	0	0	0	0	0
Personal injury	2,408	0	0	(1,100)	0	1,504	(786)	(456)	(49)	1,521
All other losses and special payments	0	0	0	0	0	0	0	0	0	0
Defence legal fees and other administration	312	0	0	(37)	0	607	(178)	(391)	0	313
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	19		0	13	0	7	(15)	(6)	0	18
2019-20 Scheme Pays - Reimbursement	0		0	0	0	0	0	0	0	0
Restructurings	0		0	0	0	0	0	0		0
Other	2,577		0	0	0	137	(486)	0		2,228
Total	7,293	0	0	(1,124)	0	4,430	(2,500)	(1,101)	(49)	6,949
Non Current										
Clinical negligence:-										
Secondary Care	0	0	0	0	0	640	0	0	0	640
Primary Care	0	0	0	0	0	0	0	0	0	0
Redress Secondary Care	0	0	0	0	0	0	0	0	0	0
Redress Primary Care	0	0	0	0	0	0	0	0	0	0
Personal injury	9,481	0	0	1,100	0	515	0	0	0	11,096
All other losses and special payments	0	0	0	0	0	0	0	0	0	0
Defence legal fees and other administration	0	0	0	37	0	66	(4)	(8)	0	91
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	73		0	(13)	0	0	0	0	0	60
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	9,554	0	0	1,124	0	1,221	(4)	(8)	0	11,887
TOTAL										
Clinical negligence:-										
Secondary Care	1,977	0	0	0	0	2,330	(863)	(93)	0	3,351
Primary Care	0	0	0	0	0	0	0	0	0	0
Redress Secondary Care	0	0	0	0	0	485	(172)	(155)	0	158
Redress Primary Care	0	0	0	0	0	0	0	0	0	0
Personal injury	11,889	0	0	0	0	2,019	(786)	(456)	(49)	12,617
All other losses and special payments	0	0	0	0	0	0	0	0	0	0
Defence legal fees and other administration	312	0	0	0	0	673	(182)	(399)	0	404
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	92		0	0	0	7	(15)	(6)	0	78
2019-20 Scheme Pays - Reimbursement	0		0	0	0	0	0	0	0	0
Restructurings	0		0	0	0	0	0	0		0
Other	2,577		0	0	0	137	(486)	0		2,228
Total	16,847	0	0	0	0	5,651	(2,504)	(1,109)	(49)	18,836

24 Contingencies

24.1 Contingent liabilities

Provision has not been made in these accounts for the following amounts:	**31 March 2022 £000**	31 March 2021 £000
Legal claims for alleged medical or employer negligence;		
Secondary care	**9,193**	5,624
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	**316**	235
Other: Damage to third party equipment	**0**	0
Total value of disputed claims	**9,509**	5,859
Amount recovered under insurance arrangements in the event of these claims being successful	**(8,290)**	(4,848)
Net contingent liability	**1,219**	1,011

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.

Pensions tax annual allowance - Scheme Pays arrangements 2019/2020
In accordance with a Ministerial Direction issued on 18 December 2019, the Welsh Government have taken action to support circumstances where pension tax rules are impacting upon clinical staff who want to work additional hours, and have determined that clinical staff who are members of the NHS Pension Scheme and who, as a result of work undertaken in the 2019/2020 tax year, face a charge on the growth of their NHS pension benefits, may opt to have this charge paid by the NHS Pension Scheme, with their pension reduced on retirement.

Welsh Government, on behalf of Welsh Ambulance Services NHS Trust, will pay the members who opt for reimbursement of their pension, a corresponding amount on retirement, ensuring that they are fully compensated for the effect of the deduction.

This scheme will be fully funded by the Welsh Government to the NHS Business Services Authority Pension Division, the administrators on behalf of the Welsh claimants.

Clinical staff have until 31 March 2022 to opt for this scheme and the ability to make changes up to 31 July 2026.

At the date of approval of these accounts, the indication was that there was very little take-up of the scheme by Welsh Ambulance Services NHS Trust staff, and there was insufficient data to enable a reasonable assessment of future take up to be made. As no reliable estimate can therefore be made to support the creation of a provision at 31 March 2022, the existence of an unquantified contingent liability is instead disclosed.

24.2. Remote contingent liabilities

	31 March 2022 £000	31 March 2021 £000
Guarantees	**0**	0
Indemnities	**0**	0
Letters of comfort	**0**	0
Total	**0**	0

24.3 Contingent assets

	31 March 2022 £000	31 March 2021 £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 were:

	31 March 2022	31 March 2021
	NHS Trust	
	£000	£000
Property, plant and equipment	**12,914**	9,268
Intangible assets	86	232
Total	**13,000**	9,500

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 2022	
	Number	**£**
Clinical negligence	10	1,962,859
Personal injury	67	699,804
All other losses and special payments	121	213,759
Total	**198**	**2,876,422**
FHoT losses and special payments	**0**	**0**
Consolidated Total	**198**	**2,876,422**

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:					
	Clinical negligence			1	704,493
	Personal injury			1	378,967
	Clinical negligence			1	632,585
	Personal injury			1	4,314,610
	Clinical negligence	1	558,681	1	708,810
	Clinical negligence	1	523,880	1	523,880
	Clinical negligence	1	425,780	1	425,780
Sub-total		**3**	**1,508,341**	**7**	**7,689,125**
All other cases		195	1,368,081	567	9,385,730
Total cases		**198**	**2,876,422**	**574**	**17,074,855**

27. Finance leases

27.1 Finance leases obligations (as lessee)

A contract was entered into with Airwave during 2007-08 in respect of the National Ambulance Radio Re-procurement Project. During the financial year 2019-20, the Airwave finance lease was extended to November 2022 due to the national replacement scheme being delayed.

This is the only asset included within 'Other' below.

Amounts payable under finance leases:

LAND		**31 March 2022 £000**	31 March 2021 £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

27.1 Finance leases obligations (as lessee) continued

Amounts payable under finance leases:

BUILDINGS	**31 March 2022**	31 March 2021
Minimum lease payments	**£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
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

OTHER	**31 March 2022**	31 March 2021
Minimum lease payments	**£000**	£000
Within one year	**1,373**	1,651
Between one and five years	**0**	1,066
After five years	**0**	0
Less finance charges allocated to future periods	**(9)**	(42)
Minimum lease payments	**1,364**	2,675
Included in: Current borrowings	**1,364**	1,616
Non-current borrowings	**0**	1,059
Total	**1,364**	2,675
Present value of minimum lease payments		
Within one year	**1,364**	1,616
Between one and five years	**0**	1,059
After five years	**0**	0
Total present value of minimum lease payments	**1,364**	2,675
Included in: Current borrowings	**1,364**	1,616
Non-current borrowings	**0**	1,059
Total	**1,364**	2,675

27.2 Finance lease receivables (as lessor)

The Trust has no finance lease receivables.

Amounts receivable under finance leases:

		31 March 2022	31 March 2021
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 Welsh Ambulance Service NHS Trust extended the contract of the Airwave Finance Lease during 2019-20, this remains the only finance lease that the Trust has. The Airwave Finance Lease has been extended to November 2022 due to the national replacement being delayed.

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 2022	31 March 2021
	£000	£000
(Increase) / decrease in inventories	(198)	(72)
(Increase) / decrease in trade and other receivables - non-current	1,488	(1,742)
(Increase) / decrease in trade and other receivables - current	(2,667)	(5,395)
Increase / (decrease) in trade and other payables - non-current	0	0
Increase / (decrease) in trade and other payables - current	7,231	998
Total	5,854	(6,211)
Adjustment for accrual movements in fixed assets - creditors	(6,547)	5,761
Adjustment for accrual movements in fixed assets - debtors	0	0
Other adjustments	100	0
Total	(593)	(450)

31. Other cash flow adjustments

	31 March 2022	31 March 2021
Other cash flow adjustments	£000	£000
Depreciation	15,190	13,707
Amortisation	1,750	1,821
(Gains)/Loss on Disposal	0	0
Impairments and reversals	6,135	638
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
Non-cash movements in provisions	2,587	4,493
Total	25,662	20,659

32. Events after reporting period

These financial statements were authorised for issue by the Chief Executive and Accountable Officer on the date they 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 transactions 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	18	38,644	-	2,437
WHSSC/EASC	50	185,736	442	2,509
Aneurin Bevan University Health Board	348	13,756	78	496
Betsi Cadwaladr University Health Board	475	6,793	88	234
Cardiff & Vale University Health Board	34	4,771	8	400
Cwm Taf Morgannwg University Health Board	84	3,054	48	593
Hywel Dda University Health Board	417	5,343	19	170
Powys Teaching Health Board	52	1,497	-	25
Swansea Bay University Health Board	97	6,093	7	159
Public Health Wales NHS Trust	52	108	-	11
Velindre University NHS Trust	2,311	1,021	219	181
Health Education and Improvement Wales (HEIW)	22	407	-	-
Digital Health and Care Wales (DHCW)	758	208	35	8
Welsh Local Authorities	1,417	243	8	1
Cardiff University	22		-	-
Swansea University	79	132	-	8
Cardiff Metropolitan University	-		-	-
University of South Wales	20		-	-
University of Wales	43		2	-
Bangor University	1		-	-
Glyndwr University	-			-
	6,300	**267,806**	**954**	**7,232**

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 (2020/21: £0.010m) with no other transactions being made. Net assets of the charity amount to £0.544m.

The Welsh Government income shown above includes £6.136m relating to impairment funding and £4.865m that relates to PDC capital received during 2021/22.

33. Related Party transactions (continued)

A number of the Trust's members have declared interests in related parties as follows:

Name	Position	Declaration
Martin Woodford *	Trust Chair and Non-Executive Director	Nil declaration.
Kevin Davies *	Vice Chair and Non-Executive Director	Colonel Commandant Queen Alexandra's Royal Army Nursing Corps. Trustee Queen Alexandra's Charity. Trustee St John Ambulance Cymru. Patron Motivation and Learning Trust. Chair ABF The Soldiers Charity (Glamorgan). Member Royal College Nursing.
Emrys Davies *	Non-Executive Director	Director and Chair, NRML (Newport Road Maintenance Ltd.) Retired member of Unite.
Bethan Evans *	Non-Executive Director	Managing Director (Employed) at My Choice Healthcare Limited. Non-Executive Board Member at RHA (Social Housing Organisation) Company Directorships: - Moorlands Rehabilitation (Staffordshire) Limited. - My Choice Healthcare South Wales Limited - Homes of Excellence Healthcare Limited. - Springfield (Bargoed) Limited. - Homes of Excellence Limited - Victoria House Care Limited - My Choice Healthcare (Three) Limited - My Choice Healthcare (Four) Limited
Paul Hollard *	Non-Executive Director	Independent consultant providing occasional services to NHS Wales organisations and Welsh Government
Ceri Jackson *	Non-Executive Director	Self-employed Management Consultant primarily working in third sector. (Not undertaking any contracts for NHS, would consult WAST Chair prior to undertaking any contracts.) Associate Director of SamKat Ltd in my capacity as self-employed management consultant. (Not undertaking any NHS contracts as part of this role and would consult WAST Chair prior to undertaking any contracts.) Stroke Association Trustee, Chair Wales Advisory Group. Stroke Association has contracts with the NHS to deliver services. Volunteer role. Cardiff Institute for the Blind Trustee (trading as Sight Life). The charity has a contract with Cardiff and the Vale Health Board to provide services. Partner employed by Arjo (global supplier of medical devices and equipment).

33. Related Party transactions (continued)

Interests in Related Parties (continued)		
Name	**Position**	**Declaration**
Joga Singh *	Non-Executive Director	Geldards LLP, paid employment. Membership of the Law Society and the Employment Lawyers Association. Member of the Fairness Inclusion and Respect Committee for the Institute of Civil Engineers in Wales, voluntary role. Independent Member of the South Wales Police Ethics Committee, 2 – 3 days a year.
Martin Turner *	Non-Executive Director	Director and shareholder Martin Turner Associates Ltd.
Jason Killens *	Chief Executive	Nil declaration
Brendan Lloyd *	Executive Medical Director	National Professional Advisor (Ambulance Services) at Care Quality Commission, one day a week for six months from 1 February 2022.
Claire Roche *	Executive Director of Quality and Nursing (to 6 March 2022)	Nil declaration.
Wendy Herbert *	Interim Executive Director of Quality and Nursing (from 7 March 2022)	Nil declaration
Chris Turley *	Executive Director of Finance and Corporate Resources	Treasurer of Royal Gwent Hospital League of Friends.
Claire Vaughan *	Executive Director of Workforce and OD	(Voluntary) Independent Sub-Committee Member for Aberystwyth University
Lee Brooks	Director of Operations	Partner employed by Welsh Ambulance Services NHS Trust.
Andy Haywood	Director of Digital	Nil declaration.
Estelle Hitchon	Director of Partnerships and Engagement	Nil declaration
Rachel Marsh	Director of Strategy, Planning and Performance	Nil declaration
Andy Swinburn	Director of Paramedicine	Strategic Advisor to the College of Paramedics.
Keith Cox	Board Secretary (to 1 August 2021)	Magistrate Cardiff and Vale.
Trish Mills	Board Secretary (from 2 August 2021)	Nil declaration.

Voting Members of the Trust are marked with an asterisk * in the Table above.
No other Trust members provided declarations of interest in related parties during the period.

33. Related Party transactions (continued)

Material transactions between the Trust and related parties disclosed on pages 69 and 70 during 2021-22 were as follows (unless already reported on page 68) :	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	3,326	0	86	0
TOTAL	**3,326**	**0**	**86**	**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

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 2021 to 31 March 2022. This has been calculated from actual Welsh Government expenditure for the 6.3% staff employer pension contributions between April 2021 and February 2022 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:

	2021-22	2020-21
STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2022	**£000**	**£000**
Revenue from patient care activities	7,841	6,966
Operating expenses	7,841	6,966
3. Analysis of gross operating costs		
3. Revenue from patient care activities		
Welsh Government	7,841	6,966
Welsh Government - Hosted Bodies	-	-
5.1 Operating expenses		
Directors' costs	76	59
Staff costs	7,765	6,907

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 2021-22 £000	Total 2020-21 £000	
Capital			
Capital Funding Field Hospitals		-	
Capital Funding Equipment & Works	**200**	1,491	
Capital Funding other (Specify)	**-**	-	
Welsh Government Covid 19 Capital Funding	**200**	**1,491**	
			As previously reported in 2020-21 £000
Revenue			
Sustainability Funding			6218
C-19 Pay Costs Q1 (Future Quarters covered by SF)			2143
Field Hospital (Set Up Costs, Decommissioning & Consequential losses)			0
Bonus Payment			3655
Independent Health Sector			0
Stability Funding	**5,368**	**12,016**	
Covid Recovery	**-**	-	
Cleaning Standards	**400**	-	
PPE (including All Wales Equipment via NWSSP)	**966**	-	
Testing / TTP- Testing & Sampling - Pay & Non Pay	**-**	-	
Tracing / TTP - NHS & LA Tracing - Pay & Non Pay	**-**	-	
Extended Flu Vaccination / Vaccination - Extended Flu Programme	**-**	-	
Mass Covid-19 Vaccination / Vaccination - COVID-19	**-**	-	
Annual Leave Accrual - Increase due to Covid	**-**	1,777	
Urgent & Emergency Care	**6,076**	-	
Private Providers Adult Care / Support for Adult Social Care Providers	**-**	-	
Hospices	**-**	-	
Other Mental Health / Mental Health	**-**	-	
Other Primary Care	**-**	-	
Social Care	**-**	-	
Other	**-**	18	
Welsh Government Covid 19 Revenue Funding	**12,810**	**13,811**	

During 2021/22 £3.577m (2020/21 £2.354m) revenue funding was provided for Covid -19 Mobile testing Units (MTU) as follows:-

- DHSC (Dept Health & Social Care) £1.796m
- UK HSA (Health Security Agency) £1.781m

37. Other Information (continued)

37.3 Changes to accounting standards not yet effective - IFRS 16 Impact

IFRS 16 Leases supersedes IAS 17 Leases and is effective in the public sector from 1 April 2022. IFRS 16 provides a single lessee accounting model and requires a lessee to recognise right-of-use assets and liabilities for leases with a term more than 12 months unless the underlying value is of low value. The FReM makes two public sector adaptions

- The definition of a contract is expanded to include intra UK government agreements that are not legally enforceable;
- The definition of a contract is expanded to included agreements that have nil consideration.

IFRS 16 gives a narrower definition of a lease that IAS 17 and IFRIC 4 by requiring that assets and liabilities will be recognised initially at the discounted value of minimum lease payments After initial recognition, right of use assets will be depreciated on a straight line basis and interest recognised on the liabilities. Except where modified for revaluation where material, the cost model will be applied to assets other than peppercorn leases which will be measured on a depreciated replacement cost basis. The right of use asset in a peppercorn lease is accounted for similarly to a donated asset.

As required by the FReM IFRS 16 will be implemented using the accumulated catch up method.

The right of use assets and leasing obligation have been calculated and indicated that the total discounted value of right of use assets and liabilities under IFRS 16 is higher than the value of minimum lease commitments under IAS 17. The impact of implementation is an

- increase in expenditure £0.145m;
- increase in assets of £13.007m and liabilities of £11.871m.

These figures are calculated before intercompany eliminations are made, these will have a material impact on the figures.

Right of Use (RoU) Assets Impact

		Property	Non Property	Total
		£000	£000	£000
Statement of financial Position				
RoU Asset Recognition				
+	Transitioning Adjustment	11,466	66	**11,532**
+	As at 1 April 2022	11,466	66	**11,532**
+	Renewal / New RoU Assets 2022-23	2,964	-	**2,964**
-	Less (Depreciation)	- 1,453	- 36	**- 1,489**
+	As at 31 March	12,977	30	**13,007**

RoU Asset Liability		Property	Non Property	Total
		£000	£000	£000
-	Transitioning Adjustment	- 10,078	- 66	**- 10,144**
-	As at 1 April 2022	- 10,078	- 66	**- 10,144**
-	Renewal / New RoU Liability 2022-23	- 2,944	-	**- 2,944**
+	Working Capital	1,306	36	**1,342**
-	Interest	- 124	- 1	**- 125**
-	As at 31 March	- 11,840	- 31	**- 11,871**

Charges		Property	Non Property	Total
Expenditure		£000	£000	£000
	RoU Asset depreciation (1)	- 1,453	- 36	**- 1,489**
	Interest on obligations under RoU Asset leases (2)	- 125	- 1	**- 126**
		- 1,578	- 37	**- 1,615**

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,

AGENDA ITEM No	**6**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**3**

ANNUAL REPORT 2021/22

MEETING	Audit Committee
DATE	7 June 2022
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 2021/22 on 6th May 2022 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.

3. An Annual Report and Accounts Highlights document, distilling key information from those documents has also been prepared.

RECOMMENDATION:

4. **That the 2021/22 Annual Report be recommended for formal approval by the Trust Board.**

KEY ISSUES/IMPLICATIONS

5. The Annual Report includes the Performance Report and the Accountability Report. Both have been developed in accordance with the NHS Wales 2021/22 Manual for Accounts.

6. The Accountability Report includes the Statement of Directors' responsibilities in respect of the Accounts (page 51) which will be signed by order of the Board by the Chair, Chief Executive and Director of Finance and Corporate Resources.

7. Welsh language translation of the Annual Report and the Accounts foreword are underway and will be ready for the Annual General Meeting on 14th July.

REPORT APPROVAL ROUTE

The draft annual report was considered by the Executive Management Team on 27th April and circulated to the Audit Committee on 28th April. The Remuneration Committee received the Remuneration Table on 21st April.

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. SBAR report. 2. Annual Report 2021/22 3. Public facing front end Annual Report

REPORT CHECKLIST			
Confirm that the issues below have been considered and addressed		**Confirm that the issues below have been considered and addressed**	
EQIA (Inc. Welsh language)	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 2021/22

SITUATION

8. The Trust submitted its Draft Annual Report 2021/22 on 6th May 2022 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

9. The Annual Report, which consists of Part 1 - Performance Report and Part 2 – Accountability Report, have been prepared in accordance with the NHS Wales 2021-22 Manual for Accounts Chapter 3.

10. 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 in June. It is anticipated that the Group will be re-established for the 2022/23 Annual Report production.

11. The timetable for the production of the Annual Report that was agreed by the Audit Committee in March 2022 has been complied with.

ASSESSMENT

12. Following submission of the draft Annual Report to Audit Wales and Welsh Government on 6th May 2022 comments were provided relating to both the Performance Report and Accountability Report which have been addressed. These related to 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.

13. This Annual Report is part of a suite of documents that provides information about the Trust. In accordance with the NHS Wales 2021/22 Manual for Accounts and HM Treasury's Financial Reporting Manual, the Annual Report for 2021/22 includes:

    - **Part 1: Performance Report** which details how the Trust performed in the year and how we adapted and responded to the COVID-19 pandemic. For 2021/22 there was no requirement to prepare a separate Annual Quality Statement, however, key quality themes are captured within the Performance Report.

    - **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.

14. The Accountability Report includes the Statement of Directors' responsibilities in respect of the Accounts (page 51) which will be signed by order of the Board by the Chair, Chief Executive and director of Finance and Corporate Resources.

15. The Remuneration Table (page 86) has been reviewed by Remuneration Committee members and the Executive Management Team.

16. An Annual Report and Accounts Highlights documents distilling the information in those documents has been prepared and is at Annex 3. This will be reviewed by Audit Wales and it will undergo a design and formatting process, with photograph montage added, prior to the Annual General Meeting.

17. The Annual Report and 'foreword' section of the Financial Accounts is in the process of Welsh language translation, as is the Highlights document and they will be available for the Annual General Meeting on 14th July 2022. 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.

18. The Welsh Government Manual for Accounts 2021-22 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 2021/22 and include the Financial Statements as 'Part 3'. This is required to be submitted to Welsh Government by 15th June 2022.

RECOMMENDATION

19. **That the 2021/22 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

2021/22

Table of Contents

Annual Report 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 2021/22.

In accordance with the NHS Wales 2021/22 Manual for Accounts and HM Treasury's Financial Reporting Manual, our Annual Report for 2021/22 includes:

Part 1: Performance Report which details how the Trust performed in the year and how we adapted and responded to the COVID-19 pandemic.

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.

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 2022 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.

For 2021/22, there was no requirement to prepare a separate Annual Quality Statement, however, key quality themes are captured within the Performance Report.

Whilst acronyms are explained in full when they are fist used, a glossary is included for ease of reference.

If you require a version of the Annual Report in printed or alternative formats/ languages please contact the Board Secretary on trish.mills@wales.nhs.uk.

Glossary

A number of acronyms are used in this Annual Report. Where the acronym is used multiple times we have included it in the glossary below for ease of reference.

Abbreviation	Term
ADLT	Assistant Directors Leadership Team
AQIs	Ambulance Quality Indicators
BAF	Board Assurance Framework
CASC	Chief Ambulance Services Commissioner
COPI	Control of Patient Information Regulations
CPR	Cardiopulmonary Resuscitation
CSD	Clinical Support Desk
EASC	Emergency Ambulance Services Committee
EMS	Emergency Medical Service
EMT	Executive Management Team
ePCR	Electronic Patient Clinical Record
ESR	Electronic Staff Register
FReM	Government Financial Reporting Manual
HSE	Health and Safety Executive
ICO	Information Commissioner's Office
IMTP	Integrated Medium Term Plan
IPC	Infection Prevention Control
MACA	Military Aid to Civil Authorities
NEPTS	Non Emergency Patient Transfer Service
NHSDW	NHSDirect Wales
NRIs	National Reportable Incidents
PPE	Personal Protective Equipment
QuESt	Quality, Patient Experience and Safety Committee
REAP	Resource Escalation Action Plan
STB	Strategic Transformation Board
STEMI	ST segment elevation myocardial infarction
The Trust	Welsh Ambulance Services NHS Trust
WTEs	Whole time equivalents

PART 1 – PERFORMANCE REPORT

This Performance Report 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 2021 to 31 March 2022.

The Performance Report is produced in line with the requirements of the NHS Wales 2021/22 Manual for Accounts, in particular, Chapter 3 and Annex 7.

1.1 Foreword from Chief Executive Officer

2021/22 has been another extraordinary year for the Trust as it has continued to work through further waves of the COVID-19 pandemic and, as society has opened up, to deal with increased pressure across the urgent and emergency care system.

Whilst staff and volunteers have stepped up to the challenge, in many instances, the Trust has not been able to respond to patients as quickly as it should, affecting patient experience and safety. The reasons are complex and multiple, with some directly related to COVID-19 and others due to underlying factors that have been present for some time, which have been exacerbated over the last two years.

The Trust's headline target is to respond to 65% of red calls (immediately life threatening) in eight minutes. The Trust did not achieve the target in 2021/22 although 67% of red calls did receive a response in ten minutes. The Trust is also concerned about patient safety and harm in the amber category where response times are long.

Working together across all levels of the organisation has enabled the Trust to deliver much of what it had set out in its plan for 2021/22. Growth continued in the Emergency Medical Services (EMS), with an additional 127 front line staff recruited. Core 111 services were rolled out, with the Trust now the national provider of 111. The final transfers of Non-Emergency Patient Transport Service (NEPTS) activity from Health Boards were completed, making the Trust the sole provider of these services in Wales. The new electronic patient care record system (ePCR) was also implemented. Significant additional support was also secured from the military and St John Cymru.

The Trust's ability to improve the quality and safety of the service it provides to patients remains at the heart of its plan for 2022/23. The plan focuses on delivery of efficiencies within the Trust's control which will increase capacity to respond. However, the level of hospital handover lost hours are now so extreme the Trust cannot offset their substantial impact. The Trust has therefore also signalled that significant further investment and/or a radical reduction in hospital handover lost hours is required in order to deliver a safe 999 patient pathway. The Trust is acutely aware of the impact of COVID-19 on the communities it serves and on its own staff. The Trust will continue its emphasis on well-being to support those affected.

The Trust is open and transparent in its monthly reporting of patient experience, patient safety and performance. The annual Performance Report brings this together, enabling the reader to form an assessment of how the Trust is doing.

Finally, I want to reiterate my thanks to all our staff and volunteers, Armed Forces, blue light partners, commissioners and the private sector, and the voluntary sector for their continued support in responding to COVID-19.

Jason Killens

Welsh Ambulance Services NHS Trust Chief Executive Officer

1.2 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 alternative treating facility.

- Non Emergency Patient Transport Service (NEPTS): taking patients to and from hospital appointments and transferring them between hospitals and treating facilities.

- The now retired NHSDirect Wales (NHSDW) service: a health advice and information service available 24 hours a day, every day, including an online and telephone offering (available in Betsi Cadwaladr and Cardiff & the Vale university health boards for the early part of 2021/22).

- The 111 service: a free-to-call service which incorporates the NHSDW service and the call taking and first stage clinical triage for the out-of-hours service. The number was live pan-Wales throughout 2021/22 and the full service was rolled out in Betsi Cadwaladr and Cardiff & the Vale university health boards in 2021/22 making the service pan-Wales.

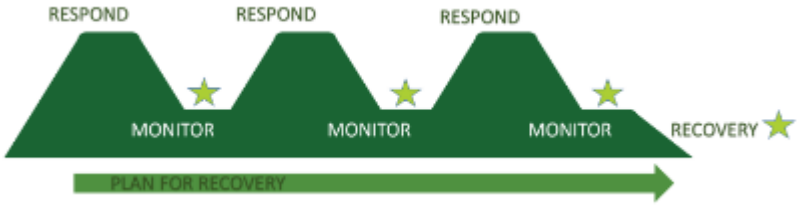
- The Trust also supports Community First Responders, Co-Responders and Uniformed Responders to provide additional response resource.

- During the pandemic, the Trust has provided the Mobile Testing Service for the whole of Wales.

- All the services had COVID-19 patients flowing through them therefore the Trust made no distinction between COVID-19 care and non-COVID-19 care in terms of its delivery arrangements in 2021/22.

1.3 Response to and impact of COVID-19

The Trust originally triggered its Pandemic Influenza Plan on 4 March 2020. The Plan sets out two phases: a response phase and a recovery phase. To allow it to respond more flexibly to waves, the Trust also introduced the concept of two positions within the Response Phase (Response Position and Monitor Position).



The Trust started the year in a Recovery phase, but on the 20 December 2021 moved back into Response phase (response position) due to the Omicron variant. The Trust continuously reviewed all the data available in terms of the overall situation across Wales and UK as well the pressure put on the organisation and in light of the improving picture was able to move from Response Position to Monitor Position on 1 March 2022. As the picture began to improve further, the Trust moved from Response Phase: Monitor Position to Recovery Phase on 18 March 2022.

The Trust has used forecasting and modelling techniques and software linked to COVID-19 forecasts supplied by Swansea University and also internal thinking about patient demand to help predict and model performance and patient safety.

Because of the government travel restrictions (an indirect impact of COVID-19) the Trust predicted very high patient demand through the summer of 2021/22 and brought forward a tactical Summer Plan to mitigate the impact of the very high demand on patient safety.

Despite the Trust's forward planning the Trust could not sufficiently mitigate the impact of this high seasonal demand, including two heat waves which created additional pressures, and on 20 July 2021 the Trust went to maximum escalation, what is referred to as "REAP 4" (Resource Escalation Action Plan). The Trust came out of REAP 4 on 29 July 2021. The Trust then went back into REAP 4 on 24 August 2021 and stayed there until 16 November 2021. This pattern of moving between REAP 4 and REAP 3 continued through the winter period until the year end. To contextualise how strained the Trust has been, in the very bad winter of 2017/18 the Trust went to REAP 4 for one day.

Whilst not directly caused by the pandemic, the Trust introduced a Clinical Safety Plan on 27 September 2021, which replaced its Demand Management Plan. Like the Trust's escalation plan, the Clinical Safety Plan moves through four levels with level 4, the highest level, requiring that Red and Amber 1 patients are clinically screened before an emergency resource is dispatched and ambulances unable to be sent to Amber 2 and Green patients.

The Trust undertook further forecasting and modelling for the winter 2021/22, making this information available in September 2021. This forecasting and modelling predicted that the Trust would have to operate at level 4 of the Clinical Safety Plan and that “radical” measures would be required to mitigate the impact of the pandemic on performance and patient safety. The impact of COVID-19 is not just on patient demand, but also sickness absence in the Trust’s workforce and the level of lost hours caused by hospital handover which have exceeded the levels that existed pre-pandemic.

As a result, the Trust decisively and proactively sought Military Aid to Civil Authorities (MACA) which resulted at peak in 250+ UK Armed Forces personnel supporting the Trust through the winter period. This aid commenced in mid-October 2021 and ended on the 31 March 2022. The Trust also received additional funding for various initiatives via the Emergency Ambulance Services Committee (EASC). The Trust’s Chief Executive also requested that any and every initiative that could have a positive impact on the winter period was brought together into a single Performance Improvement Plan (PIP), which was reported into the Executive Management Team every two weeks and to the Chief Ambulance Services Commissioner (CASC) every month i.e., the Trust retained a strong tactical grip through the winter period. The Trust’s pandemic strategy and the use of the Pandemic Plan and its supporting structures were used to support and coordinate the response not only to COVID-19 but also seasonal winter pressures.

As a result, the Trust was able to boost the level of ambulance production in a “radical” way as identified by the forecasting and modelling; however, the levels of hospital handover lost hours were so extreme that even with the radical measure of the MACA the Trust simply could not offset the lost hours at hospital and therefore operated at maximum levels of escalation for much of the winter and at high levels of the Clinical Safety Plan.

The Trust continues to review COVID-19 data through its COVID-19 Intelligence Pack; however, the major concern for the Trust now is the system pressures, in particular, high staff sickness and extreme hospital handover lost hours, caused by the pandemic and the underlying pre-pandemic position which was already very strained.

Throughout the pandemic, the Trust continued to operate its three services: 111, 999 Emergency Medical Services and Ambulance Care (including NEPTS). The pandemic did not lead to any decisions to reduce or stop these services, albeit the levels of demand, high sickness levels, social distancing (on NEPTS vehicles), the donning of PPE and lost hours to hospital handover, all of which were impacted by COVID-19, affected the Trust’s ability to deliver these services to the required performance targets, with more detail set out in following sections.

During the first wave the Trust made the decision to stop all corporate activity that was not directly and immediately relevant to the Trust’s pandemic response, however, a lesson from 2020/21 was the balance between a focus on immediate actions and continuing more strategic transformative actions which would build the

Trust's resilience in the medium term. For 2021/22 the Trust made a conscious decision to continue to run its key strategic transformation programmes.

1.4 Planning and Delivery of Safe, Effective and Quality Services

The Trust has a statutory requirement to think and plan in a generational way (the Well-Being of Future Generations (Wales) Act 2015), plan in a way that is consistent with the NHS Wales Planning Framework which takes into account the priorities for the Minister for Health & Social Services over the coming year, commissioning requirements, Welsh Government strategy (currently A Healthier Wales) and a statutory requirement to think of quality and engagement through the Trust's work – the Health & Social Care (Quality & Engagement) (Wales) Act 2020.

The Trust develops plans at every level of the organisation - strategic, tactical and operational. This will produce a hierarchy of plans that link together, aligning the Trust and all its people towards achieving its agreed strategic ambitions.

The Trust strategy, "Delivering Excellence", was published in 2019. The Trust has been working throughout on what that strategy means in practice and how services might need to change. The Trust's ambition for its core services is to get patients the right care, in the right place, every time. Eventually the Trust wants to support more people being treated closer to home. To enable these ambitions the Trust will need to support its people, embrace technology, work closely with its partners and upgrade its fleet and estate. Underpinning everything is a commitment to quality and excellent patient experience, strong clinical leadership and developing a culture of Working Safely and delivering value.

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 ambitions. The IMTP will take into account the national planning guidance issued by Welsh Government, the external environment in which the Trust operates including statutory requirements and commissioning intentions, as well as intelligence gathered from patients and staff.

1.4.1 Trust's Integrated Medium Term Plan

In developing the IMTP, the Trust also listens to and responds to what is important to patients and to its people to help the Trust develop its plans. The Trust's IMTP also describes the actions it will take to address some of its highest risks.

The Trust Board approved the IMTP for 2021/22 and submitted it to Welsh Government at the end of March 2021. For this financial year, Welsh Government did not seek to formally approve plans, but feedback was positive on the Trust's plan submitted. Key actions included in the IMTP for 2021/22 were:

(a) 111 and integrated clinical support as the Gateway to Care

- Improving the 111 website;

- Encouraging more people to use 111 by rolling out the core NHS 111 Wales service to the whole of Wales and developing and rolling out 111 First to help people to navigate the urgent and emergency health and care system;
- Recruiting and training more call takers and clinical staff to ensure there is the correct capacity to meet growing demand for the service;
- Strengthening operational and clinical leadership to improve the clinical advice and signposting available to the public;
- Implementing a new integrated system across 111 and GP Out of Hours;
- Implementing a new triage system for 999 callers;
- Developing plans to have more contact with patients by video consultation; and
- Employ mental health practitioners into the clinical support desk.

(b) EMS Operational and Clinical Transformation

- Maximising capacity to respond more quickly to callers who need an ambulance:
    - Recruit and train a further 127 EMS staff;
    - Review and redesign rosters across Wales to implement in 2022;
    - Work with Health Boards to reduce handover delays; and
    - Work in partnership with Trade Unions to modernise practices to increase time available to respond.
- Developing a new way of responding to patients in rural areas;
- Implementing the new electronic patient care record system; and
- Work with Health Boards to implement new pathways that keep people at home when it is safe to do so.

(c) Ambulance Care Transformation

- Transferring all remaining NEPTS services from Health Boards to the Trust;
- Further developing “Transport Solutions” which help people access transport when they are not eligible for NEPTS;
- Developing an action plan with our commissioners to take forward the recommendations from a review of NEPTS demand and capacity;
- Evaluating the first six months of the Grange University Hospital inter-hospital transfer service; and
- Working with commissioners to develop a consistent inter hospital transfer approach for the whole of Wales.

(d) A number of enablers were also articulated to take forward our plans including:

- Supporting staff and volunteers: actions to continue to improve the Trust as a place to work;
- Education: provision of state-of-the-art training in modern facilities at Matrix House, the new Cardiff Make Ready Depot and Ty Elwy;
- Leadership and behaviours: review of the Trust’s values and behaviours and support to allow staff to become more compassionate managers and leaders
- Where people work: continue to take steps to improve the estate, to allow staff to provide safe services;

- Fleet: renew the Trust's fleet in a way which helps to protect the environment;
- How you work: development of a Working Safely programme; and
- Equipment and technology: increased use of equipment and technology to help staff do their jobs more easily.

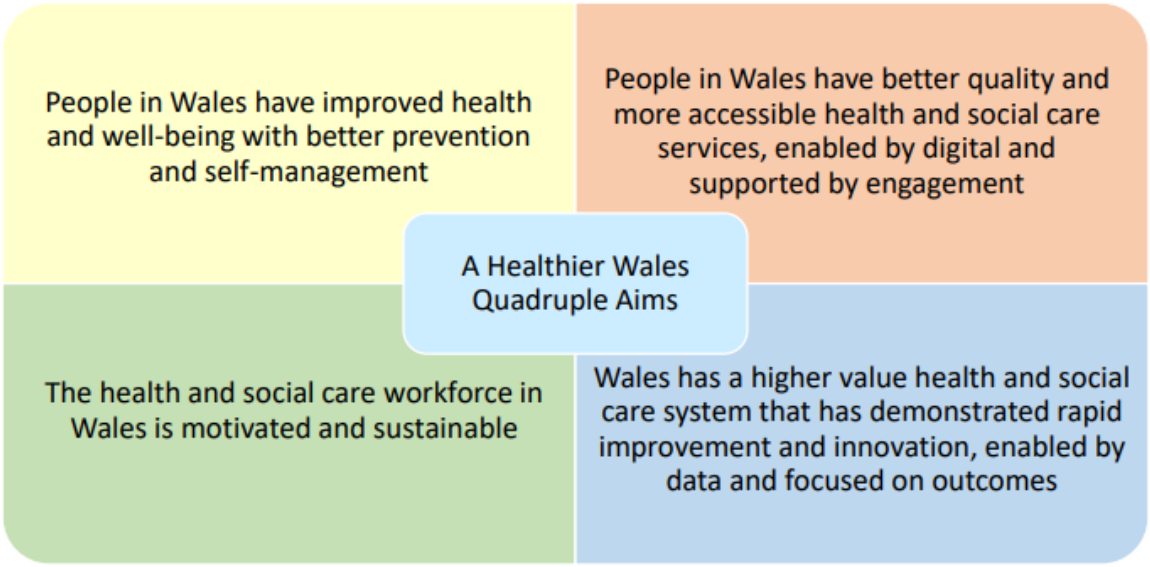
The Trust reviews its performance monthly both through analysis of key metrics and through tracking of actions and deliverables.

This next section of the report considers delivery in terms of numeric information with a supporting narrative before going onto to look at how the Trust performed in terms of its IMTP deliverables.

The Trust reviews quality and performance through four integrated lens:

i. "Our Patients (Quality, Safety and Patient Experience)";
ii. "Our People";
iii. "Finance and Value"; and
iv. "Partnerships and System Contribution".

These four areas of focus broadly correlate with the "quadruple aims" set out below from Welsh Government's "A Healthier Wales".



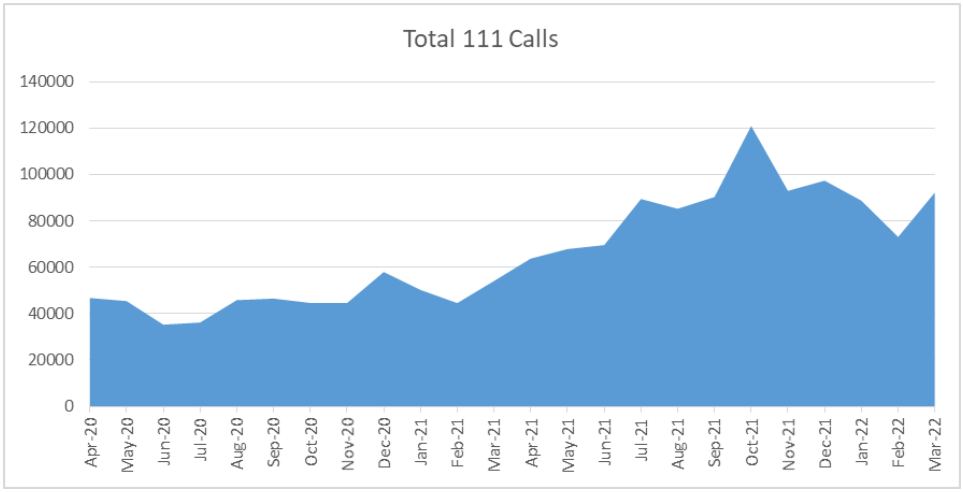
1.4.2 Internal Governance

The Trust has a Quality & Performance Management Framework which was updated during 2021/22 and approved in March 2022 by the Trust Board. The Framework details an Assurance & Governance Map and an Annual Quality & Performance Cycle, which together detail the various meetings that review performance information through the year and the cycle of reporting to these meetings. They include internal, but also external reporting arrangements.

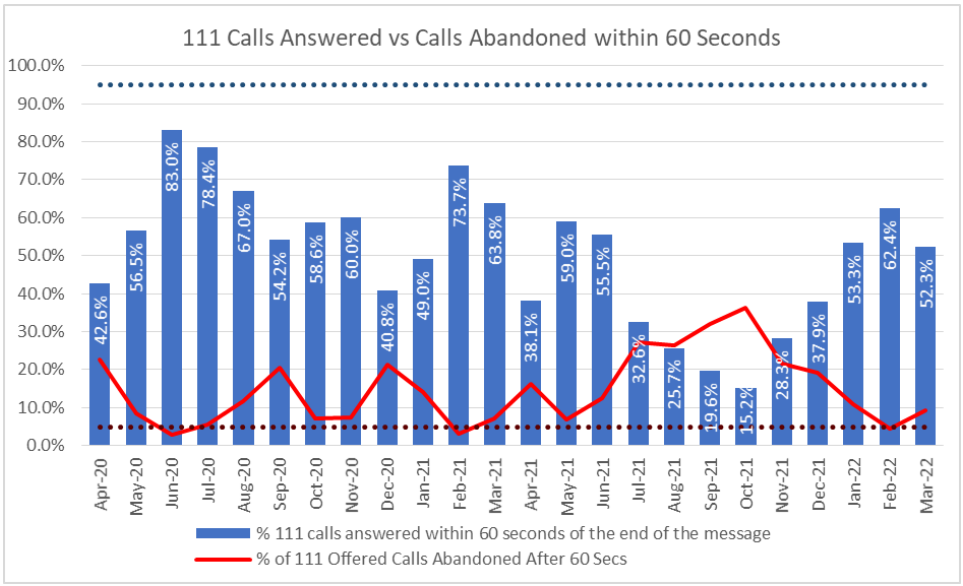
1.4.3 Our Patients (Quality, Safety and Patient Experience)

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.

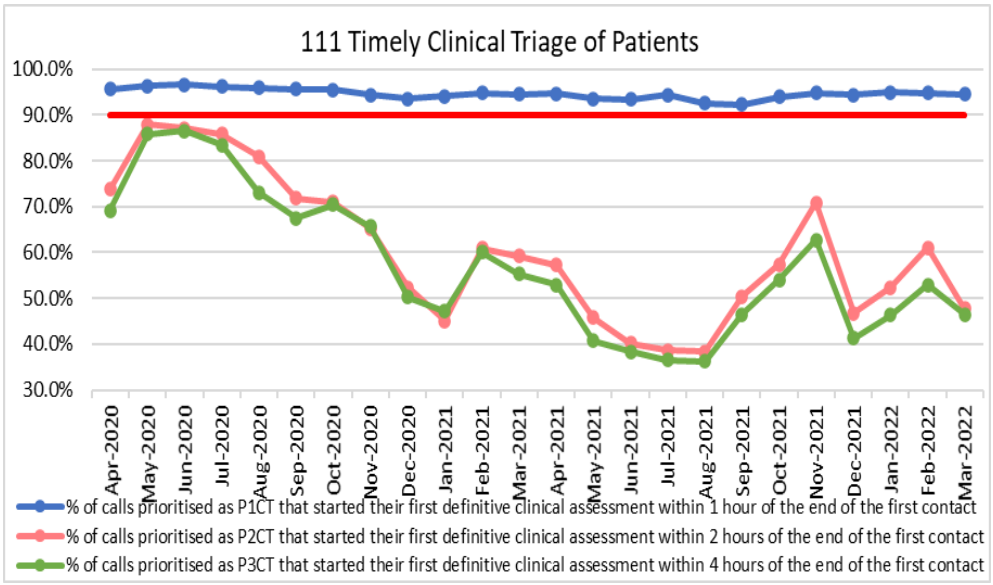
For many of the Trust's patients, the first point of contact with the Trust is the **111 service**. The 111 number is now operational across all of Wales (as part of the pandemic response), and the full 111 Service is now live in every part of Wales, with the remaining two Health Board areas, Betsi Cadwaladwr and Cardiff and Vale, moving across from the NHSDW service in 2021/22 which has contributed to the increase in calls demonstrated in the graph overleaf. The total number of 111 calls in 2021/22 was 1,031,655 compared to 552,232 in 2020/21.



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 demonstrates that the service has been significantly off target during 2021/22. 40% of 111 calls were answered within 60 seconds and 18.6% of calls to the 111 number were abandoned after 60 seconds 2021/22. As a result of a concerted recruitment and training effort, as well as internal improvement and efficiency work which remains ongoing, the Trust has started to see improvements towards the latter part of the year.



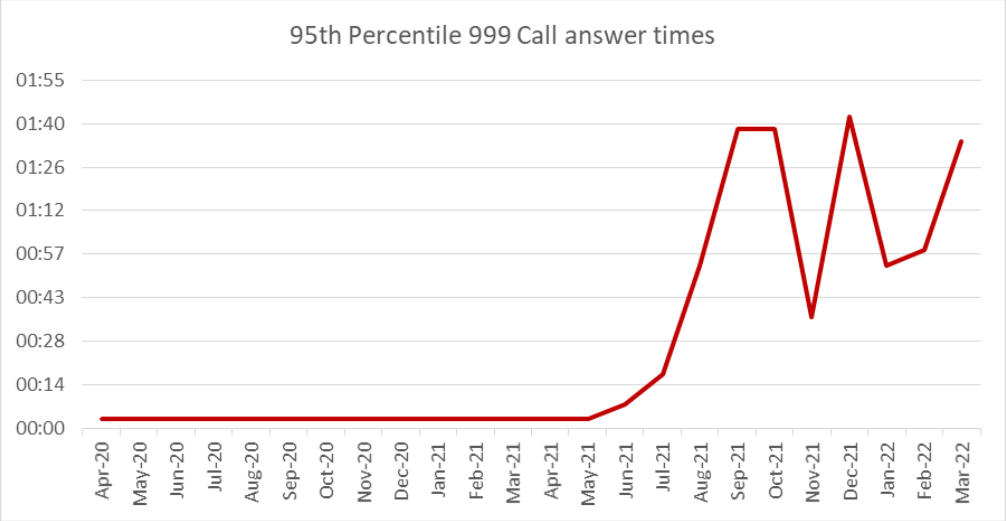
In relation to clinical ring back for triage, the Trust consistently achieves the one hour target of 90% for highest priority patients, 94% in 2021/22, but did not achieve the 90% target for other patient acuity categories. 50.6% of patients prioritised as P2CT received a clinical ring back within two hours of the end of the first contact and 46.2% of patients prioritised as P3CT received a clinical ring back within 4 hours of the end of the first contact. Patients have provided feedback on long waits and there is potential for these waits to have a knock on impact to both 999 and the rest of the urgent and emergency care system. The Trust therefore undertook a strategic demand and capacity review of 111 in quarter four 2021/22.



One of the factors in response times is demand. 111 demand has increased significantly, but this can be attributed to the service going live across Wales (bringing higher than expected demand in the North) alongside government

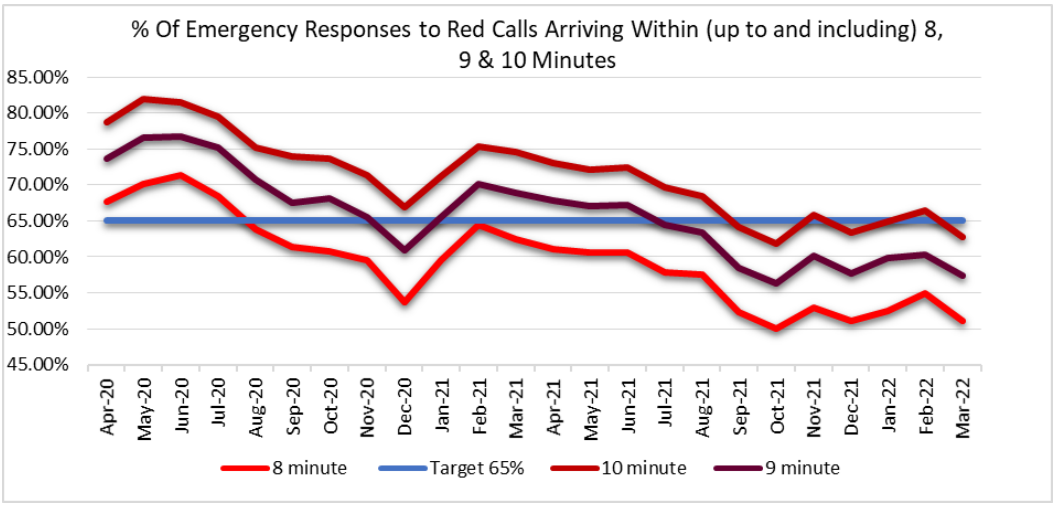
announcements relating to the pandemic, which have the effect of creating spikes in demand, and also an increasing use of the service which is increasingly seen as the "Gateway to Care" across the system.

Within the **999 service**, the Trust assesses the quality of the service it provides through a range of response times metrics, clinical indicators, and outcome measures. Call answering performance began to worsen during the summer as the Trust moved to a sustained period of maximum escalation with the 95th percentile of calls increasing from three seconds to 53 seconds. Some additional call taking capacity was built in through the year, and may be required into the future, subject to levels of activity and funding availability. 999 demand can be driven by repeat callers seeking an update when in-community wait times extend.

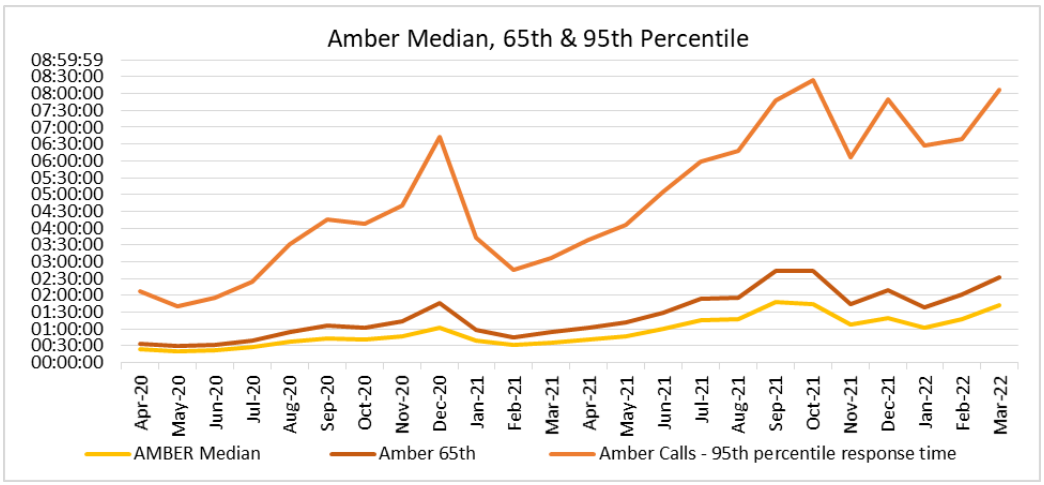


The headline patient metric for the Trust is Red 8 performance; this is the percentage of Red – immediately life threatening – incidents responded to within eight minutes. The Trust has unfortunately seen a continued deterioration in performance against the Red eight minute target, together with lengthening response times for its Amber calls which includes stroke 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. 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.

The Trust did not achieve the Red eight minute 65% Welsh Government target throughout 2021/22, this target is monthly



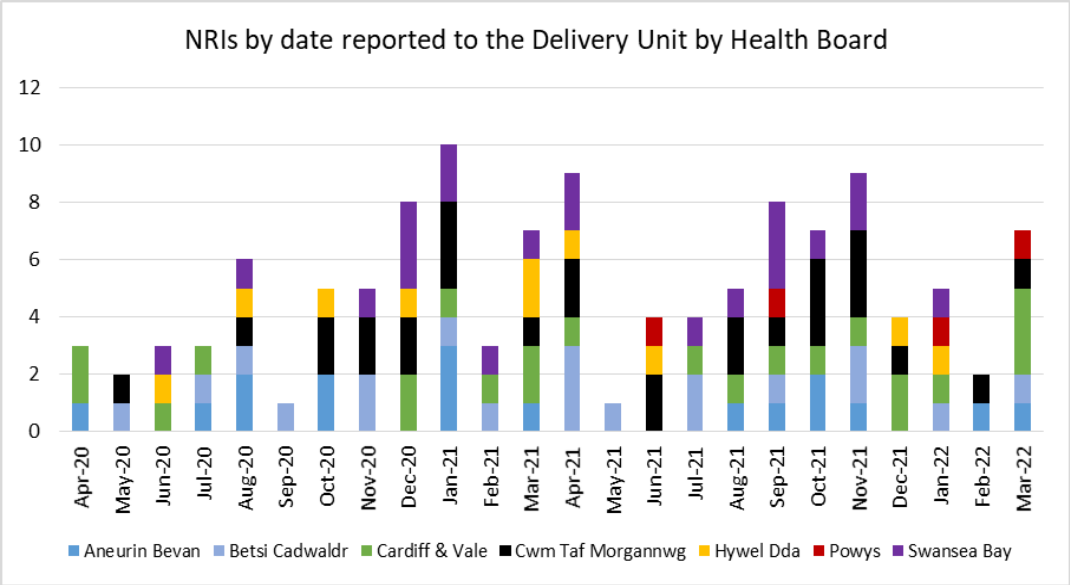
For 2021/22, the Trust's Amber performance achieved was one hour and 16 minutes (median); one hour and 56 minutes (65th percentile); and six hours and 22 minutes (95th percentile).



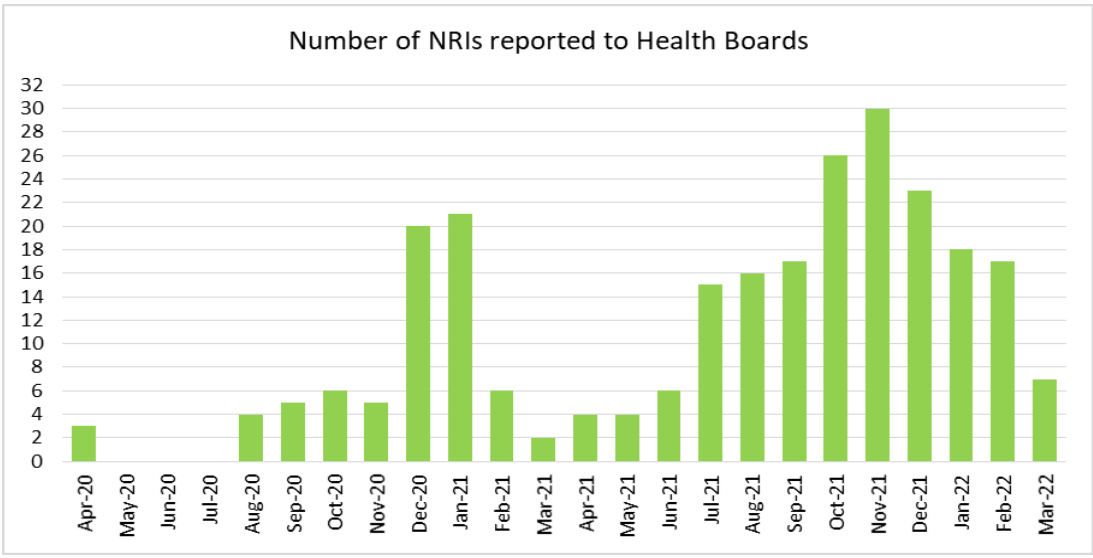
There are many reasons for these longer response times, which include increases in Red demand and overall acuity, a loss of capacity through increased sickness absence, and a loss of capacity through hospital handover delays. During quarter three and four the Trust received MACA support to help mitigate the loss of capacity which at peak was 250+ UK Armed Forces personnel. During the pandemic, the Trust also prioritised its conveying capacity (Emergency Ambulances - EAs) over Rapid Response Vehicles (RRV) which influences Red response times, and staff are also required to don and doff Level 3 PPE in line with Infection Prevention and Control (IPC) guidance, which can add minutes to the response time.

The Trust actively encourages a positive safety culture and sees all incidents/events as an opportunity for learning and improvement. There were 4,558 patient safety incidents, near misses and hazards reported in 2021/22, compared to 2,550 in 2020/21.

The Trust is seeing higher levels of National Reportable Incidents (NRIs); and also, higher levels of serious incidents referred to health boards for them to investigate. There were 65 patient NRIs in 2021/22 compared with 56 in 2020/21. This is too many and reflects the pressure in the health care system. Most, but not all of these NRIs relate to the Trust's 999 service.

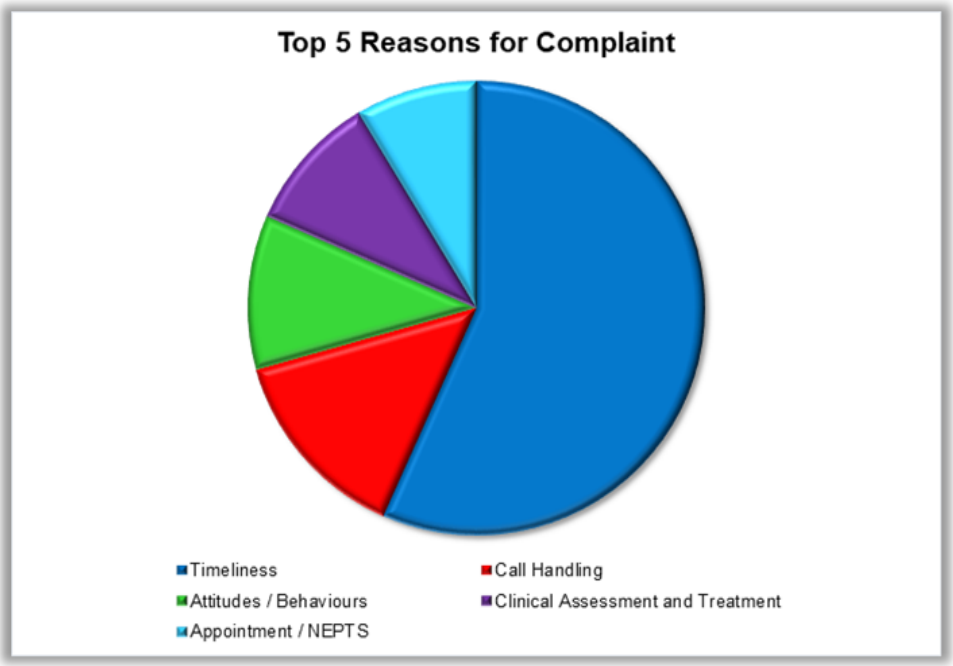


Incidents referred to Health Boards have more than doubled in the last year reflecting the severe pressures in the system. They are often due to long waits in the community because of handover delays at hospitals. There were 184 incidents referred to Health Boards in 2021/22 compared to 72 in 2020/21.



In 2021/22, there were 5,939 patient waits of 12 hours or over, compared to 1,850 in 2020/21.

The Trust has a 75% target for responding to patient concerns within 30 days, this was not achieved in 2021/22. There were 983 concerns received in 2021/22 compared to 725 in 2020/21. The majority of concerns related to timeliness of the Trust's response and a breakdown is provided below of the top five concerns:



43 cases were referred to the Public Service Ombudsman Wales (PSOW) and 15 cases remain currently open as follows:

- Eleven cases are with the PSOW's office for consideration and/or investigation;
- Two cases have been returned to the Trust to undertake further work, to complete an early resolution without the need for a full investigation by the PSOW;
- One case is at the draft report stage, where the Trust has accepted the content of the draft report, which does not uphold the complaint against the Trust; and
- One case has been received, but not yet actioned by the Trust (this is a request for sight of the complaints file).

The majority of the issues raised with the PSOW relate to timeliness of ambulance response.

The Trust received two Regulation 28 (Prevention of Future Deaths) reports during 2021/22. One case relates to the timeliness of response and the second case

relates to assessment and prioritisation of the call. The Trust has developed improvement plans in response to both cases and shared these with the respective Coroners.

A multidisciplinary panel is in place that meets on at least a weekly basis to review and discuss incidents to ensure appropriate investigations are undertaken. The Trust frequently undertakes joint investigations with health boards' 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 sub-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 Trust's Patient Experience & Community Involvement (PECI) Team remains committed to its programme of continuous engagement with our people and communities, allowing it to provide information and supporting evidence to relevant forums about people's experiences and expectations of services delivered by the Trust.

Through this engagement the Trust has also been able to feedback to communities about how their experiences have been shared and what difference their voices have made.

We use different ways to collect service user feedback and experience which includes community engagement work, social media activity and our involvement in public health. Some examples of our work this year and feedback includes:

What was good?

The Trust's 'Blue Light Hub' app continues to be recognised as an innovative way to engage with young people about using 999 services.

- *This recognition resulted in nationwide coverage about the app when the Trust was invited to appear on Crime Watch live on BBC One. This coverage helped boost app downloads and highlighted the importance of children and young people being confident to access the right service in an emergency.*

What could be improved?

The Trust was challenged by a visually impaired member of the public to create more accessible resources which support our Cardiopulmonary Resuscitation (CPR) and First Aid messaging.

- *This challenge has been duly accepted and we have started the process of speaking to sensory loss organisations about how they feel this information should be delivered, with an aim of developing customised resources for this community.*

In Wales, 80% of cardiac arrests occur in the home, so knowing what to do and being familiar with CPR and how to use a defibrillator can improve the chances of survival for a loved one. Throughout February 2022, the Trust ran the annual month-long #Defibuary Twitter campaign that raises awareness about CPR and defibrillators.

This year 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 of time when the Trust is experiencing increased demand and is at high levels of escalation.

The Patient Experience and Community Involvement Team participated in a three-day online event around co-production in mental health services, which included local, national and international speakers, workshops and creative activities. The co-production of a Mental Health Helplines leaflet developed by the Trust and the Cardiff and Vale Mental Health Forum, has been held up as an example of good practice.

As COVID-19 restrictions begun to ease, the Trust has been able to resume some face-to-face engagement in the community, through a blended approach which incorporates some online engagement sessions to promote key messages is how the Trust foresees itself working for the near future. This blended approach will ensure it:

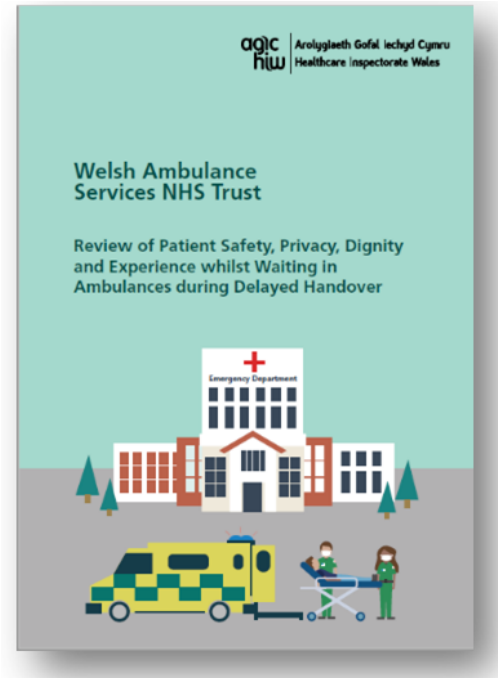
- Continues to remain visible in communities and build community trust;
- Supports people to make informed decisions on access to health care services;
- Informs people on what the Trust is doing to ensure they receive good/safe services; and
- Builds a repository of feedback and experiences to influence service plans.

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 2021/22 the Safeguarding Team have:

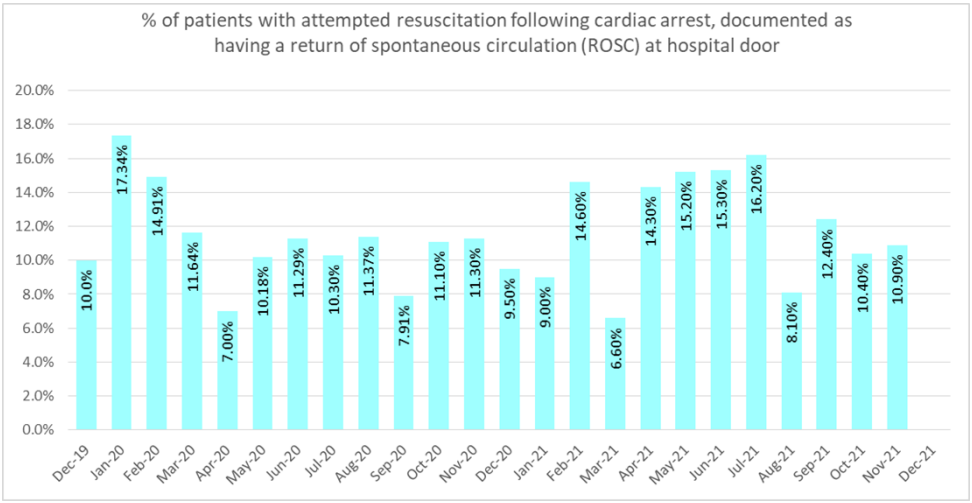
- Noted an increase in safeguarding reports submitted by Trust staff through the Docworks electronic safeguarding reporting system, both through iPads and desktop facilities;
- Expanded the functionality of Docworks to include a new referral pathway with all three regions of the Fire and Rescue Service across Wales. This enables staff to identify fire safety hazards within a patient/service user's home environment;
- Digitalised the Live Fear Free Referral Pathway to the Live Fear Free Helpline through Docworks, which helps to support victims/survivors of domestic abuse, domestic violence and sexual violence; and
- Developed Trust specific seven minute briefings to disseminate key safeguarding messages and learning in relation to safeguarding practice.

Healthcare Inspectorate Wales is the independent inspectorate and regulator of healthcare in Wales. An inspection of the Trust was undertaken covering the period April 2020 to 31 March 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 across Wales and includes a number of recommendations.



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, representatives from the Trust and Welsh Government.

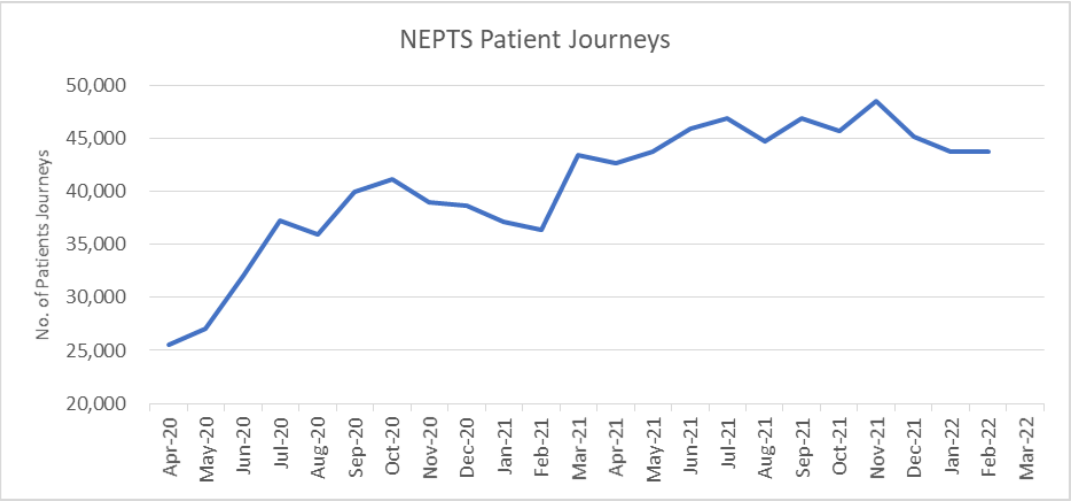
One of the clinical outcomes the Trust measures is the percentage of patients who have return of spontaneous circulation, and this remains lower than the Trust would want at 12.9% for the period April 2021 to November 2022, albeit an increase from 10.0% compared to the same period in 2020/21.



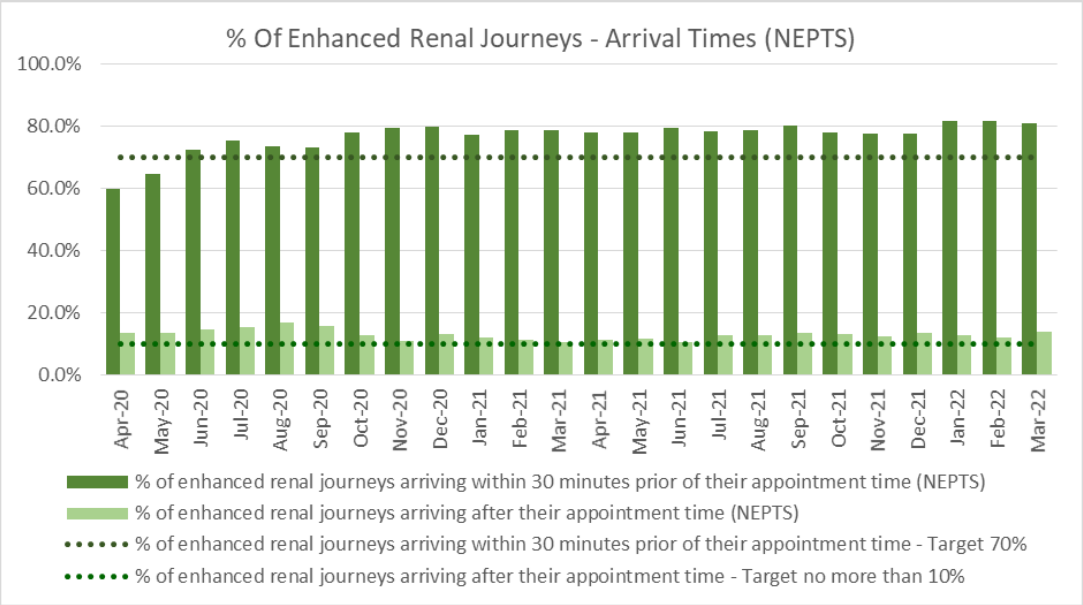
Whilst there are many factors outside of the Trust's direct control, it has developed a new service proposal, the Cymru High Acuity Response Unit (CHARU), to improve outcomes in this area, but this proposal is currently not funded. The deployment of the senior paramedic role is well underway through which it is expected to improve clinical oversight and leadership, uplifting clinical capability amongst the Trust's emergency medical services workforce.

Of the other seven clinical outcomes the Trust measures, four of the outcomes achieved the 95% target in the period April 2021 to November 2022. During this period, the ones that did not meet targets were: the percentage of older people with suspected hip fracture who are documented as receiving appropriate care bundle (including analgesia) at 88.2%; the percentage of ST segment elevation myocardial infarction (STEMI) patients who are documented as receiving appropriate STEMI care bundle at 78.6%; and the percentage of hypoglycaemic patients who are documented as receiving the appropriate care bundle at 89.6%.

In relation to the Trust's **Ambulance Care,** demand has not recovered to pre-pandemic levels. Whilst renal and oncology demand has been stable, outpatient demand is down and discharge and transfer variable. A further consideration for Ambulance Care is that social distancing reduces the number of patients who can be conveyed per journey. The total number of non-emergency patient journeys undertaken in 2021/22 was 497,570, compared to 433,524 in 2020/21 and 670,353 in 2019/20.



This has impacted on transport capacity and led to in-year investment of £2m as part of winter planning, which ceased on 31 March 2022. As a result, the quality of the service as measured through the various arrival/collection times indicators has been more stable with in-bound renal performance being achieved in every month in 2021/22. 79.1% of renal journeys arrived within 30 minutes prior of their appointment time (target 70%) and 12.6% of renal journeys arrived after their appointment (target no more than 10%) in 2021/22.



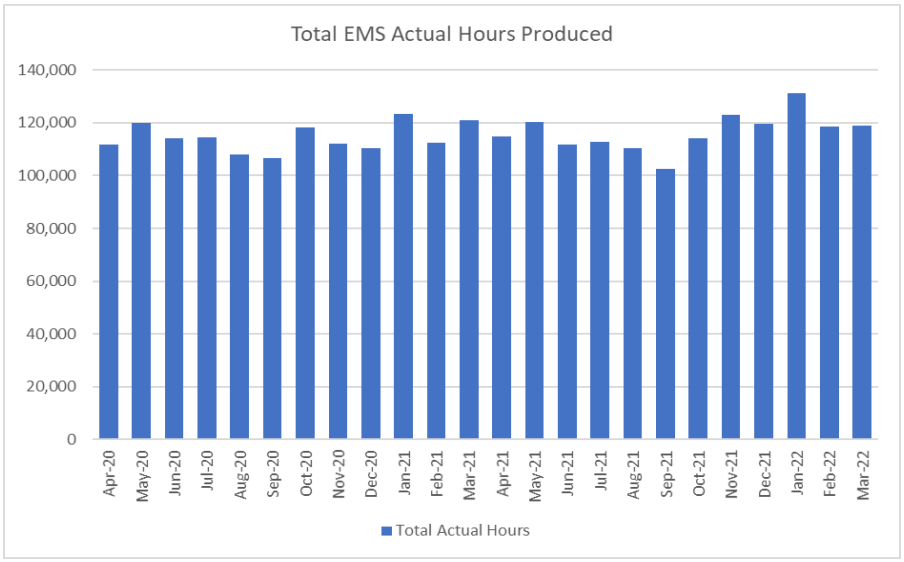
Discharge and transfer journeys also achieved the 70% target with 80% of journeys collected less than 60 minutes after their booked ready time.

Oncology performance remains off target with 55.1% of 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 is being considered further through the Ambulance Care Transformation Programme.

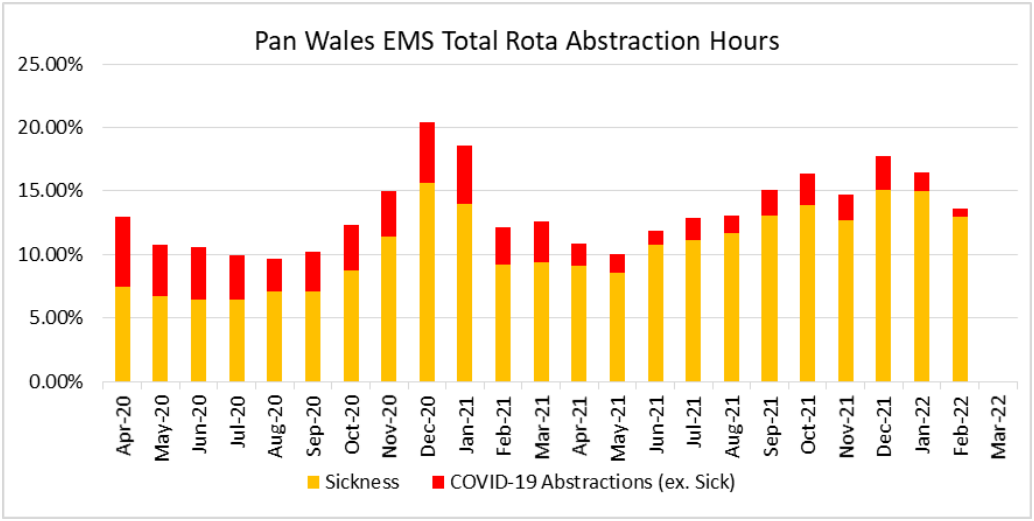
1.4.4 Our People

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 & Culture Committee.

In relation to the Emergency Medical Service (EMS), the EMS Demand and Capacity review in 2019 determined the required capacity to respond to demand based on a 30% abstraction assumption, with levels of investment provided by EASC to increase whole time equivalents (WTEs) by 263 over two years. The Trust achieved 204 WTEs against this relief gap target, but also recruited 36 Paramedics into the Clinical Support Desk and five mental health professionals. This is a significant milestone for the Trust that will bear fruit in the medium term; however, as the graph below demonstrates, despite having more staff in post, the Trust has not been able to produce many more hours, other than in the last quarter because of military aid. In 2021/22, 1,398,128 hours were produced compared to 1,372,175 hours in 2020/21.



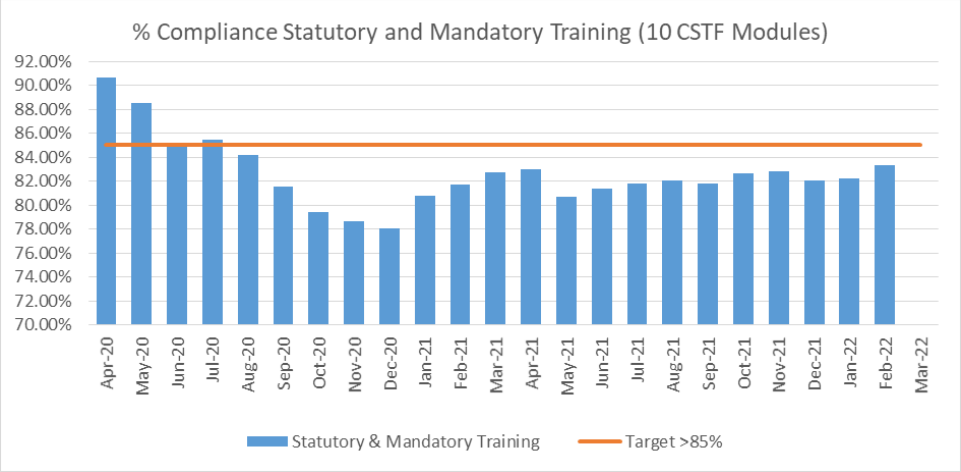
A key factor in the Trust's ability to ensure capacity to meet the demand is the impact of abstractions, and this also provides an indicator of our people's well-being. The significant impact of the last two years on our people at all levels in the Trust cannot be underestimated. To support the workforce there has been an ongoing focus on wellbeing activities across all areas of the Trust including those in frontline and support roles. Despite this, sickness has remained one of the key causes for rota abstraction. The graph overleaf shows the levels of abstraction due to sickness and due to COVID-19 factors. In 2021/22, 12.2% of abstractions were due to sickness and 1.7% were due to COVID-19.



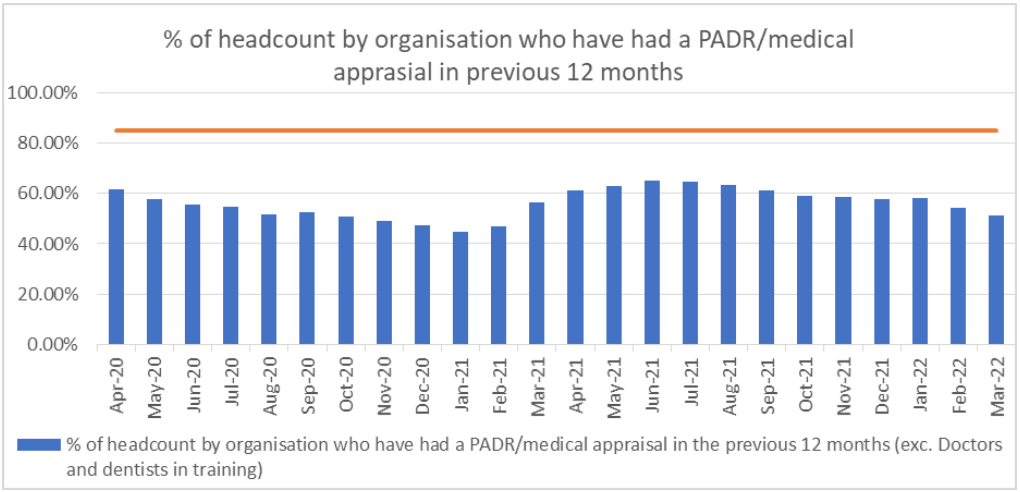
Similar pictures are seen in 111 and Ambulance Care, with a 14% abstraction due to sickness in the 111 service in 2021/22. The Trust knows that this will need to be a major focus of its plan going forward. The full sickness rates can be found within the Accountability Report.

Other indicators of how the Trust is keeping its staff safe and well include vaccination rates and statutory/mandatory training levels. As of 31 March 2022 95% of patient facing staff have received a COVID-19 booster vaccine, 94% are double jabbed and 85% have received their booster; however, the flu vaccination level for the Trust was 41% and whilst flu has not significantly affected the Trust this year, the aim is to increase the figure going forward.

In March 2022 Statutory & Mandatory Training rates had not achieved the 85% target overall with the completed level at 84.2%. It is worth noting that sustained and prolonged periods at high escalation (REAP 3 and REAP 4) levels, meant that front line delivery has been prioritised which would have had an impact on these metrics. The Working Safely Transformation Plan sets out to improve this.



In terms of staff development, the Trust reviews levels of Personal Appraisal and Development reviews (PADR) as the best way of representing development at a high level, and in March 2022 levels remained largely static at 51.5%. They continue to remain below the 85% target, despite a revised 'lite' approach during the pandemic.



1.4.5 Finance & 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.

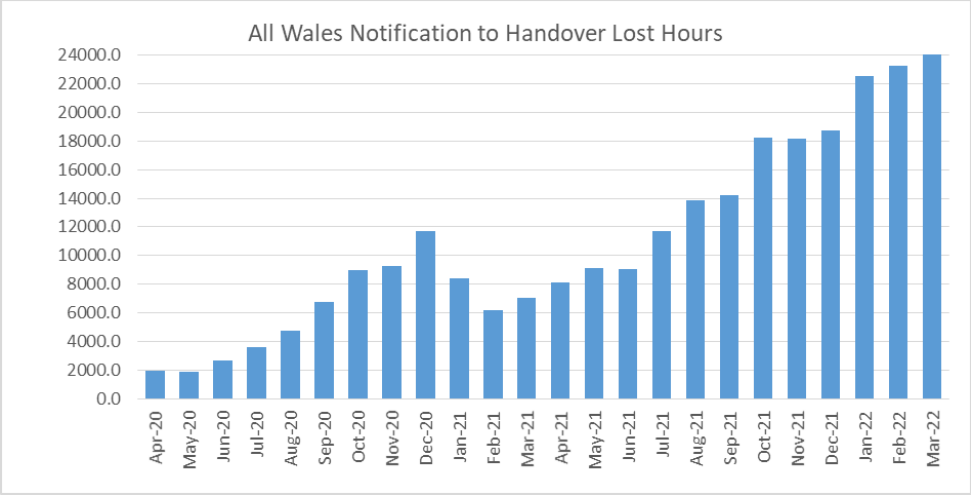
The Trust achieved financial balance in 2021/22, with a small revenue surplus of £0.075m and met its statutory duty to breakeven during this financial year. Further information can be found in the Trust's annual accounts and financial statements.

In relation to the value and efficiency of its service, the Trust developed in the last year, a utilisation measure for the EMS service, which it is working on with commissioners to make best use of it both as a tool to review retrospective performance, but also to look ahead, forecast performance and take mitigating actions where necessary.

The Trust measures the number of hours that are lost post production as these potentially indicate areas where efficiency could be improved. There are many legitimate reasons for crews needing to stand down post production and the Trust benchmarked well on Post Production Lost Hours (PPLHs) in the 2019 EMS Demand & Capacity Review with the exception of return to base meal breaks. Some concerns were raised about the accuracy of the data which are currently being resolved.

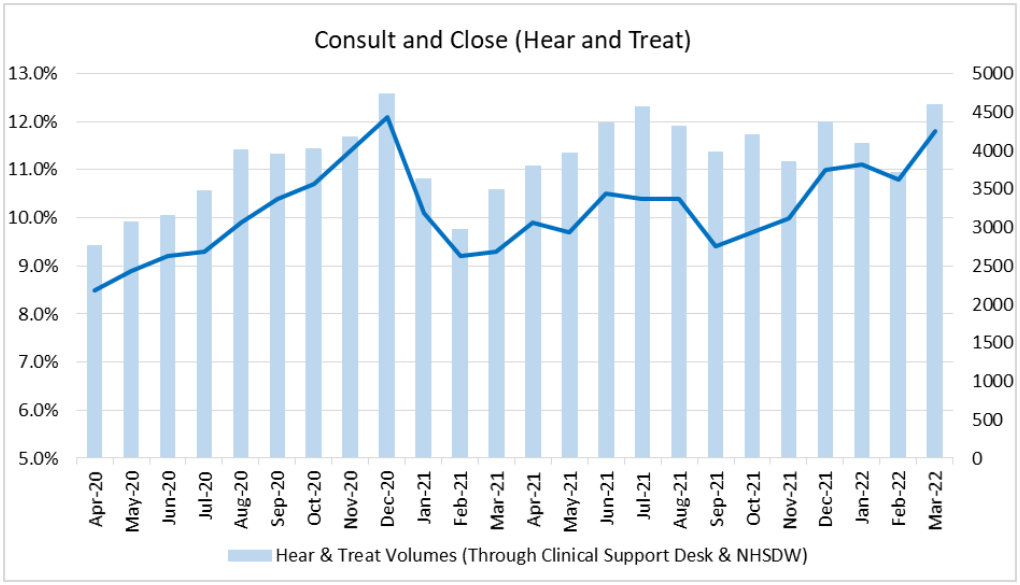
1.4.6 Partnerships & System Contribution

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 and Wales was an international outlier before the pandemic. The levels seen this winter were unprecedented. In March 2022 the Trust lost over 24,000 ambulance hours, equivalent to 48,000 people hours or 4,000 twelve hour shifts. This position has worsened month on month throughout 2021/22 with a total of 191,214 ambulance hours lost.



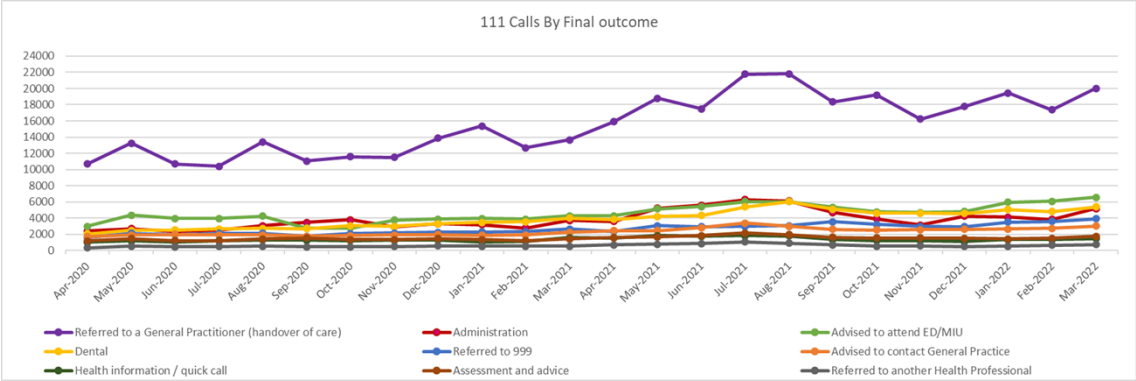
The Trust is aware that Health Boards are introducing urgent and emergency care escalation frameworks, and that there has been strong messaging from Welsh Government and the Minister for Health & Social Services that this must be tackled as a matter of priority; however, given the scale of the challenge and its links to wider system pressures, the Trust is having to plan on the basis that these levels will remain high for many months which is beyond its control, but these extreme levels 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 in consult and close (previously known as 'hear and treat') through the work of the Clinical Support Desk (CSD) and 111. In 2021/22, 10.4% of calls were ended following telephone assessment through CSD and 111.



The CSD has expanded this year to include an additional 36 WTE paramedics and five WTE mental health practitioners, although it must be noted that the lack of funding for the 36 WTE uplift has meant that the Trust has had to hold open 46 vacancies in the EMS response workforce. The 2019 EMS Demand and Capacity review benchmarked a consult and close (previously hear and treat) rate for the Trust of 10.2%, which was achieved in 2021/22, and with the expansion as described, the Trust is developing a trajectory to 15% in 2022/23. The Trust also monitors its 'see and treat' rates which have broadly remained static. The Trust's ambition, articulated through the 'inverting the triangle' work it has been doing, again is to increase this shift left activity.

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 required to identify whether these are the most appropriate and best outcomes.



1.4.7 Infection Prevention & Control (IPC)

The IPC Team continues to balance COVID-19 work demands along with emerging business as usual activities.

Successful recruitment took place in October 2021 increasing the IPC establishment to four WTE staff. This is an important step for the Trust both in terms of resilience and succession planning.

A main project within the IPC Team over the last year has been to improve fit testing within the Trust. Fit testing is a series of steps used to determine the suitability of a respirator mask for a specific user, as each respirator model will fit on the face of a user differently and mask fit testing helps to assure the best and safest fit. The two new members of the team are now certified by the British Standards Institute as competent fit testers, required by Health and Safety regulations; consequently, the process of fit testing within the Trust has been updated to comply with the required standards. Over several months fit testers currently performing this role within the Trust have been quality assured by the IPC team and the Electronic Staff Register (ESR) of fit testers updated. In addition, all documentation and training has been updated and are reflected in both the Fit Testing and Respiratory Protection Standard Operating Procedures.

Guidance for COVID-19 has changed many times over the last year and the IPC Team have ensured that these changes have been communicated and kept up to date to ensure the safety of staff and patients.

The IPC post pandemic plan includes:

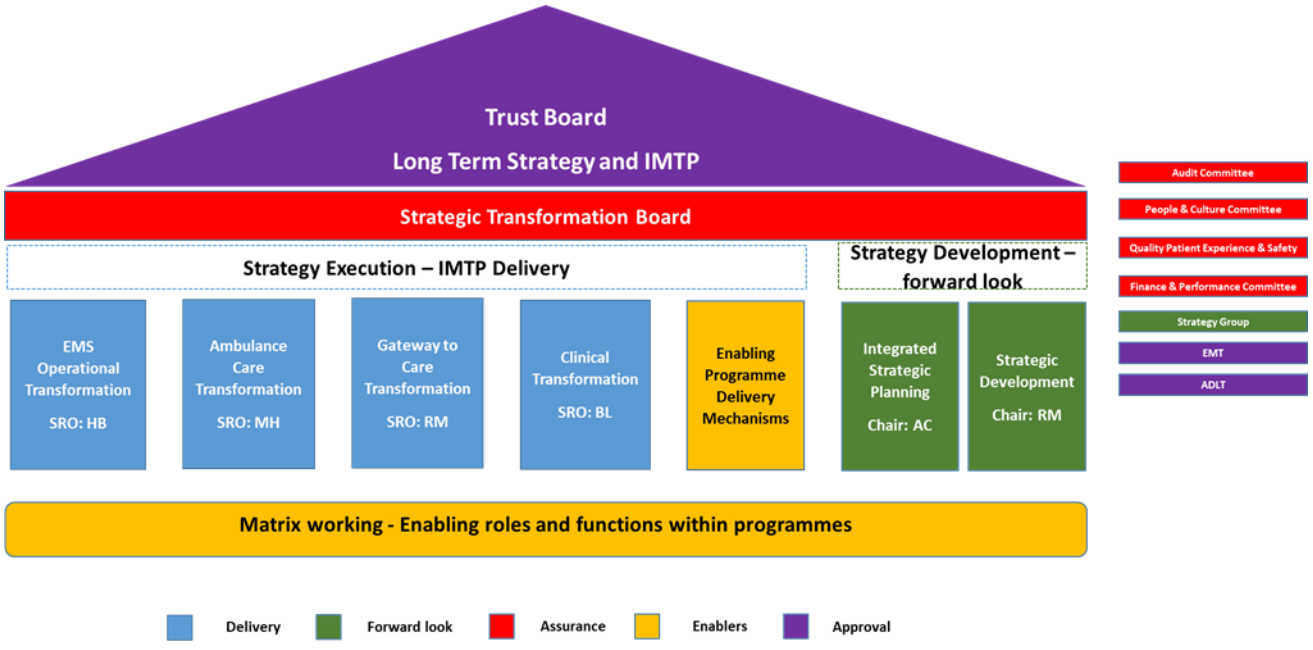
- The reintroduction of the IPC Governance Structure, with a new membership and terms of reference for the IPC Strategic Group;
- Policy Updates;
- A review of all Standard Operating Procedures;
- A review of guidance documents for business as usual;

- A review of standards for hand washing, bare below the elbow, premise and vehicle cleaning standards;
- IPC risk assessment;
- Education and Training based on the new framework recently published by Welsh Government; and
- Audits namely premises, vehicles and standard IPC practices, this will include updated audit tools.

Over the course of the pandemic IPC has remained centre stage for many actions and it is important that appropriate and necessary standards are maintained when returning to business as usual activities, the IPC team will reinforce these standards by promoting safe, clean care and visible leadership throughout the Trust to support staff and managers.

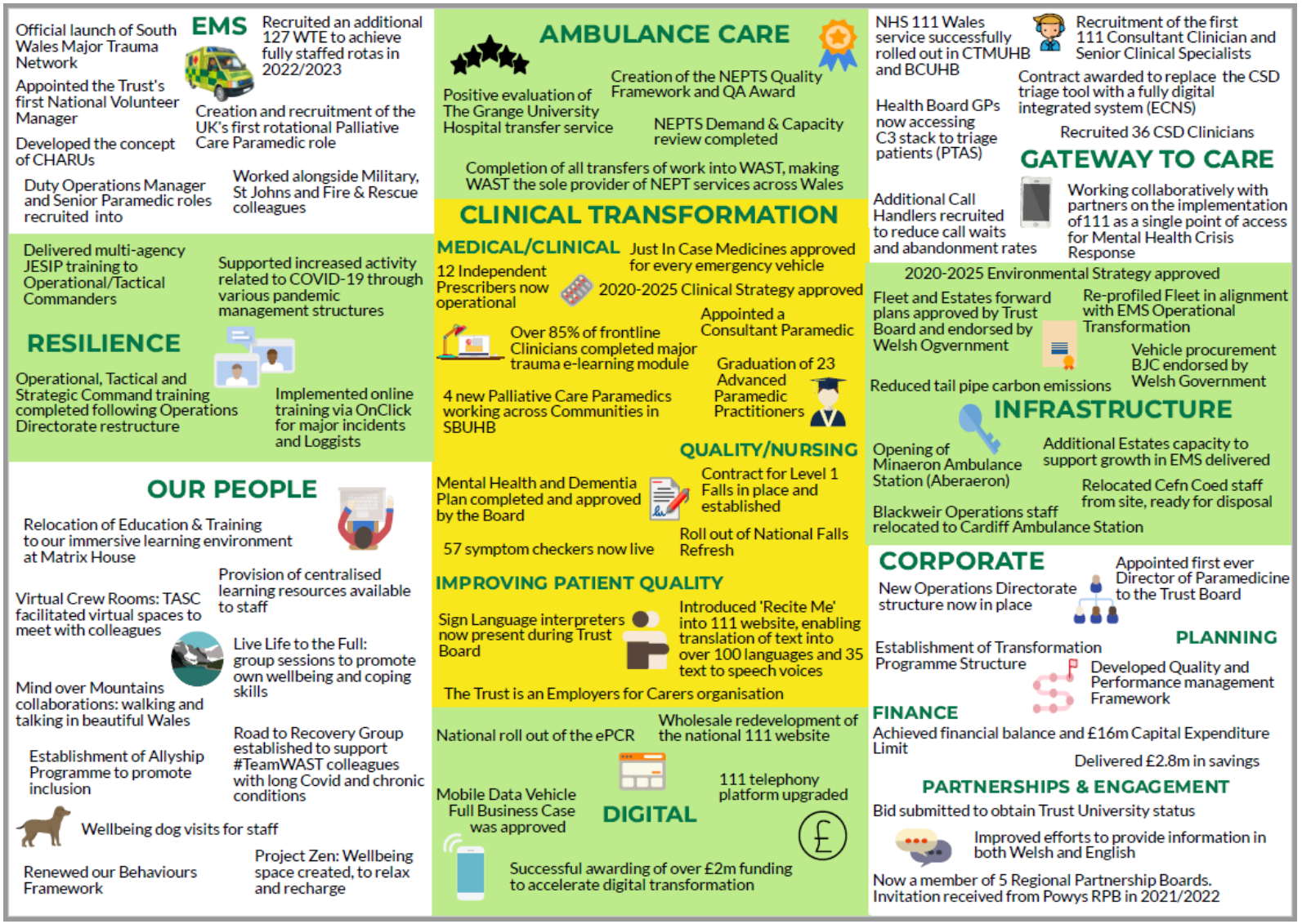
1.4.8 IMTP Delivery

The IMTP is delivered through its core services transformation programmes and enabling workstreams which report into the Strategic Transformation Board (STB). STB continued to meet regularly (every six weeks) during the ongoing pandemic response and recovery, delivering significant transformation in spite of the increased pressure across the urgent and emergency care system.



The infographic overleaf shows the extent of delivery across the planned and emergent projects throughout 2021/22.

IMTP Deliverables 2021/22



1.5 Delivering in Partnership

Strong and effective partnerships remain critical to the overall success of the Trust, something which continues to have been keenly evidenced through a further pandemic year in 2021/22.

While 2020/21 was a year in which the Trust needed to break new partnership ground, given the unprecedented challenges being faced, 2021/22 was one where many of those newer relationships began to be consolidated, while more established relationships continued to be a mainstay of its partnership work.

During 2021/22, the Trust welcomed support once again from military colleagues to help us maintain the delivery of its services in the face of extreme pressures, both in terms of demand and the availability of adequate staffing to meet those demands.

The Trust were delighted to be able to reinstate the work of its Community First Responders mid-year, as well as its co-responders in Mid Wales Fire and Rescue Service.

Throughout the year, the Trust has worked closely with a range of partners and stakeholders, some of them well-established, but some more recent, to ensure that the service could continue to maintain its services to patients while maintaining the safety of our people, as Wales remained in the grip of COVID-19.

The Trust also continued working with partners in UK government on the running of mobile testing units and with its established third sector partners, St John Ambulance Cymru.

2021/22 also saw the Trust take some significant steps towards gaining University Trust Status, which will help us redefine its relationships with higher and further education as it moves forward into the post-pandemic era, and everything that this will mean in terms of workforce, service configuration, harnessing technology, optimising opportunity for our people and the quality of services it provides to the people of Wales.

In an unprecedented emergency such as that posed by COVID-19, it would be simply unsustainable to work unilaterally. So much of what has been achieved during the last couple of years has been down to brilliant people, across so many different organisations, coming together to do brilliant and innovative things when the situation could not have been more serious – a real testament to the power of people and partnerships to move mountains.

And while the Trust continued to make a full contribution as members of statutory bodies like Regional Partnership Boards, the real power of partnership has been seen in so many of our people, working with its Trade Unions, coming together across the Trust to work much more laterally to create innovative solutions.

As the Trust moves forward into what it hopes will be a sustained phase of recovery and redefinition, the key will be to ensure that those relationships and partnerships are sustained and become embedded into its ways of working.

1.6 Workforce Management & Well-being

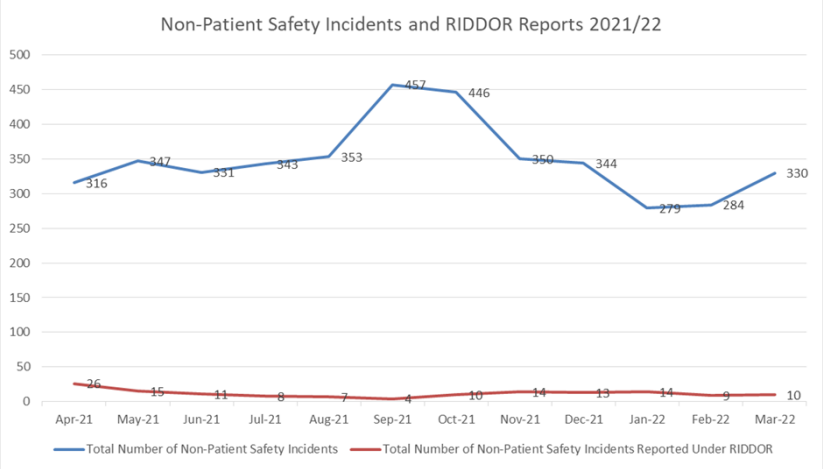
1.6.1 Staff Well-being

The Trust has continued to build on its strong focus toward the well-being of its staff. 2021-2022 has continued to see an increase in the size of the Occupational Health and Wellbeing Team. This has seen an expansion in the team in North Wales to ensure that the service provided is equitable in all areas of Wales. The plans contained in the Health and Wellbeing Strategy 2020-2024 have continued to move forward, and staff are now able to access Wellbeing apps in both Welsh and English, 24 hour access to an Employee Assistance Programme provider and access to an in-house psychologist undertaking psychological interventions for severe and complex mental health referrals/complex post-traumatic stress disorder, as well as providing education opportunities for paramedic students and staff. Drop in sessions with 111/CCC staff, various online workshops around psychological and physical issues are delivered and the Women's Health Group and the Road to Recovery Long COVID Group continue to provide positive support for specific staff groups.

The Trust has worked with the Association of Ambulance Chief Executives on reducing suicide risk and increasing awareness and established a peer support network with supervision, which is growing. Wellbeing is now integrated into leadership development and training courses and manager's consultation sessions for issues relating to mental health and wellbeing of staff or themselves have been set up. Leadership Development has recommenced after being paused until 2022.

1.6.2 Health & Safety

2021/22 continued to be a challenging year for the Trust in regard to ensuring the health, safety and welfare of its staff. This was due to the ongoing requirements due to the COVID-19 pandemic and the increase in demand on its staff during the winter period.



During the year there were 4,180 Non Patient Safety Incidents recorded by the Trust's staff, the two highest incidents recorded were for issues surrounding meal breaks and shifts as well as violence and aggression incidents where no physical

injury was recorded. Of the Non Patient Safety Incidents recorded 141 incidents were reported to the Health and Safety Executive (HSE) under the Reporting of Injuries, Disease and Dangerous Occurrences Regulation 2013 (RIDDOR). Of these incidents the highest numbers were recorded for moving and handling patients as well as slip, trip and fall incidents.

The adjustments made to the RIDDOR reporting process made in the 2020/21 financial year has resulted in improvements in the timely reporting of incidents to the HSE; however, further improvements are being investigated as the current performance is still outside of the reporting requirements set by the HSE.

Resource within the department continued to be a challenge throughout the year with staff being recruited on temporary contracts whilst a business case was created setting out the staffing requirements for the Health and Safety Department to meet the current and future demands of the Trust. During the year many of the duties required of the Health and Safety Team have been fulfilled by staff either recruited or seconded to the Working Safely Programme.

Throughout the year there has been the continual need to support areas with the workplace risk assessments required as a result of the COVID-19 pandemic. The risk assessment template has seen two revisions to aid the quality of the assessments and these have made a positive impact on Trust premises. The completion rate for the first revision was 100%, whilst the completion rate for the second revision is high the Safety Team are assisting the areas where there are questions outstanding.

The last quarter of the year saw the introduction of COVID-19 Champions in a number of the Trust premises with volunteers assessing the COVID-19 controls in place for the buildings and engaging in positive safety conversations with individuals regarding person behaviours.

The Working Safely Programme “Pump Prime” phase started in October 2021 with the aim of delivering a range of safety products to improve the safety performance and culture across the Trust. By January 2022 the roles required for this phase of the programme were filled with a mix of individuals on fixed term contracts and staff seconded as Staff Officers.

The governance arrangements for the programme have been established with the setting up of a Dynamic Delivery Group to steer the progress of the products being developed and the establishment of the Strategic Programme Board to ensure the programme delivers on its IMTP requirements.

To date the programme has delivered a number of different products such as an improved Display Screen Equipment and risk assessment process for the Trust that will be implemented during the 2022/23 financial year.

1.6.3 COVID-19 Vaccination

In August 2020, the Chief Medical Officer commenced system planning for the delivery of vaccinations in accordance with Joint Committee on Vaccination and Immunisation guidelines; arrangements were agreed for the Trust’s people to be

vaccinated by the Health Board in which they reside. This continued throughout 2021/22 and as of 31st March 2022, 95% and 94% of front line staff had received their first and second vaccinations respectively, and 85% had received their booster vaccination. The Trust is indebted to the seven population serving Health Boards and Velindre University Health Board who have provided this service to and for the Trust's people.

1.6.4 COVID-19 Staff Fatalities

There were 1,022 reports of staff members testing positive for COVID-19 during the 2021/22 financial year thankfully no staff died as a result of the infection.

1.6.5 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, planning and with key stakeholders both within and without the whole organisation to ensure availability of fully trained and capable staff working at their optimum to ensure positive patient experience. This year saw continuation of recruitment and training activity following on from the EMS Demand and Capacity Review. This has resulted in the numbers below being added to the total workforce.

Significant recruitment activity took place during 2021/2022 for almost 700 hires, including:

- over 120 hires for the EMS;
- over 80 hires for the EMS Coordination service;
- over 220 hires for the 111 service; and
- over 150 hires for the Ambulance Care directorate.

The Trust also received the following support from its volunteers:

- Volunteer Car Service Drivers: Twelve new drivers & 22 returned to service;
- Community First Responders: 36 new Community First Responders; and
- Alternative responders: Eleven Fire Stations in Mid Wales & West Fire Rescue Service online for Out of Hospital Cardiac Arrest & Non-Injured Falls.

The resultant change in workforce numbers is reflected in the Accountability Report contained within this Annual Report.

1.7 Decision Making & Governance

1.7.1 Trust's Governance & Accountability Framework

Details on the Trust's governance and accountability arrangements are set out in the Accountability Report contained within this Annual Report.

1.7.2 Ambulance Commissioning

A key aspect of the Trust's accountability and governance is that the Trust is a commissioned service for EMS and NEPTS. The commissioning is undertaken by EASC, on behalf of Health Boards, who are also supported by the CASC and the National Collaborative Commissioning Unit. EASC, and its supporting committees, have continued to meet through the pandemic period, with one or two exceptions during periods of maximum escalation. Similarly, the monthly CASC Assurance meeting has continued to function through most of 2021/22, again with one or two exceptions for maximum escalation periods. Right through the pandemic period 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 2021/22, in particular:-

- Five WTE mental health practitioners, again into the Clinical Support Desk;
- 81 WTEs (in addition to the 136 WTEs in 2020/21) towards closing the relief gap for the EMS response workforce; and
- A range of in-year mitigations to support tactical seasonal plans, including funding for patient cohorting at a number of emergency departments, additional support for the Ambulance Care service (which includes NEPTS) and the procurement of St John Ambulance Cymru support.

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 2021/22 commissioning intentions and reported its progress on the 2021/22 commissioning intentions to the 21 April 2022 EASC Management Group.

Further information on EASC and the Trust can be found here.

The Trust continues to operate a collaborative and open style of working with the CASC and his team.

1.7.3 Well-being of Future Generations (Wales) Act 2015

Whilst the Trust is not one of the 44 organisations named in the Well-being of Future Generations (Wales) Act 2015, the Trust has a long-standing commitment to working within the spirit of the act.

The Trust's focus on collaboration and on making decisions which are sustainable continues to be evidenced by its commitment to working in partnership with a range of organisations.

More particularly in 2021/22, the Trust has focused on the further development of its long-term strategy, which will be framed around the sustainable goals as it looks to "invert" its services and deal with many more patients either by remote or on-scene triage, treatment and referral.

Similarly, whilst the Trust does not participate in Public Service Boards, it is now a member of five of seven Regional Partnership Boards (RPBs) (or their subsets), having added Powys RPB to the list in 2021/22.

The Trust's membership provides positive opportunities for further long-term strategic alliances which will deliver benefit for our patients and communities more broadly as it moves forward.

2021/22 saw the launch of Welsh Government's "Six Goals for Urgent and Emergency Care" as part of the Programme for Government, which reflects the tenets of the Well-being of Future Generations Act.

As the Trust moves forward into 2022/23, the Trust will have a significant role to play in the delivery of the six goals, many of which support the long-term ambitions of the organisation.

1.7.4 Welsh Language Regulations

On 30 May 2019, the Trust moved from implementing its Welsh Language Scheme under the Welsh Language Act 1993 to implementing Welsh Language Standards which are a set of statutory requirements which clearly identify its responsibilities to provide excellent bilingual services. These can be accessed via the Welsh Language Standards section on the Trust's 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. Overall, the process of implementing the Standards has had a positive effect on the Welsh language within the Trust and an increased number of staff are engaging in the language in the workplace, supported by initiatives such as the national Cymraeg Gwaith scheme. In addition, the Trust has strengthened its capacity to provide services to patients in Welsh for its 111 Service via a new front end messaging and options menu and recruitment of Welsh speaking call handlers in North Wales. 111 Service staff are supported with a new bespoke training package on Welsh language requirements and operational skills. In order to strengthen the Trust's long-term outcome in the delivery of an "Active Offer" as an integral part of service delivery, work has commenced on the development of a bilingual skills strategy.

The Trust will report 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 will be published on the Trust's website.

1.7.5 Sustainability Report

Carbon emissions data will no longer be reported via the Sustainability Report as an addendum to this report, but via the Welsh Public Sector Net Zero Carbon reporting structure, discussions are still underway regarding metrics and format. Communication of this data needs to be agreed with all parties.

1.8 Conclusions & Look Forward

2021/22 has been another extraordinary year for the Trust as it has continued to respond to the global pandemic. 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 the challenge, patient experience and safety in 2021/22 were not at the levels the Trust, or its stakeholders, aspire to. The reasons are complex and multiple, with some directly related to COVID-19 and others due to underlying fundamentals that were a problem pre-pandemic.

As the Trust moves forward into 2022/23 it will continue to monitor and respond to the needs of COVID-19 at a tactical level, whilst continuing to progress its strategic transformation programmes designed to modernise the Trust and the service it provides to patients and people in Wales. The Trust's IMTP 2022-25 provides further details on the Trust's strategic plans.

Finally, the Trust is acutely aware of the impact of COVID-19 on the communities it serves and also its own staff, both those colleagues who have passed and those recovering from COVID-19; the Trust will continue its emphasis on well-being and work to support those affected.

1.9 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 Board Papers
27 May 2021	3.1	Bundle Trust Board (Open Session) 27 May 2021 (wales.nhs.uk)
29 July 2021	3.2	Bundle Trust Board (Open Session) 29 July 2021 (wales.nhs.uk)
30 Sept 2021	2.1 and 3.1	Bundle Trust Board (Open Session) 30 September 2021 (wales.nhs.uk)
25 Nov 2021	11 and 12	Bundle Trust Board (Open Session) 25 November 2021 (wales.nhs.uk)
27 Jan 2022	12 and 14	Bundle Trust Board (Open Session) 27 January 2022 (wales.nhs.uk)
24 Mar 2022	9 and 10	Bundle Trust Board (Open Session) 24 March 2022 (wales.nhs.uk)

Ambulance Quality Indicators (AQIs): 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 is amongst the most transparent ambulance services in the World, with the publication of the quarterly AQIs by EASC.

Home - Emergency Ambulance Services Committee (nhs.wales)

Performance Report Contact Details: Should you require any further information on this Performance Report, please contact Hugh Bennett, Assistant Director, Commissioning & 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 SI 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 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 regards 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 therefore 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. These 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. Some of the information which would normally be shown here is provided in other parts of the Annual Report and Accounts and this is highlighted where applicable.

The Statement of Accounting Officer's Responsibilities and Statement of Directors' Responsibilities in Respect of the Accounts: This requires the Accountable Officer, Chair and 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

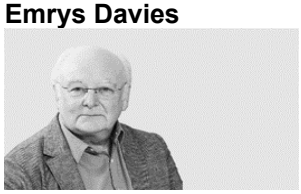
The Directors' Report provides details of the Board, Executive Team and any other individuals who were Directors of the Trust and have or had authority or responsibility for directing and controlling the major activities of the Trust at any point during the year.

Where information normally presented in this report is discussed elsewhere in the Annual Report and Accounts this will be cross-referenced to the information.

(a) Details of 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 2021/22			
Martin Woodford 	**Trust Board Chair** Remuneration Committee Chair Champion for Governance and Risk	**Prof Kevin Davies** 	**Vice Chair** Chair of Charitable Funds and Academic Partnerships Committees Champion for operational delivery; academic partnerships; armed forces and veterans; mental health; research
Emrys Davies 	**Non-Executive Director** Chair of Finance & Performance Committee Champion for Welsh language	**Bethan Evans** 	**Non-Executive Director** Chair of Quality, Patient Experience and Safety Committee Champion for Quality, patient experience and safety
Paul Hollard 	**Non-Executive Director** Chair of People and Culture Committee Champion for workforce and organisational development; Trade Union relationships; children and young people; older persons; raising concerns	**Ceri Jackson** 	**Non-Executive Director** Champion for digital and transformation; partnerships and engagement; charitable fundraising

Joga Singh 	**Non-Executive Director** Champion for environment and sustainability; resources and value for money	**Martin Turner** 	**Non-Executive Director** Chair of Audit Committee Champion for strategy development; governance and risk
Jason Killens 	**Chief Executive Officer** Accountable Officer	**Wendy Herbert** 	**Executive Director of Quality & Nursing (Interim) (rom 7 March 2022)** Caldicott Guardian Champion for children and young people; Putting Things Right Executive lead for Quality, Patient Experience and Safety Committee
Brendan Lloyd 	**Executive Medical Director**	**Claire Roche** 	**Executive Director of Quality & Nursing** (**from 1 April 2021 to 4 March 2022)** Caldicott Guardian Champion for children and young people; Putting Things Right Executive lead for Quality, Patient Experience and Safety 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	**Claire Vaughan** 	**Executive Director of Workforce & Organisational Development** Executive lead for People and Culture Committee Executive lead for Remuneration Committee Champion for violence and aggression

Non-Voting Members of the Board 2021/22			
Lee Brooks 	**Director of Operations** Champion for emergency planning	**Craig Brown** 	**Trade Union Representative at Board (RCN)**
Keith Cox 	**Board Secretary (from 1 April 2021 to 1 August 2021)** Champion for Welsh language	**Andy Haywood** 	**Director of Digital** Senior Information Risk Officer Armed Forces Champion Chair NHS Wales Digital Directors Peer Group National Digital Lead for 6 Goals of Urgent and Emergency Care Board.
Estelle Hitchon 	**Director of Partnerships & Engagement** Women's equality champion Executive lead for Academic Partnerships Committee	**Rachel Marsh** 	**Director of Strategy, Planning and Performance** Joint executive lead for Finance and Performance Committee
Trish Mills 	**Board Secretary (from 2 August 2021)** Champion for Welsh language	**Andy Swinburn** 	**Director of Paramedicine**
Damon Turner	**Trade Union Representative at Board (Unison)**		

The changes made amongst Board members during 2021/22 are set out below. These changes had no detrimental impact on the balance of the Board or on collective decision making.

- Martin Woodford's contract as Trust Chair was extended by Welsh Government from 31 March 2022 to 30 September 2022.
- Joga Singh, Non-Executive Director was re-appointed for a second term to 8 December 2025.
- Ceri Jackson was an interim appointment to the Board, and she was appointed as substantive Non-Executive Director from 1 April 2022 following advertising of that vacancy.

- Emrys Davies' contract as a Non-Executive Director finished on 31 March 2022 after serving two terms on the Board.
- Claire Roche, Executive Director of Quality and Nursing left the Trust on 4 March 2022 and Wendy Herbert was appointed as Interim Executive Director of Quality and Nursing from 7 March 2022.
- Andy Swinburn was appointed to the new post of Director of Paramedicine on 1 November 2021 (previously Associate Director of Paramedicine).
- Keith Cox, Board Secretary left the Trust on 1 August 2021 and was replaced as Board Secretary by Trish Mills on 2 August 2022.

(b) Declarations of Interest

The register of declarations of interest for Directors are as follows:

Name	Position	Declaration
Martin Woodford	Trust Chair and Non-Executive Director	Nil declaration.
Kevin Davies	Vice Chair and Non-Executive Director	Colonel Commandant Queen Alexandra's Royal Army Nursing Corps. Trustee Queen Alexandra's Charity. Trustee St John Ambulance Cymru. Patron Motivation and Learning Trust. Chair ABF The Soldiers Charity (Glamorgan). Member Royal College Nursing.
Emrys Davies	Non-Executive Director	Director and Chair, NRML (Newport Road Maintenance Ltd.) Retired member of Unite.
Bethan Evans	Non-Executive Director	Managing Director (Employed) at My Choice Healthcare Limited. Non-Executive Board Member at RHA (Social Housing Organisation) Company Directorships: - Moorlands Rehabilitation (Staffordshire) Limited. - My Choice Healthcare South Wales Limited - Homes of Excellence Healthcare Limited. - Springfield (Bargoed) Limited. - Homes of Excellence Limited - Victoria House Care Limited - My Choice Healthcare (Three) Limited - My Choice Healthcare (Four) Limited
Paul Hollard	Non-Executive Director	Independent consultant providing occasional services to NHS Wales organisations and Welsh Government.
Ceri Jackson	Non-Executive Director	Self-employed Management Consultant primarily working in third sector. (Not undertaking any contracts for NHS, would consult Trust Chair prior to undertaking any contracts.) Associate Director of SamKat Ltd in my capacity as self-employed management consultant. (Not undertaking any NHS contracts as part of this role and would consult Trust Chair prior to undertaking any contracts.)

Name	Position	Declaration
		Stroke Association Trustee, Chair Wales Advisory Group. Stroke Association has contracts with the NHS to deliver services. Volunteer role. Cardiff Institute for the Blind Trustee (trading as Sight Life). The charity has a contract with Cardiff and the Vale Health Board to provide services. Volunteer role. Partner employed by Arjo (global supplier of medical devices and equipment).
Joga Singh	Non-Executive Director	Geldards LLP, paid employment. Membership of the Law Society and the Employment Lawyers Association. Member of the Fairness Inclusion and Respect Committee for the Institute of Civil Engineers in Wales, voluntary role. Independent Member of the South Wales Police Ethics Committee, 2 – 3 days a year.
Martin Turner	Non-Executive Director	Director and shareholder Martin Turner Associates Ltd.
Jason Killens	Chief Executive	Nil declaration
Brendan Lloyd	Executive Medical Director	National Professional Advisor (Ambulance Services) at Care Quality Commission, one day a week for six months from 1 February 2022.
Claire Roche	Executive Director of Quality and Nursing (to 6 March 2022)	Nil declaration.
Wendy Herbert	Interim Executive Director of Quality and Nursing (from 7 March 2022)	Nil declaration
Chris Turley	Executive Director of Finance and Corporate Resources	Treasurer of Royal Gwent Hospital League of Friends.
Claire Vaughan	Executive Director of Workforce and OD	(Voluntary) Independent Sub-Committee Member for Aberystwyth University
Lee Brooks	Director of Operations	Partner employed by Welsh Ambulance Services NHS Trust.
Andy Haywood	Director of Digital	Nil declaration.
Estelle Hitchon	Director of Partnerships and Engagement	Nil declaration
Rachel Marsh	Director of Strategy, Planning and Performance	Nil declaration
Andy Swinburn	Director of Paramedicine	Strategic Advisor to the College of Paramedics.
Keith Cox	Board Secretary (to 1 August 2021)	Magistrate Cardiff and Vale.
Trish Mills	Board Secretary (from 2 August 2021)	Nil declaration.

(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 Trust is aware that the COVID-19 pandemic has impacted on service provision not only from an operation point of view but also environmental; with an increase of both domestic and clinical waste, plus an increase in frontline vehicle journeys

The Performance Report provides details of the work of the Patient Engagement Community Involvement Team and our volunteers during 2021/22. The Trust continues to work to create and nurture a sustained relationship with communities that stimulates interest, encourages involvement and builds the trust needed to achieve service improvement and ensure quality services accordant with community need.

(e) Cost Allocation and Charging Requirements

The Directors confirm that they have complied with the cost allocation and charging requirements set out in HM 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 are fair, balanced and understandable and I take personal responsibility for these and the judgement required for doing so.

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.

Chief Executive
Jason Killens

Dated: 13 June 2022

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 that the accounts comply with requirements outlined in the above mentioned direction by the Welsh Ministers.

By Order of the Board

Signed:

Chair
Martin Woodford
Dated: 13 June 2022

Chief Executive
Jason Killens
Dated: 13 June 2022

Director of Finance and Corporate Resources
Chris Turley
Dated: 13 June 2022

2.1.4 The Governance Statement

This Governance Statement demonstrates how we managed and controlled resources in 2021/22 and the extent to which we complied with our own governance requirements. 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 this organisation's assets. For the year ended 31 March 2022 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 Accounting Officer of NHS Wales.

The Executive Management Team assists the Chief Executive in discharging his accountabilities and meet weekly for formative discussions, support and decision making. A similar structure is mirrored for Assistant Directors in the Assistant Directors Leadership Team. The Executive Management Team meets more formally with the wider leadership management groups and has strong links to all relevant governance forums inside and outside of the Trust.

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.

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's also about how we scrutinise our performance and deal with poor

practice and other issues, 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 have for ensuring good governance, and they include:

- Standing Orders, which incorporates the Schedule of Matters Reserved to the Board and Delegated, and the Standing Financial Instructions;
- The requirement for a statutory Board and the Committees that support the Board;
- How line managers operate, including codes of conduct and accountability;
- Business planning;
- Procedural guidance for staff;
- Risk register and assurance frameworks;
- Internal audit; and
- Scrutiny by external assessors including the Welsh Government, Health Inspectorate Wales, Audit 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), into day to day operating practice. 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.

In January 2022, the Board approved revisions to the Standing Orders in line with the review undertaking of the Model Standing Orders, Scheme of Reservation and Delegation, and the Standing Financial Instructions by Welsh Government. 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.

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, finding 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.

- Quality: Sets organisation wide expectations and accountability for high performance. 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 managing risk and ensuring there is a robust system of internal controls is 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, and focuses 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 is also responsible for promoting an open culture with a view to ensuring high standards.

The Board is comprised of the Chair, Vice Chair, six Non-Executive Directors and five Executive Directors, and 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 2021/22 and seven times in private session where matters of confidentiality and/or commercial sensitivity were discussed. The Board is supported by the Board Secretary (who acts as principal adviser on all aspects of corporate governance within the Trust), five further (non-voting) Directors and two Trade Union partner representatives.

Board meetings in 2021/22 were appropriately constituted and were quorate. The Trust did not stand down any of the scheduled Board or Board Committee meetings during 2021/22, other than the Local Partnership Forum which operated under the pandemic governance structure as the Trade Union Partnership Cell. In accordance with the Public Bodies (Admissions to Meetings) Act 1960 the Trust is required to meet in public. As a result of the public health risk linked to the pandemic there have been limitations on public gatherings and it has not therefore been possible to allow the public to attend meetings of our Board and Committees. However, to ensure business was conducted in as open and transparent manner as possible members of the public, staff and stakeholders have been able to join our public Board and Committee meetings via Zoom and Teams, and have the opportunity to send questions in for consideration by the Board prior to those meetings. Board meetings

are livestreamed on the Trust's Facebook page and retained there for further reference.

Details of meeting dates and members attendance can be found in Appendix 1. Agendas for public sessions are published on the Trust's website seven days before the meeting.

The Trust held its Annual Meeting virtually on 29 July 2021 via Zoom and this too was livestreamed on the Trust's Facebook page.

The key focus of the Board during the year was delivery of performance and quality assurance and improvement during the COVID-19 pandemic whilst at the same time ensuring the Trust maintained pace in terms of strategic transformation.

Issues associated with the COVID-19 pandemic remained as key matters for the Board throughout the year and as reported in the 2020/21 Annual Report, a governance structure was established to respond to the pandemic which included a number of cells and groups across the operational, tactical and strategic levels of the organisation. Decisions and actions were recorded and maintained in the form of action logs and meeting notes with key decisions escalated where necessary.

Examples of the key governance and control matters addressed by the Board during 2021/22 were:

- Audit Wales Annual Report;
- Charitable Funds accounts;
- Financial, quality and performance reports;
- Integrated medium term plan – delivery and refresh;
- Quality and performance management framework;
- Incidents;
- Risk and board assurance framework;
- Standing orders, scheme of reservation and delegation, standing financial instructions;
- Strategic transformation programmes: structure and governance;
- Trust Annual Report, accounts and governance statements; and
- Welsh language Annual Report

Further details on the working of the Trust Board in 2021/22 can be found here.

The Board Development Programme continued in 2021/22 with a focus on understanding, learning and reflection. 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. An external facilitator worked with the Board during the year on its long term collective development and effectiveness.

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. The Trust Board acts as the Corporate Trustee of the Charity.

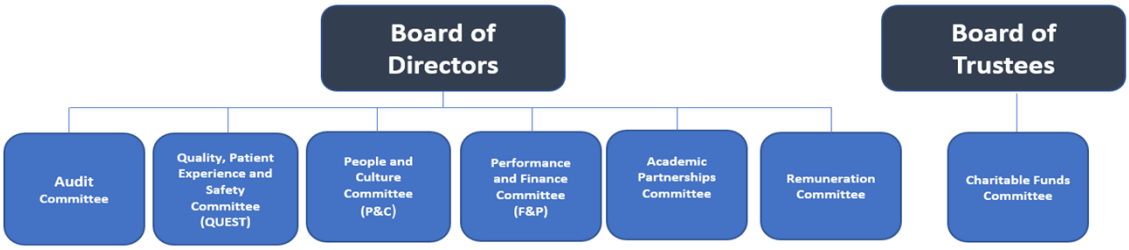
The Corporate Trustee is responsible for the general control, management, and administration of its charity, as well as setting its strategic aims and objectives. Oversight of the Charity is carried out by the Charitable Funds Committee.

The Charity Annual Report and Accounts for 2020/21 are contained here.

Board Committees

The Board has seven standing Board Committees, each chaired by a Non-Executive Director. Committees have a key role in relation to the system of governance and assurance, scrutiny, assessment of current risks and quality and performance monitoring. 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' 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 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 a comprehensive review and update of the terms of reference for each Board Committee during 2021/22, with the revised terms of reference approved by each Committee during March 2022 and for presentation to the Board on 26 May 2022.

Each Committee prepared an annual report of its business and effectiveness, with the annual reports and revised terms of reference for each Committee being accessed via this link.

The **Audit Committee** is a key source 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 2021/22 and considered the following key governance and control matters:

- Review and endorsement for Board approval of the Annual Accounts, Accountability Report and Governance Statement;
- 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 Head of Internal Audit Opinion;
- Agreed the Annual Counter Fraud Plan and monitored counter fraud activities
- Monitored the development of the risk management improvement programme;
- Reviewed the Board Assurance Framework and Corporate Risk Register;
- Endorsed approval of the revised Standing Orders;
- Reviewed losses and special payments, tender updates and waiver reports;
- Oversight of COVID-19 enquiry preparations.

Further details on the working of the Audit Committee in 2021/22 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 and met seven times during 2021/22.

The **Academic Partnerships Committee** is a 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 twelve months as the Trust pursues University Trust Status. The Committee met four times in 2021/22 and the following key matters were discussed:

- Advance practice and specialist working, consult and close and service transformation, including research
- Decarbonisation, fleet modernisation and sustainability
- Digitisation enabling better outcomes
- University Trust Status submission

Further details on the working of the Academic Partnerships Committee can be found here.

The purpose of the **Charitable Funds Committee** is to make and monitor arrangements for the control and management of the Trust's charitable funds. The Committee met five times during 2021/22 when it discussed a number of issues, including the Charitable Funds Annual Report and Accounts and the development of

the charity's first strategy. The Committee also reviewed and refreshed the bursary scheme and the Bids Panel authority and membership.

Further details on the working of the Charitable Funds Committee in 2021/22 can be found here.

The **Finance and Performance Committee** supports the Board by providing assurance with regards 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. The Committee met six times during 2021/22 and the following key matters were considered:

- Assurance for major incident arrangements;
- Business justification case – fleet replacement programme;
- Capital programme 2021/22 updates;
- Finance performance reports;
- Quality and performance management framework;
- Integrated quality and performance report;
- Policy approvals e.g., fire safety;
- Board Assurance Framework and Corporate Risk Register relevant to its remit;
- Transfer of Non-Trust NEPTS work to the Trust – Cwm Taf Morgannwg University Health Board

Further details on the working of the Finance and Performance Committee in 2021/22 can be found here.

The **People and Culture Committee** supports the Board by providing assurance to the Board with regards 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 2021/22 and the following key matters were considered:

- Committee assurance framework;
- Facilities agreement for trade union partners;
- People and culture strategy;
- Trust behaviours roll-out;
- Policy approvals e.g., pay progression, secondments
- Revised procedure for NHS staff to raise concerns;
- Staff suspension updates;
- Welsh language progress/updates;
- Integrated Quality and Performance Report
- Performance Management Framework;
- Workforce performance scorecards;
- Minutes of sub-committees;
- Audit recommendations relevant to its remit;
- Board Assurance Framework and Corporate Risk Register relevant to its remit.

Further details on the working of the People and Culture Committee in 2021/22 can be found here.

The **Quality, Patient Experience and Safety Committee** supports the Trust Board by providing assurance with regards 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 2021/22 and the following key matters were considered:

- Quality strategy 2021/24;
- Incident reporting and lessons learned;
- Integrated Quality and Performance Report;
- Performance Management Framework;
- Older persons framework;
- Patient experience and community involvement highlight reports;
- Policy approvals e.g., adverse incident reporting;
- Safeguarding Annual Report.
- Audit recommendations relevant to its remit;
- Board Assurance Framework and Corporate Risk Register relevant to its remit.
- Deep dive: losses and special payments;
- Health Inspectorate Wales: clinical contact centre patient safety review;

Further details on the working of the QuESt Committee in 2021/22 can be found here.

Advisory Groups

In support of the Board, the Trust has established the Local Partnership Forum as a forum where the Trust Executives, 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 key stakeholders engage with each other to inform, debate and seek to agree local priorities on workforce and health service issues.

During the pandemic the Local Partnership Forum was stood down and a Trade Union Partnership Cell under the pandemic structure was formed. This Cell was jointly chaired by the Executive and the Trade Union to support and enable consistent and timely sharing of information, and to enable discussion and a representative view from all Trade Unions to facilitate timely and effective decision making. The Advisory Group will reform under new terms of reference in 2022.

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 Welsh Health Specialised Services Committee was established in 2010 to ensure fair and equal access across NHS Wales to the full range of specialised

services. The Committee is hosted by Cwm Taf Morgannwg University Health Board and regular activity reports are received by the Board. The Trust is not a member of the Committee but is a regular attendee.

The Emergency Ambulance Services Committee 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.

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.

Reports from these Committees are included in each Board pack.

Chairs Working Group

Supporting the formal Board and Committee structure is a Chairs' Working Group that meets at the start of each quarterly business cycle. The Group is comprised of the Trust Board Chair, the Chairs of the Board Committees, Executive leads for Committees and the Board Secretary. Its purpose is to promote discussion on a range of issues that affect the Board and its Committees including but not limited to:

- New and revised governance procedures that affect Committees and the Board;
- Standardisation of practice at Committees, including reporting, papers and flow of communication;
- Approach and timing of the annual review of effectiveness of Committees and evaluation of the Board;
- Reflections from meetings with a view to continuous learning and application of best practice governance principles;
- Committee membership; and
- Cross-cutting Committee work to ensure appropriate range of responsibilities across Committee and to reduce duplication.

Improvements to the Governance Framework

During 2021/22 a number of improvements have been made to the Trust's governance framework including the following:

- Committee highlight reports in an 'alert, advise, assure' model which enhance assurance to Board;
- Introduction of new templates for the Board and Committees for the agenda and action logs;
- The Board Secretary attending all Committees to support the development of highlight reports to the Board and cross-referencing of actions across Committees;

- Revised terms of reference and mapping of the full extent of Board responsibilities across Committees;
- Governance Practice Notes to aid in the application of Standing Orders;
- Revised articulation of key risks;
- Monthly Board development sessions focused on strategy, culture and behaviours, and regulatory environment; and
- Development of the Board induction programme for new Board members.

(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 2022 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, 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 our governance arrangements to 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.

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 that provides a line of sight to the controls and related assurances, and the actions the Trust will take to mitigate the risks.

The Risk Management Strategy and Framework 2018-2021 is in place and will be revised and developed as one component part of the Trust's risk transformation programme as set out in the Integrated Medium Term Plan (IMTP) 2022/2025. The risk transformation programme was reviewed and supported by the Audit Committee in December 2021.

Alongside the Strategy and Framework, the Risk Register Development Guide describes the Trust processes to assess and treat risk through local, directorate and corporate risk registers. The Datix Risk Management System is used to manage the risks on these registers and 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 and levels of escalation are set out in these documents to enable lower rated risk to be managed locally by the risk owner and delegated officers, teams and managers best placed to mitigate the risks.

Whilst risk is inherent in many of our activities, the Trust 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, which operates as part of a publicly funded healthcare system in Wales, does not have unlimited resources and therefore it determines the appropriateness and cost of resources required to address principal risks. This is a major influence in determining the risk appetite of the organisation which is set and developed by the Board. Separate and distinct risk appetite statements will be developed as part of the risk management transformation programme.

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.

Internal and external factors are putting services under severe pressure which presents risks to patient safety and delivery of agreed plans for service transformation. The highest rated risks on the Corporate Risk Register below seek to mitigate these and continue to be closely monitored by management, Board Committees and Trust Board.

Risk Profile

The risk profile of the Trust, described in the table below, is subject to senior management scrutiny. As at the 24 March 2022 Trust Board meeting there were eleven organisational wide risks scoring 15 or above on the Trust's Corporate Risk Register which can be viewed via this link.

CORPORATE RISK REGISTER: Summary					
RISK ID	**RISK**	**RISK CATEGORY**	**EXECUTIVE OWNER**	**CURRENT RISK SCORE**	**ASSURANCE COMMITTEE**
223	The Trust's inability to reach patients in the community causing patient harm and death	Service Delivery	Director of Operations	**25 (5x5)**	Quality, Patient Experience and Safety Committee

CORPORATE RISK REGISTER: Summary					
RISK ID	**RISK**	**RISK CATEGORY**	**EXECUTIVE OWNER**	**CURRENT RISK SCORE**	**ASSURANCE COMMITTEE**
224	Significant handover delays outside A&E impacts on access to definitive care being delayed and affects the trust's ability to provide a safe and effective service	Quality & Safety	Director of Quality & Nursing	**25 (5x5)**	Quality, Patient Experience and Safety Committee
160	High sickness absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service	Resource Availability	Director of Workforce & Organisational Development	**20 (5x4)**	People and Culture Committee
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	Statutory Duties	Director of Quality & Nursing	**20 (4x5)**	Audit Committee; Quality, Patient Experience and Safety Committee
139	Failure to Deliver our Statutory Financial Duties in accordance with legislation	Statutory Duties	Director of Finance and Corporate Resources	**16 (4x4)**	Finance and Performance Committee
244	Impact on EMS CCC service delivery due to estates constraints	Service Delivery	Director of Operations	**16 (4x4)**	Finance and Performance Committee
311	Failure to manage the cumulative impact on estate of the EMS Demand & Capacity Review, the NEPTS Review and GUH	Resource Availability	Director of Finance & Corporate Resources	**16 (4x4)**	Finance and Performance
458	A confirmed commitment from EASC and/or Welsh Government required regarding funding for recurrent costs of commissioning	Service Delivery	Director of Finance and Corporate Resources	**16 (4x4)**	Finance and Performance Committee
201	Trust Reputation	Stakeholder Relationships	Director of Partnerships and Engagement	**15 (3x5)**	People & Culture Committee
245	Inability to maintain safe & effective services during a disruptive challenge due to insufficient capacity in EMS CCCs.	Service Delivery	Director of Operations	**15 (3x5)**	Finance & Performance Committee

CORPORATE RISK REGISTER: Summary					
RISK ID	**RISK**	**RISK CATEGORY**	**EXECUTIVE OWNER**	**CURRENT RISK SCORE**	**ASSURANCE COMMITTEE**
260	A significant and sustained cyber-attack on the Trust, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems	Service Delivery	Director of Digital	**15 (3x5)**	Finance & Performance Committee

The timely review of risk and associated mitigation plans has been impacted by the challenges faced as a result of our operational response to the pandemic with some review dates having passed their identified review date. These risks have, nevertheless, been subject to scrutiny and challenge by the Trust Board and relevant Board Committees. This area for improvement has been acknowledged by the operational risk leads.

Risks 223, 224 and 160 were exacerbated by the pandemic however they have been subject to regular review throughout.

Risk Assessment and Risk Review Process

The Trust's Assistant Director Leadership Team (ADLT), Executive Management Team (EMT), Audit Committee and Trust Board regularly received, considered, and commented on the Corporate Risk Register during 2021/2022. Furthermore, risks relevant to the remit of the Finance & Performance, People and Culture and the Quality, Safety and Patient Experience Committees were reported at each meeting for scrutiny and challenge.

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 ADLT continue to review the risk assessments on all new corporate risks in addition to reviewing any changes to existing corporate risks and mitigating actions. Each of these risks have been developed by the delegated, responsible officers and the risk owners and agreed at Directorate Business Meetings prior to review by ADLT and the activity is then reported to the EMT, 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 are discussed at the All Wales Chief Executive's forum. In addition to this, as part of the Trust's risk maturity, the ambition is to undertake joint discussion 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.

The Audit Wales Structured Assessment Phase 2 Report, received in November 2021 noted the following in relation to the management of risk in the Trust:

"We found that the Trust has taken steps to further strengthen its risk management arrangements".

Internal Audit undertook a further, planned audit on risk management in Quarter 4 2021/22, with the overall objective to provide assurance that the Trust has a robust risk management and assurance framework arrangements in place to address both strategic and operational risks. That review concluded that there was reasonable assurance on risk management and assurance arrangements for the Trust, with four recommendations raised, one of which was a high priority, two medium and two low. The areas highlighted to strengthen will form part of the Risk Management Improvement Programme under the IMTP 2022/25.

Board Assurance Framework

The Trust Board and Committees have received the Board Assurance Framework (BAF) throughout the year alongside the Corporate Risk Register, following its approval by the Executive Management Team.

In Quarter 4 an exercise was carried out to re-articulate the highest rated risks in an 'if, then, resulting in' methodology to more fully describe the risk and its potential impact. The Trust took this opportunity to review all controls and assurances against these risks and describe the actions planned to mitigate the gaps. The risk owners, EMT and the Board were fully engaged in the process and were updated on this work as it matured. In March 2022 the Audit Committee agreed to pause the formal reporting of the BAF until its June meeting to allow this work to take place. The ADLT, EMT, Trust Board and Committees will continue to receive reports on the Corporate Risk Register during this time.

Risk Management Training

The continuing impact of the COVID-19 pandemic has meant that face to face training has been paused, however, the Trust has been committed to continuing to deliver risk training throughout the pandemic and since January 2021, the Head of Risk/Deputy Board Secretary, has delivered virtual training sessions at the Assistant Directors Leadership Team meeting, Directorate business meetings, and at the Duty Operations Managers induction programme.

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.

The Head of Risk/Deputy Board Secretary is working 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, which is schedule to be implemented within the Trust in Quarter 3 of 2022.

Risk Management Improvement Programme – Focus for 2022/2023

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 remains committed to implementing a positive risk management culture through delivery of our risk management transformation and areas of significant focus during 2022 are:

- A refresh of the risk management strategy and associated procedures with a focus on strengthening the articulation and management of risk;
- Developing a risk management policy;
- Developing and embedding a revised Board Assurance Framework;
- Developing a programme of training and education for the whole organisation;
- Establishing a programme of Board education on risk management including the development of risk appetite statements; and
- Implementing the Once for Wales Risk Management System (Datix) and aligned training programmes.

In addition to this transformation programme, work is ongoing to consider and develop potential new risks for inclusion on the Corporate Risk Register as follows:

- Patient Safety/Putting Things Right Team
- NHS decarbonisation
- Supply chain issues – digital equipment
- Securing stakeholder support to deliver the strategy and IMTP
- Capacity to deliver change (IMTP)
- Ongoing impact of COVID and increasing demand for services (IMTP)

Emergency Preparedness/COVID-19 Risks

The need to plan and respond to the COVID-19 pandemic has continued to present several challenges to the Trust throughout 2021/22. A number of new and emerging risks related to the pandemic were identified. As required by the Civil Contingencies Act 2004, the organisation has a major incident and business continuity plan in place, however the scale and impact of the pandemic has been unprecedented and the Trust has utilised its pandemic plan to assist in the response throughout the Pandemic.

The Trust has developed an Incident Response Plan to replace our Major Incident Plan which considers the national risk register, the local resilience forum risk register, NHS Wales's guidance and UK ambulance service guidance documents. This plan includes the Trust's response to counter terrorism incidents, mass casualty incidents and incidents that require specific actions to be taken, such as responding to airports and railway incidents.

Aligned to the Incident Response Plan, a new Command Policy has been developed and implemented to support the Trust Commanders, along with an Incident Notification and Escalation Procedure that clearly defines types of incidents and the response required. These plans have been tested in both the exercise and live environments, including the declaration of Business Continuity Incidents, Critical Incidents and trust Extraordinary Incidents, along with planning for incidents that the Trust management team anticipated an impact on the Trust, such as Storm Eunice, Public Order Incidents and the EU Exit. Our Resource Escalation Action Plan (REAP) has been revised to align with other UK Ambulance Trusts, alongside our Clinical Safety Plan which allows us to dynamically manage the demands on the service.

Our Senior Pandemic Team took on a dual remit over the winter period by addressing the significant challenges of the Omicron variant alongside the pressures associated with the winter period. Additional support cells have aided the logistical challenges associated with the deployment of the military through the MACA arrangements from October 2021 until March 2022. A range of tactics to support welfare arrangements for staff have been deployed alongside additional capacity tactics such as St John Ambulance Cymru Urgent Care Service capacity, and cohorting at key hospital sites through private ambulance providers to aid the offload at hospital sites. Staffing abstractions have presented a significant challenge because of the Omicron variant, particularly in our contact centre environments. Several new and innovative tactics were deployed to mitigate the impact of these abstractions including the deployment of COVID Champions to act as a visible reminder on infection, prevention and control measures.

The organisation continues to work closely with a wide range of partners, including the Welsh Government as it continues with its response, and planning into the recovery phase. The Trust has developed clear ‘Monitor to Recovery’ criteria which will be underpinned by robust risk management arrangements and the ability to identify, assess and mitigate risks which may impact on the ability of the organisation to achieve its strategic objectives.

The Trust has sustained a full Hazardous Area Response Team (HART) and increased its Specialist Operational Response Team (SORT). A further expansion to the SORT has been outlined in a Business Case that has been submitted to Welsh Government for consideration in line with the expansion that has already been funded in England.

The Trust has continued to work in partnership, through Local Resilience Forums (LRF), to address and mitigate the wide impacts of the pandemic on the population and our organisation. We have been key members of the four LRF Strategic Coordination Groups, Tactical Coordination Groups, and their subgroups, and as we reach a point where we enter formally into a recovery position, our Business Continuity and Recovery Team will work to develop working practices beyond the acute phase of the pandemic, into a “living with COVID” state.

The Trust continues to engage and support at a national and local level to remain prepared, with the ability to respond to any likely impact on the organisation and population. The Trust remains vigilant to the monitoring of any outbreaks locally,

and the emergence of any new variants, with confidence in its ability to stand up structures at short notice which is now tried and tested.

(e) The Control Framework

Quality Governance Arrangements

Over 2021/22, regular reporting of quality governance has continued to provide assurance to the Quality, Patient Experience and Safety Committee (QuESt). The quarterly 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 is due to be enforced from April 2023.

In 2021, the Trust Board approved the Quality Strategy 2021-24 which sets out our high-level ambitions to ensure our services are safe, effective, and provide positive experiences. The QuESt committee have overseen the development of the implementation framework for this strategy, including the development of functions and forums to integrate the citizens' voice, the design and development of quality leadership roles and management systems; 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, it further increases clinical risks to our patients through being delayed to receive treatment and, sometimes, not receiving their basic nursing needs. 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.

The Trust has a Clinical Audit Programme which contributes to improving the level of care delivered to patients. In 2020, the programme was put on hold due to the pandemic and was fully reinstated by mid-2021 as part of the recovery plan, and four audits were then completed by March 2022. 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 included on an action tracker, with progress of the programme and action tracker monitored by various groups and the QuEST committee.

The Clinical Audit and Effectiveness Team provides data for monthly clinical indicators that are reported on within the Trust and form part of the Ambulance Quality Indicators produced by the Emergency Ambulance Services

Committee. These indicators measure specific criteria to demonstrate the level of care delivered to patients, compliance to these is monitored and improvement plans developed as required. The indicators include stroke, STEMI (heart attack), hip fracture, hypoglycaemia (diabetes) and ROSC (return of spontaneous circulation from cardiac arrest). The implementation of the electronic Patient Clinical Record from November 2021 will provide the Trust with an opportunity to report on a wider range of data, combine time-based measures with clinical data and to link this this data with the wider healthcare to look at outcomes.

The Trust continues to strive to raise quality and safety issues to the surface, ensuring Committee and Executive oversight of key issues and risks. Over 2021/22, the Board and Executive team have continued to elevate and inform system partners and stakeholders of the challenges across the urgency and emergency care system.

Information Governance Arrangements (Including Data Security)

The Trust operates a robust information governance framework and has a statutory responsibility to ensure that effective information governance controls and arrangements are in place, whilst remaining accountable for handling personal data during the COVID-19 public health emergency.

An Information Governance Steering Group is established and receives reports on information governance matters and developments. In addition, the Trust has an established suite of information governance and information security policies and procedures which continue to serve, inform, and guide the organisation to ensure compliance is met in practice. The QuEST Committee has oversight of information governance.

As part of the COVID-19 pandemic response, NHS Wales were issued with a Notice under Regulation 3(4) of the National Health Service (Control of Patient Information Regulations) 2002 (COPI) to require NHS Wales to share confidential patient information with organisations entitled to process this information under COPI for COVID-19 purposes. A number of data sharing agreements were implemented and these agreements will be subject to review on cessation of the COPI notice currently extended to 30 June 2022.

A Welsh Information Governance Toolkit annual self-assessment was submitted in 2021/22 and following the previous reporting year's submission, an Improvement Plan has been developed and is subject to ongoing monitoring by the Information Governance team and Information Governance Steering Group. However, as a result of the impact of COVID-19, progress on some areas of the improvement plan have been delayed, whilst focus has remained on ensuring current and planned projects within the Trust continue to meet compliance requirements. The Improvement Plan will be revised to include the 2021/22 annual submission results.

During the reporting period, the Trust received 'Substantial Assurance' following an Internal Audit of the Mobile Testing Units as part of a COVID-19 initiative, providing assurance to the Trust on the Information Governance arrangements in place.

The Trust uses the Datix System to capture data breaches via the incident module. Each reported data protection incident is reviewed and assessed in accordance with

the NHS Wales Breach Assessment Guidelines, and remedial actions taken where required. During the reporting period, a total number of four incidents were reported the Information Commissioner's Office (ICO). 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 2022 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.

(f) Planning Arrangements

In accordance with expectations from Welsh Government, the Trust submitted its 2022/25 Integrated Medium Term Plan (IMTP) on 31 March 2022 following its approval by the Board on 24 March 2022.

Further details on the Trust's IMTP and planning arrangements are set out in the Performance Report contained within this Annual 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. 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.

- Whilst specific risk assessments and carbon reduction delivery plans were not developed in 2021/22 in relation to the impact of climate change on business continuity, the wider Trust's Decarbonisation Strategy is developed to ensure that the Trust's obligation under the Climate Change Act and the adaption

reporting requirements are complied with. The implementation of this strategy is overseen by the Finance and Performance Committee.

- The Trust had no reported serious untoward incidents during 2021/22 in relation to data security.

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, robust processes, and expert-in-the-loop data checks, 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 our data quality lead.

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 as 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.

Similarly, intelligence is offered to the Board through a variety of reports which first pass through appropriate committees at differing levels of granularity for review and discussion. This means any data presented to Board will have undergone several rounds of interrogation prior. In future it could be possible for this 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 imposed on the Trust during the period 1 April 2021 to 31 March 2022.

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.

(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. All of which have effectively carried out their duties and responsibilities during 2021/22.

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. The Board reviewed its effectiveness during Board Development sessions in October 2021 with external facilitators, and by way of its compliance with the Governance Code.

Each Board Committee has undergone extensive effectiveness reviews in Quarter 4 of 2021/22 resulting in changes to terms of reference and membership to strengthen assurance and scrutiny to the Board.

The Chair's performance is evaluated annually by the Minister for Health and Social Services. Annual performance appraisal for the Vice Chair, Chief Executive and Non-Executive Directors is carried out by the Chair, and for the Executive Directors by the Chief Executive.

Health Inspectorate Wales

Under the Joint Escalation and Intervention Arrangements, Health Inspectorate Wales meets with Welsh Government and Audit Wales twice a year to discuss the overall assessment of the Trust.

Two tripartite meetings were held in 2021/22 and on both occasions the escalation status of the Trust remained unchanged at 'routine arrangements'.

The most recent meeting in March 2022 noted concerns and issues to be addressed relating to handover and response time and the impact on patient experience; actions to address quality and governance measures; plans in place for capacity issues when the military exit in March 2022; and the ongoing relationship between management, the Trade Unions and staff.

Internal Audit

Internal Audit provides the Accountable Officer and the Board, through the Audit Committee, with a flow of assurance on the system of internal control. The Accountable Officer commissioned a programme of audit work which was delivered 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 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 need to respond to the COVID-19 pandemic with some audits deferred, cancelled or curtailed as the organisation responded to the pandemic. The Head of Internal Audit is satisfied that there has been sufficient internal audit coverage during the reporting period in order 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 fully completed.

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 to the Reasonable Assurance Head of Internal Audit Opinion reported in the Trust's 2020/21 Governance Statement.

The 2021/22 reasonable assurance conclusion is derived from 21 Internal Audit reviews.

Internal Audit Assurance Conclusion	Number of Reports
No Assurance	0
Limited Assurance	2
Reasonable Assurance	16
Substantial Assurance	2
Advisory	1
Total	**21**

For the fifth consecutive year there has been no 'No Assurance' Internal Audit Reports of Trust business. Set out below are two reports that had a conclusion of Limited Assurance that were reported to Audit Committee during 2021/22.

NEPTS – Transfer of Operations
The review by Internal Audit sought to provide assurance that the capturing, reporting and monitoring of benefits realised reflected those identified at the outset of the transfer project. The review concluded that many of the outset benefits may have been realised now that the transfer had been completed, but that the Trust needed to undertake an exercise to support and demonstrate this.

Three recommendations for action were identified, of which two were categorised as high priority (to complete the mapping exercise of the expected benefits; and to ensure documentation is maintained and that effective handover is provided to ensure that knowledge is not lost). A management action plan was agreed by Audit Committee in March 2022 and progress will be monitored by the Committee during 2022/23.

Waste Management
The audit was undertaken to assess the Trust's compliance with relevant waste management legislation and guidance, and progress towards agreed national and local waste reduction targets.

Seven recommendations were identified, of which six were categorised as high priority; these are in relation to waste process documents, operational responsibility for clinical waste management at each site, compliance issues, clinical waste transfer arrangements and waste audits.

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 2021-22 can also be found via this link having been considered by Audit Committee at the 7 June 2022 meeting.

<u>External Audit – Audit Wales</u>

The Auditor General for Wales is the Trust's statutory external auditor and since 1 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, key risk areas and the Internal Audit function.

Reports are produced by Audit Wales in line with an Audit Committee approved annual programme of work and include a management response by the Trust for reports which contain recommendations. All Audit Wales reports are considered by the Audit Committee and their recommendations are subsequently recorded in the Trust's audit recommendations tracker which is subsequently 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 2021 the Audit Wales Structured Assessment work was designed in the context of the ongoing response to the COVID-19 pandemic and was undertaken in two phases:

- Phase 1: considered the planning arrangements underpinning the development and delivery of the Trust's operational plan for quarters three and four of 2020-21
- Phase 2: considered how corporate governance and financial management arrangements adapted over the year.

The Phase 1 report was considered and agreed by Audit Committee in June 2021. It concluded that the *"Trust has continued to adapt and refine its planning approach to respond to new requirements, the challenges of the COVID-19 pandemic and maintain oversight of its long-term ambitions. However, as a result of operational pressures some aspects of monitoring and reporting of plan progress were paused or altered during the year and there is scope to clarify these arrangements going forward".*

The Phase 2 report key messages were that the *"Trust has continued to develop its corporate governance, planning and financial management arrangements in the context of significant service delivery pressures which are compromising the effectiveness and safety of emergency ambulance services and longer-term service transformation*". The report added that *"the Trust continues to improve governance, risk management and quality and safety assurance arrangements, but it has yet to revise its performance management framework. It has good arrangements for developing plans. However, issues both within its control and otherwise mean services are under severe pressure presenting risks to patient safety and delivery of agreed plans for service transformation"*.

With regards to managing financial resources, the Phase 2 Structured Assessment stated *that "the Trust has succeeded in meeting its financial objectives for 2020/21 and continues to improve financial controls and there are good reporting arrangements in place. However, the Trust should continue to monitor and consider contingencies to prevent spending pressures or the non-reimbursement of additional COVID-19 related expenditure risking future objectives."*

The Phase 2 Structured Assessment was considered and agreed by Audit Committee in December 2021 and whilst there were no formal recommendations in either the Phase 1 or Phase 2 Structured Assessments, progress on the issues set out above will be monitored and, where appropriate, reported to Audit Committee during 2022/23.

(i) Conclusion

As indicated throughout this statement, the need to plan and respond to COVID-19 has had a significant impact on the organisation, wider NHS and society as a whole. It has required a dynamic response which has presented a number of opportunities in addition to risks. The need to respond and recover from the pandemic will be with the organisation and wider society throughout 2021/22 and beyond. I will ensure our Governance Framework considers and responds to this need.

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 2022 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.

Chief Executive:
Jason Killens

Date: 13 June 2022

(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 2021/22 (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)	Champion Roles
Martin Woodford	Trust Board Chair	Trust Board (Public): 7 of 7 Trust Board (Closed): 7 of 7 Remuneration Committee: 7 of 7	Governance and risk.
Kevin Davies	Vice Chair	Trust Board (Public): 7 of 7 Trust Board (Closed): 6 of 7 Academic Partnership Committee: 4 of 4 Charitable Funds Committee: 4 of 5 People and Culture Committee: 2 of 4 Quality, Patient Experience & Safety Committee: 4 of 4 Remuneration Committee: 3 of 7	Operational delivery Academic partnerships Armed forces and veterans Mental health Research.
Emrys Davies	Non-Executive Director	Trust Board (Public): 7 of 7 Trust Board (Closed): 7 of 7 Audit Committee: 4 of 4 Charitable Funds Committee: 5 of 5 Finance and Performance Committee: 6 of 6 Quality, Patient Experience & Safety Committee: 4 of 4	Welsh Language
Bethan Evans	Non-Executive Director	Trust Board (Public): 7 of 7 Trust Board (Closed): 7 of 7 Charitable Funds Committee: 5 of 5 Finance and Performance Committee: 6 of 6 People and Culture Committee: 4 of 4 Quality, Patient Experience & Safety Committee: 4 of 4	Quality, safety and patient experience
Paul Hollard	Non-Executive Director	Trust Board (Public): 7 of 7 Trust Board (Closed): 7 of 7 Academic Partnership Committee: 4 of 4 Audit Committee:4 of 4 People and Culture Committee: 4 of 4 Quality, Patient Experience & Safety Committee: 4 of 4	Workforce and organisational development Trade union relationships Children and young people Older persons Raising concerns (staff).
Ceri Jackson	Non-Executive Director	Trust Board (Public): 7 of 7 Trust Board (Closed): 6 of 7 Charitable Funds Committee: 5 of 5 Finance and Performance Committee: 5 of 6 Quality, Patient Experience & Safety Committee: 3 of 4	Digital and transformation Partnerships and engagement Charitable fundraising
Joga Singh	Non-Executive Director	Trust Board (Public): 3 of 7 Trust Board (Closed): 2 of 7 Charitable Funds Committee: 5 of 5 Finance and Performance Committee: 5 of 6 Quality, Patient Experience & Safety Committee: 3 of 4 Remuneration Committee: 4 of 7	Environment and sustainability Resources and value for money.
Martin Turner	Non-Executive Director	Trust Board (Public): 7 of 7 Trust Board (Closed): 5 of 7 Academic Partnership Committee: 2 of 4 Audit Committee: 4 of 4 Remuneration Committee: 4 of 7	Strategy development Governance and risk
Voting Executive Directors			

Name	Position	Board and Committee Record of Attendance (Actual Attendance of Total Held Meetings)	Champion Roles
Jason Killens	Chief Executive	Trust Board (Public): 7 of 7 Trust Board (Closed): 7 of 7 Remuneration Committee: 5 of 7	
Brendan Lloyd	Executive Medical Director	Trust Board (Public): 7 of 7 Trust Board (Closed): 7 of 7 Quality, Patient Experience & Safety Committee: 2 of 4	
Chris Turley	Executive Director Finance and Corporate Resources	Trust Board (Public): 7 of 7 Trust Board (Closed): 7 of 7 Audit Committee: 4 of 4 Charitable Funds Committee: 5 of 5 Finance and Performance Committee: 6 of 6	Fire safety.
Claire Roche (to 4/3/22)	Executive Director Quality and Nursing	Trust Board (Public): 6 of 6 Trust Board (Closed): 4 of 5 Quality, Patient Experience & Safety Committee: 4 of 4	Caldicott guardian Children and young people Putting things right (and patient safety).
Wendy Herbert (from 7/3/22)	Executive Director Quality and Nursing	Trust Board (Public): 1 of 1 Trust Board (Closed): 2 of 2	Caldicott guardian Children and young people Putting things right (and patient safety).
Claire Vaughan	Executive Director Workforce and OD	Trust Board (Public): 6 of 7 Trust Board (Closed): 4 of 7 Academic Partnership Committee: 1 of 4 Charitable Funds Committee: 3 of 5 People and Culture Committee: 4 of 4 Remuneration Committee:5 of 7	Violence and aggression.
Non-Voting Executive Directors			
Lee Brooks	Director of Operations	Trust Board (Public): 5 of 7 Trust Board (Closed): 4 of 7 Audit Committee: 1 of 4 Finance and Performance Committee:5 of 6 People and Culture Committee: 4 of 4 Quality, Patient Experience & Safety Committee: 2 of 4	Emergency planning.
Andy Haywood	Digital Director	Trust Board (Public): 6 of 7 Trust Board (Closed): 6 of 7	
Estelle Hitchon	Director of Partnerships and Engagement	Trust Board (Public): 7 of 7 Trust Board (Closed): 6 of 7 Academic Partnership Committee:4 of 4 People and Culture Committee: 4 of 4	
Rachel Marsh	Director of Strategy, Planning and Performance	Trust Board (Public): 6 of 7 Trust Board (Closed): 7 of 7 Finance and Performance Committee: 6 of 6	
Andy Swinburn	Director of Paramedicine	Trust Board (Public): 7 of 7 Trust Board (Closed): 6 of 7	
Board Secretary			
Keith Cox (to 1/8/21)	Board Secretary	Trust Board (Public): 3 of 3 Trust Board (Closed): 1 of 1 Academic Partnership Committee: 1 of 1 Audit Committee: 1 of 1 Charitable Funds Committee: 1 of 1 People and Culture: 1 of 1 Remuneration Committee: 1 of 1	Welsh language
Trish Mills (from 2/8/21)	Board Secretary	Trust Board (Public): 4 of 4 Trust Board (Closed): 6 of 6 Academic Partnership Committee: 3 of 3 Audit Committee: 3 of 3 Charitable Funds Committee: 4 of 4 Finance and Performance Committee:4 of 4 People and Culture Committee: 3 of 3 Quality, Patient Experience & Safety Committee: 3 of 3 Remuneration Committee: 6 of 6	Welsh language.

Appendix 2 - Board and Committee Meeting Dates

The following Table sets out the dates of all Board and Committee meetings held in 2021/22. All Trust Board and Board Committee meetings in 2021/22 were quorate.

Meeting Title	Meeting Dates 2021-22
Trust Board (Public)	27/5/21, 10/6/21, 29/7/21, 30/9/21, 25/11/21, 27/1/22, 24/3/22.
Trust Board (Closed)	21/5/21, 30/9/21, 25/11/21, 16/12/21, 27/1/22, 25/2/22, 24/3/22.
Academic Partnership Committee	27/4/21, 21/9/21, 9/12/21, 8/3/21
Audit Committee	3/6/21, 16/9/21, 2/12/21, 3/3/22
Charitable Funds Committee	3/6/21, 26/8/21, 4/11/21, 17/1/22, 10/2/22.
Finance and Performance Committee	13/5/21, 22/7/21, 23/9/21, 18/11/21, 20/1/22, 17/3/22,
People and Culture Committee	11/5/21, 7/9/21, 30/11/21, 22/2/22.
Quality, Patient Experience & Safety Committee	7/5/21, 9/9/21, 16/11/21, 17/2/22.
Remuneration Committee	10/6/21, 25/8/21, 7/10/21, 21/10/21, 7/12/21, 7/3/22, 21/3/22.

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 manager's 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 Boards members, i.e., the Executive and Non-Executive Directors including the Chair and Chief Executive; five 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 directive on pay for senior managers in NHS Wales, a 3% consolidated pay uplift was applied for employees from 1 April 2021. Whilst this uplift had been applied to all pay scales for individuals holding executive and senior posts, some senior staff of the Trust are on individually negotiated spot rates and where these staff were in post before 1 April 2021, the 3% pay uplift was also applied.

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 up to four year terms, 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 on the Trust, the contractual notice employees are required to give to the Trust and which employees are entitled to receive, is as follows: Bands 1-6 = 4 weeks; Bands 7 = 8 weeks; Bands 8 & 9 = 12 weeks

The notice provisions for Pay Bands 1-7 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 1 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 2021/22.

Remuneration Relationship

Details of the Trust's remuneration relationship are set out in Note 10.6 of the 2021/22 Annual Accounts.

Senior Managers in Post 2021/22

Name	Position Title	Assignment Category	Start Date in Position	Fixed Term End Date
Martin Woodford	Non-Executive Director/ Trust Chair	Fixed Term	7 April 2014	31 September 2022
Emrys Davies	Non-Executive Director	Fixed Term	1 April 2014	31 March 2022
Kevin Davies	Non-Executive Director/ Trust Vice Chair	Fixed Term	5 January 2015	31 December 2022
Bethan Evans	Non-Executive Director	Fixed Term	6 December 2019	5 December 2022
Paul Hollard	Non-Executive Director	Fixed Term	1 April 2016	31 March 2024
Ceri Jackson	Non-Executive Director	Fixed Term	1 April 2021	31 March 2026
Joga Singh	Non-Executive Director	Fixed Term	9 December 2019	8 December 2025
Martin Turner	Non-Executive Director	Fixed Term	13 December 2019	12 December 2023
Jason Killens	Chief Executive Officer	Permanent	Prior to 1 April 2021	Not Applicable
Wendy Herbert	Executive Director	Permanent	7 March 2022	Not Applicable

Name	Position Title	Assignment Category	Start Date in Position	Fixed Term End Date
Brendan Lloyd	Executive Director	Permanent	Prior to 1 April 2021	Not Applicable
Claire Roche	Executive Director	Permanent	Prior to 1 April 2021	Not Applicable
Christopher Turley	Executive Director	Permanent	Prior to 1 April 2021	Not Applicable
Claire Vaughan	Executive Director	Permanent	Prior to 1 April 2021	Not Applicable
Lee Brooks	Director	Permanent	Prior to 1 April 2021	Not Applicable
Keith Cox	Board Secretary	Permanent	Prior to 1 April 2021	Not Applicable
Andy Haywood	Director	Permanent	Prior to 1 April 2021	Not Applicable
Estelle Hitchon	Director	Permanent	Prior to 1 April 2021	Not Applicable
Rachel Marsh	Director	Permanent	Prior to 1 April 2021	Not Applicable
Trish Mills	Board Secretary	Permanent	2 August 2021	Not Applicable
Andy Swinburn	Director	Permanent	1 December 2021	Not Applicable

Further details of the contract arrangements of the Trust's senior managers in 2021/22 can be found in the Remuneration Table (and Notes) set out later in this Remuneration and Staff Report.

Senior Managers seconded from the Trust during 2021/22

Name	Position Title	Assignment Category	Start Date in Position	Secondment Date
Hannah Evans (Note 1)	Director	Permanent	Prior to 1 April 2021	6 August 2018

Senior Managers who left the Trust during 2021/22

Name	Position Title	Assignment Category	Start Date in Position	Leaving Date
Keith Cox	Board Secretary	Permanent	Prior to 1 April 2021	1 August 2021
Hannah Evans (Note 1)	Director	Permanent	Prior to 1 April 2021	16 July 2021
Claire Roche	Executive Director	Permanent	Prior to 1 April 2021	4 March 2022

Note 1: Hannah Evans initially left the Trust on external secondment to Swansea Bay University Health Board on 6 August 2018 and subsequently left the Trust's staffing establishment on 16 July 2021 for employment with Cardiff and Vale University Health Board.

Hutton Report 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 is the first year disclosures in respect of the 25th percentile pay ratio and 75th percentile pay ratio are required.

	2021-22	**2021-22**	**2021-22**		2020-21	2020-21	2020-21
	£0	**£0**	**£0**		£0	£0	£0
Total pay and benefits	**Chief Executive**	**Employee**	**Ratio**		Chief Executive	Employee	Ratio
25th percentile pay ratio	**162,500**	**24,565**	**6.62:1**		167,500	22,945	7.3:1
Median pay	**162,500**	**31,805**	**5.11:1**		167,500	30,523	5.49:1
75th percentile pay ratio	**162,500**	**44,814**	**3.63:1**		167,500	42,287	3.96:1
Salary component of total pay and benefits							
25th percentile pay ratio	**167,500**	**21,777**	**7.69:1**		167,500	21,142	7.92:1
Median pay	**167,500**	**24,882**	**6.73:1**		167,500	24,157	6.93:1
75th percentile pay ratio	**167,500**	**39,027**	**4.29:1**		167,500	33,779	4.96:1
Total pay and benefits	**Highest Paid Director***	**Employee**	**Ratio**		Highest Paid Director*	Employee	Ratio
25th percentile pay ratio	**162,500**	**24,565**	**6.62:1**		167,500	22,945	7.3:1
Median pay	**162,500**	**31,805**	**5.11:1**		167,500	30,523	5.49:1
75th percentile pay ratio	**162,500**	**44,814**	**3.63:1**		167,500	42,287	3.96:1
Salary component of total pay and benefits							
25th percentile pay ratio	**167,500**	**21,777**	**7.69:1**		167,500	21,142	7.92:1
Median pay	**167,500**	**24,882**	**6.73:1**		167,500	24,157	6.93:1
75th percentile pay ratio	**167,500**	**39,027**	**4.29:1**		167,500	33,779	4.96:1

In 2021/22, 0 (2020/2021, 0) employees received remuneration in excess of the highest-paid director.

Remuneration for all staff ranged from £18,576 to £167,500 (2020/21 £18,185 to £167,500). The all staff range includes directors (including the highest paid) and excludes pension benefits of all employees.

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

Financial year summary: NHS and social care financial recognition scheme bonus of £735 payment to reward eligible NHS staff has not been included in the NHS Remuneration Report calculations. This bonus payment is not a contractual payment, but a one off payment to reward eligible staff for their commitment and tireless efforts in the most challenging circumstances.

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.

Following the change of presentation of the disclosure note, a new methodology has been implemented resulting in a different report having to be utilised, this has resulted in the median pay for 2020/21 increasing by £1,510 from the figure disclosed in the 2020/21 accounts. The reason behind this increase is that the new report takes their gross salary as at 31 March 2022 whereas the previous report calculated their cumulative gross pay.

Percentage Changes	**2020-21**		2019-20
	to		to
	2021-22		2020-21
% Change from previous financial year in respect of Chief Executive	**%**		%
Salary and allowances	**-3.0**		3.1
Performance pay and bonuses	**0**		0
% Change from previous financial year in respect of highest paid director*			
Salary and allowances	**-3.0**		3.1
Performance pay and bonuses	**0**		0
Average % Change from previous financial year in respect of employees takes as a whole			
Salary and allowances	**3.6**		4.7
Performance pay and bonuses	**0**		0

Salary and Pension entitlements of senior managers

A) Remuneration

Name and Title	2021-22					2020-21				
	Salary (bands of £5000)	Bonus Payments (bands of £5000)	Benefits in Kind Rounded to the nearest £100	Pension benefits Rounded to the nearest £1000	Total (bands of £5000)	Salary (bands of £5000)	Bonus Payments (bands of £5000) (Note 14)	Benefits in Kind Rounded to the nearest £100	Pension benefits Rounded to the nearest £1000	Total (bands of £5000)
Martin Woodford (Chairman)	40-45				40-45	40-45				40-45
Kevin Davies (Non Executive Director / Vice Chairman)	15-20				15-20	15-20				15-20
Pamela J Hall (Non Executive Director) (Note 1)						5-10				5-10
Emrys Davies (Non Executive Director)	5-10				5-10	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) (Note 2)	5-10				5-10					
Jason Killens (Chief Executive) (Note 3)	160-165		600	35	195-200	160-165	0-5	4,600	41	210-215
Christopher Turley (Executive Director of Finance & Corporate Resources) (Note 4)	105-110		-	10	115-120	110-115	0-5	2,500	57	170-175
Dr Brendan Lloyd (Executive Medical Director) (Note 5)	135-140		-		135-140	155-160	0-5	2,100		160-165
Claire Vaughan (Executive Director of Workforce & OD)	95-100		-	36	135-140	95-100	0-5	-	26	120-125
Claire Roche (Executive Director of Quality and Nursing) (Note 6)	100-105		1,800	54	155-160	105-110	0-5	2,300	214	325-330
Gail Wendy Herbert (Interim Director of Quality and Nursing) (Note 7)	5-10		-	6	10-15					
Estelle Hitchon (Director of Partnership & Engagement) (Note 8)	95-100		-		95-100	90-95	0-5	-	11	100-105
Rachel Marsh (Director of Strategy Performance & Planning) (Note 9)	100-105		-	46	150-155	100-105	0-5	-	52	155-160
Lee Brooks (Director of Operations) (Note 10)	115-120		4,200	27	145-150	115-120	0-5	4,200	27	150-155
Andrew Haywood (Director of Digital Services)	110-115		-	28	135-140	105-110	0-5	-	26	130-135
Andrew Swinburn (Director of Paramedicine) (Note 11)	100-105		400	84	185-190	90-95	0-5	7,700	21	120-125
Patricia Mills (Board Secretary) (Note 12)	60-65		-	14	75-80					
Keith Cox (Board Secretary) (Note 13)	40-45		-	0	40-45	90-95	0-5	-		90-95

Note 1 - Pamela J Hall retired on 31st December 2020

Note 2 - Ceri Jackson joined the Trust as Non Executive Director on 1st April 2021

Note 3 - Jason Killens' salary excludes £4,785 sacrificed in respect of NHS Fleet Solutions. 2020-21 salary included an accrual of £3,093 for annual leave sold prior to 31st March 2021

Note 4 - Christopher Turley's salary includes £3,112 in terms of annual leave sold and excludes £10,612 sacrificed in respect of NHS Fleet Solutions. 2020-21 salary included an accrual of £3,022 for annual leave sold prior to 31st March 2021 and excluded £5,306 sacrificed in respect of NHS Fleet Solutions

Note 5 - 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 full year equivalent is 75-80 (bands of £5000). 2020-21 salary included an accrual of £4,173 for annual leave sold prior to 31st March 2021

Note 6 - Claire Roche left the Trust on 4th March 2022. 2020-21 salary included an accrual of £2,056 for annual leave sold prior to 31st March 2021

Note 7 - Gail Wendy Herbert was appointed Interim Director of Quality and Nursing from 7th March 2022. Salary full year equivalent is 110-115 (bands of £5000)

Note 8 - Estelle Hitchon chose to leave the pension scheme on 31st October 2020. Salary includes £2,005 in terms of annual leave sold

Note 9 - Rachel Marsh's 2020-21 salary included an accrual of £3,124 for annual leave sold prior to 31st March 2021

Note 10 - Lee Brooks' 2020-21 salary included £4,008 paid in terms of annual leave sold and an accrual of £3,012 for annual leave sold prior to 31st March 2021

Note 11 - Andrew Swinburn was appointed Director of Paramedicine on 1st December 2021. Salary full year equivalent is 110-115 (bands of £5000). Salary includes £3,811 paid in terms of annual leave sold. 2020-21 salary included £673 paid in terms of annual leave sold

Note 12 - Patricia Mills joined the Trust as Board Secretary on 2nd August 2021. Salary full year equivalent is 90-95 (bands of £5000)

Note 13 - Keith Cox retired on 1st August 2021

Note 14 - The one off non-consolidated non-pensionable bonus payment of £735 gross, payable to all directly employed NHS staff with at least one month's continuous service in the NHS in Wales between 17 March 2020 and 28 February 2021. The payment does not apply to Board Chairs and Non-Executive Directors

B) Pension Benefits

Name and title	Real increase in pension at age 60 (bands of £2,500)	Real increase in Lump sum at aged 60 related to real increase in pension (bands of £2,500)	Total accrued pension at age 60 at 31 March 2022 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2022 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2022	Cash Equivalent Transfer Value at 31 March 2021	Real increase in Cash Equivalent Transfer Value	Employer's contribution to stakeholder pension
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Jason Killens (Chief Executive)	0-2.5	-2.5-0	50-55	115-120	859	805	27	33
Christopher Turley (Executive Director of Finance & Corporate Resources)	0-2.5	-2.5-0	45-50	100-105	863	829	15	22
Dr Brendan Lloyd (Medical Director / Interim Deputy Chief Executive) *	-35--32.5	-100--97.5	-	0	-	-	- 17	25
Claire Vaughan (Executive Director of Workforce & OD)	0-2.5	0-2.5	25-30	45-50	474	430	28	21
Estelle Hitchon (Director of Partnership & Engagement) **	-32.5--30	-65--62.5	0	0	-	557	- 559	-
Claire Roche (Executive Director of Quality and Nursing)	2.5-5	2.5-5	40-45	110-115	890	810	56	21
Gail Wendy Herbert (Interim Executive Director of Quality and Nursing)	0-2.5	0-2.5	35-40	95-100	759	663	5	1
Rachel Marsh (Director of Strategy Performance & Planning)	2.5-5	0-2.5	45-50	60-65	736	676	43	21
Lee Brooks (Director of Operations)	0-2.5	0	30-35	0	354	323	12	24
Andrew Haywood (Director of Digital Services)	0-2.5	0	5-10	0	78	56	7	23
Andrew Swinburn (Director of Paramedicine)	2.5-5	7.5-10	35-40	85-90	726	632	77	20
Patricia Mills (Board Secretary)	0-2.5	0	0-5	0	39	16	7	12
Keith Cox (Board Secretary) ***	0	0	0	0	-	-	-	-

*Dr Brendan Lloyd re-joined the pension scheme from 1st September 2020 and left the scheme on 31st December 2021

** Estelle Hitchon chose to leave the pension scheme on 31st October 2020

***Keith Cox chose not to be covered by the NHS pension arrangements in the prior year, as well as the current reporting year until retirement on 1st August 2021

Staff Numbers

An analysis of staff numbers by category during 2021/22 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 WTE). These figures have been calculated to include inward secondments and agency staff and to reconcile with the financial accounts.

Category	2021/22	2020/21*
Additional Clinical Services	2,064	1,755
Additional Professional, Scientific & Technical	2	1
Administrative, Clerical and Board Members	581	558
Allied Health Professionals	1,052	1,106
Estates & Ancillary	62	62
Medical & Dental	1	1
Nursing and Midwifery	207	170
Total	**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 2022 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	7	37
Male	12	63
Total	**19**	**100**

Sickness Absence Data

	2021/22	2020/21
Days lost (long term)	100,910.74	65,017.51
Days lost (short term)	50,050.55	31,864.22
Total days lost	**150,961.30**	**96,881.73**
Average working days lost	329.20	16.79
Total staff employed in period (headcount)	4,231	3,907
Total staff employed in period with no absence (headcount)	1,035	1,496
Percentage staff with no sick leave	**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 and locum 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 a number of actions in 2021/2022. These include*:*

- A project plan for improving attendance has been developed and rollout has started. The plan has seven work streams to deliver, including additional coaching and development for managers to support their teams more effectively;
- Sickness audits;
- Pilot to report sickness absence to line managers rather than Resourcing;
- Quarterly checks of GRS and ESR 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 EMS to discuss complex sickness cases and alternative duties arrangements;
- Face to face fortnightly drop in workshops for anxiety, trauma, wellbeing and mental health awareness are being held in 111NHSDW and Clinical Contact Centre sites across the Trust;
- 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;

- Occupational Health and Wellbeing provided ad hoc support to managers and colleagues where colleagues had suffered the bereavement of a colleague;
- Occupational Health continued to monitor Datix for musculo-skeletal incidents to inform staff of the Trust's fast track physiotherapy service, which has continued to see a rise in staff access;
- The 'road to recovery' support group meet weekly with a range of invited speakers to offer support to staff who are currently unwell due to long COVID;
- A fortnightly women's health group (previously menopause café) is held virtually to give information and offer a safe area of peer support to women within the Trust. Speakers in 2021 included the Endometriosis Society, dermatologists, nutritionists and a sleep expert;
- Investment in occupational health and wellbeing in 2021 has allowed an increase in the wellbeing and nursing contingent in North Wales, thus increasing access to face to face services and expansion of the service in this area; and
- 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 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 2021/2022 the Trust launched an Ally Programme to help create a more inclusive, compassionate and culturally responsible workforce in line with the organisation's Strategic Equality Objectives. The programme encompasses allyship to all underrepresented groups and communities and promotes self-guided learning, reflective practice, and courageous dialogue. 93% of staff have completed the Trust's mandatory equality and human rights training, called 'Treat Me Fairly'.

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 our staff who juggle work and caring responsibilities. Further, the Trust has an established Flexible Working Policy to help create a more flexible workplace to enable the recruitment and retention of staff and to facilitate a healthy work-life balance that is essential to the health and wellbeing of our workforce. We have supported and celebrated numerous days and events, such as International Women's Day, Black History Month as well as LGBT History Month and more.

In January 2022 we appointed a Head of Inclusion and Engagement with a focus on leading the Equality, Diversity and Inclusion agenda in line with Intermediate Medium Term Plan deliverables.

During 2021/22 the Trust Board undertook a development session on the Socio-Economic Duty which prompted a review of the Equality Impact Assessment (EqIA) template to incorporate the duty and for this to become an equality and health impact assessment. A small task and finish group is being established to take this work forward in 2022/23.

As part of our wider equality, diversity and inclusion work, we have continued to provide employment information to inform national strategies, such as nurse staffing forecasts and information to inform the national mental health workforce plan for Wales.

Expenditure on Consultancy

Expenditure during 2021/22 in respect of consultancy costs was £0.878m (2020/21 £0.434m) across the following areas:

	£
Finance	3,450
Human Resources, Training and Education	88,761
IT/IS	22,004
Legal Services	30
Marketing and Communication	24,900
Organisation and Change Management	537,194
Programme and Project Management	26,864
Property and Construction	73,937
Strategy	99,974
Technical	648
Total	**877,762**

Off-Payroll Engagements

The Trust has a nil return in 2021/22 for off-payroll engagements. This is consistent to that reported in 2020/21.

Exit Packages

The Trust has a cost of £0.292m in 2021/22 for six staff exit packages. This compares to a return of £0.306m in 2020/21. Exit packages are described in Note 10.5 within the financial statements.

2.4 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.

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 2021/22 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 2021/22 accounts. This is consistent to that reported in 2020/21.

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 NHS Trust for the year ended 31 March 2022 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 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 2022 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 of 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 report. I am 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 report.

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.

Report on other requirements

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 information given in the Governance Statement for the financial year for which the financial statements are prepared is consistent with the financial statements and Governance Statement has been prepared in accordance with Welsh Ministers' guidance;
- the information given in the Foreword, Performance Report and Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements and the Foreword, Performance Report and Accountability Report has been prepared 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 Foreword, Performance Report, Accountability Report and Governance Statement.

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

- 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 Remuneration 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; orI have not received all the information and explanations I require for my audit.

Responsibilities

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 the preparation of financial statements which give a true and fair view and for such internal control 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.

In preparing the financial statements, the Directors and Chief Executive are responsible for 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 deemed inappropriate.

Auditor's responsibilities for the audit of the financial statements

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 an auditor's report 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, the audited entity's head of 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 the following area: management override; and
- 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.

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, the Audit Committee and legal advisors about actual and potential litigation and claims;
- reading minutes of meetings of those charged with governance and the Board;
- 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 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.

Responsibilities for regularity

The Chief Executive is responsible for ensuring the regularity of financial transactions.

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

Report
I have no observations to make on these financial statements.

Adrian Crompton
Auditor General for Wales
15 June 2022

24 Cathedral Road
Cardiff
CF11 9LJ

The maintenance and integrity of the Welsh Ambulance Services NHS Trust's website is the responsibility of Accounting Officer; the work carried out by auditors does not involve consideration of these matters and accordingly auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the website.

PART 3 – FINANCIAL STATEMENTS

ANNUAL REPORT 2021/22 HIGHLIGHTS

[Note this document will undergo a design and formatting process, with photograph montage added, prior to the Annual General Meeting]

WELCOME

Welcome to the Welsh Ambulance Services NHS Trust Annual Report 2021/22. It's been another very challenging year for all of us, and the Welsh Ambulance Service has been no exception.

With a combination of the ongoing pandemic, coupled with a return to high levels of our "routine demand" and the impact of the pandemic starting to be felt significantly both by our staff and the wider health and care system, it's fair to say that 2021/22 has not been easy.

We acknowledge that, in the last 12 months, many patients have not received the level of service we aim to provide, nor that they have a right to expect. While the challenges have been acute, we have tried our best to maintain our services, including via support from colleagues in the military, which helped us greatly at times of real pressure.

In amongst the challenges, there have been pockets of real positivity and progress, which you can read about through the course of this document. We've taken a slightly different approach to our annual report this year, which includes this shorter introductory section and more opportunity for you to explore the detail in the main section of the formal annual report.

We've also inserted some hyperlinks so that you can jump to the sections of the main document that interest you most, which we hope is helpful.

We continue to build opportunities to engage with our stakeholders, despite the challenges of the pandemic. Our online Board meetings have been very successful in building interest and "attendance" from a range of people, while now that we are starting to emerge from (hopefully) the worst of the pandemic, we are looking at hybrid models of engagement, blending face-to-face with online opportunities, including in our engagement with patients.

If you're interested in finding out more about what's happening at the Welsh Ambulance Service, or are interested in joining a Board meeting or other engagement event, keeping an eye on our social media is a good place to start. You can find us on Twitter @welshambulance, on Facebook and Instagram.

We hope you find the 2021/22 Annual Report helpful. We're always happy to listen to feedback so, if you have any observations to make, please let us know by emailing was.communications@wales.nhs.uk

Yours Sincerely

Martin Woodford
Chair

Jason Killens
Chief Executive

WHAT WE DO

We provide healthcare services for people across 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 alternative treating facility.

- Non-Emergency Patient Transport Service (NEPTS): taking patients to and from hospital appointments and transferring them between hospitals and treatment facilities.

- The now retired NHSDirect Wales (NHSDW) service: a health advice and information service available 24 hours a day, every day, including an online and telephone offering which was available in Betsi Cadwaladr and Cardiff & Vale University Health Boards for the early part of 2021/22 prior to their migration to the 111 service.

- The 111 service: a free-to-call service which incorporates the NHSDW service and the call taking and first stage clinical triage for the out-of-hours GP service. The number was live pan-Wales throughout 2021/22 and the full service was rolled out in Betsi Cadwaladr and Cardiff & Vale University Health Boards in 2021/22, making the complete service universally available across Wales.

- We also support Community First Responders, Co-Responders and Uniformed Responders to provide additional resources to respond to those most in need of help in our communities.

- During the pandemic, we have provided the Mobile PCR Testing Service for the whole of Wales.

We have continued to run all our services during 2021/22, caring for a range of patients, including those with COVID-19.

You can read more about the services we provide in our **Annual Performance Report (inser hyperlink)**.

THE YEAR IN REVIEW

In this section, we provide you with some of the key headlines from the year. There's lots more detail in our **Annual Performance Report (insert hyperlink**), our **Annual Governance and Accountability Statement (insert hyperlink)** and our **Annual Accounts (insert hyperlink).**

Performance

The 2021/22 year has been a difficult one when it comes to our performance. We have done our best to maintain our services but, perhaps inevitably, the impact of the continued COVID-19 pandemic, coupled with a return to in excess of our usual levels of demand, has meant that our performance has suffered.

Our key target set for us by Welsh Government is “Red 8”. This is the percentage of Red – immediately life threatening – incidents responded to within eight minutes. Our target is to reach 65% of such calls across Wales within the eight minute window.

Unfortunately, we have seen a continued deterioration in performance against the Red eight minute target, together with lengthening response times for in the Amber category of calls, which includes strokes and heart attacks.

The reasons for this diminished performance are many and various. You can read more about the background and reasons in our **Performance Report (insert hyperlink).**

We know that the bulk of patient safety incidents occur in the Amber category, and that these long response times directly impact on patient outcomes. We continue to work with partners to improve our performance, impressing upon partners that these are issues for which the entire system is responsible and that we need to act as a system if they are to be resolved.

We did not achieve the Red eight minute 65% Welsh Government target in any month in 2021/22. While the **Performance Report (insert hyperlink)** provides greater detail, there are a number of headline reasons why this has been the case, including increases in Red demand and overall acuity, a loss of capacity through increased sickness absence, and a loss of capacity through hospital handover delays.

Delays at hospitals were extremely challenging in 2021/22. Hours lost waiting to hand over the care of patients to hospital teams were very high prior to the pandemic. The levels seen during the 2021/22 winter were unprecedented. In March 2022, we lost more than 24,000 ambulance hours, equivalent to 48,000 people hours or 4,000 twelve hour shifts. This position has worsened month on month throughout 2021/22, with a total of 191,214 ambulance hours lost.

During quarters three and four of 2021/22, we received military support to help mitigate the loss of capacity. During the pandemic, we also prioritised our conveying capacity (Emergency Ambulances – Eas over Rapid Response Vehicles -RRVs) which influences Red response times.

When dealing with certain patients, including those with suspected or actual COVID-19, staff were also required to don and doff Level 3 PPE in line with Infection Prevention and Control (IPC) guidance, which can add minutes to the response time.

In relation to our Non-Emergency Patient Transport Service (NEPTS) and Urgent Care Service, demand has not recovered to pre-pandemic levels. Whilst renal and oncology demand has been stable, outpatient demand is down, and discharge and transfer activity has been variable.

A further consideration has been that social distancing reduces the number of patients that can be conveyed per journey. The total number of non-emergency patient journeys undertaken in 2021/22 was 497,570, compared to 433,524 in 2020/21 and 670,353 in 2019/20.

For many of our patients, the first point of contact with the Trust is the 111 service. The 111 number is now operational across all of Wales (as part of the pandemic response), and the full 111 Service is now live in every part of Wales, with the remaining two Health Board areas, Betsi Cadwaladwr and Cardiff and Vale, moving across from the NHSDW service in 2021/22, which contributed to the increase in calls. The total number of 111 calls in 2021/22 was 1,031,655 compared to 552,232 in 2020/21.

In the **111 service**, we measure the quality of the service we provide through call answering times and clinical ring back times. We aim to answer 95% of calls within 60 seconds and to have an abandonment rate of less than 5%, but the service has been significantly off target during 2021/22. 40% of 111 calls were answered within 60 seconds and 18.6% of calls to the 111 number were abandoned after 60 seconds in 2021/22. As a result of a concerted recruitment and training effort, as well as internal improvement and efficiency work which remains ongoing, the Trust has started to see improvements towards the latter part of the year.

In relation to clinical ring back for triage, the Trust consistently achieves the one hour target of 90% for highest priority patients, 94% in 2021/22, but did not achieve the 90% target for other patient acuity categories.

You can read more about all aspects of performance in our **Performance Report. (Insert hyperlink)**

Quality

Providing a quality service is very important to us. We are acutely aware that 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.

We actively encourage a positive safety culture and see all incidents/events as an opportunity for learning and improvement. There were 4,558 patient safety incidents, near misses and hazards reported in 2021/22, compared to 2,550 in 2020/21.

We are also seeing higher levels of National Reportable Incidents (NRIs); and also, higher levels of serious incidents referred to health boards for them to investigate. There were 65 patient NRIs in 2021/22, compared with 56 in 2020/21. This is too many and reflects the pressure in the health care system. Most, but not all of these NRIs, relate to our 999 service.

Incidents referred to Health Boards have more than doubled in the last year, reflecting the severe pressures in the system. They are often a result of long waits in the community because of handover delays at hospitals. There were 184 incidents referred to Health Boards in 2021/22, compared to 72 in 2020/21.

We continue to highlight to the wider NHS Wales system our concerns about the quality of experience which patients are receiving, and hope to make improvements in 2022/23, in line with the rest of NHS Wales.

You can read much more about how we measure quality, what we do when things don't go as planned, and what we are doing to improve matters in our **Performance Report (insert hyperlink).**

Our People

It's been another challenging year for the people who work for us in the Welsh Ambulance Service. Whether working on the frontline as a clinician, call handler or non-emergency team member, or a member of one of our corporate or support teams, everyone has worked hard to deliver for patients at an unprecedented time.

Our staff numbers have grown in 2021/22, largely a result of investment from our commissioners. An analysis of staff numbers by category during 2021/22 is 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 WTE). These figures have been calculated to include inward secondments and agency staff and to reconcile with the financial accounts.

Category	2021/22	2020/21*
Additional Clinical Services	2,064	1,755
Additional Professional, Scientific & Technical	2	1
Administrative, Clerical and Board Members	581	558
Allied Health Professionals	1,052	1,106
Estates & Ancillary	62	62
Medical & Dental	1	1
Nursing and Midwifery	207	170
Total	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 2022 is 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	7	37
Male	12	63
Total	19	100

Sickness absence has deteriorated since last year. This is in part a result of the rise of the Omicron and BA2 variants of COVID-19, which had a marked impact on our staff in the latter half of 2021/22. It's also symptomatic of what we describe as the "moral injury" staff feel as a result of working under considerable pressure in a log-jammed health and care system. The table below shows this deterioration.

	2021/22	2020/21
Days lost (long term)	100,910.74	65,017.51
Days lost (short term)	50,050.55	31,864.22
Total days lost	150,961.30	96,881.73
Average working days lost	329.20	16.79
Total staff employed in period (headcount)	4,231	3,907
Total staff employed in period with no absence (headcount)	1,035	1,496
Percentage staff with no sick leave	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 and locum 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.

We recognise that staff need to be supported, both to regain their health and to feel better about coming to work. We also need to support staff when they are at work to prevent absence becoming an issue in the first place.

Among the actions underway to improve attendance are:

- A project plan for improving attendance has been developed and rollout has started. The plan has seven work streams to deliver, including additional coaching and development for managers to support their teams more effectively
- Sickness audits

- Regular case reviews were undertaken across EMS to discuss complex sickness cases and alternative duties arrangements
- Face to face fortnightly drop in workshops for anxiety, trauma, wellbeing and mental health awareness held in 111/NHSDW and Clinical Contact Centre sites across the Trust;
- 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;
- Occupational Health and Wellbeing provided ad hoc support to managers and colleagues where colleagues had suffered the bereavement of a colleague
- Our fast track physiotherapy service has continued to see a rise in staff access;
- The 'road to recovery' support group met weekly with a range of invited speakers to offer support to staff who are currently unwell because of long COVID-19
- A fortnightly women's health group (previously menopause café) is held virtually to give information and offer a safe area of peer support to women within the Trust. Speakers in 2021 included the Endometriosis Society, dermatologists, nutritionists and a sleep expert;
- Investment in occupational health and wellbeing in 2021 has allowed an increase in the wellbeing and nursing contingent in North Wales, thus increasing access to face to face services and expansion of the service in this area; and
- 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 TRiM and wellbeing support as well as supporting health campaigns for staff.

During 2021/2022, we launched an Ally Programme to help create a more inclusive, compassionate and culturally responsible workforce in line with the organisation's Strategic Equality Objectives. The programme encompasses allyship to all under-represented groups and communities and promotes self-guided learning, reflective practice, and courageous dialogue. 93% of staff have completed the Trust's mandatory equality and human rights training, called 'Treat Me Fairly'.

We have 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 our staff who juggle work and caring responsibilities. We also have an established Flexible Working Policy to help create a more flexible workplace to enable the recruitment and retention of staff and to facilitate a healthy work-life balance.

Amidst all the hard work, we have taken time to support and celebrate numerous days and events, such as International Women's Day, Black History Month as well as LGBT History Month and more.

You can read more about what we are doing to support our workforce in our **Performance Report (insert hyperlink**).

HOW WE WORK

Our **Accountability Report (insert hyperlink)** contains a wealth of information about how we are governed and the legislative framework in which we operate.

A key aspect of the Trust's accountability and governance is that the Trust is a commissioned service for 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 Services Commissioner (CASC) and the National Collaborative Commissioning Unit. EASC, and its supporting committees, have continued to meet through the pandemic period.

Similarly, our Board and Committees have continued to meet, with high levels of digital engagement from the public and stakeholders at our Board meetings, which have been held digitally.

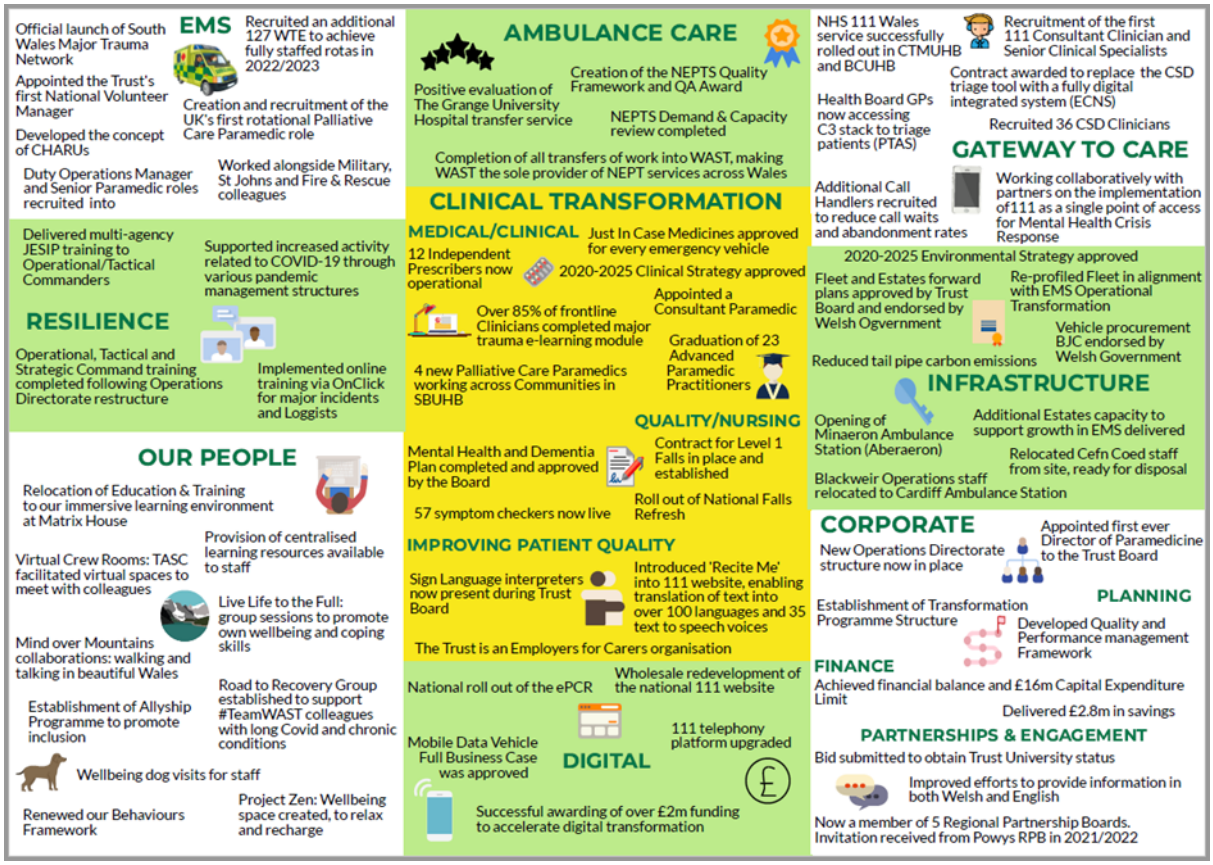
In 2022/23, we will move to a more hybrid approach to meetings to ensure that the benefits of face-to-face engagement, including with the public, are retained.

You can read more **here (insert link to Accountability Report)**

Highlights

Despite all of the pressures, it hasn't all been bad news. There have been some very positive developments and we have continued to push forward with much of the work we outlined in our Integrated Medium Term Plan (IMTP), which is outlined in the visual below.

In fact, it's been important to keep moving forward. The pandemic has been a catalyst to accelerate some of our developments, and will also shape those developments yet to come. Standing still and awaiting a return to a "2019 normal" has not been an option, as we need to continue to move forward to keep pace with developments and to make improvements for our patients and our people.



This year, we were delighted to be able to reinstate the work of our Community First Responders mid-year, as well as our co-responders in Mid Wales Fire and Rescue Service.

Throughout the year, we have worked closely with a range of partners and stakeholders, some of them well-established, but some more recent, to ensure that the service could continue to maintain its services to patients while maintaining the safety of our people, as Wales remained in the grip of COVID-19.

The Trust also continued working with partners in UK government on the running of mobile testing units and with its established third sector partners, St John Ambulance Cymru.

2021/22 also saw us take some significant steps towards gaining University Trust Status, which will help us redefine our relationships with higher and further education as we move forward into the post-pandemic era, and everything that this will mean in terms of workforce, service configuration, harnessing technology, optimising opportunity for our people and the quality of services we provide to the people of Wales.

Our 'Blue Light Hub' app continues to be recognised as an innovative way to engage with young people about using 999 services.

This recognition resulted in nationwide coverage about the app when we were invited to appear on Crime Watch live on BBC One. This coverage helped boost app

downloads and highlighted the importance of children and young people being confident to access the right service in an emergency.

The Year in Pictures

We've put together this montage of pictures to give you a visual flavour of our year. From awards to new vehicles, there have been a number of highlights which we hope you enjoy. **[montage to be inserted]**

Managing our Money

Our financial performance in 2021/22 was again underpinned by strong financial management, including the delivery of a significant level of savings and achievement of all statutory financial targets, including the payment of invoices within 30 days and achieving a small revenue surplus against the budget.

We will continue to operate in a challenging financial environment and will need to continue to deliver further, and indeed increased, planned savings into 2022/23.

In 2021/22, the Trust achieved all of its financial targets as follows:

	Actual	2021/2022
Breakeven - Achievement of revenue financial balance.	**Delivered**	
CEL - Capital spend equal to, or less than, the WG set Capital Expenditure limit.	**Delivered**	
EFL - Remain within External Financing Limit*	**N/A**	
PSPP - 95% of Non NHS invoices by number are paid within 30 days.	**Delivered**	
**Due to the COVID-19 pandemic, the EFL requirement continues to be temporarily suspended by Welsh Government.*		

At the end of the 2021/22 financial year, we reported a revenue surplus of £0.260m in our audited final accounts. Of this, £0.185m related to the transfer of a donated asset from the Trust's Charity.

We are required to achieve financial breakeven over a rolling 3 year period. The Trust has met its financial duty to break even over the 3 years 2019/20 to 2021/22.

During the 2021/22 financial year, we expended Capital Investment funds of £27.942m in new property, fleet, plant, equipment and ICT, utilising 100% of the Trust's Welsh Government set Capital Resource Limit, without exceeding it. In addition a further £0.029m, being the netbook value of assets disposed of, was also invested, resulting in the total investment of £27.971m.

The Trust is required to pay at least 95% of the number of non-NHS invoices received within 30 days of receipt of goods or a valid invoice (whichever is later). We met this target, paying 97.2% within the specified time.

In respect of our total income, £276.5m was received in year (compared to £241.8m 2020/21), an increase of £34.7m.

Total revenue expenditure increased by £34.6m (14.3%) in absolute terms (2021/22 £276.4m, 2020/21 £241.8m).

In common with other public sector bodies across Wales, the Trust is facing a further challenging year especially with the potential recurrent impacts of the pandemic in the 2022/23 financial year.

To deliver a fully balanced financial plan this has resulted in a requirement to deliver a minimum of a further £4.3m savings via cost reduction, cost containment and cost avoidance schemes in 2022/23.

Full details of the Trust's service, operational, workforce and financial plans are contained within the **Integrated Medium Term Plan (IMTP) (insert hyperlink**) for the financial year 2022/23, which was submitted in accordance with the NHS Wales Planning Framework to WG in March 2022 with approval awaited alongside other NHS Wales organisations.

You can read all about our finances in our **Financial Statements and Accounts (insert hyperlink)**

A LOOK AHEAD

As we move forward into 2022/23, the outlook is, at best, challenging. We know that there remains much to do if the health and care system across Wales is to recover from everything the COVID-19 pandemic has thrown at us, and the extended impact it is likely to have on patients and people working in health and care.

We are committed to improving the quality of the service we provide, improving timeliness of response for those most critically in need of our help. But we cannot do this alone and, at the time of writing, discussion continues with organisations across NHS Wales and Welsh Government to identify rapid and meaningful actions to improve the current situation.

We are also looking at accelerating the pace of change across our organisation, building on our **Delivering Excellence (insert hyperlink)** long-term strategy. Our ambition is to ensure most people get the care they need away from the hospital, whether that's by advice on the phone or online, or by clinicians caring for more people at home or on scene. We also want the ability to refer patients to other health services, making things more convenient and appropriate for patients, and reducing the numbers of people we take to hospital.

You will be hearing more about our plans as we move through 2022/23 so please keep an eye on our social media feeds and **website (insert hyperlink)** to find out more.

Head of Internal Audit Opinion & Annual Report 2021/2022

May 2022

Welsh Ambulance Services NHS Trust

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

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

Contents

Report status:	Final
Draft report issued:	May 2022
Final report issued:	May 2022
Author:	Simon Cookson, Director of Audit and Assurance
Executive Clearance:	Trish Mills, Board Secretary
Audit Committee:	7th June 2022

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.

As a result of the continued impact of COVID-19 our audit programme has been subject to change during the year. In this report we have set out how the programme has changed and the impact of those changes on the Head of Internal Audit opinion.

1.2 Head of Internal Audit Opinion 2021-22

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 2021/22 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

Due to the considerable impact of COVID-19 on the Trust, the internal audit plan has needed to be agile and responsive to ensure that 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 2021/22 year was initially presented to the Committee in March 2021. 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 Internal Auditors (in 2018), and our own annual Quality Assurance and Improvement Programme (QAIP) have both confirmed that our internal audit work continues to 'generally conform' to the requirements of the Public Sector Internal Audit Standards (PSIAS) for 2021/22. For this year, as in 2020/21, our QAIP has considered specifically the impact that COVID-19 has had on our audit approach and programmes. We are able to state that our service '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, and in part reflecting the impact of COVID-19, 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 2021/22

Substantial Assurance	Reasonable Assurance
• Mobile testing unit • Follow up review	• Risk management and assurance • Financial planning and budgetary control • IMTP • Network and Information Systems (NIS) Directive • Collaboration • Service reconfiguration • Asset management system (RAM) • Medicines management – controlled drugs • Information management – consult & close and see & treat • I.T. service management • Digital governance • NEPTS procurement • Role of Advanced Paramedic Practitioner • Recruitment practices: Equality, diversity and inclusion • Respiratory protective equipment • Capital projects: Cardiff make ready depot
Limited Assurance	**Advisory/Non-Opinion**
• NEPTS – transfer of operations • Waste management	• Organisational culture – a learning organisation
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 2021/22 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 two audits in 2021/22).

2.4.2 Basis for Forming the Opinion

The audit work undertaken during 2021/22, 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, two were allocated Substantial Assurance, 16 were allocated Reasonable Assurance and two were allocated Limited Assurance. No reports were allocated a 'no assurance' opinion. In addition, one advisory or non-opinion report was also 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 two reviews in this area.

Whilst the overall rating for the **Risk management and assurance** audit was **reasonable** assurance, and is a positive reflection of the arrangements the Trust has in place, the Board Assurance Framework (BAF) element was assigned limited assurance. The BAF has been paused for a period of three months to allow for a transitional BAF to be developed. There will continue to be reporting of high scoring corporate risks to assuring committees as mitigation. A high priority recommendation was raised to address the inconsistencies in the management and review of risks at operational directorate level.

Our **Follow up review** was a positive report, again delivering a **substantial** assurance rating, which recognises the systems in place to monitor progress with the implementation of actions in response to internal audit reports.

The **Health and Safety** audit, to review the Trust's structures and arrangements for complying with legislation, was deferred to 2022/23, allowing recent changes to embed.

Strategic Planning, Performance Management & Reporting

We have undertaken three reviews in this area.

The **IMTP** audit received **reasonable** assurance rating, which recognised the approach taken by the Trust to the development of the quarterly planning returns during 2020/21 and the 2021/22-23/24 IMTP. We identified no significant issues for reporting.

Reasonable assurance was reported in relation to **Collaboration**. This reflects the Trust's arrangements to collaborate with stakeholders to ensure commitment is included in the IMTP and appropriate action is being taken. We highlighted that the Engagement Strategy and delivery plan required revision and found in some cases performance targets had not been set for new initiatives.

Our review of **Service reconfiguration** focussed on the transfer and discharge service at the Grange University Hospital, noting the intention to expand the model across Wales. A **reasonable** assurance rating was issued, reflecting positively on the Trust's approach to managing service change. Four medium priority findings were raised, including the need to renew the service specification document and incomplete collaborative project group meeting documentation.

Financial Governance and Management

We have undertaken two reviews in this area.

Reasonable assurance was reported in relation to **Financial planning and budgetary control**. This reflects the arrangements in place to financial planning and to oversee financial performance during the year.

Our review of the **Asset management system (RAM)**, which focussed the extent to which benefits realised reflect planned outcomes, derived **reasonable** assurance. A high priority finding was raised, highlighting the need for a more proactive approach to the physical verification of assets.

The review of **Savings plans** was moved to 2022/23 following discussion with management, as the Trust would gain more value by deferring the review.

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 four reviews in this area.

Our review of **Medicines management – controlled drugs** reported **reasonable** assurance. This is an improvement on the limited assurance rating issued in previous reviews and recognising the impact of the new Abloy system. The matters requiring management attention included the need to analyse the results of both the Omnicell medicine cabinet cycle counts and vehicle medicines audits and to review of the Abloy keys listing.

Reasonable assurance was provided following our review of **Information management – consult & close and see & treat**. We recommend that greater use is made of referral data in the incident records to inform further developments of current and future referral pathways, and to extend current analysis and examination of the 'Can't Send' call responses to include other 'See and Treat' and 'Consult and Close' incident responses.

Our review of the **Role of Advanced Paramedic Practitioner (APP)** raised a high priority recommendation to undertake a formal lessons learned exercise of the programme to realise its full potential. Despite this, a **reasonable** assurance rating was provided, reflecting that there is evidence to support that the use of APPs reduces conveyances to hospitals.

The **Respiratory protective equipment** audit received reasonable assurance reflecting the arrangements in place for its provision. A high priority finding was raised following gaps identified in local records in respect of Fit testing and device maintenance logs. Consideration is also needed to the development of a sustainable Fit testing model.

Information Governance & Security

We have undertaken three reviews in this area.

Reasonable assurance was provided in relation to the arrangements in place for the implementation of the **NIS Directive**, including the Cyber Assessment Framework. Three medium priority recommendations were raised, relating to the retention of supporting information, to develop an improvement action plan going forward and the reporting of cyber security matters.

The review of **I.T. service management** received **reasonable** assurance. A high priority issue was raised because the provision of services and the level of support have not been agreed with user departments. We also identified that there is no process in operation for event and problem management.

Reasonable assurance was reported in relation to **Digital governance**. The matters requiring management attention include developing a Strategic Outline Programme that sets out how the Digital Strategy will be implemented and the required resourcing, defining the timescales for delivery of the Digital Strategy, and establishing the structures for linking Digital with the operational parts of the organisation.

Operational Service and Functional Management

We have undertaken three reviews in this area.

The **NEPTS – transfer of operations** review derived **limited** assurance. Our overall assurance rating relates to the capturing, reporting and monitoring of benefits realised. Whilst we acknowledge that many of the benefits may have been realised now that the transfer has completed, the Trust needs to undertake an exercise to support and demonstrate this.

NEPTS procurement and the application of the 365 Response framework received **reasonable** assurance. This reflects positively on the impact of the framework in improving contract governance and quality monitoring. Key matters arising concerned that the Trust is not obtaining assurances that all monthly repository updates have been received from providers, and the implementation of the advisories tracker to facilitate monitoring.

Substantial assurance was reported in relation to the **Mobile testing unit (MTU)**. Our overall classification reflects the narrow scope of this audit and the limited role that MTU staff have in processing and accessing patient identifiable information which may pose an Information Governance risk. Matters arising concerned areas for refinement and further development.

Workforce Management

We have undertaken two reviews in this area.

The advisory review of **Organisational culture – a learning organisation** found that the goal of continuous quality improvement

through learning directs much of the development work the Trust does, and it is visible widely across the organisation. Areas were highlighted where enhancements could lead to further improvement and to strengthen organisational learning.

Our review of **Recruitment practices: Equality, diversity and inclusion** reported **reasonable assurance** on the arrangements in place. Four matters were raised requiring management attention, including limited analysis of the effectiveness of initiatives to attract new staff, and no regular analysis of candidate progress to establish and assess barriers to applicants from minority backgrounds.

The **Trade union release time follow up** review (limited Assurance report issued during 2018/19), already deferred from the 2019/20 and 2020/21 internal audit programmes, was further deferred to 2022/23 to allow time for the refreshed trade union facilities agreement to embed.

Capital & Estates Management

We have undertaken two reviews in this area.

Reasonable assurance was provided following our review of the **Cardiff make ready depot**, reflecting the arrangements in place to support the management and delivery of the scheme. The key priorities raised for management attention included the need to conclude on the assessment of project delays and instruct appropriately in accordance with the contractual requirements, and to formally review the project team's performance. Noting that the project was due to complete shortly at the time of reporting, the remaining recommendations are primarily for the benefit of future projects and should be considered as part of a formal Post Project Evaluation.

Our review of **Waste management** derived **limited** assurance. Whilst it is recognised that the Trust's total waste production is significantly lower than other NHS organisations, the Trust still has a duty of care for the waste it does produce. Several significant issues were identified, recognising the period of review was impacted by the Covid response. Eight recommendations for action were identified, of which six were categorised as high priority. Key matters arising include the need to review and update waste management procedural guidance; the need to assign executive leadership, committee responsibility and operational responsibility for waste related matters; to confirm Natural Resources Wales approval of clinical waste arrangements; the need to evidence the transfer of Waste to other NHS organisations; and to re-introduce Clinical Waste Duty of Care and Clinical Waste Pre-acceptance audits to inform internal reporting.

The review of **Decarbonisation** was deferred to 2022/23, recognising that Health Bodies are not required to publish their Decarbonisation Action Plans until March 2022 and the timing of expenditure of the initial capital allocations provided by Welsh Government.

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.

For the second year in a row, due to the impact of COVID-19, we are aware that it has been more difficult than usual for NHS organisations to implement recommendations to the timescales they had originally agreed. In addition, we also recognise that for new recommendations it may be more difficult to be precise on when exactly actions can be implemented by. However, it remains 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. Where appropriate, we have adjusted our approach to follow-up work to reflect these challenges.

Going forward, given that it is very likely that the number of outstanding recommendations will have grown during the course of the pandemic, audit committees will need to reflect on how best they will seek to address this position.

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 2021/22. but the pandemic effected the ability of management to take forward recommendations in some areas. The Corporate Governance team has continued to review all outstanding recommendations with management and the outcomes have been reported to each meeting of 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 all of the sampled recommendations and therefore provide the Audit Committee with additional assurance around the accuracy of the tracker.

The proposed follow up review on Trade Union Release Time (Limited Assurance report issued during 2018/19), already deferred from the 2019/20 and 2020/21 internal audit programmes, was further deferred to 2022/23 following approval from the Audit Committee, to allow time for the refreshed trade union facilities agreement to embed.

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 this year's (and to an extent last year's) programme 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 2021/22 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 2021/22.

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 Internal Auditors (IIA) in February and March 2018. The IIA concluded that NWSSP's Audit & Assurance Services conforms with all 64 fundamental principles and '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 2021/22.

Our conformance statement for 2021/22 is based upon:

- the results of our internal Quality Assurance and Improvement Programme (QAIP) for 2021/22 which will be reported formally in the Summer of 2022; and
- the results of the work completed by Audit Wales.

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 2021/22 QAIP report. There are no significant matters arising that need to be reported in this document.

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
Procure to Pay (P2P)	Reasonable	To evaluate and determine the adequacy of the systems and controls

		in place over the management of the NWSSP Procure to Pay (P2P) service.
Payroll	Reasonable	To evaluate and determine the adequacy of the systems and controls in place for the management of Payroll Services.

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
Data Centre Transition	Substantial	To evaluate and determine the adequacy of the processes in place in DHCW for the management of the Data Centre move and the current Data Centre Service.
Data Analytics (Information)	Reasonable	To provide assurance to DHCW that arrangements are in place to enable NHS Wales to maximise the use of analytics in an appropriate and secure manner.
System Development	Reasonable	To provide assurance over the adequacy of the processes in place in DHCW for securely developing and

		maintaining applications for NHS Wales.

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 – Governance arrangements	Reasonable	To evaluate and determine the adequacy of the governance arrangements in place with a focus on the governance framework and the mechanisms of committees and groups.

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 2022/23 operational audit plan.

The audit plan approved by the Committee in March 2021 contained 23 planned reviews. Changes have been made to the plan with two audits added and four 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 21 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 2021/22	G	March 2021	By 30 June	Not agreed	Draft plan	Final plan
Total assignments reported against adjusted plan for 2021/22	G	100%	100%	v>20%	10%<v<20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	90%	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	A	62%	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	95%	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 21 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

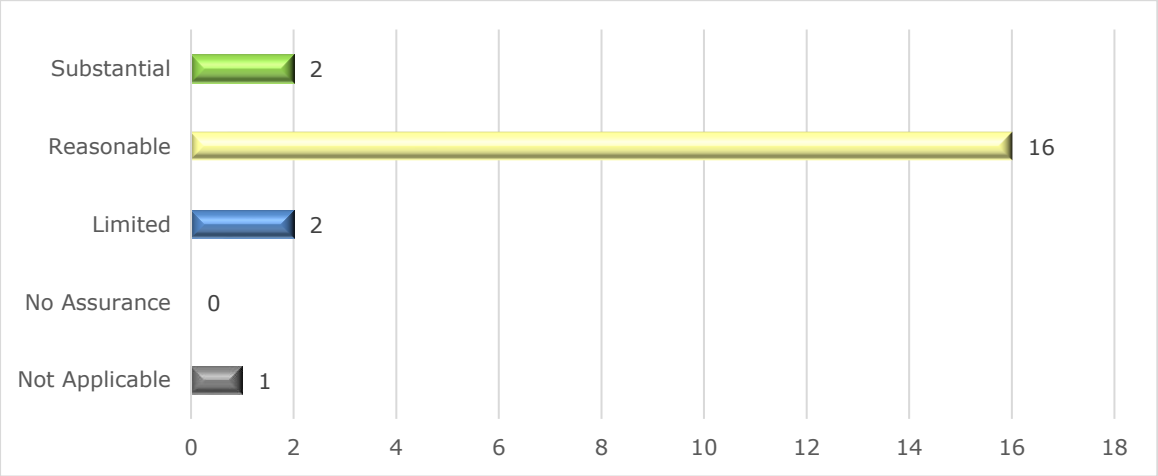


Figure 2 above does not include the audit ratings for the reviews undertaken at NWSSP, DHCW or EASC.

The assurance ratings and definitions used for reporting audit assignments are included in **Appendix B**.

In addition to the above, there were four audits which did not proceed following preliminary planning and agreement with management. In some cases, the impact of COVID-19 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)

In the following review areas, the Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. Those few matters that may require attention are compliance or advisory in nature with low impact on residual risk exposure.

Review Title	Objective
Mobile testing unit	The overall objective of the audit was to provide assurance on the Information Governance arrangements and an assessment of the

Review Title	Objective
	appropriateness of staff supervision and training.
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.

5.3 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 purpose of this audit was to assess whether the Trust has a robust risk management and assurance framework arrangements in place to address both strategic and operational risks.
Financial planning and budgetary control	The audit was undertaken to assess financial planning through the IMTP process and how financial plans align with operational and workforce objectives. The review focused on Primary Care objectives. We also reviewed the arrangements for effective budgetary management and control to assess compliance with key corporate policies.
IMTP	The overall objective of this audit was to assess the approach taken to the development of the quarterly planning returns during 2020/21 and the 2021/22- 23/24 IMTP. The review focused on the effectiveness of assessing IMTP priorities within 2020/21 Operational Plans, and the alignment of the 21-24 IMTP to national criteria. We also reviewed mechanisms to identify IMTP priorities, engagement with

Review Title	Objective
	stakeholders, scrutiny and assurance arrangements and actions to address key risks.
Network and Information Systems (NIS) Directive	The purpose of this audit was to review arrangements in place for the implementation of the NIS Directive within the Trust, including the Cyber Assessment Framework, improvement plan and overarching governance.
Collaboration	The audit was undertaken to assess how the Trust is collaborating with stakeholders, including engagement with the National Primary & Community Care and Urgent and Emergency Care Programme Boards, to ensure commitment is included in the IMTP and appropriate action is being taken. The scope included the role of the Emergency Ambulance Services Committee (EASC).
Service reconfiguration	The objective of this audit was to provide assurance that the relationship between the Trust and Commissioner is effective in ensuring expected operational outcomes in its support of health board service changes.
Asset management system (RAM)	The purpose of this audit was to review the extent to which benefits realised reflect planned outcomes
Medicines management – controlled drugs	This review sought to assess the effectiveness of the ABLOY system following our previous limited assurance report on the management of controlled drugs.
Information management – consult & close and see & treat	The objective of this audit was to assess, in respect of 999 calls, the availability of information on patient discharges through 'Consult and Close' ('Hear and Treat'), 'See and Treat' and 'Can't Send' emergency responses and how this is analysed to inform patient safety and quality improvement.
I.T. service management	The purpose of this audit was to provide assurance that a process is in place for ensuring IT services are provided in an efficient and secure manner and that reflect the needs of the organization.

Review Title	Objective
Digital governance	This review sought to provide assurance that the Trust's governance of digital services is appropriate to provide oversight and deliver the organisation's digital strategic objectives.
NEPTS procurement	This audit assessed the systems in place for the management of NEPTS Procurement and the application of the 365 Response framework, and its impact on improving contract governance and quality monitoring.
Role of Advanced Paramedic Practitioner	The review assessed whether APPs are being utilised in an effective way to support patient care and outcomes. We included a comparison between Health Boards.
Recruitment practices: Equality, diversity and inclusion	The purpose of this audit was to provide assurance that benefits realised reflect those identified at the outset of the transfer of works project.
Respiratory protective equipment (RPE)	The objective of this audit was to review that there are adequate arrangements in place for the provision of RPE.
Capital projects: Cardiff make ready depot	The review was undertaken to evaluate the processes and procedures put in place by the Trust to support the management and delivery of the Cardiff Make Ready Depot (MRD) scheme.

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
NEPTS – Transfer of operations	The objective of this audit was to provide assurance that benefits realised reflect those

Review Title	Objective
	identified at the outset of the transfer of works project.
Waste management	The audit was undertaken to assess the Trust's compliance with relevant waste management legislation and guidance, and progress towards agreed national and local waste reduction targets.

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
Organisational culture – a learning organisation	The overall objective of the advisory review was to provide assurance that the Trust is maximising opportunities for quality improvement and to what extent it is supporting a learning environment and leadership reinforced learning.

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
Savings plans	Following discussion with management agreed to do in 2022/23 as the Trust would gain more value by deferring the review.
Health and safety	Deferred to 2022/23 allowing recent changes to embed. The audit was replaced by the review of the arrangements in place for the provision of RPE, which is considered high risk.
Trade union release time follow up	Deferred to 2022/23 to allow time for the refreshed trade union facilities agreement to embed.
Decarbonisation	Moved to 2022/23, recognising that Health Bodies are not required to publish their Decarbonisation Action Plans until March 2022 and the timing of expenditure of the initial capital allocations provided by Welsh Government. The review was replaced by the waste management audit.

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 2021/22 plan.

Simon Cookson
Cyfarwyddwr Archwilio a Sicrwydd /Director of Audit & Assurance
Gwasanaethau Archwilio a Sicrwydd/Audit and Assurance Services
Partneriaeth Cydwasanaethau GIG Cymru/NHS Wales Shared Services Partnership

May 2022

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.
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.

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Partneriaeth Cydwasanaethau
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Risk Management & Assurance
Final Internal Audit Report

May 2022

Welsh Ambulance Services NHS Trust

GIG CYMRU NHS WALES
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Shared Services Partnership
Audit and Assurance Services

GIG CYMRU NHS WALES
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Welsh Ambulance Services NHS Trust

EXTERNAL • QUALITY • ASSESSMENT

Contents

Review reference:	WAST-2122-001
Report status:	Final
Fieldwork commencement:	7th February 2022
Fieldwork completion:	19th April 2022
Draft report issued:	25th April 2022/3rd May 2022
Debrief meeting:	29th April 2022
Management response received:	27th May 2022
Final report issued:	27th May 2022
Auditors:	Simon Cookson, Director of Audit and Assurance Osian Lloyd, Deputy Head of Internal Audit Jonathan Jones, Audit Manager
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 & 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 that the Trust has robust risk management and assurance framework arrangements in place to address both strategic and operational risks.

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- Inconsistencies in management and review of risks at operational directorate level.
- Gap in oversight of directorate risk management arrangements across the Trust.
- Lack of guidance and training available to support risk management.

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

Report Classification

		Trend
Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	⇔ 2019/20

Assurance summary[1]

Assurance objectives		Assurance
1	Risk Management Strategic Alignment	Reasonable
2	Board Assurance Framework	Limited
3	Risk Management processes	Reasonable
4	Risk Register content	Reasonable
5	Risk guidance and training	Limited
6	Risk reporting	Reasonable

Key matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
1	BAF Guidance	2	Design	Low
2	Directorate management and escalation arrangements	3, 4	Operation	High
3	Arrangements to support Trust risk management	3	Design	Medium
4	Risk management guidance and training	5	Design	Medium
5	Committee reporting	6	Operation	Low

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

1. Introduction

1.1 The Welsh Ambulance Services NHS Trust (the 'Trust') 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 in place which includes key 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 highest scoring held within a Corporate Risk Register (CRR). Risks within the CRR are owned by Executive Directors and reported to the Board and its Committees where appropriate for oversight and assurance. The Audit Committee retains oversight of the risk management process.

1.4 The Risk portfolio transferred from the Quality, Safety and Patient Experience directorate to the Board Secretary directorate in November 2020.

1.5 At the December 2021 meeting of the Trust's Audit Committee an update was provided on the intention to review the Trust's Risk Management Strategy and Framework. This is to be accompanied by a Risk Management Procedure to support the risk management and BAF cycles, revision of the BAF, and development of a Risk Appetite Statement.

1.6 A number of more immediate actions were also outlined including a focus on articulating risks, development of guidance on the identification of controls and actions, and a review of the escalation and reporting structures within the Trust.

1.7 The key risks considered in this review are:

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 is not taken.

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

Audit objective 1: Risk Management is aligned to the Trust's corporate objectives and strategic direction.

2.1 Following the transfer of the risk portfolio in November 2020, and the appointment of a new Board Secretary in 2021, the Trust has outlined its intentions to develop a risk improvement plan. A broad direction of travel was shared with the Audit Committee in December 2021 and Trust Board in January 2022, and a draft action plan is to be presented to the Audit Committee in June 2022.

2.2 The December 2021 Audit Committee paper outlined that significant work had been undertaken to embed a culture of identifying and managing risks within the Trust, but it was clear that the Covid-19 pandemic, other pressures and limited resources had affected the Trust's risk maturity journey. Discussion with the Board Secretary highlighted that improvement within this area will support wider Board governance development.

2.3 Development of an action plan is underway to support this work and a risk improvement session was arranged in February 2022 with input from Quality Improvement and Planning and Performance colleagues. Presentation material from the session indicates next steps were discussed and we note these have now been included within the deliverables of the 2022-25 IMTP. Whilst the action plan itself was not available at the time of fieldwork, it is positive to note that through inclusion within the IMTP there will be updates provided within the IMTP delivery structure.

2.4 Year one priorities include:

- implement the new Once for Wales Risk module;
- undertake a detailed review of each corporate risk, strengthening the articulation and management;
- development of a Risk Management Policy;
- refresh of the Risk Management Strategy and procedures;
- Board education on risk management and development of Risk Management appetites;
- development of a new BAF; and
- develop and deliver a programme of training and organisation for the whole organisation.

2.5 The development of a new Risk Management Policy and refresh of the Risk Management Strategy will address the expiration of the current Risk Management Strategy and Framework 2018-21, which was last reviewed and updated in January 2020.

2.6 The current resource assigned to support this work has been through agency support, but we were informed that a substantive Risk Officer post has been agreed and the job description finalised and is to be advertised shortly.

2.7 We note that as reported to the Audit Committee there has been immediate action to refresh and review the Trusts highest scoring corporate risks, this is further discussed at 2.29.

2.8 The March 2022 Audit Committee approved a request to pause the reporting of the Board Assurance Framework for three months, and we note this provides an opportunity to ensure further alignment between the Trust's risk management arrangements and its strategic objectives.

Conclusion:

2.9 We note that the Trust has identified its key priorities within risk management and is embarking on an ambitious improvement plan linked to its recently approved IMTP 2022-25. Noting the scale of the ambition, current team resource and the intention to populate a full action plan, we assign **Reasonable** assurance for this objective.

Audit objective 2: The Board Assurance Framework has been integrated with wider risk management arrangements and there is action to address gaps in controls or assurance.

2.10 Our previous review of risk management undertaken in 2019/20 noted that since the introduction of the BAF in September 2017 there was scope to strengthen some areas such as addressing any gaps identified in assurances and controls.

2.11 The process to review the BAF mirrors that of the Corporate Risk Register (CRR) and we were provided evidence of requests through the Assistant Directors Leadership Group (ADLT), with the Head of Risk/Deputy Board Secretary then making manual adjustments to the BAF document itself.

2.12 A change in format was made during the pandemic and we note there was a simplification where assurances were no longer mapped against local, corporate and external sources, instead presented in a list form. Additionally, risks were presented in score order, and content for the actions to address gaps in assurances and controls was not consistently populated.

2.13 Discussion at the risk improvement session in February included some outline of areas to be addressed, including mapping against objectives, assurance on control effectiveness, heat maps and executive ownership and accountability. In discussion with the Board Secretary, it was also outlined that actions to address gaps would need to be developed using SMART (Specific, Measurable, Achievable, Realistic, and Timely) methodology. The Head of Risk shared a copy of a revised action reporting spreadsheet which is intended to support future reporting and monitoring in this area.

2.14 The BAF has been 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. A template has been finalised and an example risk (ID223) populated to be shared with the Audit Committee at its June 2022 meeting. There will continue to be reporting of high scoring corporate risks to assuring

committees as mitigation whilst BAF reporting is paused. Noting the ongoing action in this area, and its communication to the Audit Committee, we have not raised a corresponding recommendation. However, it will result in a temporary gap in the reporting of risks against the Trust's strategic objectives.

2.15 A previous BAF Guidance document was provided to us as part of fieldwork which contains an outline of purpose, components and use. The refreshment of this document to support future iterations of the BAF would be useful. **See MA1**

Conclusion:

2.16 The change in format to the BAF had not contributed to strengthening the document, and its pausing to redevelop will allow the Trust to address this as part of its Risk Improvement plan. Whilst acknowledging the intent to address this area and scheduled action, with the BAF currently paused we assign this objective **Limited** assurance.

Audit objective 3: Risk management arrangements operate in accordance with approved processes.

2.17 We requested documentation and discussed with key contacts the ongoing risk management arrangements at both corporate and directorate (Operations and Quality Safety Patient Experience) levels within the Trust. Review of risk register entries follows within the next objective.

2.18 Directorate – Quality, Safety & Patient Experience (QSPE)

The directorate has established dedicated risk management meetings which align with the responsibilities assigned between the two Assistant Directors. Each Assistant Director is supported by relevant Heads of Service, and each 'team' of Heads of Service meets on a quarterly basis to review risks held, with the support from the directorate's Business Manager. Following this initial review meeting, a second 'reflection' meeting is held with attendance by Assistant Directors and the Executive Director to review and agree further actions, such as escalation of risks between local, directorate and corporate registers. Terms of Reference for the group meetings were provided indicating they were finalised in October 2021.

2.19 An action log supports the operation of both the review and reflection meetings and supports that there is a review of key information held within Datix for each risk. This includes risk titles, assurance levels for internal and external controls, target dates, current risk ratings, date of last review, escalation/de-escalation and risk transfer. The notes within the logs suggest that the decision to escalate/de-escalate, transfer or close risks receives the agreement of the Executive Director of Quality & Nursing.

2.20 The most recent meeting scheduled for January 2022 was cancelled due to operational pressures. However, we were provided with notes to confirm previous meetings were held in October and June 2021, and the Business Manager informed us that there are regular catch ups with individual Heads of Service which would allow for the discussion of specific risks if required. Review of meeting

notes identified that Assistant Director attendance at reflection meetings varied, but there was consistent attendance from the Executive Director.

2.21 Directorate – Operations

The directorate underwent a restructure in 2021 and we note that this has been accompanied by the introduction of a Senior Operational Team (SOT) which supports the directorate's Senior Leadership Team (SLT). Membership of SOT includes Heads of Service alongside resourcing, finance, workforce, quality improvement, clinical lead and the Operations directorate Business Manager. The SOT role is to provide support and assurance to the SLT and its terms of reference includes '*Review the Directorate Risk Register including controls and treatments, escalating as required to SLT.'*

2.22 The SOT meeting is supported by a work programme, and we note that risk register review has been included as a monthly item. Example meeting agendas were provided and included the most recent presentation of the directorate register. The register included corporate and directorate risks, but not local register risks. At the time of fieldwork local level risks made up 67/77 of the Operations risks within Datix. With the directorate restructuring now complete, and the immediate pressures of the pandemic easing, we were informed that there would now be opportunity for engagement with Heads of Service and Service Managers on local risks. **See MA2**

2.23 We identified four high (15+) scoring local risks and queried if these had been considered for escalation to the directorate register. The Business Manager undertook to contact risk owners, but no confirmation had been received at the time of fieldwork closing. **See MA2**

2.24 We were also informed that Emergency Medical Services hold local registers outside of Datix at territory or locality level which would be subject to review at local business meetings. We requested copies of local registers across the four territories but registers could not be provided for all. Review of those provided noted that risks contained within the registers reflect the directorate's corporate and directorate risks, with only a small number of locally specific risks alongside these. We were informed that the Business Support Officers circulate local registers to the Business Manager for awareness, but it is unclear if there are formal escalation processes in place. **See MA2**

2.25 We also identified that Datix contained 23 risks listed against the 111 service which contained last review dates of 2020. We were informed that risks for the service were being managed locally via excel, local reviews were taking place and that there would be action to update Datix.

2.26 Corporate arrangements

Our previous review included the role of ADLT and EMT in the monitoring of corporate 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.'

2.27 ADLT meets on a fortnightly basis, and we note that risk has been added to its work programme as a standing agenda item. We requested papers for ADLT meetings ahead of CRR presentation to the Audit Committee (December 2021) and Trust Board (January and March 2022). Minutes show ongoing discussion of risk, with the use of a 'Risk Log' capturing individual actions and forwarded recommendations to EMT. The group did not receive the full CRR/BAF at each meeting, but we were provided with emails circulating those documents with requests for members to review and update as appropriate.

2.28 Risk assessments for new risks for escalation to the CRR have also been presented and developed across ADLT meetings, ahead of further presentation to EMT for approval. These are captured within the risk log with a narrative outline of progress or next steps where appropriate. We did identify one entry within the risk log related to a score amendment which had been included within the log since August 2021 for further discussion, this remained outstanding and was highlighted to the Head of Risk during fieldwork. Refreshed templates for capturing and monitoring risk information and ongoing actions were shared with us as further improvements to the reporting process are considered.

2.29 ADLT membership has contributed to the ongoing work to strengthen the title and descriptions of the Trust's highest scoring risks. In February 2022, it received an outline of the changes to be made to the five highest scoring to incorporate the format of 'if, then, resulting in'. Further meetings have been scheduled to map controls and sources of assurance which continued at the time of fieldwork. CRR entries are further considered at 2.38.

2.30 We note that as part of the presentation in February 2022, ADLT received a breakdown of risks within Datix by directorate and risk level. The Trust previously had a dedicated Risk Development Group to support organisation wide risk management. Whilst ADLT has received a high level outline of the number of corporate, directorate and local risks within Datix, there is no evidence that it has undertaken any review of directorate registers to support wider consistency and completeness. Discussions with the Board Secretary and Head of Risk indicated awareness of this and future considerations for a senior management risk forum are under development. **See MA3**

2.31 We requested EMT papers and minutes in line with the above. EMT received summary risk reports in November 2021, January 2022 and March 2022, which included copies of the CRR/BAF and the risk log containing recommendations from ADLT. Minutes support that there was discussion and approval of amended risk scores and escalated risks.

2.32 In March 2022, EMT received and approved the rearticulation of key risks ahead of later presentation to Trust Board later that month.

Conclusion:

2.33 We note that corporate arrangements for risk management are firmly embedded with ADLT providing updates on new risks, score amendments and requests for the closure of risks. The Trust does lack a dedicated risk forum and arrangements at directorate level have appeared inconsistent and require attention. We assign this objective **Reasonable** assurance.

Audit objective 4: Information within risk registers is relevant, accurate, reliable and timely.

2.34 Using the same sampled directorates, QSPE and Operations, we selected a sample of risks to review to confirm the level of completeness and frequency of review.

2.35 QSPE Risk Register

Noting the most recent scheduled risk review meetings in January 2022 had been cancelled, we identified a sample of 10 directorate and local risks which had actions listed from the directorates October 2021 set of meetings and sought to establish if those actions were now complete through updating of risk records within Datix. Two discrepancies were noted (amendment of a score outstanding since June 2021, and escalation of a risk from local to directorate register).

Both of the above were highlighted to the QSPE Business Manager for information, but we note that overall, the directorate's arrangements have supported regular updates and Executive Director oversight.

2.36 Operations Risk Register

A summary review of the directorate register identified that:

- 56/77 risks had expired review dates.
- 49/77 had not received an update for over 12 months; and
- 8/77 held no 'current' risk score, indicating the entry had not been reviewed since entry onto the system

We sampled 10 directorate and local risks and noted that:

- six had passed the date of review;
- three where progress updates held more recent information on actions to mitigate the risk not featured within the controls and assurances fields;
- two were dependent on external IT actions to address the risk and it is noted that Datix had been used to prompt further engagement in this area; and
- one risk scoring 15 held just one listed control and assurances were listed as 'TBC'. **See MA2**

2.37 Noting that EMS Territories and the 111 Service were managing local registers in excel rather than Datix we requested copies to support ongoing management and review. Three of the four EMS registers could be provided, the Central territory was noted to have no current register, and the North territory register containing risks identified in April 2022 only. The 111 service register was provided indicating that the last review undertaken was in December 2021 **See MA2**

2.38 Corporate Risk Register

A summary review of the CRR as at January 2022, against the version presented to the Trust Board at the start of the pandemic shows some significant changes have occurred. We note five risks have closed as a result of mitigating actions and meeting target scores, one de-escalated and modification of another into two separate entries. This suggest that whilst the Trust has experienced a period of extended operational pressure there has been continued focus on the management of key risks.

2.39 We also reviewed a sample of five longstanding corporate risks and note that the Datix record for each confirmed recent review. Whilst it was the case that there were updates to progress notes for most supporting these ongoing reviews, we note that these had not resulted in original controls and assurances being updated to reflect changes.

2.40 In raising the above with the Head of Risk/Deputy Board Secretary, we were informed a programme of review and updating had taken place outside of Datix through the population of revised risk assessment forms using the 'if, then, resulting in' format. We requested the revised risk assessments for the same five risks as reviewed in Datix and all could be supplied in the new format. Content for three of these (ID223, ID160, ID199) indicated refreshed matching of controls and assurances and progress being made in identifying those actions to support mitigation, which can be monitored going forward with identified risk owners and target dates. We were informed following Trust Board approval of the new format, all corporate risks will now be updated in line with the refreshed risk assessment format within Datix, and incorporated into the transitionary BAF.

Conclusion:

2.41 Our review of Datix indicates that there is active management of risks at corporate level, and it is positive to note the progress in refreshing controls, assurances and identification of monitorable actions in the new format. We note a more mixed picture at directorate level and would support further attention and support being provided as appropriate. We assign this objective **Reasonable** assurance.

Audit objective 5: Appropriate training and guidance is available to the Trust Board and to support staff at all levels of the organisation.

2.42 We note that the previously approved Risk Development Guide is not available on the WAST Siren SharePoint site, and we are informed it is in the process of being refreshed. Risk management remains listed under the QSPE directorate, despite the portfolio moving to Corporate Governance in November 2020. This was highlighted to the Head of Risk who requested action to address this. **See MA4**

2.43 Risk assessment forms and some guidance '*Risk Assessment at a Glance*' were available through the QSPE page on siren to support staff, and the document does include both scoring methodology and risk terminology.

2.44 Discussion with the Board Secretary and Head of Risk outlined that there is an intention to commission external expertise to support the development of Board level training on risk management, BAF and risk appetite. We note IMTP deliverables for the above, and further organisation wide training programmes, have been agreed.

2.45 Development in this area was communicated to the Audit Committee in December 2021. It was noted the Trust would contribute to the Risk Management Community of Practice Group which is taking forward risk training to align with the roll out of the Datix Once for Wales risk module.

2.46 We were provided with emails and actions demonstrating the above groups development of a Training Needs Analysis, which is set out across three levels:

- Level 1 – all staff through induction
- Level 2 – staff with responsibility for operational risk management
- Level 3 – board members and senior management.

Conclusion:

2.47 We note that there is currently limited guidance available to support staff through the Trust SharePoint site. The development and delivery of guidance and training across all levels of the organisation is an IMTP deliverable and will align with the all-Wales programme. We note the clear intention to address this area, however currently can only assign this objective **Limited** assurance.

Audit objective 6: 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.

2.48 Our previous audit in 2019/20 had confirmed that most, but not all, committees had received information on their assigned corporate risks. Review of papers and minutes confirmed that each Committee currently receives a risk report, or at People and Culture Committee, an assurance framework report is received at each meeting.

2.49 We note that the Audit Committee retains responsibility for overall oversight of the CRR, and there has been enhancement of reporting to include date of risk presentation to relevant committees following Audit Committee request in March 2021. This reporting does not necessarily capture any queries or discussion of risks by assuring committee and we note there could be scope to capture this as highlighted by Non-Executive Directors at the September 2021 Audit Committee. **See MA5**

2.50 Whilst all risks are assigned to committees, our review of papers identified that the information within the Committee Assurance Framework at the People & Culture Committee did not always reflect the all the risks assigned to the committee. Risk ID201 (Trust Reputation) was not included within the CAF report. As a result, this risk has not received the same level of scrutiny as other corporate risks. We also identified that due to the pausing of BAF reporting, the full detail

of controls and assurances of a newly developed risk (ID458 - a confirmed commitment from EASC and/or Welsh Government required regarding funding for recurrent costs of commissioning) were not shared with the assuring committee, although outline of the context had been provided through its development at previous meetings.

2.51 Discussion with the Board Secretary outlined that future reporting to committees would align with the ongoing review of terms of reference and development of individual committee business cycles. A draft example was shared, and we note this included review of committee assigned corporate risks and BAF risks.

2.52 Review of Trust Board papers for the period January 2021 – January 2022 found that there was presentation of the CRR/BAF at all but one Trust Board meeting. Risk reports have included coverage of score changes, escalation/de-escalation and risk closures. The Board has also received an outline of the areas being taken forward through the risk improvement plan in January 2022, following the outline provided to the Audit Committee in December 2021.

Conclusion:

2.53 Established risk reporting has continued, with all committees and the Trust Board regularly receiving information on assigned risks, although an oversight meant one risk has not been regularly presented to its assuring committee. The intention to implement committee business cycles which include corporate risks and BAF risks is a positive development and will support the strengthening of the Trust's assurance reporting. We assign this objective **Reasonable** assurance.

Appendix A: Management Action Plan

Matter arising 1: BAF Guidance (Design)	Impact
We note that a Trust guidance notes document was produced to support the introduction of the previous Board Assurance Framework in 2017. Alongside an overall outline of purpose of the BAF itself there was outline of: • BAF components (Strategic aims, Principal risks, Key Controls, Assurances); • guidance on how to make effective use of the BAF; and • key questions for Board members to ask about the BAF and its supporting reporting. Whilst we recognise that there is specific board training and risk education to be established as part of the risk improvement plan, there would be benefit from review and refreshing BAF guidance to be issued alongside the new BAF.	Potential risk of: • Effectiveness of BAF use may be impacted where not supported by guidance.

Recommendations	Priority
1.1 We recommend BAF specific guidance is included to support and complement the redevelopment of the BAF document.	Low

Management response	Target Date	Responsible Officer
1.1 Agreed. BAF guidance is in the transformation programme action plan.	30th September 2022	Julie Boalch Head of Risk / Deputy Board Secretary

Matter arising 2: Directorate management and escalation arrangements (Operation)	Impact

Review of the risk management review and escalation processes within the Operations Directorate highlighted the following:
• Risk is scheduled as a regular agenda item at the recently established Senior Operational Team meeting. However, this is limited to corporate and directorate level risks and did not include high scoring Local risks.
• Escalation processes appeared unclear - we identified four high scoring (15+) risks held within the local risk register, but there were no records of the risks being considered for inclusion within the directorate register.
• Review of the directorate register and information within Datix highlighted:
  ○ 56/77 risks had passed their review date (of these 49 were over 12 months overdue), and an additional eight were identified where no review has taken place since initial entry on to the system.
• Sample review of ten individual risks within Datix identified:
  ○ six beyond date of review, three where narrative progress notes held more complete information on controls and assurances than the relevant fields, and one risk scoring 15 which included one control and assurances listed as 'tbc'. Local risk registers for the 111 Service and Emergency Medical Services at territory level, where in place, are being managed outside of Datix.
	Potential risk of:
	• Inconsistent monitoring, management, and escalation of risks within the Trust.

Recommendations	Priority
2.1 We recommend the Trust consider the issues identified above regarding risk management occurring outside of Datix and develop guidance to support the operational escalation criteria and processes which can be implemented across the organisation.	High

Management response	Target Date	Responsible Officer
2.1 Agreed. This will form part of the guidance and procedures that are currently being strengthened as part of the Risk Transformation programme and will include easy read guides, definitions, matrices and escalation and reporting structures.	30th September 2022	Julie Boalch Head of Risk / Deputy Board Secretary

Matter arising 3: Arrangements to support Trust risk management (Design)	Impact
The Assistant Directors Leadership Team's (ADLT) responsibilities as outlined within the extant Risk Management Strategy & Framework 2018-21 includes that it will '*regularly undertake deep dives into the Directorate Risk Registers providing advice and support as did the previous Advisory Group*.' The ADLT Terms of Reference include that it will undertake the Risk Development Groups role in review of directorate risk registers. Review of papers and minutes did not identify ADLT fulfilling the above, and currently there is no alternative Trust wide risk management group in operation. Discussion with the Board Secretary and Head of Risk confirm intention to address this.	Potential risk of: • Inconsistent management and escalation of risks

Recommendations	Priority
3.1 We recommend the Trust consider arrangements to support the consistency and monitor the completeness of directorate registers.	Medium

Management response	Target Date	Responsible Officer
3.1 Agreed. This will encompass the training of Risk Champions for each Directorate and a review of escalation and risk management structures is part of the transformation programme local action plan.	31st December 2022	Julie Boalch Head of Risk / Deputy Board Secretary

Matter arising 4: Risk management guidance and training (Design)	Impact
Risk Management guidance is currently still listed under the Quality Safety & Patent Experience directorate within the Trust sharepoint 'Siren' page, despite having moved to the Board Secretary portfolio in November 2020. The page does hold some template documentation such as blank risk assessment, but not the Risk Development Guide which had been finalised in 2020, discussion with the Head of Risk indicates that the document is subject to review. There is currently an All Wales risk management community of practice group which is developing three levels of training to be provided across all staff/induction, operational management and senior management/board level. The training will align with the new risk management module within DatixCloud. Whilst we acknowledge the intention to address this area there is currently little information available to staff.	Potential risk of: • Lack of guidance and/or clarity of risk management arrangements for staff.

Recommendations	Priority
4.1 We recommend the Trust ensure there is risk management guidance made available to staff in the interim period prior to the roll out of the new risk module within DatixCloud.	Medium

Management response	Target Date	Responsible Officer
4.1 Agreed. This will form part of the guidance and procedures that are currently being strengthened as part of the Risk Transformation programme and will include easy read guides.	30th September 2022	Julie Boalch Head of Risk / Deputy Board Secretary

Matter arising 5: Committee reporting (Operation)	Impact
The Audit Committee retains overall oversight and responsibility for the corporate risk register, and we have confirmed that risks are assigned and reported to assuring committees. Information provided on the reporting of risks to committees has been enhanced in response to Non-Executive Director requests, and the Executive Summary report now contains the dates committees have received their risks. We note discussion at the September 2021 Audit Committee that feedback to the committee on discussion of risks was limited, the Board Secretary outlined that the development of the BAF would assist in this area.	Potential risk of: • Opportunities for enhanced scrutiny and assurance may not be realised.

Recommendations	Priority
5.1 Acknowledging that the redevelopment of the BAF may provide assurance from assuring committees to the Audit Committee, there is scope to enhance the level of detail provided currently and management should consider how to capture and report this.	Low

Management response	Target Date	Responsible Officer
5.1 Agreed. A section for any specific feedback raised at Committees will be included in the quarterly report to Audit Committee.	30th June 2022	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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Network & Information Systems (NIS) Directive

Final Internal Audit Report

May 2022

Welsh Ambulance Service 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-2122-005
Report status:	Final
Fieldwork commencement:	22 March 2022
Fieldwork completion:	08 April 2022
Draft report issued:	26 April 2022
Management response received:	17 May 2022
Final report issued:	18 May 2022
Auditors:	Simon Cookson, Director of Audit and Assurance Osian Lloyd, Deputy Head of Internal Audit Martyn Lewis, IT Audit Manager Sian Harries, IM&T Audit Manager
Executive sign-off:	Andy Haywood, Director of Digital
Distribution:	Aled Williams, Head of ICT James Rowland, Senior ICT Security Specialist
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

Review arrangements in place for the implementation of the NIS Directive in the Trust, including the Cyber Assessment Framework (CAF), improvement plan and overarching governance.

Overview

An appropriate process was in place to complete the CAF which accurately reflects the Trust's cyber security position.

The matters requiring management attention include:

- No retention of supporting information provided to the Cyber Resilience Unit as part of the self-assessment process.
- Improvement action plan has not yet been developed.
- Insufficient oversight of cyber security matters by appropriate governance committees.

Report Classification

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

Assurance summary[1]

Assurance objectives		Assurance
1	CAF completion and maintenance of evidence	Reasonable
2	Accurate self-assessed position supported by evidence	Substantial
3	Improvement plan implementation	Reasonable
4	Governance	Reasonable

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

Key Matters Arising		Assurance Objective	Control Design or Operation	Recommendation Priority
1	Supporting information retention	1	Operation	Medium
2	Improvement action plan	3	Design	Medium
3	Cyber security reporting	4	Operation	Medium

1. Introduction

1.1 Cyber security and resilience is the protection of computer systems and networks from the theft of or damage to their hardware, software, or electronic data, as well as from the disruption or misdirection of the services they provide.

A core piece of legislation relating to cyber security are the Network and Information Systems Regulations of 2018 (NIS Regulations), transposed into UK law in May 2018 from the EU Security of Networks & Information Systems (NIS) Directive, with the intention to raise levels of cyber security and resilience of key systems across the EU.

At the core of this piece of legislation is the aim to drive improvement in the protection of the network and information systems which are critical for the delivery of digital services and essential services in the UK. These regulations require bodies to have processes in place to protect themselves from attack, detect potential intrusions and react appropriately when intrusions occur.

Although cyber security is not a devolved matter, Welsh Government (WG) is the competent authority for the NIS in the case of essential health services in Wales.

Within NHS Wales, Digital Health and Care Wales (DHCW) takes a leading and coordinating role for the maintenance and improvement of cyber security on behalf of WG and is responsible for establishing the compliance framework for operators of essential services, which includes defining the scope of the regulations, reporting thresholds, and processes for reporting and dealing with cyber incidents. The Individual Trusts and Health Boards which fall within scope must adopt and comply with these arrangements.

1.2 The potential risks considered in the review are as follows:

- poor or non-existent stewardship in relation to cyber security;
- failure to comply with regulations; and
- loss of data or services and inappropriate access to information.

1.3 We note that the purpose of the audit is to provide assurance on the processes within the Welsh Ambulance Services NHS Trust ('the Trust') for assessing its current position in relation to cyber security and developing an improvement plan that will address the key identified weaknesses. This report does not assess the current state of cyber security within the organisation and this function is the responsibility of the Cyber Resilience Unit (CRU) within DHCW.

2. Detailed Audit Findings

Objective 1: a process exists for completion of the self-assessment and maintenance of appropriate evidence.

2.1 As part of the initial process, the Director of Digital, Head of Information and Communications Technology (ICT) and Senior ICT Security Specialist engaged with the CRU through a series of Microsoft Teams workshops. Following this, the Head of ICT gave a presentation to the Trust's Health Information Forum to appraise members of the NIS regulations and expected requirements.

2.2 Under direction from the CRU, one critical system was to be chosen to complete the Cyber Assessment Framework (CAF). As an Operator of Essential Services (OES), the Trust has a limited number of critical systems, therefore, undertaking the self-assessment against the Computer Aided Dispatch (CAD) system was unanimously decided upon.

2.3 We were informed by the Senior ICT Security Specialist that information to support each CAF objective was provided through discussions with the CRU via Microsoft Teams calls. The CRU did not specifically request evidence in the form of documentation as part of the assessment. However, we noted that records of the discussions and information provided have not been retained. As the self-assessment will be repeated annually, the lack of recorded information and clarifications sought from the CRU may hinder the timeliness and efficiency of future iterations. **See Matter Arising 1 at Appendix A.**

Conclusion:

2.4 Our review noted the work undertaken by the Trust's ICT team to prepare for and complete the self-assessment. However, records of discussions have not been appropriately retained for future iterations of the CAF. Consequently, we have concluded **Reasonable** assurance for this objective.

Objective 2: the self-assessed position is accurate and supported by evidence.

2.5 The CAF was completed by the Senior ICT Security Specialist with involvement from the Clinical Contact Centre Manager and Critical Systems Support Manager for technical input. Prior to submitting the CAF to the CRU, it was reviewed and signed-off by the Head of ICT.

2.6 Our review highlighted the completeness of the CAF with justifications included to support the scoring for each objective. We reviewed a sample of three objectives within the finalised CAF to ensure appropriate scoring:

- B3.b Data in Transit;
- B5.b Design for Resilience; and
- D2.b Using incidents to drive improvements.

Whilst we noted above that evidence was not retained as part of the self-assessment process, documentation was readily available to demonstrate that the

corresponding Trust statements and scoring were an accurate reflection of current position.

Conclusion:

2.7 Our review of the CAF found it to be complete with supporting justifications provided for each objective. We consider the self-assessed position to be accurate and whilst evidence was not retained as part of the process, it was provided to us during our review. Consequently, we have concluded **Substantial** assurance for this objective.

Objective 3: an improvement plan is in place to improve the cyber security position within the organisation, is being implemented appropriately and monitored.

2.8 In January 2017, Stratia Consulting undertook an external cyber security assessment within the Trust. As part of this, a NIS Directive readiness assessment was undertaken, which identified that further work was required to ensure compliance with the NIS Regulations. A summary report and improvement plan were published following the assessment, which the Trust's ICT team have been working on to enact in preparation for the NIS self-assessment.

2.9 We note that whilst a formal improvement action plan is not yet in place due to the Trust awaiting the CAF outcome from the CRU, work to identify improvement objectives has commenced and a full action plan will be developed shortly. **See Matter Arising 2 at Appendix A.**

2.10 Whilst no critical remedial work was identified when undertaking the self-assessment, the ICT team have progressed some of the areas highlighted where improvements could be made. For example, the Trust held an extensive scenario-based exercise with the Operations Directorate and business continuity leads to review and improve business continuity plans for digital infrastructure failure.

Conclusion:

2.11 Initial progress has been made to identify gaps in compliance and to improve the Trust's current cyber security position. Whilst the ICT team are awaiting feedback from the CRU prior to developing a full improvement plan, Welsh Government guidance states that Operators of Essential Services will need to propose appropriate measures for improvement, and it will be for the CRU and Welsh Ministers to determine their sufficiency. Consequently, we have concluded **Reasonable** assurance for this objective.

Objective 4: there is monitoring and reporting of the progress of the improvement plan and gaps in compliance to an appropriate governance group.

2.12 As noted above, whilst a formal improvement plan has not yet been developed, our review has highlighted the work undertaken to date to strengthen compliance gaps identified within the self-assessment. In our recent *Digital Governance* audit report, it was noted that oversight of the Digital agenda would be clarified. The Information Governance Steering Group (IGSG) has been recommenced as a

formal sub-committee of the Quality, Patient Experience and Safety Committee (QuEST). The terms of reference (TOR) for QuEST has recently been updated and approved, in which Information Governance and Information Security oversight has been strengthened. Paragraph 3.7(b) of the TOR specifically addresses adherence to the NIS Directive and states that the Committee will review progress of measures to improve information security.

2.13 Whilst there is now an identified governance route to report on cyber security matters, we noted that to date there has been limited narration. There are currently no metrics which track the status of cyber security and the efficiency in which issues or incidents are dealt with. We were informed that work to progress this matter is underway with intention to report monthly to the IT Senior Management Team and wider governance structure. **See Matter Arising 3 at Appendix A.**

2.14 A cyber security and data protection awareness session, led by the Trust's Director of Digital and joined by representatives from the National Cyber Security Centre, WG and the IT Director from Copeland Council, was held with the Trust Board in January 2022. Board members were appraised of the NIS Directive and given an overview of the effect of a ransomware attack experienced by Copeland Council to highlight the importance of cyber security. Board members also reviewed the risk of cyber-attacks and potential mitigations, and considered the elevation of the risk to the formal corporate register. We can confirm that the risk was rearticulated, approved by the Executive Management Team, and included within the Risk Management and Board Assurance Framework report presented to the Trust Board for approval on 24 March 2022.

Conclusion:

2.15 A cyber security and data protection awareness session was recently held with the Trust Board and progress has been made to emphasise its importance and its governance, including the escalation of the cyber security risk to the corporate risk register. Whilst there is now an identified governance route to report on cyber security matters, we noted that to date there has been limited updates provided to Board and its Committees. Consequently, we have concluded **Reasonable** assurance for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Supporting information retention (Operation)		Impact
Our review highlighted that records of discussions and supporting information provided to the CRU have not been captured and maintained throughout the self-assessment process.		Potential risk of: • poor or non-existent stewardship in relation to cyber security.
Recommendations		**Priority**
1.1 Management should ensure that for all future annual self-assessments, records of discussions and information provided to and from the CRU are captured.		Medium
Agreed Management Action	**Target Date**	**Responsible Officer**
1.1 The Trust will develop a central repository to hold supporting information in relation to the CAF and other associated IS standards along with associated procedures to ensure information is captured and its accuracy is maintained.	Dec 2022	Head of ICT

Matter Arising 2: Improvement plan (Design)		Impact
Whilst we were informed that a formal improvement action plan is not yet in place due to the Trust awaiting the outcome of the CAF, Welsh Government guidance states that Operators of Essential Services will need to propose appropriate measures for improvement.		Potential risk of: • poor or non-existent stewardship in relation to cyber security; and • failure to ensure that structures are developed to enable compliance with regulations.
Recommendations		**Priority**
2.1 Management should ensure that an improvement action plan is developed promptly in order to avoid delays in implementation.		Medium
Agreed Management Action	**Target Date**	**Responsible Officer**
2.1 Since the audit the Senior ICT Security Specialist has produced a draft CAF improvement plan. This is under review along with associated planning activities such as identifying the budgetary requirements required.	Sep 2022	Head of ICT

Matter Arising 3: Cyber security reporting (Operation)	Impact
3.1 Whilst there is an identified governance route to report on cyber security matters, we noted that to date there has been limited updates provided to Board and its Committees. There are currently no metrics which track the status of cyber security and the efficiency in which issues or incidents are dealt with.	Potential risk of: • poor or non-existent stewardship in relation to cyber security; and • failure to ensure that structures are developed to enable compliance with regulations.

Recommendations	Priority
3.1 Management should ensure that cyber security metrics are developed and reporting arrangements are strengthened to assure statutory committees and the Trust Board of improvements to information security arrangements and compliance with NIS Regulations.	Medium

Agreed Management Action	Target Date	Responsible Officer
3.1 The Senior ICT Security Specialist is currently developing a cyber dashboard to aid reporting on IS & Cyber issues. This will form part of the future structured reporting of IS via IGSG into the Trust QUEST committee (target meeting 09.02.2023).	Dec 2022	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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Respiratory Protective Equipment
Final Internal Audit Report

May 2022

Welsh Ambulance Services NHS Trust

GIG CYMRU NHS WALES
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Shared Services Partnership
Audit and Assurance Services

GIG CYMRU NHS WALES
Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru
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Contents

Review reference:	WAST-2122-021
Report status:	Final
Fieldwork commencement:	27th January 2022
Fieldwork completion:	6th April 2022
Draft report issued:	20th April 2022
Debrief meeting:	4th May 2022
Management response received:	3rd May 2022/20th May 2022
Final report issued:	23rd May 2022
Auditors:	Simon Cookson, Director of Audit & Assurance Osian Lloyd, Deputy Head of Internal Audit Jonathan Jones, Audit Manager
Executive sign-off:	Wendy Herbert, Interim Director of Nursing & Quality
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Committee:	Audit Committee

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

Acknowledgement

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

Executive Summary

Purpose

To review that there are adequate arrangements in place for the provision of Respiratory Protective Equipment (RPE).

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- Gaps identified in local records for Fit test records and device maintenance logs.
- Consideration needed to development of a sustainable Fit testing model.
- Amendments to SOP to incorporate monitoring (RPE) and Continuous Personal Development (Fit testing) requirements.

Report Classification

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

Assurance summary[1]

Assurance objectives		Assurance
1	Policies and procedures	Reasonable
2	Executive and operational responsibilities	Reasonable
3	Training and QA resourcing	Reasonable
4	Compliance with policies and procedures	Limited
5	Reporting arrangements	Limited

Key matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
1	RPE Monitoring arrangements	1	Design	Medium
2	Fit tester Continuous Personal Development	2	Design	Medium
3	Quality Assurance Outcomes	3	Operation	Medium
4	Resource to address Fit testing	3, 5	Design	Medium
5	RPE Maintenance Logs & Fit test Records	4	Design	High
6	RPE Reporting	5	Design	Medium

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

1. Introduction

1.1 The Health and Safety at Work Act 1974 requires employers to prevent or control the exposure of employees to hazardous substances at work. As a result of the Covid-19 pandemic demand for Respiratory Protective Equipment (RPE) and required training increased substantially.

1.2 RPE can come in many forms, including FFP3 disposable masks to powered full/half hoods. The effectiveness of face fitting masks is dependent on ensuring good contact between the wearer and the face seal of the equipment. There can also be variations in fit across the various manufactures and models available.

1.3 Health and Safety Executive (HSE) guidance *INDG479 Guidance on respiratory protective equipment fit testing* states that RPE should be subject to a Fit test and that this should be undertaken by a competent tester.

1.4 In July 2020 the Trust identified a risk (ID322) relating to a lack of compliance in terms of the provision of competent registered Fit testers within the Trust, noting weak management and governance in relation to RPE testing and training across the organisation.

1.5 A Programme of Improvement work was initiated under the Head of Infection Prevention and Control (IPC). This captured a number of actions including external British Safety Industry Federation accreditation for a small number of Fit testers within the IPC team.

1.6 The September 2021 meeting of the Trust's Quality, Patient Experience and Safety (QUEST) committee received an update indicating progress with the improvement plan and that further consideration of the longer-term strategic approach to Fit testing was underway.

1.7 The key risk considered in this review is a lack of compliance with statutory regulations leading to staff harm and associated financial and reputational implications.

1.8 The audit excluded review of RPE stock ordering or distribution processes.

2. Detailed Audit Findings

Audit objective 1: The Trust has approved policies and procedures related to Respiratory Protective Equipment and these are available to staff.

2.1 Fit testing within the Trust over the last twelve months has been required on an extensive basis due to the pandemic; this has been exacerbated by the frequent changes in RPE available through supply chains, resulting in provision of multiple models and new equipment requiring additional fit tests.

2.2 There are four key Trust documents which relate to Respiratory Protective Equipment. These include the *Infection Prevention & Control Policy: Elimination of Healthcare Associated Infections*, *Covid-19 Guidance – Infection Protection &*

Control (IPC) & Personal Protective Equipment (PPE) guidance document, *Respiratory Protective Equipment Standard Operating Procedure*, and *Fit Testing Standard Operating Procedure*.

2.3 The latest version of the Trust IPC policy is version 1.4 and was issued in September 2020. Within the policy, section 6.5 '*Personal Protective Equipment*' includes a number of headline instructions on the use of RPE, including that staff should only use masks for which they have been fit tested and should undertake a fit check ahead of each use. Further direction is noted through the listing of the RPE SOP under the heading '*To be read in conjunction with'* of related policies and procedures.

2.4 To support the overarching IPC Policy the Trust also has a specific *Covid-19 IPC/PPE Guidance* document which reflects nationally issued guidance. It contains IPC control measures for health and social care organisations based upon the current pandemic threat level and contains a hyperlink to the current RPE SOP.

2.5 Version 2.3 of the RPE SOP was approved by the Senior Pandemic Team (SPT) on 4th November 2021. The document seeks to provide clarity of terminology, risks and agreed principles when selecting appropriate RPE. The SOP states that '*All staff will be FFP3 Fit tested by competent fit testers following the standards as set out by the Health & Safety Executive (HSE),'* and the HSE definition of competency is also included as is reference to the Trust's Fit Testing SOP. Section 8 includes information related to each type of mask available/in use within the Trust, covering background and reference to the Trust PPE level, cleaning and decontamination/filter guidance where applicable, including links to training videos. The SOP includes 10 appendices which support these areas through inclusion of picture guides/instructions/charts, documentation to be retained to support use, and a list of high consequence infectious diseases where use of RPE would be appropriate.

2.6 Earlier versions of the RPE SOP had included within in it guidance on the Fit testing process. However, for practicality and ease of use, a dedicated Fit Testing SOP has been introduced. The current version 1.4 was approved by SPT on 26th April 2021. It contains further details on the HSE competent person definition, noting they should be appropriately trained, qualified and experienced in either quantitative (use of a portacount machine) or qualitative (subjective assessment of sweet/bitter aerosol). The SOP provides detailed guidance across the mask types available to staff within the Trust and direction to appendices which contain staff records and maintenance documentation alongside training materials.

2.7 HSE Operational Circular 282/28 *'Fit Testing of Respiratory Equipment Facepieces'* provides advice and guidance related to the suitability of Fit testing methods and results, including inspection. We compared this guidance against the Trust SOP and found the Trust has established documentation which is consistent with the guidance. We note the circular states that inspectors should check that the *'fit test is valid and does relate to the correct RPE and the wearer. Checks should be carried out to establish the authenticity of the fit test certificate'*. The Trust's RPE

SOP includes a section on monitoring arrangements, but these are limited to the overall number of staff tested/trained. **See MA1**

2.8 All guidance and SOP documents are available within the IPC section of the Trust's intranet site. However, the IPC Policy listed is the previous version (1.3), which does not contain a link to the RPE SOP. This is raised for management information.

Conclusion:

2.9 The Trust has established policies and procedures to support the selection, Fit testing and use of RPE. We have highlighted one area where additional clarity of future monitoring would be beneficial and assign this objective **Reasonable** assurance.

Audit objective 2: Executive and operational responsibilities are clearly defined ensuring accountability.

2.10 We note a high level of consistency of content across both documents in outlining Executive responsibilities. The Executive Director of Nursing & Quality has delegated responsibility for IPC, and as such the directorate is responsible for the provision and content of training. We note a small enhancement within the Fit Testing SOP that this training be provided by 'competent' trained staff.

2.11 Operational management has responsibility for identifying those staff who will need RPE, and for ensuring training records are retained and entered on ESR. We note that Fit test provision is not explicitly outlined, but is arranged by local management. Responsibility for selection or nomination of staff to undertake Fit testing is not outlined within the SOP, but we understand this is at local management discretion, we later discuss the model for delivery at 2.24-30.

2.12 Individual members of staff are responsible for undertaking training and, following issue of a device, to maintain, clean and store their equipment. Staff should also inform their manager of any facial changes which would require a re-test. The need to undertake a self-fit check and to check their device prior to use is also outlined.

2.13 Continued Personal Development (CPD) requirements are outlined within the RPE SOP. The Trust has adopted a three-year period for staff to be retested, which is to be managed by operational teams. We note that the Fit Testing SOP refers to re-testing every three years, but not to any specific competency related requirements for Fit testers, although discussion with the IPC team indicate an annual review will be undertaken. **See MA2**

2.14 We note that monitoring and reporting arrangements outlined within the SOPs are limited. Within the RPE SOP it includes reporting training compliance, through the Trust's Quarterly Assurance Report. There is no reference to ongoing performance or quality measurement. This is also the case for the Fit Testing SOP, which also does not set out any future CPD requirements for Fit testers. **See MA2**

2.15 Discussion with IPC team members indicated that updates to SOP and associated documentation/templates have been communicated through 'Siren' announcements; a review of the Trust intranet confirms this has been the case.

Conclusion:

2.16 Our review of the relevant SOP notes that there is an outline of responsibilities and accountabilities. However, we did identify a gap related to the review and CPD requirements of the Fit Testing SOP. Noting this we assign this objective **Reasonable** assurance.

Audit objective 3: Training requirements and quality assurance mechanisms are resourced appropriately.

2.17 Fit testing has historically been provided on a 'train the trainer' model within the Trust, and those providing Fit tests do so alongside their substantive duties or whilst on alternative duties for a relatively short period of up to 12-16 weeks. This provides a challenge in maintaining practice and standards and alone this would not meet the HSE definition of competent. There was also no follow up review of those who were providing tests and so little assurance that standards had been maintained.

2.18 Within the RPE SOP it is outlined that "*All staff will be FFP3 Fit tested by competent fit testers following the standards as set out by the Health & Safety Executive (HSE)*." HSE guidance notes that competence can be demonstrated through achieving accreditation under the Fit2Fit RPE scheme developed by the British Safety Industry Federation (BSIF). Two members of the IPC team have gained this accreditation and are responsible for ensuring that training material and processes within the Trust meet accredited standards.

2.19 The IPC team has produced training materials/action cards which address the three mask types currently in use (FFP3 Disposable, Corpro Half Mask, Versaflo Powered Hood), and the two Fit testing methods (qualitative and quantitative). These provide guidance across selection, donning, doffing, device maintenance/cleaning and documentary requirements. These are available through the Microsoft Teams channel established for Trust Fit testers, which also contains supporting record keeping forms.

2.20 The team has developed matching quality assurance (QA) action cards when reviewing the competence of Fit testers and there is evidence of refinement and enhancement in response to the identification of good practice. Timings for each competency have been shared but there are a number of factors which can impact the length of a review, particularly where refresher training is needed by the Fit tester.

2.21 Information was sourced from ESR in early 2021 to support the establishment of a quality assurance programme for review of active Fit testers. Discussion with the team outlined that there were difficulties encountered due to input errors where those Fit tested were entered as Fit testers. Additionally, ESR included

those who were Fit tested whilst on alternative duties but had now returned to substantive roles. Contact was also made with Locality Managers directly to confirm those undertaking Fit testing currently, although few direct responses were received.

2.22 The team now maintains an email distribution list of active Fit testers based upon the responses from Locality Managers and the those who have been initially trained by the team. A spreadsheet record of Fit testers who have received a quality assurance review has also been populated and maintained. An early opportunity to assess operational Fit testing had taken place in May 2021. However, the majority of assessments were undertaken during November and December 2021, following the team gaining its accreditation. At the time of our fieldwork, the team's spreadsheet held 52 Fit testers, of which 44 have been undertaken since accreditation.

2.23 We note that progress in the roll out of the programme was impacted by the need to support the Fit test of around 300 military staff deployed to support the Trust in January 2022. We were also informed that the release of operational staff during the recent REAP escalation had also been a challenge, alongside making arrangements to cover the organisation as the two accredited members are based in North Wales and Pembrokeshire. The complexities of the Fit testing process can also mean the team continues to support those who have been quality assured for some time, where further support has been requested by the Fit tester.

2.24 Discussion with the team also highlighted that they have modified initial practice from group QA to individual review, having noted group sessions negatively impacted response and practical assessment. The team also noted that where staff had not undertaken Fit testing for some time there was a deficiency of practice and, despite training materials being circulated ahead of assessment, gaps in knowledge.

2.25 The turnover of staff providing Fit testing provision is high as they usually no longer perform testing once they return to their normal duties; thus, their skills competency in fit testing diminishes. Discussion with the IPC team highlighted a number of instances of 'skill fade' where additional refresher training has been required to support a Fit Testers QA review. The team have also asked Fit testers to refrain from undertaking the role where concerns over practice and approach have been identified.

2.26 We sampled five records from the team's local spreadsheet and completed QA assessments could be provided for four. One assessment was record on a training action card as opposed to a QA form. All records were signed by a Fit tester and IPC team member. The forms contain prompts for the capture of the number of tests/retests and pass mark, but we note only an overall pass was captured. Forms did contain narrative outline of areas that require addressing, but we note the spreadsheet in use does not include this detail. **See MA3**

2.27 ESR now includes competencies for those Fit testers who have been assessed by the IPC team. Whilst not all of those within the team's spreadsheet have been

added, we note that review of the ESR report did not identify any entries not on the spreadsheet.

2.28 We were informed there will be a requirement for the team to provide an annual assessment of those Fit testers that have been reviewed previously. As there are still around 50+ Fit testers who are yet to be assessed, and the team continues to provide support for standard fit test training, it is unclear if there are adequate resources currently available to fulfil the SOP objective that all Fit testers meet the competency requirement. At the time of our fieldwork there was a focus on supporting the South East territory, but that requests received were for training fit testers in that region rather than for the QA of testers. **See MA4**

2.29 There have been discussions on future models for the provision of competent Fit testers within the Trust, necessary to provide safe respiratory protection for staff. An options paper developed for SPT recognised Fit testers need to be the experts within this field, having a broad and deep competence in terms of knowledge, skill and experience, through practice and education. It also highlighted the challenges to attain this with the Trust's current model which is not sustainable as it does not provide resilience in this provision.

2.30 The options paper estimated a requirement of 7,000 hours of fit testing across a 3-year schedule, on the basis that there are 3,000 patient facing staff within the Trust and 500 Community First Responders. We were informed that a decision had not been progressed and at the time of our fieldwork a further options paper was under consideration but that it was unlikely that additional funding would feature to support arrangements. **See MA4**

Conclusion:

2.31 Following IPC accreditation there has been development of training materials and a quality assurance programme to support the Trust approach to Fit Testing and the HSE competency definition. The current model makes the ongoing delivery of the programme difficult, but noting the progress in this area we assign the objective **reasonable assurance**.

Audit objective 4: Mechanisms are in place to capture compliance with Trust policies and procedures.

2.32 Objectives within the RPE SOP include clarity on terminology, the level of RPE that should be applied and provides guidance to staff for the decontamination and maintenance of reusable RPE. The SOP contains links to both manufacturer and Trust training videos on assembling and cleaning devices.

2.33 ESR reports are available to support the monitoring of Emergency Medical Services (EMS) and Non-Emergency Patient Transport Services (NEPTS) staff tested. Reports produced at the end of January 2022 indicated high levels of compliance across the Trust, with EMS reporting 94.65% and NEPTS 88.69%.

2.34 Whilst the QA programme provides a mechanism for the review of Fit testers, there is currently no routine check of standard Fit test documentation. Within

recent updates to the SOP there has been the inclusion of template maintenance logs to demonstrate devices are being used in accordance with manufacturers' guidance.

2.35 HSE guidance (Respiratory protective equipment at work – HSG53) notes that maintenance is a requirement for all reusable RPE and where use is occasional examination and testing of equipment should be carried out at least every three months. Additionally, the guidance includes a number of key points such as the need to follow manufacturers' instructions, keep records of examination and testing, and ensure maintenance intervals are appropriate.

2.36 Within recent updates to the RPE SOP there has been the inclusion of template maintenance logs to demonstrate devices are being used in accordance with manufacturers' guidance. We note use of Siren in April 2021 to issue a notice from the Director of Operations reminding staff of the need to check equipment prior to each use, follow the guidance within the RPE SOP and undertake and document maintenance checks on the provided templates.

2.37 Using ESR as a source record, we requested Fit test records and associated maintenance logs for five staff across four separate localities. Noting current operational pressures we undertook a limited sample.

2.38 We received 13 of the 20 requested records. Of those that were not provided:

- Three Fit tests not retained within locality records;
- Two records not were available (but alternative dates/devices could be provided);
- one was noted as no record of staff member within the locality records; and
- one staff transfer with record outstanding at time of closing fieldwork.

2.39 Review of the Fit test records provided highlighted three did not contain details of the device (batch number) of the issued Corpro device (linkage between record and device is a HSE requirement), whilst another six contained gaps in completeness regarding any re-tests which were required. **See MA5**

2.40 Only four of the 20 maintenance logs requested were provided. Of these, one log was blank and the remaining three contained only one entry covering filter use. No entries were supplied to support monthly equipment checks, suggesting that use of the log may not be embedded in everyday practice. Responses received indicated that staff were not aware of the requirement to log usage. HSE guidance notes that records of equipment maintenance in line with manufacturer's instructions should be retained. **See MA5**

2.41 The IPC team presentation to the Strategic IPC group in January 2022 highlighted that there is awareness that maintenance logs are not being used consistently across the Trust. Discussion with the team outlined that electronic records and logs have been developed to support operational use, but these are still in development. **See MA5**

Conclusion:

2.42 The Trust has high overall compliance for staff Fit testing, and our request of records supports that there is some compliance with Fit test record keeping. However, maintenance logs for devices and filters were not available for 16/20 staff. The IPC team are developing electronic recording options to support this but these are not currently rolled out and so we assign this objective **limited** assurance.

Audit objective 5: The Board receives assurance on compliance, with appropriate escalation mechanisms in place.

2.43 Discussion with the Head of IPC indicated that the Strategic IPC Group would be the forum which received reporting related to RPE. The group had primarily been stood down as a result of the operational pressures brought on due to the Covid-19 pandemic but has met in May 2021 and January 2022. We note both these meetings received updates related to the Fit testing programme but did not provide information relating to overall compliance or performance. **See MA6**

2.44 The Strategic IPC group has revised terms of reference which include that highlight reports from the group would be provided to the Clinical Quality Governance Group, which in turn will report to the QUEST committee. At the time of fieldwork, no Clinical Quality Governance Group meetings had taken place, however we note an IPC Highlight report was provided to the Assistant Directors Leadership Group in February 2022. The report listed RPE under the alert/escalate category, noting the impact of supporting military personnel with Fit testing and general issues around access to operational Fit testers. As with the information to the Strategic IPC group, there was no detail on overall compliance/performance included. **See MA6**

2.45 The Head of IPC raised a risk due to the lack of compliance with Health and Safety regulations relating to competent Fit testers (ID322) in July 2020. The risk was initially rated at 15, but following the improvement programme including accreditation, review of documentation and the start of the QA programme the risk was closed due to meeting its target score in December 2021. Discussion with the Head of IPC indicated that there is consideration of including a new risk related to the long term provision and resourcing of Fit testing, but at the time of fieldwork this risk had not been added to Datix.

2.46 We note that longer term provision of Fit testing was outlined within an 'Options' paper provided to the Senior Pandemic Team and a number of models were outlined to support the longer term strategic approach to delivery. We have not identified any further progress in this area, and whilst we could confirm Fit testing has been included within the Trust's Working Safely Programme, no detail on next steps was available at the time of our fieldwork. **See MA4**

2.47 A report provided to QUEST Committee in September 2021 had included the risk assessment, alongside copies of the SOPs, training and documentary materials. The report was welcomed by the Committee, with members noting it demonstrated the Trust's emphasis on protecting both staff and the public.

Conclusion:

2.48 There have been updates provided to the Strategic IPC group and QUEST committee relating to the improvement programme, and there is a clear line of reporting available for escalation should it be required. However, we note that reporting has focused on programme improvements, but is yet to be followed by information related to ongoing performance. As such we assign this objective **limited** assurance.

Appendix A: Management Action Plan

Matter arising 1: RPE monitoring arrangements (Design)	Impact
The Health and Safety Executive has issued an operational circular to support the Fit testing of Respiratory Protective Equipment Facepieces (OC 282/28). We note paragraph 10 (3) outlines that HSE inspections would include checks to confirm that the Fit test certificate is valid, relates to the RPE issued, and that the device is clean and well maintained. The Trust RPE SOP includes an outline of monitoring arrangements, which include the results of Fit testing being recorded via the Electronic Staff Record and compliance levels to be reported. However, it does not include requirements for checks to be undertaken following the Fit test or mechanisms for ongoing review of Fit test records or device maintenance.	Potential risk of: • Insufficient monitoring arrangements.

Recommendations	Priority
1.1 Consideration should be given to establishing future monitoring arrangements related to RPE/Fit testing, to provide a mechanism for ongoing assurance on RPE issued and its maintenance.	**Medium**

Management response	Target Date	Responsible Officer
1.1 The RPE SOP (page 13) includes narrative on audit requirements of RPE. The RPE SOP will be reviewed to incorporate quality inspections to be undertaken by members of the IPC Team; this will be scheduled within the IPC Audit Work Programme.	June 2022	Louise Colson, Head of Infection Prevention & Control

Matter arising 2: Fit Testing CPD (Design)	Impact
The RPE SOP includes that repeat Fit testing for staff is recommended on a 3 yearly basis, and this should be managed operationally through continued personal development. The Fit Testing SOP does not include an equivalent outline of how frequently Fit testers should receive a follow up review or assessment. Discussion with the IPC team indicated that this would likely be on an annual basis. We also note that whilst there is an outline of summary monitoring and reporting routes within the RPE SOP, no performance or quality measurements for Fit testing, or further reporting is included within the SOP.	Potential risk of: • CPD requirements not documented.

Recommendations	Priority
2.1 Ongoing CPD requirements for Fit testers should be confirmed and reflected within the Fit Testing SOP. 2.2 Management should consider developing relevant performance or quality measurements related to the provision of Fit testing, and document appropriate reporting measures for these within the SOP.	**Medium**

Management response	Target Date	Responsible Officer
2.1 The Fit Testing SOP will be reviewed and amended to outline the refresher/update requirements of Fit Testers, including the frequency of such activities.	June 2022	Louise Colson, Head of Infection Prevention & Control
2.2 As part of pandemic recovery, the IPC team will establish arrangements for business as usual performance measures. A Fit Testing/RPE quality performance framework will be developed; a reference will be incorporated into the Fit Testing SOP. Due to the nature of the proposed information system, the target date from completion is September 2022.	September 2022	Louise Colson, Head of Infection Prevention & Control

Matter arising 3: Quality Assurance outcomes (Operation)	Impact
We note that comprehensive quality assurance action cards have been created to support the review of Fit testers. The format of these include an outline of areas repeated or where improvement/retesting was required. Currently the spreadsheet in use to support the quality assurance process captures limited details on the assessment, such as date of review and a 'notes' column which has inconsistent usage. Modification to include outcomes could support future reporting across themes or areas of inconsistent practice.	Potential risk of: • Detail on outcomes and themes not captured formally.

Recommendations	Priority
3.1 The IPC team monitoring spreadsheet should be modified to capture outcomes and include any areas of repeat inconsistent practice.	**Medium**

Management response	Target Date	Responsible Officer
3.1 The recommendation is accepted. The Quality Assurance Tool will be redesigned utilising a new information system, ensuring IPC staff undertaking inspection/checks enter required information. Additionally, this will improve consistency for report.	June 2022	Louise Colson, Head of Infection Prevention & Control

Matter arising 4: Resource to address Fit Testing (Design)	Impact
Challenges to the current and future delivery of quality assuring all Fit testers within the Trust are complicated by the current model, which can include staff on temporary alternative duties or is undertaken voluntarily which can result in the tester withdrawing from practice at any time. The quality assurance programme has reviewed around half of the testers, however progress in this area is impacted by the cycle of changes in Fit testers and the team providing operational support to train new testers. A paper prepared for the Senior Pandemic Team in 2021 estimated that over a three year period up to 7000 hours of Fit testing would be required to comply with HSE legislation. The paper outlined possible options including: • Retain current model with risk that compliance would not be achieved • Establish a dedicated Fit test team • Incorporation of Fit testing into the Workforce and OD welfare team • Incorporation into the Duty Office Manager portfolio • Incorporation into the Resilience team as part of the Make Ready Establishment. No update could be provided on the outcome from the above paper, and at the time of fieldwork arrangements were again subject to review.	Potential risk of: • Detail on outcomes and themes not captured formally.

Recommendations	Priority
4.1 We recommend the Trust refreshes the above paper in light of the challenges in meeting the requirement to quality assure all Fit testers under its current model. 4.2 Recognising the challenges in delivery of the quality assurance programme due to operational pressures, we recommend that the programme be recommenced with progress updates provided to the Strategic IPC group on a regular basis.	**Medium**

Management response	Target Date	Responsible Officer
4.1 A report will be provided to the Clinical & Quality Governance Group on the output of the Quality Assurance programme recently undertaken. Furthermore, it will outline proposal for the emerging risk of sustainable fit testing across the Trust. A cross-directorate position on a sustainable Fit Testing model will be developed.	September 2022	Louise Colson, Head of Infection Prevention & Control

4.2	A regular update on the quality assurance programme will be provided to IPC Strategic Group on a routine basis. This will commence from the next diarised Strategic Group meeting in October 2022.	October 2022	Jonathan Turnbull-Ross, Assistant Director of Quality Governance

Matter arising 5: RPE Maintenance Logs & Fit testing records (Design)	Impact
HSE guidance requires that reusable RPE receive regular examination and testing, and that this should be recorded and undertaken at regular intervals. The RPE SOP includes a *decontamination, filter and maintenance log.* The document supports recording of: • Filter usage and rest time. • Monthly maintenance to filter, facepiece, straps and other equipment aspects. • Decontamination and sanitising log. As part of our fieldwork we requested the above documentation for 20 EMS staff based across four localities. Only four filter logs were provided, and of these one was blank and the remaining logs held only one entry each. No monthly maintenance record or decontamination log were supplied. The IPC team are developing electronic resources to replace the paper documents to assist with ongoing recording, but these were still to be issued at time of fieldwork. Additionally, we requested related Fit test records for the staff above, with only 13 records available to support entries made within ESR. Noting the Trust's current high compliance reported for EMS and NEPTS staff this could indicate wider noncompliance with Trust SOPs or gaps in record keeping.	Potential risk of: • Noncompliance with recording of maintenance and decontamination logs • Noncompliance with record keeping requirements/SOP

Recommendations	Priority
5.1 The Trust should progress with the development of electronic resources to support the recording of RPE maintenance and decontamination and prioritise the distribution of these alongside guidance for use. 5.2 The Trust should consider mechanisms to monitor and provide assurance on compliance with the documentary requirements of the RPE and Fit Testing SOPs.	**High**

Management response	Target Date	Responsible Officer
5.1 The Trust will finalise development of the digital maintenance log, and issue its release for use to the workforce. The distribution of information to the workforce will be undertaken through the Operations Directorate leadership structures.	May 2022	Louise Colson, Head of Infection Prevention & Control / Judith Bryce, Assistant Director of Operations National Operations & Support

5.2	The RPE SOP and Fit Testing SOP will be reviewed to incorporate arrangements for the formal monitoring of compliance. This will be considered by the Operations Directorate leadership structures, and through the Clinical & Quality Governance Group, which will sit in June 2022.	June 2022	Louise Colson, Head of Infection Prevention & Control / Judith Bryce, Assistant Director of Operations National Operations & Support

Matter arising 6: RPE Reporting (Operation)	Impact
The Strategic IPC Group has been stood down as a result of the operational pressures of the Covid-19 pandemic, although two meetings have taken place in May 2021 and January 2022. Agendas confirm that meetings received updates against the Fit testing Programme, but we note these provided outlines of progress in action rather than metrics on performance.	Potential risk of: • Lack of scrutiny on delivery and progress

Recommendations	Priority
6.1 There is a need to further outline the performance or quality outcomes for RPE and Fit testing and we would note there is opportunity to establish areas for monitoring to allow for any necessary escalation through the Trust's structure as appropriate.	**Medium**

Management response	Target Date	Responsible Officer
6.1 A routine agenda item on performance metrics will be added to the IPC Strategic Group Meeting agenda; from the next diarised meeting (October 2022). Management response action 2.2 and 5.2 will support delivery of data reporting.	October 2022	Jonathan Turnbull-Ross, Assistant Director of Quality Governance

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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Service Reconfiguration
Final Internal Audit Report

May 2022

Welsh Ambulance Services NHS Trust

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

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

Contents

Review reference:	WAST-2122-008
Report status:	Final
Fieldwork commencement:	1st February 2022
Fieldwork completion:	22nd April 2022
Draft report issued:	28th April 2022
Debrief meeting:	27th April 2022
Management response received:	27th May 2022
Final report issued:	27th May 2022
Auditors:	Simon Cookson, Director of Audit & Assurance Osian Lloyd, Deputy Head of Internal Audit Chris Scott, Internal Audit Manager
Executive sign-off:	Rachel Marsh, Director of Strategy, Planning and Performance
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Committee:	Audit Committee

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

Acknowledgement

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

Executive Summary

Purpose

To provide assurance that the relationship between the Trust and Commissioner is effective in ensuring expected operational outcomes in its support of health board service changes.

Overview of findings

Key matters arising concerned:

- service specification document (not agreed until after the service commenced) extended at the first anniversary of the service delivery needs review and re-issue.
- limited evidenced inter-site transport service performance reporting within the Trust.
- absence of the new inter-site transport service from the Trust's CCC auditing and spot-check process.
- incomplete collaborative project group meeting documentation.

Report Classification

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

Assurance summary[1]

Assurance objectives		Assurance
1	Engagement with collaborative fora	Substantial
2	Modelling service change	Reasonable
3	Plan to deliver new service	Reasonable
4	Assessing the new service	Limited
5	Sub Committee/ Board oversight	Reasonable

Key matters arising

		Assurance Objective	Control Design or Operation	Recommendation Priority
1	Renewing the service specification document	2	Operation	Medium
2	Inter-site transport journey operational performance review	4	Design	Medium
3	Inter-site transport journey auditing and spot-check scrutiny process	4	Design	Medium
4	Collaborative GUH Project meeting documentation	5	Operation	Medium

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

1. Introduction

1.1 Through its commissioning intentions, the Emergency Ambulance Service Committee (EASC) set an expectation that the Welsh Ambulance Services NHS Trust ('the Trust' or 'WAST') should support health board system transformation to be responsive to the new emerging demands and patterns of service delivery.

1.2 The Trust supports a range of regional developments and other health board initiatives through its Integrated Strategic Planning Group. The Group has oversight of health board operational and strategic service changes to comprehend and coordinate implications on the Trust and to design and implement responses to support these plans.

1.3 During 2020, the Trust supported the implementation of the South Wales Major Trauma network in September 2020 and the early opening of the Grange University Hospital (GUH) in November 2020.

1.4 Emerging from the latter, the GUH inter-site transport service, live since the opening of the hospital, was the first of its kind in Wales and is providing learning for a potential all Wales model. The Trust has delivered this service from its inception and supported EASC in an evaluation of the service completed in October 2021.

1.5 The overall objective of the audit was to provide an assurance that the relationship between the Trust and Commissioner is effective in ensuring expected operational outcomes. The audit focussed on the sharing of information and engagement around the GUH inter-site transport service, an example of service change that included transport plans across both the Emergency Medical Service (EMS) and Non-Emergency Patient Transport Service (NEPTS).

1.6 The key risks considered in this review included:

a) patient harm as a result of insufficient planning arrangements;

b) lack of resource availability due to insufficient planning, resulting in increased financial costs; and

c) lack of awareness of revised operational arrangements and reputational damage as a result of services not operating as intended.

1.7 The impact of the early opening of the Grange University Hospital on the service reconfiguration example examined in the audit (GUH inter-site transport service) was taken into consideration in our assessment of the appropriateness of the arrangements in place.

2. Detailed Audit Findings

Audit objective 1: The Trust engaged with health boards in collaborative forums where service redesign was planned and developed.

2.1 We sought to establish that the Trust is responsive to the directions of commissioners and the changing needs of the health boards in respect of wider service changes arising from shifts in health care priorities and service delivery reconfiguration.

2.2 We noted the Trust engages with health boards and the Emergency Ambulance Services Committee (EASC) as well as community and patient groups (although the latter did not form part of the scope of this review) in a variety of consultative and collaborative fora, through which joint initiatives are identified, developed and delivered.

2.3 WAST and EASC communicate and work collaboratively with support from the National Collaborative Commissioning Unit (NCCU), which has the following vision: *'Leading quality assurance and improvement for NHS Wales through collaborative commissioning'*. The NCCU deliver work programmes on behalf of EASC, working collaboratively with clinicians, organisations and Welsh Government. The EASC annual plan for 2021/22 centres on transformational work programmes, which includes national transfer and discharge services.

2.4 Chaired by the Chief Ambulance Services Commissioner (CASC), the EASC Management Group (EASC MG) and NEPTS Delivery and Assurance Group (DAG) are the collaborative forums of EASC, health boards and WAST in which the joint initiatives emerge, are captured and managed (this area was included in the scope of our 2021/22 report titled 'Collaboration'). Meetings of these groups are nominally monthly and each submit highlight reports to the EASC committee meetings that take place every 2 months.

2.5 WAST monitors the service change programmes that they are involved with via the Integrated Strategic Planning Group (previously the Senior Planning Forum) to strengthen arrangements within the Trust. With the aid of a tracking tool, a high-level management record which we have not tested in detail in this audit, progress is reported to the Service Transformation Board (STB) which monitors the progress of the Trust's Integrated Medium Term Plan (IMTP) deliverables and regularly reports on their status to the Board.

2.6 We noted health boards are also being encouraged by WAST to provide more notice of service changes to enable them to better respond to these (fora set up with health boards, focussing on ABUHB in this review, to deliver service change initiatives are examined under subsequent audit objectives).

2.7 In addition to being captured in the EASC Annual Plan, we noted that service change and other joint initiatives are captured in the IMTPs of the respective organisations which are developed and shared in a collaborative manner.

Conclusion:

2.8 The Trust engages with health boards and EASC in a variety of collaborative fora through which joint initiatives are identified, developed and delivered. There are implications on WAST of short term reactive service changes by their partners and the Trust has taken steps to encourage health boards and others to recognise this and give early notice of change. We have noted the role of the Integrated Strategic Planning Group to strengthen arrangements to monitor service change programmes and consequently have provided **Substantial** assurance for this objective.

Audit objective 2: The Trust modelled new patient flows and assessed the impact of these on the service.

2.9 Service changes within NHS Wales frequently affect patient flows, creating impacts on WAST to which they must respond. There are a number of such service reconfiguration initiatives underway at any given time and we noted five in progress in the South-East region at the time of the audit.

2.10 For the purposes of the evaluation of the WAST response to service changes, the audit focussed on the inter-site transport requirements for the Grange University Hospital. This involved WAST providing both emergency and non-emergency transport for new patient flows between the acute GUH and its neighbouring re-designated lower acuity 'enhanced local general' and community hospitals. The service was commissioned by ABUHB and began in November 2020 on the earlier than planned opening of the GUH which posed a significant challenge (original opening date March 2021, early opening date of November 2020 signalled in WAST project documents and at the ABUHB Board meeting in June 2020).

2.11 We sought to establish that there was effective modelling of a range of possible service delivery options, that there had been appropriate scrutiny and challenge of the models put forward, and that an evaluation process had been undertaken that compared the impacts on current WAST services in South East Wales of the different configuration options.

2.12 Following detailed work by ABUHB clinicians using historical case data to determine the resources needed and costs of delivery, examination and modelling of four service configuration scenarios was carried out by an external consultant using estimates of volumes, mix of acuity, destinations, journey times, crews etc. All four scenarios evaluated involved the establishment of an ABUHB manned Flow Centre co-located with the WAST Clinical Contact Centre (CCC) at Vantage Point House (VPH) near Cwmbran, using a Transfer Triage Tool (software tool) to assess caller's needs. The scenarios were:

Scenario 1:	Fully ring-fenced tier of additional Emergency Ambulances, staffed by Paramedics
Scenario 2:	Absorb all additional workload within the existing EMS service (Optima preferred model)

Scenario 3:	Four-tiered pool of ring fenced resources. (ABUHB Hybrid Model)
Scenario 4:	Some activity undertaken by EMS, and remaining activity delivered by a two-tier pool of vehicles. (WAST Proposed Model)

2.13 Detailed evaluation of the scenarios was carried out by the WAST project team who then proposed and presented their recommended service model to ABUHB (scenario 4) who would be commissioning it (although we noted that the recommendation was not the option preferred by Optima who had conducted the scenario modelling).

2.14 We noted testing of the Transfer Triage Tool (TTT) and Flow Centre processes (both common to all four scenarios) took place prior to go-live where the use of these tools and processes were piloted. We saw action logs which captured and addressed the issues that arose, and we noted a number of amendments were made to systems and processes as a result of the pilot runs that were conducted.

2.15 We noted oversight of the governance of the project by decision making groups of WAST (including GUH Project Board, Senior Operations Team and Executive Management Team) and the ABUHB Board was evidenced in a decision log which recorded choices, options and judgements made across the project timeline. We noted the regular schedules of meetings were in some cases interrupted by the pandemic in 2020 but nevertheless, subsequent meeting records of key oversight groups (including EASC MG, WAST STB and the collaborative GUH Transport Group (NCCU, ABUHB, WAST) and its ABUHB Flow Centre groups) make later reference to the inter-hospital transport requirements for the GUH project and the choice of the model recommended to deliver the service. The GUH project group decision log captures regular involvement, engagement and approval from the Trust's Executive Management Team, which also received project highlight reports, often through e-mail confirmation from the Trust's Director of Strategy, Planning and Performance.

2.16 Formal acceptance by ABUHB of the service model that had been recommended was evidenced in a letter from the ABUHB CEO to the WAST CEO in July 2020 and in April 2021 the Chief Ambulance Service Commissioner (CASC) was informed of the commissioning and commencement of the service. The Heads of terms agreement was signed by ABUHB, WAST and EASC prior to the brought forward go live date. We noted recognition that it had taken some time to finalise and agree terms of the full commissioning agreement resulting from the early opening of the Grange and that the service specification set for the first 12 months of service delivery had expired in November 2021. We were advised this was extended for a period of 6 months (although we have not seen evidence of this) and is now in the process of review by the collaborative GUH inter-hospital transfer service forum, on conclusion of which it will be agreed and re-issued (see **Matter arising 1**).

Conclusion:

2.17 The project developed and tested a range of models for delivery of the service and selected a preferred option for implementation. We noted however, the service specification that formalises the commissioned service, and which had taken some time to finalise, is now due for review and re-issue and consequently have provided **Reasonable** assurance for this objective.

Audit objective 3: The Trust established an operational plan for the delivery of the proposed transfer and discharge arrangements.

2.18 We sought to establish how WAST planned the integration of the new transport service into its existing ambulance transport framework.

2.19 Project development and implementation was driven by a task level plan managed by the project team in a GANNT style format (although we did not examine these plans at the workstream level) and we saw that outstanding tasks for the delivery of the proposed new service were monitored in the project highlight reports as the go-live date approached.

2.20 We noted that the plan for the implementation and delivery of the inter-site transport service was being led by the collaborative GUH Transport Group in which staff of ABUHB, WAST and NCCU (chairing) were involved. Although we examined only example material rather than testing a formal audit sample of the documentation of the group, topics we noted being covered by the latter in their action plan were wide ranging but included arranging their co-location at Vantage Point House (VPH), staff consultation for operational site management at sites and development of standard Operating Procedure (SOP) documents.

2.21 We sought to establish the means by which WAST had incorporated the new GUH inter-site transport service into its operational planning and delivery framework.

2.22 For delivery of the inter-site transport service, dedicated resources were provided at levels determined through the service modelling work and confirmed in the commissioning agreement between WAST and ABUHB.

2.23 We noted there is a WAST SOP in place which describes the deployment of WAST commissioned resources to planned hospital transfers (inbound and outbound) between the GUH and enhanced Local General Hospital (eLGH) sites in ABUHB. Within this SOP, all planned transfers are directed through the ABUHB Flow Centre and any patients requiring Ambulance transport are booked via the Flow Desk based at VPH adjacent to the WAST CCC. The SOP has been approved by the CCC Technical Manager and Area Manager for EMS CCC and we were advised it also went through both the Project Team and the Senior Operations Team meetings for approval prior to go live. The SOP is to be included in the scope of a post-evaluation development group where it will be reviewed and amended if necessary. We also received separate ABUHB SOPs for step down patients (adults) and step up patients (adults) respectively, but noted that the copies provided were in draft.

Conclusion:

2.24 The Trust programmed additional dedicated ambulance and people resources into its operational plan to support the delivery of the new service. We have provided **Reasonable** assurance for this objective.

Audit objective 4: The Trust conducted assessment of the running of the reconfigured service, identifying and addressing any issues that emerged.

2.25 We sought to establish the means by which WAST had assessed the effectiveness of the transport model it had chosen and implemented and to what extent they had identified and addressed any issues that emerged from that assessment. The commissioned service was designed to facilitate 72 transfers (33 step up transfers & 39 step down transfers) per day, utilising both dedicated transfer resources and accessing a pool of emergency service ambulances.

2.26 As part of the service's commissioning arrangements, it was agreed an evaluation would be completed following the first 6 months of service delivery and we noted post implementation assessments were undertaken by both EASC and WAST in the middle of 2021.

2.27 We noted the EASC evaluation findings included the following matters:

- *the model in use matched that which had been recommended by WAST to ABUHB, albeit adapted to respond to the challenges of the Covid19 pandemic and the requirements of the population it served;*
- *the overall demand for the service was significantly less than expected because of these adaptations;*
- *the level of transfer ambulance resources were appropriate given that the service modelling was developed using higher demand profiles;*
- *performance measures had not been achieved due to the challenges experienced by ABUHB and WAST in responding to the requirements of the population during the Covid19 pandemic;*
- *the Transfer Triage Tool was supported as an effective and safe tool for the clinical triaging of patients requiring inter hospital transfer;*
- *a safe and high quality patient service had been delivered to date with minimal, if any, harm to patients reported;*
- *initial mechanical and build quality issues with the new transfer ambulances had been overcome;*
- *challenges remained with booking and communications systems which required improvements in order to make better use of the available resource, improve quality for patients and the performance of the service overall.*

The evaluation report, which was submitted to the WAST Finance and Performance committee in September 2021, went on to recommend a series of actions to address the issues that had been identified. These recommendations were handed over to the WAST Ambulance Care Programme Board.

2.28 In the Autumn of 2021, the WAST evaluation was set out in a formal closure report from the WAST GUH Project Board. This report detailed what had been

achieved by the new service in the first six months of its running. Overall, it concluded that a safe and good quality patient service had been delivered with minimal, if any harm to patients reported and this had been running in a steady operational state, but the following key issues were raised:

- flow, patterns of demand (high variability) and activity types impacting on performance;
- opportunities within WAST for further system improvements; and
- losing hours through handover delays, issues with discharge lounge.

2.29 The report also included sections on benefits achieved to date, the achievement of planned objectives and products / outputs, follow on actions (including those set out in EASC's independent evaluation) and lessons learnt. It set out the risks remaining open or pending closure without final project board closure decision and the recommended action in order to close down the risks and the project. We saw evidence that these matters had been handed over to operational business as usual, via the WAST Ambulance Care Programme Board as noted above, who were tasked with realising the benefits from the delivery of the project. We saw an action plan was put in place to address the recommendations, although we noted these remained open at the time of this audit.

2.30 The inter-site transport service is separately commissioned and therefore subject to external scrutiny and monitoring and this is delivered through a collaborative Tier group meeting structure involving EASC (chair), WAST and ABUHB who monitor service delivery against the service levels set in the commissioning agreement between ABUHB and WAST. The structure has 2 levels comprising an oversight level (Tier 2) and an operational level (Tier 3). We noted Tier group 2 meetings receive reports of ABUHB Flow Centre ambulance transport activity which cover a range of ambulance journey related metrics across EMS, NEPTS and EMRTS functions, with a set of outputs specifically covering the GUH inter-site transport activity.

2.31 We also identified volumes and values of these journeys, albeit at summary level, and within a very extensive information pack, in the Senior Operations Team weekly performance, demand and capacity slide decks. Through this they are included in the scope of the review of this oversight group but this we noted was restricted to the lost hours metric only. We were advised that analysis of transport metrics, including step up / step down volumes, one and four hour response statistics, that is seen by the Tier 2 group is operationally reviewed at the General Managers Performance meeting within NEPTS every week, although we note that these meetings have agendas but are not minuted so we were unable to review evidence of matters discussed (see **Matter Arising 2**). We were also unable to establish where, if anywhere, this same ambulance transport activity is included in the regular quality assurance auditing conducted by the WAST CCC (see **Matter Arising 3**). We understand that the inter-site transport activity is included within the scope of the Ambulance Care indicator in the MIQPR, although we did not see the inter-site transport being specifically referred to in recent indicator tables or accompanying narrative.

2.32 The GUH inter-site transport project was an element of the broader IMTP objective 'Engage with Aneurin Bevan UHB (ABUHB) on the implementation of the Clinical Futures Strategy & opening of The Grange University Hospital' included in the WAST IMTP operational delivery plan 2020-21 and as such its delivery status was regularly reported to the WAST Strategic Transformation Board. We noted that the IMTP Delivery Programme's Q2 Assurance Report to the Board in November 2021 recorded in the update of the Ambulance Care Transformation Programme that the evaluation of the Grange Transfer and Discharge service had been completed and that all outstanding actions and risks had been handed over to Operations from the Project (although we did not conduct any testing to confirm these were subsequently incorporated into business as usual activities).

Conclusion:

2.33 Assessments of the new service in its first 6 months of operation were generally supportive of its running, however we noted a low level of performance metrics of the inter-site ambulance transport activity in regular WAST operational performance management reports. We were also unable to establish where this same activity is included in the regular quality assurance auditing conducted by the WAST CCC. Consequently, we have given a **Limited** assurance rating for this objective.

Audit objective 5: The Trust reported to Trust Board and Commissioners the progress and outcomes of the reconfigured service and collaborated in the building of an all-Wales model for roll-out.

2.34 We sought to evidence that appropriate reporting to oversight bodies of the inter-site transport service progress and outcomes was taking place.

2.35 The GUH inter-site transfer project reported to a range of oversight groups (STB, EASC MG, EMS Demand & Capacity group, GUH Transport group and the Senior Clinical Forum) and we reviewed records of the STB and EASC MG meetings and the GUH Transport group to confirm oversight had been active during the project phase.

2.36 The Trust Board receives a regular report of IMTP deliverable status updates from the STB. As mentioned above under the previous audit objective, this project is an element of the IMTP deliverable 'Engage with ABUHB on the implementation of the Clinical Futures Strategy & opening of The Grange University Hospital' and we noted this was given a green RAG status in the August, September, October and November 2020 STB updates, the latter shortly before the inter-site transport service commenced. As regards the partners, ABUHB and NCCU were in collaboration with the Trust in the development of the project through their involvement in regular Commissioning meetings and collaborative groups.

2.37 We noted updates on the progress of the inter-site transfer project in the meeting minutes of the EASC MG (comprising NCCU, WAST, and all health boards) and the GUH Transport group (NCCU, WAST and ABUHB). We saw evidence of oversight activity in meetings agendas, papers, highlight reports, minutes and action logs, although we tested only example documentation of the latter rather than a formal

audit sample. From this, we understand there was a period when some of the joint meetings with NCCU and ABUHB had not been minuted, noteworthy given the significance of this service change and the intention to replicate across Wales. (see **Matter Arising 4**).

2.38 We were provided with materials to demonstrate that the WAST GUH Project Team conducted regular meetings, weekly before the go-live date and fortnightly after, and examined example meeting agendas, minutes, actions log, highlight reports and the project risk register.

2.39 EASC Commissioning intentions include an ambition that implementation of inter-site transport models of this kind be used to inform like developments in other health board areas through the development of an all-Wales model and we sought to establish what progress had been made with the latter.

2.40 We noted the WAST project closure report commented on the longer-term strategic direction of the trust in developing an all-Wales model that could be deployed to support other health boards across the country. This report includes an action to work with ABUHB on the future model and clinical profile required in conjunction with NCCU and the All Wales Transfer and Discharge service, which aligns with the related component of the EASC commissioning intention CI6: Wider Health System.

2.41 We were advised that the post-implementation evaluation report of the GUH inter-site transport activity has been shared with Hywel Dda University Health Board who are exploring a similar service change. We note lessons learned in the design, development and deployment of the ABUHB inter-site service may be of value to the broader EASC led initiative which is targeting completion of a business case by the end of Q4 2022-2023 in support of an all-Wales proposal.

Conclusion:

2.42 Trust collaboration with and reporting to its commissioners in the development and implementation of the new service was evident, although we have raised a finding drawing attention to gaps in the collaborative oversight group's meeting records. Whilst the experience gained in the development of this inter-site transport service may be of value in the design of an all-Wales model, further work will be required to determine whether the model adopted to support the Grange and its eLGH partners will suit other deployments and consequently have provided **Reasonable** assurance for this objective.

Appendix A: Management Action Plan

Matter arising 1: Renewing the service specification document (Operation)	Impact
We noted recognition that it had taken some time to finalise and agree the full commissioning agreement / service specification that was drawn up to cover the first 12 months running of the inter-site transport service. The original agreement expired in November 2021 and we were informed that it was extended for 6 months, which was approaching expiry at the time of the audit. A renewed and potentially revised specification (the project closure report noted that there had been problems once in operation over the division of responsibility for managing the service) has not yet been put in place to replace it (but is being progressed by the collaborative GUH inter-hospital transfer service forum). This has significance beyond the two parties to this service activity as the SLA may be drawn on to inform an all-Wales model for similar future service reconfigurations.	Potential risk that the service model going forward does not reflect and adopt lessons learned during the first year of running and that as a result maximum service efficiency is not attained.

Recommendations	Priority
1.1 We recommend that the service specification is finalised and reissued for the period beginning June 2022, reflecting any amendments to the model that post-implementation service reviews have indicated. This is particularly significant because of the contribution this project may make to an upcoming all-Wales model to cover similar service reconfigurations. Future service change SLAs must be signed before the renew date.	Medium

Management response	Target Date	Responsible Officer
1.1 The timescale is dependent on commissioners agreeing the longer term commissioning agreement. Meetings with commissioners (ABUHB and NCCU leading) have commenced to take forward the recommendations of the GUH Evaluation and this should include the agreement on the next commissioning agreement. However this may need to be backdated.	30 September 2022	Mark Harris, Assistant Director of Operations NEPTS / Deborah Kingsbury, Senior Planning and Performance Business Partner

Matter arising 2: Inter-site transport journey operational performance review (Design)	Impact
Whilst the GUH inter-site transport journeys are included in the scope of the regular performance scrutiny work conducted by the WAST Senior Operations Team, we noted this is limited to the lost hours metric. We noted the analysis of transport metrics (step up / step down volumes, one and four hour response statistics) that is seen by the collaborative Tier 2 group is operationally reviewed at the General Managers Performance meeting within NEPTS every week. However, although these meetings have agendas we understand they are not minuted so we were unable to review evidence of the matters discussed.	Potential risk that performance of the inter-site transport activity does not receive sufficient management oversight.

Recommendation	Priority
2.1 We recommend that the weekly NEPTS General Managers Performance meetings are minuted and that consideration is given for the Senior Operations Team to delegate responsibility to review and scrutinise the transport activity further within the Trust, given the intention to expand the model across Wales.	Medium

Management response	Target Date	Responsible Officer
2.1 This is agreed. NEPTS General Manager responsible for the Grange to ensure performance reporting mechanisms in place internally ahead of external tier 1 and tier 2 meetings, and agreement to be sought from SOT on delegation of responsibility to review performance of this service, with agreed routes for escalation of risks and issues arising from review and scrutiny.	30 June 2022	Gaurav Shinde, Head of Transformation

Matter arising 3: Inter-site transport journey auditing and spot-check scrutiny process (Design)	Impact
Whilst an auditing activity of incident handling (assessment, allocation, despatch etc.) is conducted by a dedicated team within the WAST CCC, we noted that the GUH inter-site transport journeys fall outside of this and are therefore not subjected to this quality review and scrutiny process.	Potential risk that the inter-site transport activity does not receive quality and scrutiny review.

Recommendation	Priority
3.1 We recommend that the inter-site transport service activity is incorporated into the regular case auditing activity operated by the CCC to ensure it is subjected to this quality review and scrutiny process.	Medium

Management response	Target Date	Responsible Officer
3.1 WAST CCC Management Team to work with NEPTS control to review how this can be incorporated into auditing activity, in line with other internal audit recommendations.	30 September 2022	Kate Blackmore, Head of Service, EMS Coordination / Gaurav Shinde, Head of Transformation

Matter arising 4: Collaborative GUH Project meeting documentation (Operation)	Impact
We noted updates on the progress of the inter-site transfer project in the meeting minutes of the collaborative GUH Transport group (NCCU, WAST and ABUHB). Whilst we saw evidence of activity in meetings agendas, papers, highlight reports, minutes and action logs, although we examined only example documentation of the latter rather than a formal audit sample, and understand there was a period when some of these joint meetings had not been minuted.	Potential risk that project progresses without heed to events or decisions because of a lack of recording of these.

Recommendation	Priority
4.1 We recommend that full and regular project meeting materials are maintained of collaborative as well as internal project meetings throughout the duration of projects of this nature, to ensure complete records of project decisions and actions. This should also assist in informing the transfer and discharge service model across Wales.	Medium

Management response	Target Date	Responsible Officer
4.1 The external management of meetings is outside WAST Control, however we will request that a minimum set of project records are kept in joint projects with Health Boards and/or NCCU. There is already in place a minimum set of documentation requirements for programmes and projects in WAST.	Complete	Alex Crawford, Assistant Director of Planning and Transformation

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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Waste Management
Final Internal Audit Report

May 2022

Welsh Ambulance Services NHS Trust

NWSSP Audit and Assurance

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

GIG CYMRU NHS WALES
Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Contents

Review reference:	SSU-WAST-2122-02
Report status:	Final
Fieldwork commencement:	4th January 2022
Fieldwork completion:	7th March 2022
Draft report issued:	18th March 2022
Draft report meeting:	29th April 2022
Management response received:	24th May 2022
Final report issued:	25th May 2022
Auditors:	NWSSP Audit & Assurance: Specialist Services Unit
Executive sign-off:	Executive Director of Finance and Corporate Resources Executive Director of Quality and Nursing
Distribution:	Assistant Director of Capital and Estates Head of Infection Prevention and Control Head of Capital Development Head of Risk/Deputy Board Secretary Environment & Sustainability Manager
Committee:	Audit Committee

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

Acknowledgement

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

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Executive Summary

Purpose

The audit was undertaken to assess the Trust's compliance with relevant waste management legislation and guidance, and progress towards agreed national and local waste reduction targets.

Overview

Whilst recognising the period of review was impacted by the Covid response, we identified several significant issues for reporting in our review, resulting in an overall Limited assurance.

Whilst it is recognised that the Trust's total waste production is significantly lower than other NHS organisations, the Trust still has a duty of care for the waste it does produce.

The Trust acknowledges the need to clarify accountability around oversight and management of clinical waste within the organisation, and is currently completing an Organisational Change Process (OCP) through which this will be addressed.

Matters arising concerned the following:

- Once the OCP is completed there is an urgent need to review and update out of date waste management procedural guidance;
- The need to assign executive leadership, committee responsibility and operational responsibility for waste related matters;
- To confirm Natural Resources Wales approval of clinical waste arrangements – noting that Health Courier Services is no longer part of WAST and that the waste is transferred to non-WAST premises.
- The need to evidence 'Duty of Care Transfer Notes' for the transfer of Waste to other NHS organisations.
- To re-introduce Clinical Waste Duty of Care and Clinical Waste Pre-acceptance audits to inform internal reporting on waste.

Report Classification

Limited

More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Assurance summary

Assurance objectives		Assurance
1	Policy & Procedures	Limited
2	Governance & Management	Limited
3	Contractual Arrangements	Limited
4	Operational Practice	Substantial
5	Monitoring & Reporting	Limited

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

Other recommendations are within the detail of the report.

Matters Arising		Assurance Objective	Control Design or Operation	Recommendation Priority
1.1 & 1.2	The Waste Process document requires update/ approval to comply with WHTM 07-01.	1	Design	**High**
2.1, 2.2 & 3	An Executive lead, committee responsibility and supporting operational responsibilities should be assigned for Waste related matters.	2	Operation	**High**
4	A formal training needs assessment to determine the training requirements across the Trust.	2	Operation	**Medium**
5.1	The Trust should review the arrangements in place for the transfer of clinical waste and gain assurance that the current relationship with HCS meets the legal responsibilities that are placed on WAST as the producer of clinical waste.	3	Operation	**High**
5.2	In addition the Trust should seek assurance from Natural Resources Wales that the change in arrangements with HCS continues to conform with the original ruling on waste transfer (and transfer notes).	3	operation	**Medium**
6	To obtain a duty of care transfer notes on an annual basis covering handover of clinical waste Health Boards.	3	Operation	**High**
7	Clinical Waste Duty of Care audits and Clinical Waste Pre-Acceptance audits should be completed as a matter of course.	5	Operation	**High**

1. Introduction

1.1 Welsh Health Technical Memorandum (WHTM) 07-01: '*Safe Management of Healthcare Waste'* provides a framework for best practice waste management, to help healthcare organisations meet legislative requirements as well as identify opportunities to improve waste minimisation and reduce the associated environmental and carbon impacts of managing waste.

1.2 Effective waste management also requires compliance with the requirements of various regulatory regimes, including environment and waste, controlled drugs, infection control, health and safety and transport.

1.3 Noting that waste arising from Covid-19 patients is designated as infectious clinical waste, specific guidance has additionally been developed in the last year ('Covid-19 waste management standard operating procedure').

1.4 The Welsh Government's waste reduction targets were set out in its 'Towards Zero Waste' strategy, first published in 2010 – with a target of 70% recycling / recovery rate by 2025, and for all waste to be recycled by 2050.

1.5 This audit assessed Welsh Ambulance Services NHS Trust's (the Trust) compliance with the relevant legislation and guidance, and progress towards agreed national and local waste reduction targets.

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

- Safety of Trust staff, patients, visitors and contractors.
- Environmental damage.
- Non-compliance with legislation, risking financial penalties or prosecution.
- Failure to achieve mandated waste reduction targets.
- Reputational damage associated with negative publicity.
- Failure to achieve value for money for the Trust.

2. Detailed Audit Findings

Policy & Procedures: To ensure an appropriate Waste Management Policy and supporting procedures were in place.

2.1 WHTM 07-01 requires, as a minimum, that a healthcare waste policy is signed off at Board level to demonstrate high level commitment. The Trust however do not have a formal policy on Waste Management instead utilising a Guidance Note. It is not clear when the Guidance Note was first approved or at which forum it was ratified, although it was due for review in October 2015, however it also notes this is version 1.2 amended September 2019 (see **MA1**).

2.2 Whilst the Guidance Note was found to cover much that the WHTM 07-01 requires, enhancements were required to ensure full compliance with the WHTM requirements and best practice.

2.3 Recognising the status of the Guidance Note, **limited assurance** has been determined.

Governance & Management: To ensure an appropriate governance structure was operating, budgets were appropriately monitored, risks recorded, monitored and escalated, and training appropriately delivered.

2.4 The Trust's Waste Guidance Note detailed that the National Estates Manager as the nominated General Waste and Recycling Manager, however there was no reference to Executive level responsibility within the Guidance Note (see **MA2**).

2.5 Operational responsibility for Clinical Waste at each site had also not been formally assigned, however it was advised that there is an Organisational Change Process currently underway and that this issue is to be addressed as part of this (see **MA2**).

2.6 The Trust did not have a dedicated waste forum and a review of the committee papers noted no reporting of waste issues. It is recognised that the Trust's total waste as reported for 2019/20 was only a tenth of that reported by some Health Boards for the same period. Regardless, waste matters should be subject to regular review and scrutiny by an appropriate committee/ group (see **MA 3**).

2.7 WAST are not part of the All-Wales Clinical Waste Consortium but a Trust representative did however attend meetings during the Covid Pandemic. Historically WAST's interests were represented by Health Courier Services (HCS) which were disaggregated from WAST in 2017 and are now part of NHS Wales Shared Services Partnership (NWSSP). HCS have continued to transport Clinical Waste from WAST sites to other Consortium member sites. This relationship is discussed further at the next section.

2.8 The Trust utilised on-line training through ESR which encompassed both Environmental and Waste training, Waste was also part of the standard induction training. Due to issues with the IT system which were beyond the control of WAST, no data was available for attendance/completion of waste related training for 2021/22 – accordingly, training compliance was not reported in the period (see **MA 4**).

2.9 A formal training needs assessment had not been undertaken to determine the wider training needs and responsibilities across the Trust. At the time of the audit fieldwork, there were no arrangements in place to deliver wider training to clinical and general staff, in respect of e.g. handling of clinical waste / recycling etc. (see **MA4**).

2.10 Noting the above, **limited assurance** has been determined in this area.

Contractual arrangements: Assurance that waste contracts were appropriately procured and were monitored against agreed performance targets. That appropriate controls operated in the payment of invoices.

2.11 The Trust's contractual arrangements for general waste / recycling was centrally procured and managed by NWSSP Procurement Services. The contract is currently in year 4 of 5.

2.12 Clinical waste is collected from Trust sites by Health Courier Services (HCS) and transferred to two locations, Mamhilad in Pontypool and NWSSP Denbigh Stores. From there it is collected by the waste contractor for incineration. Management advised that the Trust does not have a direct contractual relationship with the contractor, but it accesses the contract via HCS. The SLA put in place following the disaggregation of HCS in 2017 did not reference waste management arrangements. It is recommended that the Trust look at the revised arrangements to ensure that it continues to meet its full obligations, noting that it is unlikely to be able to rely on HCS as being part of WAST (see **MA5.1**).

2.13 In 2015, Natural Resources Wales agreed that HCS transfer notes were not required for collecting clinical waste from WAST sites. However, this refers back to a time when HCS was a part of WAST and the waste was being transferred from WAST Ambulance Stations to WAST premises. In the North, the waste in now taken to Denbigh Stores, which is a facility operated by NWSSP. It is concluded that Natural Resources Wales should be approached to reaffirm that the revised arrangements continue to comply (see **MA5.2**).

2.14 As part of operational practice Ambulances routinely decant clinical waste when visiting Hospitals to transfer patients – given the limited amount of clinical waste that can be physically stored on the vehicles. However, whilst noting that this is good practice, WHTM 07-01 goes on to note that *"where the WAST drops its waste off at a hospital, this is classed as waste transfer. Therefore, duty of care applies and the WAST should ensure that the appropriate agreements are in place to enable it to transfer its waste to the hospital"*.

2.15 WHTM-07-01 goes onto note that whilst waste transfer notes are not required, *"A duty of care transfer note is, however, required, although there are mechanisms to enable this to be done on an annual basis".* No evidence was provided to demonstrate that WAST have obtained the (annual) duty of care transfer notes from the respective Health Boards. (**MA6**)

2.16 Noting the uncertainty about the current arrangements surrounding the transfer and ownership of clinical waste **limited assurance** has been determined.

Operational Practice: A review of operational arrangements in key areas such as segregation, storage, safe handling, transfer etc. and associated record keeping, to assess compliance with the Trust's policy and procedures, WHTM 07-01 and relevant legislation. A review of waste reduction initiatives pursued by the Trust.

2.17 Operational arrangements were observed at Rhyl Locality Ambulance Office & Station and Aberconwy Ambulance Station. The site visits incorporated a review of waste management arrangements in areas including main entrances, garage areas, staff rest areas, and the external waste compounds.

2.18 Good practice was observed in all areas reviewed, including the following:

- Appropriate provision of clearly labelled and suitable bins to facilitate correct segregation of waste at source;
- Appropriate frequency of removal of waste from source to central holding areas, to prevent build-up of waste;
- Appropriate labelling and packaging of waste in accordance with WHTM 07-01 requirements; and
- Tidy and secure external compound areas for the holding of waste prior to collection.

2.19 Recognising the good practice observed in all areas of operational practice reviewed, with no non-compliances with WHTM 07-01 identified, **substantial assurance** has been determined in this area.

Monitoring & Reporting: Adequate arrangements were in place to record, monitor and report waste management activities, including incidents, compliance audits, costs and performance against agreed targets. That reporting was appropriately directed at both operational and executive level.

2.20 Appropriate arrangements had been determined for the recording and investigation of waste-related incidents. Management confirmed that no incidents had occurred during the last three years.

2.21 The Trust participates in several waste-related reviews each year, including:

- ISO14001 Environmental System external audit; and
- Annual internal Sustainability Management Review.

2.22 However, the Trust has not undertaken Clinical Waste Duty of Care audits (reviewing contractor practices); or Clinical Waste Pre-Acceptance audits (reviewing the segregation and handling of clinical waste on Trust premises). This is due to the historical arrangement that HCS transport clinical waste from WAST premises to central locations and that the clinical waste contract rests with HCS. A recommendation has been raised in respect of this (see **MA7**).

2.23 Prior to Covid-19, compliance audits were undertaken in respect of general waste and recycling, these were undertaken by the waste contractor and also by the Trust's Environmental and Sustainability Manager. These have not been conducted for 2 years, but Trust management advised these audits would be reinstated as soon as practicably possible (see **MA7**).

2.24 Separately, the handling of clinical waste is picked up as part of the Infection Prevention and Control Team audits, however these had similarly been affected by Covid with no audits undertaken during the pandemic. The Head of Infection Prevention and Control at The Trust advised that they are currently preparing a plan for this work to recommence

2.25 Noting issues within the Governance & Management section and the absence of independent assurances during the period, a **limited assurance** has been determined in this area.

Appendix A: Management Action Plan

Matter Arising 1: Policy & Procedures (Design)	**Impact**
Welsh Health Technical Memorandum (WHTM) 7.1: '*Safe Management of Healthcare Waste,*' sets out the importance of a healthcare waste policy: *"To effectively manage healthcare waste, all those involved in the management of the waste stream should have access to an appropriate healthcare waste policy that identifies who is responsible for the waste and provides clearly written instructions on how it should be managed"* (6.2); The Trust do not have a formal policy on Waste Management instead utilising a Guidance Note. It is not clear when the Guidance Note was first approved or at which forum it was ratified. Although it notes it was due for review in October 2015, it also notes this is version was amended in September 2019. Therefore, it would not appear to be compliant with the WHTM 07-1 which recommends that the policy should include: *"a clear statement, outlining the aims and rationale of the policy, signed off at board level to demonstrate high-level commitment"* (6.4). Whilst the document was found to cover much that the WHTM 07-01 recommends, it was noted the following areas were not incorporated: • Confirmation of Board-level Committee responsibility for waste management; • Document Executive Level Responsibility • Detail of contractual arrangements (including contingencies); • The process of identifying improvement programmes; • Detail regarding staff training arrangements. It is recognised, that procedural guidance was clearly displayed on site (as confirmed during the site visits to Rhyl and Aberconwy Ambulance Stations), providing relevant instruction to staff at the point of waste disposal.	Potential risk of: • Absence of Board-level commitment does not provide the Trust's approach with the support required;

Recommendations		Priority
The Waste Process document review should be concluded as scheduled, with consideration given to the Policy guidance set out in WHTM 07-01, and with enhanced detail regarding governance structure and training arrangements. The Trust should ensure the Waste Process document, following review and update, is approved at the relevant Board-level Committee as a formal policy, in accordance with WHTM 07-01 requirements		**High**
Agreed Management Action	**Target Date**	**Responsible Officer**

Agreed as the key priority, recommendation and action for immediate further improvement from this review. From which the response and resolution for many of the other actions will naturally follow. To progress many of these, it has been jointly agreed at Exec level that a task and finish group (TFG) will be immediately created with representatives from the following departments • Estates and Facilities • IPC • Health and Safety • Operations • ICT • Fleet • Corporate Services • Training • Finance • Medical directorate (for drug management issues) • Clinical equipment and logistics • TU rep The TFG will develop a National Waste policy to cover both domestic waste and clinical waste. The policy will identify the management structure for both sections of waste (which will be different) and therefore a reporting structure, including through to Board Committees (likely to be by exception) and therefore Trust Board itself. It will also identify training needs and all compliance and audit obligations.	Immediate (Policy writing may take a few months and process to be followed for Policy Committee. However all attempts will be made to fast track this) 30th September 2022	Richard Davies (Assistant Director of Capital and Estates) and Nicci Stephens (Environment & Sustainability Manager) to create group and overview writing of the policy.

Matter Arising 2: Governance Structure (Operation)		**Impact**
It is important that an Executive lead is assigned with championing Waste related matters. The Waste Guidance Note does not include details of the nominated Executive. The Trust's Waste Guidance Note document details that the National Estates Manager is the nominated General Waste and Recycling Manager, however operational responsibility for Clinical Waste across each site had not been formally assigned. Management advised that there is an Organisational Change Process currently underway and that this issue is to be addressed as part of this.		No accountability assigned for Clinical waste issues within the Trust.
Recommendations		**Priority**
An Executive lead should be identified for Waste related matters. The Trust should conclude the exercise to assign operational responsibility for Clinical waste management at each site.		**High**
Agreed Management Action	**Target Date**	**Responsible Officer**
Agreed. Whilst in practice there has always been Exec oversight to the various aspects of waste management, it is accepted that this isn't formally documented. As above, the TFG work will identify a full management reporting structure and therefore executive leads, for which there is a potential for this continuing to be more than one. Clarity on this (and any split of responsibilities) will be required through along with the resulting reporting mechanisms. Formal correspondence relating to operations responsibility will be completed as part the TFG work and waste management policy.	On completion of written policy 30th September 2022	An output from the T&F group work and resulting waste management policy, to be overseen by Richard Davies (Assistant Director of Capital and Estates) and Louise Colson (Head of Infection Prevention & Control)

Matter Arising 3: Governance Structure (Operation)		**Impact**
The Waste Guidance Note document does not identify any Trust Committee with responsibility for waste management. Conformation was sought as to the forum at which Waste Management is routinely discussed, it was advised that Waste Management has not historically been an agenda item at any Trust committees/meeting groups. The National Estates Manager did advise that a 'Logistic Cell' has received information on waste as required, during the Covid pandemic, including waste contracts.		Absence of Board-level commitment.
Recommendations		**Priority**
Both clinical and general waste compliance/ issues should be formally reported periodically within the confines of a set Committee/ Group.		**High**
Agreed Management Action	**Target Date**	**Responsible Officer**
Once the TFG work is complete and executive lead(s) re-confirmed, this will then inform the committee/group receiving waste information. Routinely it is noted that reporting through to a Board Committee is likely to be on an exception only basis. Consideration will be given to ensure that Board members are sighted on more routine waste issues and compliance, at least annually. The National Waste Policy will also inform reporting timescales.	Process will be confirmed on completion of written policy 30th September 2022	An output from the T&F group work and resulting waste management policy, to be overseen by Richard Davies (Assistant Director of Capital and Estates) and Louise Colson (Head of Infection Prevention & Control)

Matter Arising 4: Training		Impact
Waste management training is a module within Electronic Staff Records for all staff as well as being part of the standard induction process. For 2021/22, training compliance data was not available, management citing issues with the IT system which were beyond their control but were however escalated at the time. Furthermore, a formal training needs assessment had not been undertaken to determine more specific training needs and responsibilities for key roles. At the time of the audit fieldwork, there were no arrangements in place to deliver wider training to clinical and general staff, in respect of e.g. handling of clinical waste / recycling etc.		Key staff are not appropriately trained.
Recommendations		**Priority**
Training compliance date will be compiled and reported to an appropriate forum. A formal training needs assessment is required to determine the training requirements across the Trust.		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
Agreed. A formal training needs assessment will be detailed under the TFG work and implemented by the National Training Department. Any remaining IT issues will be further escalated for resolution ASAP	30th November 2022	An output from the T&F group work and resulting waste management policy, to be overseen by Richard Davies (Assistant Director of Capital and Estates) and Louise Colson (Head of Infection Prevention & Control)

Matter Arising 5: Clinical Waste Transfer Arrangements	Impact
Clinical waste is collected from Trust sites by Health Courier Services (HCS) and transferred to two locations, these being Mamhilad in Pontypool and NWSSP Denbigh Stores. From there it is collected by the contractor for incineration. HCS were previously part of WAST but were disaggregated and are now part of NWSSP. Just prior to disaggregation HCS in a letter dated 2nd July 2015 agreed with Natural Resources Wales that they do not need to supply transfer notes when collecting clinical waste from WAST sites. Noting: "*As we understand your operations waste produced on ambulances by healthcare activities is removed from the vehicle at ambulance stations when they return to base or drop off before another call at another base. This particular waste is then collected periodically by Health Courier Vehicles and taken to regional hubs in Pontypool and St Asaph. From here it is collected by external contractor for onward movement to treatment*." In the North the waste in now taken to Denbigh Stores, which is a facility operated by NWSSP. It is not clear therefore whether the present situation is in keeping with the spirit of the original ruling by NRW. We are advised that the Trust do not have a direct contract with the clinical waste contractor, the Trust accesses the contract via HCS. However, WAST are the producers of this clinical waste and as such have a legal responsibility. In specific guidance provided in WHTM 07-01 for the Welsh Ambulance Services Trust it notes: The *ambulance service, as a producer of healthcare waste and specifically infectious waste, is required to comply with waste regulations including the Hazardous Waste Regulations and therefore needs to ensure that waste is segregated, described, classified and disposed of appropriately*. WHTM 07-01 clarifies that: *For waste that is disposed of through the ambulance station, the ambulance service should have a waste disposal contract with a registered and licensed waste contractor to safely collect, transport and dispose of its waste appropriately.*	The Trust may be breaching the rules pertaining to Waste producers.

It is not clear that the Trust have complied with this in that HCS, who are no longer part of WAST and are not the producers of the Waste, have the contract with clinical waste contractor. In addition, WAST do not therefore have formal representation on the All-Wales Clinical Waste Consortium so it is not clear how they as the waste producer have a 'cradle-to-grave' responsibility for the control, management, transport and disposal of their waste. For example, waste producers should undertake a waste audit trail, at least every year. This to ensure that waste is being transported in accordance with the Carriage Regulations and disposed of at appropriately permitted facilities in accordance with duty-of-care requirements and local waste management procedures. In addition, if the waste contractor establish any non-conformance as regards waste submitted for treatment/incineration it is not clear how WAST as the producer would be held accountable.		
Recommendations		**Priority**
5.1 The Trust should review the arrangements in place for the transfer of clinical waste and seek to gain assurance that the current arrangements as detailed are in keeping with the requirements of WHTM-07-01.		**High**
5.2 The Trust should gain clarification from NRW regarding whether supply transfer notes are required for the revised arrangements for clinical waste.		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**

5.1 – The WHTM 07-01 was amended from HTM 07-01 in 2013, this predates the separation of HCS from WAST. Under its current form WAST is not able to comply with this particular section of the document as WAST does not have a direct contract with the current clinical waste contractor. NWSSP FS, the documents authors, have been contacted regarding this point. The WHTM is due for review. However, those confirmed under the TFG as clinical waste lead will produce an annual hazardous waste transfer note for Denbigh Stores and Pontypool Ambulance Station for completion by HCS, therefore compliant with current hazardous waste legislation. 5.2 HCS has already been contacted for clarity regarding NRW exemption – the NRW exemption belongs to HCS not WAST. Confirmation received that NRW exception is live and covers changes to location.	Amendment to WHTM – immediate (correspondence already send) Complete	Nicci Stephens (Environment & Sustainability Manager)

Matter Arising 6: Clinical Waste Transfer-Hospital Sites		**Impact**
As part of operational practice Ambulances routinely decant clinical waste when visiting Hospitals to transfer patients. This is because they are limited in the amount of clinical waste that can be physically stored on the vehicles. However, whilst noting that this is good practice WHTM 07-01 goes on to note that: *"Where the WAST drops its waste off at a hospital, this is classed as waste transfer. Therefore, duty of care applies and the WAST should ensure that the appropriate agreements are in place to enable it to transfer its waste to the hospital".* WHTM-0701 goes onto note that whilst waste transfer notes are not required: *"A duty of care transfer note is, however, required, although there are mechanisms to enable this to be done on an annual basis".* No evidence was provided to demonstrate that WAST have obtained the transfer notes from the respective Health Boards.		Trust not in compliance with requirements of WHTM07-01.
Recommendations		**Priority**
WAST should contact the respective Health Boards on an annual basis to obtain a duty of care transfer note covering handover of clinical waste from Ambulances at Health Board sites, in keeping with the requirements as stipulated in WHTM 07-01.		**High**
Agreed Management Action	**Target Date**	**Responsible Officer**

The WHTM 07-01 was amended from HTM 07-01 in 2013. HTM 07-01 is the English management of waste in healthcare technical note. On amending the HTM to the WHTM this section should have been replaced. As a commissioned service to the health boards clinical waste sits with the patient and therefore the health board. NWSSP FS, the documents authors, have been contacted regarding this point. However, to further add to the assurance of this, it is also now requested that the TFG will propose the production of an annual hazardous waste transfer note for each Health board, therefore compliant with current hazardous waste legislation. This will be included in the national waste management policy.	Immediate (correspondence already sent) On completion of written policy 30th September 2022	Nicci Stephens(Environment & Sustainability Manager) An output from the T&F group work and resulting waste management policy, to be overseen by Richard Davies (Assistant Director of Capital and Estates), and Louise Colson (Head of Infection Prevention & Control)

Matter Arising 7: Independent reviews		Impact
The Trust participates in several waste-related audits each year, including: • ISO14001 Environmental System external audit; and • Annual internal Sustainability Management Review. However, the Trust has not undertaken Clinical Waste Duty of Care audits (reviewing contractor practices) or Clinical Waste Pre-Acceptance audits (reviewing the segregation and handling of clinical waste on Trust premises). Management advised that these have not been conducted due to the historical arrangement that Health Courier Services (HCS) transport clinical waste from WAST premises to central locations and that the clinical waste contract rests with HCS. Compliance audits were previously undertaken in respect of general waste and recycling, however these were suspended during the Covid-19 response and have not been reinstated. Infection Prevention and Control Team audits were similarly affected by the Covid response with no audits undertaken during the pandemic. The Head of Infection Prevention and Control at The Trust advised that they are currently preparing a plan for this work to recommence		Independent assurance has not been obtained in respect of operations.
Recommendations		**Priority**
The Trust will conduct its own Clinical Waste Duty of Care audits and Clinical Waste Pre-Acceptance audits. Infection Prevention and Control Team audits will be reinstated. General waste and recycling compliance audits will be reinstated when safe to do so.		**High**
Agreed Management Action	**Target Date**	**Responsible Officer**

Audits will be resumed when safe to do so. This will be reviewed on a quarterly basis by the Clinical waste lead and Domestic Waste lead. Clinical waste audits will be completed as part of general IPC audits not as a specific waste stream audit. General waste audits are completed by Biffa as required under tendered contract. Further overseeing of this will be ensured.	30th September 2022 (assuming safe to do so)	Clinical waste: To be determined as part of the T&F group work, to be overseen by Richard Davies (Assistant Director of Capital and Estates) and Louise Colson (Head of Infection Prevention & Control) Domestic Waste: Estates (Biffa) overseen by Nicci Stephens (Environment & Sustainability Manager)

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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Follow Up Review

Final Internal Audit Report

May 2022

Welsh Ambulance Services NHS Trust

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

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

Contents

Review reference:	WAST-2122-022
Report status:	Final
Fieldwork commencement:	28 February 2022
Fieldwork completion:	6 April 2022
Draft report issued:	21 April 2022
Debrief meeting:	N/A
Management response received:	26 May 2022
Final report issued:	26 May 2022
Auditors:	Osian Lloyd, Head of Internal Audit Johanna Butt, Principal Auditor
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 & 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

We undertook a follow-up review of the following limited assurance reports to assess whether the Welsh Ambulance Services NHS Trust (the Trust) has implemented the related Internal Audit recommendations:

- *Job Evaluation process;*
- *Fire Safety; and*
- *ICT Disaster Recovery.*

We tested a sample of 10 findings, focusing on high and medium priority recommendations that have been recorded as implemented in the Trust's Audit Recommendations Tracker.

Overview of findings

The Trust has effective arrangements to track progress in relation to audit and review findings.

Our testing confirmed that all recommendations tested were appropriately classified as completed on the tracker. However, it is recognised that further action is ongoing to fully mitigate the risks identified.

Follow-up Report Classification[1]

Substantial

Follow up: All recommendations implemented and operating as expected

Assurance summary

	High	Medium	Low	**Total**
Closed	6	4	-	**10**
Superseded	-	-	-	**-**
Partially closed	-	-	-	**-**
Outstanding	-	-	-	**-**
Total	**6**	**4**	**-**	**10**

[1] The scope of this follow-up review provides assurance against the implementation of the agreed actions from prior years' audit reports. It does not provide assurance against the full scope and objectives of the original audits.

1. Introduction

1.1 We undertook a follow-up review of limited assurance internal audit reports issued during 2020/21, to provide assurance that the Welsh Ambulance Services NHS Trust (the Trust) has implemented the related recommendations appropriately and in a timely manner. We also reviewed the systems and arrangements the Trust has in place to monitor progress with the implementation of actions.

1.2 Our review incorporates recommendations raised in the following reports:

i. Job evaluation process - An assurance that the system in place supports a consistent and rational approach;
ii. Fire Safety - To assess compliance against the processes and procedures put in place by management to operate the estate and compliance with statutory regulations in relation to fire precautions; and
iii. ICT Disaster Recovery - An assessment of the effectiveness of back up and disaster recovery arrangements to ensure they are fit for purpose.

1.3 We tested a sample of recommendations from these reports, focusing on those rated high and medium priority that have been recorded as implemented in the Trust's Audit Recommendations Tracker (the Tracker).

1.4 We took into consideration the impact of the Covid-19 pandemic in our assessment of the arrangements in place.

1.5 The scope of this follow-up review will not provide assurance against the full scope and objectives of the original audits. The 'follow-up review opinion' provides assurance against the level of implementation of the recommendations as identified above.

1.6 The potential risks considered in this review are:

i. failure to implement agreed audit recommendations in a timely manner;
ii. increased financial, clinical, statutory and reputational risk for the Trust; and
iii. inaccurate reporting of the Tracker within the Trust.

2. Detailed Audit Findings

2.1 As previously reported, the Trust has effective arrangements to monitor progress in relation to the implementation of recommendations.

2.2 The audit tracker is maintained by the Corporate Governance Team. The Team receives all audit reports (both internal and external) for inclusion in Committee papers which ensures that the recommendations tracker captures all recommendations raised.

2.3 The tracker is reviewed by the Assistant Directors Leadership Team (ADLT), on a monthly basis, and the Executive Management Team prior to Audit Committee to

ensure realistic timescales have been proposed and a rationale is included to support any revisions to completion dates.

2.4 The Audit Committee reviews the internal and external audit recommendation report and tracker at each meeting. The format of the tracker enables committee members to view updates on progress in relation to the implementation of each recommendation and it provides an opportunity to challenge and scrutinise. The Trust also submits extracts of the audit tracker to relevant Board Committees to support oversight and scrutiny of recommendations relating to their remit.

2.5 We acknowledge that there is currently a requirement for Executive Directors to attend Audit Committee to provide assurance to members where 'Limited' or 'No Assurance' reports have been issued. We have observed Executive Directors / responsible officers also attending Committee in other health bodies, where a concentration of overdue recommendations is highlighted. The Trust may wish to consider this approach to further strengthen its scrutiny process.

2.6 This section captures a summary of our previous findings from our testing sample, along with the progress made to implement the associated recommendations:

Job Evaluation Process

2.7 This report included two high priority and five medium priority recommendations, all of which were reported as being completed on the tracker. We tested both high priority recommendations and one medium priority recommendation in our sample.

Finding 1 - Local Process for Job Assessment Questionnaires (JAQ's) (Design)

2.8 Set national profiles are available to NHS Bodies through the Computer Assisted Job Evaluation (CAJE) and used as benchmarks to match against as part of the process. However, due to the particular nature of the Ambulance Service there are a limited number of national operational profiles available that fit their purposes.

2.9 In such circumstances the NHS Job Evaluation Manual allows for a localised process of job matching to take place via completion of a JAQ. Our original audit identified that the Trust had a backlog of cases to be job matched that is creating a bottleneck at a time that the Trust faced severe operational pressures. In response to this situation the Trust was designing and implementing a new approach to JAQ's that would shorten the process. We understood that the process will not follow the prescribed National route and so could leave the Trust exposed to further challenges, though governance processes should mitigate this risk.

2.10 Our current audit noted the development of a JAQ Lite protocol. The procedure can be applied to roles which have previously completed the job evaluation process and following a review by the All Wales Team, have been identified as needing to be locally evaluated. Additionally, the procedure can be applied to new roles in the Organisation when it has been determined that there is no suitable national job profile to match a job description against.

2.11 The protocol has been developed and agreed in partnership with the Trade Union Partner Lead for Job Evaluation and implemented in March 2021, following approval by the Trust's Executive Management Team (EMT) in February 2021 to commence a pilot. It was agreed that five job descriptions would go through the process and a detailed review and evaluation would be undertaken and the findings reported back to EMT.

2.12 A report providing an assessment of the robustness of the JAQ Lite process, was presented to EMT in August 2021. EMT approved the continuation of the JAQ Lite process, with a second review to be undertaken on the completion of a further ten job descriptions.

2.13 Whilst further work is ongoing to fully mitigate the risk, this finding is considered **fully implemented** and is therefore **closed**.

Finding 2 - Strategic Assessment (Design)

2.14 Our original audit found that the Trust was experiencing significant operational pressures which were accentuated by the pandemic. One of the sources of this pressure was that operational staffing levels were below compliment and the Trust needed to recruit to fill these vacancies as well as the need to recruit to progress transformation programmes at pace. At the same time, the job evaluation function was being re-modelled following a review in 2019 by the All Wales Job Evaluation Group (AWJEG) that identified significant issues with Trust processes.

2.15 At an operational level the main issues had been addressed with assistance from the AWJEG. The focus was to provide greater assistance and support to managers in order to improve the front-end process. Consequently, this led to a more streamlined process, particularly of the matching process generating clearer outcomes. As such a sound platform existed to develop the function in response to the challenges it faced.

2.16 At a strategic level though a suitable framework to assist decision making and strengthen governance arrangements had not been mapped out to capitalise on the improvements in the operational side and define the way forward for the function.

2.17 A paper was presented by the Director of Workforce and Organisational Development (WOD) to EMT in March 2021, following the strategic review of the capacity and capability of the Trust's Job Evaluation function. The purpose of the report was to provide an overview of the key areas identified following our review and confirm the actions required to strengthen capacity and capability. An action plan was included to set out the next steps and timescales. We note that all but one of these actions were rated red or amber.

2.18 Whilst further work is ongoing to fully mitigate the risk, this finding is considered **fully implemented** and is therefore **closed**.

Finding 6 - Lessons Learned (Operation)

2.19 In 2019, the AWJEG undertook a review of jobs that identified significant concerns over the integrity of the process across the Trust. With the assistance of the AWJEG those jobs with significant issues were identified and corrected. However, due to the workload involved and the need to keep up the operational function, those jobs with secondary and administrative issues were not fully debriefed. These pressures meant that there had been no opportunity to draw up a list of formal lessons learned.

2.20 Our current audit found that the Director of WOD presented a paper to the People and Culture Committee, to provide an update on the Job Evaluation function. The paper set out that a review of the 2019 All Wales feedback was undertaken in partnership in July 2020 and a formal log of lessons learned and outcomes was completed in June 2021. The paper also explained that the review had enabled the Job Evaluation Team to identify three areas where improvement was needed and detailed the actions that were being taken in response.

2.21 In addition, we note that the paper showed a considerable improvement in the average turn-around times for job evaluation requests, which had reduced from 91 days as at the end of March 2021 to 30 days by the end of June 2021. The number of completed job descriptions had more than doubled during this time. This improvement continued into quarter ended September 2021. A decline in turnaround times was noted during the quarter ended December 2021, but we were informed that this was due to annual leave commitments and the delivery of job matching training impacting on the frequency of job matching panels.

2.22 Whilst further work is ongoing to fully mitigate the risk, this finding is considered **fully implemented** and is therefore **closed**.

Fire Safety

2.23 This report included two high priority and nine medium priority findings, all of which were reported as being completed on the tracker, with the exception of one medium priority finding which was not yet due. We tested all high priority findings and three completed medium priority recommendations in our sample.

Finding 2 - Board Reporting (Operation)

2.24 The Trust's Fire Safety Policy states the overall accountability for fire safety rests with the Board and the Trust's '*Executive Director with responsibility for Fire Safety*', being the Director of Finance and Corporate Resources. However, it did not state the responsible committee for Fire Safety and / or the associated reporting requirements.

2.25 Minutes of the Fire Safety Group (FSG) (07/07/2020) noted that the '*Fire Safety Group was set up to raise awareness of Fire Safety matters in the organisation and raise the profile of the Trust. Regular reporting to the Health and Safety Committee is now happening, for information to flow through to Trust Board and reassure governance*'. However, the National Joint Committee for Health & Safety

was suspended due to the pandemic and did not reconvene until March 2021. It was understood that Fire Safety was not discussed at that meeting. Accordingly, our previous audit found there was no evidence of upward reporting from the FSG.

2.26 Our current audit found that the Terms of Reference (ToR) for the FSG has been revised. These detail the formal assurance reporting line into the National Health and Safety Committee (NH&SC), which in turn reports into Quality, Patient Experience and Safety Committee (QuEST) through to the Board.

2.27 The newly drafted, but not yet approved, NH&SC ToR does not specifically draw out fire safety and reporting from the FSG. We were informed that management decided to incorporate Fire Safety under the reporting of Estates. This treatment is consistent with other groups that report into the NH&SC, as it was considered making explicit reference to all of these would make the ToR for the NH&SC unwieldly. However, we note that the Board Secretary had highlighted in September 2021 that the draft NH&SC ToR did not specifically make reference to the FSG. The decision that it will be included under the general heading of Estates has not been discussed with the Board Secretary.

2.28 The original recommendation is **closed**. However, management should confirm with the Board Secretary that the proposed approach is satisfactory. Additionally, once the proposed approach has been agreed the NH&SC ToR should be appropriately approved.

Finding 3 - Fire Safety Group (Operation)

2.29 The formation and operation of a FSG is recommended as part of oversight within NHS Organisations by the WHTN-05-01 Firecode. The Trust's Fire Safety policy stated that '*a Fire Safety Group will be established to review all Fire Safety matters. The Group will comprise the Fire Safety Manager, Deputy Fire Safety Managers, Health & Safety Managers and other nominated officers as appropriate including staff representatives. The Fire safety Group will meet quarterly*'.

2.30 Following a previous Internal Audit Report into Fire Safety at the Trust (2016/17), there was a commitment to implement a FSG with defined reporting lines through the National Joint Committee for Health and Safety through to the Board by 31st December 2017.

2.31 Our previous audit found that, since the relaunch of the FSG, there was a set agenda covering all of the pertinent fire safety matters. Minutes recorded that key fire safety matters were discussed. However, structured and consistent reporting on key fire issues was not observed.

2.32 Our current audit found that the FSG meetings reconvened in November 2021 and quarterly meetings for 2022 and 2023 have been scheduled. We note that the first meeting for 2022 was rescheduled from 16 February 2022 to 16 March 2022 to align with the NH&SC meeting date, which was rescheduled.

2.33 A new reporting structure and agenda has been established for these meetings and these are detailed in in the ToR for the FSG. The ToR were taken to the November 2021 FSG and were due to be ratified at the March 2022 meeting.

2.34 The original recommendation is **closed**. Noting that the FSG should continue to meet quarterly and appropriately report into the NH&SC.

Finding 4 - Annual Fire Safety Reports (Operation)

2.35 WHTN-05-01 Firecode notes that an essential element of any fire safety management system is a robust reporting and audit process.

2.36 The Trust's Fire Safety Policy noted that the FSG would produce an annual report on Fire Safety for presentation to the Trust Board in accordance with the requirements of Firecode. The report would provide a position to the Trust Board, identify key risks and any actions complete in the period or proposed. Our previous audit found that annual fire safety reports had not been provided for the past two financial years.

2.37 Our current audit found that an Annual Fire Safety Report was included as part of the Estates Annual Report 2020-21, produced in July 2021. The Estates Annual Report was presented at the NH&SC 's January 2022 meeting.

2.38 The original recommendation is **closed**. Noting that the Trust should continue to produce an annual fire safety report in line with the policy which should also be presented to the NH&SC.

Finding 8 - Training (Operation)

2.39 The Trust's Fire Safety Policy includes roles and responsibilities for Locality Managers and Fire Safety Wardens, stating that these roles will receive additional specific training. The Policy also states that "*Fire safety training is essential for all staff and is a legal requirement under the Regulatory Reform (Fire Safety) Order 2005.*"

2.40 The minutes of the FSG meeting held in December 2020 recorded that there were no Fire Wardens in 13 of the Trust premises. The level of training compliance was not provided during the audit and was not discussed in detail at the FSG.

2.41 We note that we were unsighted on the details of the 13 premises in question that did not have trained Fire Safety Wardens in place. During our current audit we were informed that Fire Safety Wardens have been identified for 12 of the named premises and they were trained between September and November 2021, with refresher training due to take place in late 2024 and early 2025.

2.42 Quarterly performance reports include compliance against Health and Safety statutory and mandatory training, which includes a Fire Safety module. The compliance rate for Fire Safety training as at 31 December 2021 was 58.94%.

2.43 The original recommendation is **closed**. Noting that the Trust still need to name the one remaining premises and identify and train an appropriate Fire Safety Warden. Additionally, whilst we acknowledge that there is reporting of compliance against the statutory and mandatory fire safety module, the percentage compliance needs to be improved to meet the All Wales target.

Finding 10 - Dangerous Substances and Explosive Atmospheres Regulations (DSEAR) (Operation)

2.44 The Dangerous Substances and Explosive Atmospheres Regulations 2002 (DSEAR) require employers to control the risks to safety from fire, explosions and substances corrosive to metals. Dangerous substances are any substances used or present at work that could, if not properly controlled, cause harm to people as a result of a fire or explosion or corrosion of metal. They can be found in nearly all workplaces and include such things as solvents, paints, varnishes and flammable gases.

2.45 The Lampeter Ambulance Station included vehicles stored on site and oxygen cylinders held external to the building and in vehicles. At the time, management commented that '*Flammable substances have been factored into the Trust Fire risk assessment and are considered as part of premises risk assessments. A small oxygen store is present at Lampeter and the findings of the property condition surveys are awaited to determine suitability*'. It was therefore unconfirmed during our previous audit that the arrangement was acceptable in accordance with DSEAR requirements.

2.46 Our current audit found that a DSEAR assessment has been carried out at Lampeter Ambulance Station. The assessment was discussed at the NH&SC's January 2022 meeting as part of the Estates Report and a commitment was made to undertake similar assessments at other WAST premises.

2.47 The original recommendation is **closed**. Noting that the Trust should ensure that it undertakes any similar assessments as appropriate.

ICT Disaster Recovery

2.48 This report included three high priority and one medium priority recommendations, all of which were reported as being completed on the tracker, with the exception of one high priority recommendation which was not yet due. We tested both completed high priority recommendations.

Finding 3 - Backup processes (Design)

2.49 While backups were taken at regular intervals and there was an electronic notification to show the success of the process, our previous audit found there was no formal backup policy and/or procedure in place outlining the responsibilities of staff and backup requirements of applications and servers. Additionally, notification on the success or failure of a backup were monitored by one member of staff only.

2.50 Our current audit found that the Trust has produced a *'Data Backup Procedure*', which was approved by the ICT Senior Management Team (SMT) in March 2022. We were informed that only a few staff have access to manage backups and restores and these have been involved in the development of the procedure. Additionally, we were informed that the capacity of the resilience in the team has been increased through training an additional member of staff.

2.51 The procedure was reviewed which confirmed that *'Section 6: Backup Reporting*' details the process in respect of backups. '*Section 7: Fault Escalation Process*' details the process to follow in the event of an un-successful backup, including the escalation route.

2.52 This finding is considered **fully implemented** and is therefore **closed**.

Finding 4 - Recovery testing processes (Design)

2.53 While in the past ICT staff were able to perform restoration of corrupt or missing files and databases following requests from users on an ad hoc basis, our previous audit found there was no restoration and testing policy/procedure in place nor had the organisation set out or communicated the required frequency of restoration testing.

2.54 Our current audit found that '*Section 8: Test Recovery and Restores'* of the *'Data Backup Procedure*' referred to above details the process that should be followed in regard to the testing and restoration of backups. The suggested frequency per the procedure being monthly.

2.55 This finding is considered **fully implemented** and is therefore **closed**.

Appendix A: 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. **Follow up:** All recommendations implemented and operating as expected
 **Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved. **Follow up:** All high priority recommendations implemented and progress on the medium and low priority recommendations.
 **Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved. **Follow up:** No high priority recommendations implemented but progress on most of the medium and low priority recommendations.
 **No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved. **Follow up:** No action taken to implement recommendations

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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Organisational culture – a learning organisation

Final Advisory Review Report

May 2022

Welsh Ambulance Services NHS Trust

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

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

EXTERNAL • QUALITY • ASSESSMENT

Contents

Review reference:	WAST-2122-019
Report status:	Final
Fieldwork commencement:	8th March 2022
Fieldwork completion:	3rd May 2022
Draft report issued:	9th May 2022
Debrief meeting:	10th May 2022
Management response received:	27th May 2022
Final report issued:	27th May 2022
Auditors:	Simon Cookson, Director of Audit & Assurance Osian Lloyd, Deputy Head of Internal Audit Chris Scott, Internal Audit Manager
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Committee:	Audit Committee

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

Acknowledgement

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

Executive Summary

A learning organisation is skilled at creating, acquiring, and transferring knowledge, and at modifying its behaviour to reflect new knowledge and insights.

Learning organisation models vary, but typically point to developing strength in five main activities: systematic problem solving, experimentation with new approaches, learning from their own experience and past history, learning from the experiences and best practices of others, and transferring knowledge quickly and efficiently throughout the organisation.

The Trust is engaged in a programme of development which will advance its learning and subsequent change of practices, and that will improve the quality of patient care. The Trust strives for continuous quality improvement through learning, and implementing the lessons taken from that learning, but, whilst accredited against an array of quality and practice standards, the Trust is not at present pursuing formal 'accreditation' as a 'Learning Organisation'. Rather, their main thrust and focus is on delivering an effective ambulance response where that is essential to saving harm or life, and this is their overriding organisational objective.

Notwithstanding, the goal of continuous quality improvement through learning directs much of the development work the Trust does. It is visible widely across the organisation and this review sought to establish the level of attainment of that against these five learning related objectives:

- a culture of continuous improvement and learning is promoted within the Trust;
- working practices are designed to enable collaboration, engagement and sharing of learning and best practice, with appropriate technology to facilitate;
- systems are in place to capture and communicate individual, team and organisational learning;
- learning is designed into working practices, with access provided to opportunities for ongoing education and growth; and
- the Trust receives sufficient reporting and assurance of continuous improvement and learning, to inform development of strategy and vision.

The review is intended to be helpful and informative, rather than judgemental, and as it is advisory we have not provided an assurance rating. We have, however, recorded where we consider enhancements could lead to further improvement and provided recommendations to strengthen and improve Organisational Learning in the following areas:

- to progress the behaviours reset delivery action plan;
- feature lessons learned within project and development initiative protocols;
- capturing actions arising from analysis and evaluation of staff stories; and
- re-issuing the expired Transforming Education and Training strategy.

1. Introduction

1.1 The Welsh Ambulance Services NHS Trust ('the Trust' or 'WAST') in 2021 published its Quality Strategy 2021-24. The development of the Strategy, aligned to the Trust's Delivering Excellence 2030 vision and complementing the organisation's wider strategic plans and priorities, has been informed through staff and patient experiences, and recognition of the challenges that they face. In addition to internal influences, the Strategy has been driven by new legislative requirements for health and care organisations in Wales, including the Health and Social Care (Quality and Engagement) (Wales) Act 2020. This places legal duties upon the Trust including, the duty of quality, the duty of candour and new engagement requirements with the Wales' Citizen Voice Body. The Strategy provides a high-level intent on how the requirements will be ascertained.

1.2 The Trust has quality management systems in place and integrated governance to accelerate learning and ensure improvement across the Trust. The Quality, Patient Experience and Safety (QuEST) Committee is responsible for oversight of quality in the Trust's services, and receives a range of regular updates from functional groups across the organisation tasked with quality and safety objectives to fulfil this responsibility.

1.3 The Trust also has a Transforming Education and Training Strategy which forms an integral part of the three-year People and Culture Committee Strategy and is aimed at supporting the entire workforce to maximise the benefits of lifelong learning. Workforce and Organisational Development provide a broad range of learning and education resources for staff across the Trust and the dedicated WAST Learning Zone platform provides staff with a variety of interactive online training modules and digital resources.

1.4 The advisory review's scope was limited to learning available to the Trust from the monitoring activities in the areas outlined above and sought to establish the effectiveness of the Trust's responses to the issues these highlight.

1.5 The key risks considered in this review included:

i) opportunities to improve practices from learning are not acted on which may have an impact on service quality and lead to a recurrence of incidents resulting in patient harm; and

ii) the Trust may fail to achieve its strategic objectives.

Advisory review

1.6 The overarching objective of the review was to provide a view on whether the Trust is maximising opportunities for quality improvement, and to what extent it is supporting a learning environment through leadership reinforced learning.

1.7 The review involved assessing WAST development activities in the context of five learning related objectives.

1.8 This is an advisory review therefore we have not provided an assurance rating. We have identified learning and provided recommendations to strengthen and improve processes. Our recommendations are set out in Appendix A.

2. Detailed Review Findings

Objective 1: A culture of continuous improvement and learning is promoted within the Trust.

2.1 We sought to establish to what extent the culture of the Trust promotes and supports continuous learning by its staff.

2.2 The Trust has a stated vision to 'deliver excellence' and continuous improvement and learning is recognised as key in achieving this.

2.3 We noted the Trust is currently engaged in an exercise to 're-set' its culture and organisational behaviours, focussed on four primary outputs:

- *diverse leaders upskilled in listening to the organisation;*
- *a clear picture of Trust culture, sub-cultures and what drives them;*
- *a refreshed set of organisational behaviours;* and
- *a plan for how to embed behaviours for sustained change.*

2.4 The review, conducted by an external provider, completed in November 2021, recommending that WAST address the following tasks:

- *further address the systemic and symptomatic wellbeing issues;*
- *conduct a systematic harassment and bullying review;*
- *build psychological safety through inclusive leadership;*
- *make everyone feel like a valuable part of the future;*
- *celebrate the strength of TeamWAST during the pandemic;*
- *enhance career development dialogue;* and
- *build upon the whole TeamWAST identity.*

2.5 The findings of the review are to be delivered through a 'Behaviours reset' initiative to be rolled out during 2022 and the Trust launched their new behaviours at the CEO roadshows in March 2022. We were advised these have been welcomed across the organisation and that work continues to roll out associated promotional material and guidance. Going forward the intention is to continue to embed these behaviours within WAST teams over the coming months, but we noted many actions set out in the reset delivery plan are overdue and there are a large number with a red RAG status (**Matters Arising 1**).

2.6 The inclusion of a duty of quality in the Health and Social Care (Quality and Engagement) (Wales) Act creates an imperative within the Trust to deliver quality and to demonstrate this. This has prompted the inclusion of learning 'ambitions' in the Trust's corporate planning documentation and subsequently, the development of learning strategies, the latter to be delivered by the organisation through Trust wide programmes of training and education.

2.7 Following on from this, we sought to identify learning strategies in the Trust's People & Culture, Transforming Education and Training and Quality strategy documents and to ascertain how these are linked to quality improvement.

2.8 We noted the following in our review of these strategy documents:

- the People & Culture strategy includes an education objective '*transforming our approach to education and training, providing quality assured, person centred development opportunities, nurturing a supportive Trust-wide culture of lifelong learning*;
- the Quality strategy links quality and learning through its recognition of the '*Duties of Quality and of Candour'* set out in the Health and Social Care (Quality and Engagement) (Wales) Act'; and
- the Transforming Education and Training strategy recognises the quality objectives that drive the services that WAST deliver and lists '*Quality*' as the first of its five strategy themes.

2.9 We sought to establish how Trust staff are encouraged to learn and contribute to continuous improvement and innovation and what initiatives are in place to empower staff.

2.10 We noted the Transforming Education and Training strategy themes address these elements and the delivery plan expands further, listing actions for delivery, including the following:

- *develop our Education and Training team to enable transition from a 'teaching' to 'facilitation' style;*
- *recognise dual professionalism of colleagues involved in education and provide meaningful CPD opportunities;*
- *encourage personal ownership of education and development by supporting and developing reflective practice, moving away from directed learning;*
- *support nominated education leads to identify and develop relevant learning opportunities for specific areas;*
- *conduct education and training survey(s) to better understand training needs;*
- *develop a Training policy that includes Statutory and Mandatory requirements;*
- *develop the Education and Training delivery team to ensure they have the appropriate qualifications and skills to provide and support education of the highest standard;*
- *establish a rotational model for education staff, which incorporates operational exposure;*
- *establish and implement development pathways for Clinical and Driving Instructor roles, enabling effective succession planning to take place;* and
- *design and deliver appropriate CPD programmes for Practice Educators.*

Conclusion:

2.11 We noted the activity to implement changes to organisational behaviours to increase opportunities for learning and development is being reinforced within the

Trust, at various committees and sub-groups (see further in objective 3), and that learning ambitions articulated in Trust level and functional strategies are targeted to improve service quality.

Objective 2: Working practices are designed to enable collaboration, engagement and sharing of learning and best practice, with appropriate technology to facilitate.

2.12 We sought to establish how effective the Trust is at collaborating, engaging with partner organisations and sharing and learning best practice, by examining some recent examples of development initiatives.

2.13 **Older Persons Improvement Programme**

The Older Persons Improvement Programme has been developed to ensure that WAST considers the needs and opinions of Older People in all their services, planning, quality and improvement processes. This development programme is underpinned by the Older Persons Framework, produced in August 2021.

Collaboration

The older persons framework has been developed with healthcare partners, including care homes and domiciliary care providers, volunteer response including community first responders, community-based response services and fire and rescue falls responders, to provide opportunities for improvement across all aspects of health and social care including primary, acute, local authority and the third sector.

Engagement and sharing of learning and best practice

The Health and Social Care (Quality and Engagement) (Wales) Act 2020 actively encourages the involvement of citizens, in this instance older people, in the design, development and delivery of services throughout the organisation. Through co-production and co-design, older people are able to contribute positively to influence the future vision and strategy of the service by ensuring organisation learning occurs through fully understanding the citizens' perspective. This will include developing opportunities for the utilisation of digital technology for patients to provide feedback and actively develop services.

2.14 **Falls and Frailty Framework**

The Falls and Frailty Response Service model has been developed to provide a timely and appropriate response to older and frail persons who contact the Trust for assistance.

Collaboration

The framework aims to support collaboration between organisations, through developing shared awareness, increased confidence and opportunities to improve services. Frailty and Falls Response Services are delivered through a range of collaborative partners including care homes and domiciliary care providers, volunteer response including community first responders, other community-based

response services and fire and rescue falls responders, as well as being supported by Welsh Government and the Emergency Ambulance Service Committee (EASC).

Engagement and sharing of learning and best practice

The Older Persons Education Action Group (OPEAG) has been established to provide a mechanism by which the Trust can develop an action focused, improvement driven, cross directorate approach to the delivery of change in regard to education and older person care for WAST staff across Wales.

The OPEAG has a broad range of objectives in its remit, and this includes to work collaboratively, both within WAST and with external organisations, to identify opportunities for improvement and through the use of quality improvement methodology, lead and advise on the implementation of change. This is achieved through representation from across the Trust by individuals with an interest in education, and who are in a position to action change, challenge and implement quality improvement.

2.15 **Research Innovation & Improvement Hub**

The WAST Research Innovation & Improvement Hub (RIIH) delivers research, innovation and improvement initiatives to support the key service change development themes in the IMTP (e.g. to develop services to influence a 'shift left' of patient demand towards scheduled care as far as possible).

Collaboration

The work is carried out in collaboration with Welsh Government and co-ordinated across Wales, with similar units in each of the Regional Partnership Board areas. Initiatives in progress include:

- advancing the crisis prevention and 'investing to save' agenda, with a cross-sectoral collaboration that connects communities through social prescribing;
- progressing a Welsh NHS Trust innovation partnership model (with PHW and Velindre NHS Trust) for large programmes of collaborative work; and
- a pan-Wales 'missed opportunities' project, comprising Emergency Departments and WAST, to identify barriers and enablers to hospital admission avoidance, which will set the scene for subsequent work streams.

Engagement and sharing of learning and best practice

Work programmes are shared with counterparts in the other RIIH's and several of the initiatives being developed are pan-Wales with involvement from all of the hubs.

2.16 We noted also the Trust has the WAST Improvement & Innovation Network (WIIN) to support the development of innovative ideas put forward by staff (see more under objective 3).

2.17 **Safeguarding**

A variety of Safeguarding related issues that emerge through routine activities are now being addressed through the development of the '7 minute briefing' communications.

Collaboration

Improvement opportunities are identified through the work of Safeguarding teams in collaboration with colleagues across the Trust.

Engagement and sharing of learning and best practice

The patient engagement team of the Safeguarding function prepare and distribute the 7 minute briefings to WAST staff through a variety of digital channels. The briefings have improved patient services in the areas they have addressed. In particular, WAST have seen improvements in the uptake in referrals to the 'Live Fear Free' all Wales specialist domestic abuse helpline, and to the Fire Service Home Safety Team following the running of 7 minute briefings on these topics.

2.18 We noted a further example of engagement and sharing of learning and best practice in the new revised paramedic model structure. This involved the creation of a new band 6 Senior Paramedic (SP) role, to operate in a supervisory capacity and to aid the development of practices through review and analysis of paramedic team responses. Learning gained through this is shared with the clinical leadership team and members of the operations management team, via a dedicated Senior Paramedics Teams channel. We were advised that data gathered from the SPs analysis of paramedic activity is used to help progress priorities, increase compliance and improve quality.

Conclusion:

2.19 Examples of working practices involving collaboration, engagement and sharing of learning are widespread in the Trust.

Objective 3: Systems are in place to capture and communicate individual, team and organisational learning, for use in policy design, strategy development and decision making.

2.20 We sought to establish what systems are in place within the Trust to capture and communicate learning and how this is then used to inform Trust plans and decision making.

2.21 Individual Learning

The Electronic Staff Record (ESR) system captures and records individual staff learning in their personal records. These accounts record an individual's learning objectives in the Personal Appraisal Development Review (PADR) documentation and clinical supervision helps identify individual clinical staff training needs. ESR dashboards provide summary level information of staff training status across mandatory courses linked to their role.

2.22 Learning through the capture of innovative ideas

Across the Trust, staff are encouraged to identify and share ideas for innovation through WIIN. WIIN offers an on-line portal for the submission of new ideas, encourages innovative thinking across the workforce and offers organisational learning where these ideas are developed into new or enhanced practices. All ideas submitted to the group are carefully considered, assessed, shared, and where selected, developed and rolled-out as practice amendments.

2.23 Ideas are accepted for all areas of activity but there is rigorous assessment and testing of these, including for 'fit' to the Trust's IMTP priorities. Assessment of opportunities is carried out by the WIIN Business Meeting, a cross-directorate group of Trust colleagues who hold expertise and insight in improvement and innovation. The remit of the group includes, but is not limited to, providing expert advice, guidance, recommendations and reporting on WIIN improvements and innovations. Challenging cases that require further scrutiny before approval are escalated to the Assistant Directors Leadership Team (ADLT) for analysis and decision.

2.24 We noted the work of the WIIN group had been interrupted by the pandemic and had only recently been relaunched as a result. The group was unable to identify any recent examples of ideas that had led to practice changes, but we noted developments in the areas of PADR compliance and hospital handover delays had taken place previously as a result of WIIN submissions.

2.25 Learning taken from projects and development initiatives

Lessons learned from projects are typically identified through and captured in project highlight, Situation-Background-Assessment-Recommendation (SBAR) and closure reports shared with relevant committees, committee sub-groups, and the Trust Board. The WAST operational plan progress report to STB includes lessons learned through the work delivered as does the IMTP deliverable assurance report.

Development initiatives similarly report their progress in highlight reports and their outcomes to their oversight committees and these may include sections on lessons learned. We examined several examples where this had been done (although we did not conduct a formal audit sample test of the Trust project lessons learned process).

Regarding what is prescribed in respect of lessons learned reporting, we were advised this area is covered in a WAST Project methodology but because of resource issues, this has not been fully trained or rolled-out across the project management community as yet (see **Matters Arising 2**).

2.26 Learning from adverse incidents and events

Key learning in the Trust is taken from the capture and analysis of adverse incidents and concerns. A framework is in place to record, assess and report incidents and events that take place and, in respect of concerns, to capture patient and community group feedback. Typically, learning is captured within the

functional groups responsible and then shared with the wider organisation via reporting streams to appropriate committees and the Trust Board.

2.27 The framework is made up of several key elements described in the paragraphs below.

2.28 Incidents and events are captured in the DATIX incident reporting system. All members of staff have access to this central database and are encouraged to record any adverse incident that they have experienced or witnessed. System content is routinely analysed, assessed and reported to oversight groups, and key issues that arise are communicated through the governance framework. Any cases that are considered as potentially causing significant harm are identified and a briefing report is prepared and taken to the Trust Serious Case Incident Forum for discussion. If necessary, they are reported as Nationally Reportable Incidents (NRIs) to the NHS Wales Delivery Unit and investigated accordingly.

2.29 Learning from these investigations is presented to the Trust's Patient Safety, Learning and Monitoring Group and these cases are included in a regular Patient Safety report to the WAST CEO (covering patient safety incidents, concerns, ombudsman cases, coroners cases, NRIs (previously serious adverse incidents) and claims). Patient Safety Highlight reports are also presented regularly to QuEST, through which they feed back to the wider Trust where they include a section on key achievements and learning.

2.30 Examples of WAST team learning in recent reports include:

- issue of clinical notices - these are issued to the clinician community for implementation;
- record of clinical reviews held by each of the health boards (which were prompted by incidents that took place) - these record the learning opportunities identified from the reviews e.g., timely deployment of support resources; and
- the issue of coaching bulletins for Call Handlers and Dispatchers.

2.31 Complaints from patients are received and handled by the 'Putting Things Right' team. Cases are examined through a formal process, underpinned by a statutory framework that denotes such things as written response protocols and time limits. Following examination, complainants are offered explanations and where applicable, apologies and / or assurances. In serious cases, complainants can pursue compensation, dealt with under the Trust's losses and special payments framework (see below). Cases are analysed and reported to the QuEST Committee and we noted examples are given of actions that have been taken to address root causes.

2.32 The Trust also processes and reports on compensation claims through the losses and special payments process. Quarterly, the Audit Committee receive a paper in relation to the financial payments that have been made by the Trust. This includes the payments made in relation to claims and more recently, themes and trends, and where appropriate, lessons learned. Wider learning for the Trust is achieved by individual line managers sharing information with their staff, and various

reporting including on the learning from closed personal injury claims biannually, an annual report on themes, trends and lessons learned from road traffic collisions and the Welsh Risk Pool Services 'Learning from Events' reports.

2.33 Learning from patients and community

The Patient Experience & Community Involvement (PECI) team liaise with community and patient groups to capture a range of feedback and patient experience material. This is then compiled and incorporated into a quarterly PECI highlight report, which provides information on the different ways the Trust collects service user feedback and experience, what it means, and how the Trust is using it to improve the services they provide. Included within this report, presented to the QuEST Committee, is evidence of community engagement work, social media activity and the Trust's involvement in public health.

2.34 Patient and staff stories are another means of capturing events and incidents that lead to organisational learning and changes in practice. These stories are shared via the QuEST Committee (patient stories) and Trust Board (patient / staff stories). Patient stories are analysed using a 'driver diagram', providing a structured means of generating an action plan to address the patient story issue. We note there is no such process for the issues raised in the staff stories (see **Matters Arising 3**).

2.35 The Trust also has an established 'Have your Say' facility live on its website, which enables people to leave feedback about a particular service, including emergency 999 response. Information captured through this channel is shared with relevant managers and reported within patient feedback information to the QuEST Committee.

2.36 In response to the patient voice initiative associated with the recently introduced 'duty to listen' mechanism, the Trust has introduced the People and Community network. A key component of the Trust's Quality Strategy, the network will enable people and communities to become more involved in the work of the Welsh Ambulance Service, amplifying the citizen's voice, ensuring it is heard across the organisation. This is a new initiative to engage with the community and, through the recruitment of network members, improve communications with patients. This network seeks to engage with people the Trust may not have engaged with before and enlist as broad a spectrum of people as possible to facilitate the delivery of more person-centred care. We noted quarterly PECI highlight reports record the communication initiatives that network members have been involved in.

Conclusion:

2.37 Effective learning cascades through the organisational frameworks and gives rise to positive changes to plans and / or processes. We saw this in action in a variety of areas and noted a number where process enhancements might increase learning further.

Objective 4: Learning is designed into working practices, with access provided to opportunities for ongoing education and growth.

2.38 We sought to establish the extent to which the Trust is providing staff with opportunities for education and growth, through access to learning opportunities. We also reviewed processes in place for directorates to identify staff development opportunities and needs, and to design and deliver development activities to address these.

2.39 The Transforming Education and Training Strategy sets out how education and training needs are to be met and a deliverables appendix records how actions to do so will be rolled out. This is supported by the Strategic Education Steering Group, which has a role to oversee and provide strategic direction in relation to the transformation of education and training within WAST. We noted that the period of the strategy ended at the end of 2021/22 and that a number of the training and education deliverables were overdue and will be carried over into the new strategy period. The new strategy is being developed, but at the time of the audit it's launch was overdue (see **Matters Arising 4**)

2.40 We noted staff development needs emerge from a variety of sources which are recorded below:

- mandatory training programmes which are prescribed for all of the UK ambulance services;
- regular quality review work (auditing, spot checks, clinical audits) conducted in functional activities which identify weaknesses in ways of working that need to be addressed;
- through capture and evaluation of concerns and SAIs;
- from objectives set at staff PADR meetings with their line mangers;
- digital expansion, innovation and automation in the workplace;
- changes in legislation, national competency frameworks, professional standards;
- changes in service demands and demographics; and
- learning ambitions recorded in WAST strategies.

2.41 Training opportunities for WAST staff are broad and varied and extend to a range of apprenticeships, the paramedic degree level programme provided by Swansea University, and research opportunities with partner organisations e.g., other health bodies, research institutions and universities.

2.42 Continuing professional development (CPD) is encouraged and staff are freed from rosters to undertake courses relevant to their roles. Annual provision for CPD in the Trust varies according to role but all Advanced Paramedic Practitioners, Paramedics, Emergency Medicine Technicians and Urgent Care Service officers are allocated 52 CPD hours per year.

2.43 We note that to drive developments in this area, the Academic Partnership Committee is responsible for strategic collaboration and partnership working with higher and further education and wider education providers across and beyond

Wales. With the support of this committee, WAST is in the process of applying for University Trust status.

Conclusion:

2.44 Education is pre-eminent in the Trust and staff are offered a broad range of opportunities to increase their learning. Activity in this area is strategy driven but we did note that some of the deliverables of the outgoing strategy document had not been achieved to planned timescale, and that the revised strategy document for the new period had not yet been finalised and issued.

Objective 5: The Trust receive sufficient reporting and assurance of continuous improvement and learning, to inform development of strategy and vision.

2.45 We sought to establish the mechanisms through which functions report their progress in respect of learning objectives to oversight steering groups or committees.

2.46 We noted that corporate level learning objectives are not stated in corporate level planning and strategy documents, but rather, they tend to be articulated as ambitions in functional strategies (examples of these are cited in para 2.8 above), where they serve as enablers to the achievement of the related organisational priorities. We found that progress against the learning ambitions in these documents is typically shared in highlight reports to oversight sub-groups or committees, who then in turn update the Board through the Trust's governance structure.

2.47 We sought to establish how each strand of organisational learning are brought together to demonstrate assurance to the Board and we were provided with materials evidencing an ongoing committee effectiveness review.

2.48 The review indicated changes were needed to improve the range and impact of the committees' work, which would be achieved through the following actions:

- review and revision of the terms of reference of all Trust committees to include learning objectives;
- identifying and scheduling the assurance pieces that the committees would receive to address their objectives, and drafting forward plans setting out their cycles of business;
- ensuring that committee forward plans and related cycles of business cover the terms of reference objectives; and
- implementing new sub-committee highlight reporting to each Trust Board meeting, to replace the sharing of sub-committee meeting minutes.

We noted that that revised terms of reference have been approved by the individual committees and will be presented to Board for approval in May 2022.

2.49 We noted the Board Assurance Framework (BAF) has been paused pending the development of a new model, although we were assured that the Board continues to review the Corporate Risk Register (CRR) in the normal manner.

2.50 We were advised that development work is underway to rearticulate the current corporate risks into a more meaningful format *('If: Then: Resulting in'*), against which assurance sources will be mapped with greater clarity in the revised BAF model.

Conclusion:

2.51 Oversight committees receive reports of working groups and projects tasked with learning objectives who in turn update the Board through the Trust's governance structure. A committee effectiveness review is in progress that will lead to greater effectiveness and clarity, and improvements to the Corporate Risk Register and Board Assurance Framework.

Appendix A: Management Action Plan

Matter arising 1: Behaviours reset delivery action plan (Operation)	Impact
We noted the Trust had embarked on a Behaviours study in mid-2021 to identify areas for change. The study, conducted by an external consultant, looked at how the Trust could address difficult issues and emotive subjects, particularly in the wake of a very testing period which had seen enormous pressure placed upon staff and the service as a whole. The aim of this was to make the Trust as inclusive as possible, allowing for free and frank discussions and exchanges of views between managers and staff, with the aim of building a more collaborative workplace where staff were engaged in the process. The study concluded with a 'Behaviours reset' delivery plan, which set out a series of actions to address the themes that had emerged and implement changes to improve ways of working. Whilst we were advised that the Behaviours reset initiative was shared with the workforce at the CEO Roadshows in March 2022, and a progress highlight report was included in papers to the People & Culture Committee in February 2022, we noted a substantial number of actions were overdue at the time of the advisory review. There were a large number of red rated RAG status actions and consequently, we were unable to establish the current status of the delivery plan.	Lack of clarity over the status of the organisational level Behaviours reset plan actions and consequently of the volume and complexity of the work ahead to address the organisational changes it contains.

Recommendations	Priority
1.1 We recommend that the behaviours reset delivery plan is brought up to date as a matter of priority in order to clarify current status of this initiative.	Medium

Management response	Target Date	Responsible Officer
1.1 Management accepts this recommendation, and it has been completed with regular review meetings now in place.	Completed	Faz Tahir Organisational Development Manager

Matter arising 2: Sharing project and development initiative lessons learned (Design)	Impact
We noted examples of the sharing of learning arising from projects or developments through lessons learned reporting, but were not able to gain assurance that this practice is universal and operates across all projects and development initiatives. Whilst we noted that project PIDs may record a lessons learned section and signal how and when in the project lifecycle this will be delivered, and saw several examples of learning recorded in project closure reports and lessons learned logs, we were unable to gain assurance that all such projects and developments routinely capture and share lessons learned.	Potential risk that errors or oversights that were identified in a project or development are repeated in subsequent projects or developments.

Recommendation	Priority
2.1 We recommend that project and service development models clearly feature a step to record and share lessons learned to ensure this is firmly embedded in the respective workflows.	Medium

Management response	Target Date	Responsible Officer
2.1 Management accepts this recommendation and a step will be added to PIDs to record and share lessons learned in an appropriate named forum with a target date and responsible officer.	June 2022	Hugh Bennett Assistant Director of Commissioning

Matter arising 3: Analysis of and actions arising from staff stories (Design)	Impact
The Trust captures and learns from adverse incidents through a variety of channels, one of these being patient and staff stories of their experiences. We noted that patient stories are captured in a 'Driver diagram' template which are used to derive the action that needs to be taken to address the issues raised. However, we saw that this is not the case for staff stories and as a result there is less clarity around how issues identified through these pieces are being addressed.	Potential risk that learning from the experiences reported in staff stories do not translate into actions to address the issues they describe and that as a result, these persist.

Recommendation	Priority
3.1 We recommend that staff stories are evaluated to identify and deliver actions to address the issues they raise.	Medium

Management response	Target Date	Responsible Officer
3.1 Management accepts this recommendation and staff stories will now automatically include an evaluation sheet to be completed by the person curating the story.	June 2022	Catherine Goodwin Interim Director of WOD

Matter arising 4: Transforming Education and Training Strategy re-issue (Operation)	Impact
We noted the Transforming Education and Training Strategy 2019 – 2022 expired in March 2022 and, at the time of the review, had not been revised and re-issued for the new strategy period. We noted that the strategy is transformational and therefore key in supporting delivery of the Trust's long-term strategic ambitions. We understand that a number of areas of the outgoing strategy are yet to be delivered and as a result will need to be rolled over into the new document.	Potential risk that the Transforming Education and Training agenda is interrupted or delayed in the absence of a current strategy document.

Recommendation	Priority
4.1 We recommend that the expired Transforming Education and Training Strategy is refreshed and re-issued as a matter of priority.	Medium

Management response	Target Date	Responsible Officer
4.1 Management accepts this recommendation, the Education and Training Strategy will be refreshed and re issued as planned as a framework following the delayed refresh of the people and culture strategy. The People and Culture Strategy refresh has been delayed due to system pressures.	December 2022	Jo Kelso Head of Education Transformation

Appendix B: Action plan risk rating

Prioritisation of Recommendations

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

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

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

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Audit Wales

Audit Committee Update – Welsh Ambulance Service NHS Trust

Date issued: June 2022

Document reference: 2995A2022

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

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

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Contents

Audit Committee update:

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
Audit of 2020-21 Financial Statements	The Auditor General certified the Performance Report, Accountability Report and Financial Statements on 15 June. The next day they were laid by the Senedd, with a published statement by the Welsh Government.
Independent Examination of the 2020-21 Charitable Funds' Financial Statements	Complete – Presented to Charitable Funds Committee on 17 January 2022. Trust Board approved the Trust Charity Annual Report and Accounts Committee on 27 January 2022.
2021-22 Audit of the Financial Statements	Audit commenced 29 April 2022 and is nearing completion. Audit of Accounts Report to be presented to Audit Committee on 7 June 2022, with the final financial statements to be considered by Trust Board on 13 June 2022.

Performance audit update

3 The following tables set out the performance audit work included in our current and previous Audit Plans, summarising:

- work that is currently underway or completed (**Exhibit 2**); and
- planned work not yet started or revised (**Exhibit 3**).

Exhibit 2 – Work currently underway

Topic	Focus of the work	Current status and Audit Committee consideration
Quality Governance	As an extension to structured assessment, this work will consider the structures, information and assurance flows that support quality governance.	Report drafting underway – Anticipated to report to Audit Committee in September 2022
NHS Structured Assessment 2022	A review of the corporate arrangements in place at the Trust in relation to: • Governance and leadership. • Financial management. • Strategic planning • Use of resources (such as digital resources, estates, and other physical assets).	Fieldwork due to begin June 2022 – Anticipated to report to Audit Committee in December 2022
Review of Unscheduled Care	Our Unscheduled Care data tool was published in April 2022. The remainder of the review will be split into three areas: Part 1: Patient Flow out of Hospital	Fieldwork for part 1 due to begin in June/July 2022 – Anticipated to report to Audit Committee in December 2022

Topic	Focus of the work	Current status and Audit Committee consideration
	Part 2: Access to the Unscheduled Care System Part 3: National arrangements for supporting the unscheduled care system	

Exhibit 3 – Planned work not yet started or revised

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

Good Practice events and products

4 In addition to the audit work set out above, we continue to seek opportunities for finding and sharing good practice from all-Wales audit work through our forward planning, programme design and good practice research.

5 There have been no Good Practice Exchange (GPX) events since we last reported to the Committee in March 2022. Details of future events are available on the GPX website.

6 In response to the Covid-19 pandemic, we have established a **Covid-19 Learning Project** to support public sector efforts by sharing learning through the pandemic. This is not an audit project; it is intended to help prompt some thinking, and hopefully support the exchange of practice. We have produced a number of outputs as part of the project which are relevant to the NHS, the details of which are available here.

NHS-related national studies and related products

7 The Audit Committee may also be interested in the Auditor General's wider programme of national value for money studies, some of which focus on the NHS and pan-public-sector topics. These studies are typically funded through the Welsh Consolidated Fund and are presented to the Public Accounts Committee to support its scrutiny of public expenditure. **Exhibit 4** provides information on the NHS-related or relevant national studies published during the past six months. It also includes all-Wales summaries of work undertaken locally in the NHS.

Exhibit 4 – NHS-related or relevant studies and all-Wales summary reports

Title	Publication date
Tackling the Planned Care Backlog in Wales	May 2022
NHS waiting times tool	May 2022
Unscheduled Care in Wales: Data Tool and Blog	April 2022
Direct Payments for Adult Social Care	April 2022
Joint working between Emergency Services	January 2022
Care Home Commissioning for Older People	December 2021

8 **Exhibit 5** provides information on NHS-related or relevant national studies work in progress with indicative publication dates.

Exhibit 5 – NHS-related or relevant studies and all-Wales summary work currently in progress

Title	Indicative publication date
Orthopaedic services	2022
Unscheduled care – a whole system view	2022

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

Archwilio Cymru
Audit Wales

Audit of Accounts Report – Welsh Ambulance Services NHS Trust

Audit year: 2021-22

Date issued: June 2022

Document reference: 2990A2022

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 issues to report to you prior to their approval.

Audit of Accounts Report

Introduction

1 We summarise the main findings from our audit of your 2021-22 accounts in this report.

2 We have already discussed these issues with the Executive Director of Finance and Corporate Resources.

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 £2.763 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 a lower materiality level for these, as follows:

- Related Parties
- Senior officers' remuneration

6 We have now substantially completed this year's audit, but at the time of drafting this report, the following areas of work are outstanding:

- Payroll;
- Property, plant and equipment and specifically assets under construction;
- Our final stage review of our audit work coupled with our final review of the revised financial statements.

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.

Impact of COVID-19 on this year's audit

8 The COVID-19 pandemic has had a continuing impact on how our audit has been conducted. We summarise in **Exhibit 1** the main impacts. Other than where we specifically make recommendations, the detail in **Exhibit 1** is provided for information purposes only to help you understand the impact of the COVID-19 pandemic on this year's audit process.

Exhibit 1 – impact of COVID-19 on this year's audit

Timetable	• The deadline for completing your accounts was 29 April 2022. • We received the draft accounts on 29 April 2022. • We expect your audit report to be signed on 15 June 2022.
Audit evidence	As in previous years, we received the majority of audit evidence in electronic format. We continued to build on our experience of working remotely during the pandemic and have used various techniques to ensure audit evidence has been appropriate and sufficient to support our audit opinion. Specifically: • Trust officers provided audit evidence to the audit team via the Digital Health and Care Wales' Secure File Sharing Portal (a secure, web-based portal); • Trust officers were available via Teams for discussions, and for the sharing of on-screen information/evidence; and • Our Analytics Assisted Audit application was also used during the audit for risk assessing journals, carrying out financial statement tests and sampling populations. This application uses the Trust's general ledger data provided independently by NWSSP which provides additional assurance over the transactions included within the financial statements.
Other	• Video-conference-based Trust Audit Committee meetings have enabled us to proficiently discharge our responsibility for reporting to those charged with governance.

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 Last year the audit report included an emphasis of matter paragraph, drawing the reader's attention to Note 24 of the accounts. The note described the impact of a Ministerial Direction issued on 18 December 2019 to the Permanent Secretary of the Welsh Government, instructing her to fund NHS clinical staffs' pension tax liabilities incurred by NHS Wales bodies in respect of the 2019-20 financial year.

12 As last year, the Trust has disclosed the existence of a contingent liability at 31 March related to this issue, however given this was highlighted last year, I no longer consider there is a need for an Emphasis of Matter paragraph in relation to this issue and my opinion is not modified in respect of this matter.

13 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.

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

Significant issues arising from the audit

Uncorrected misstatements

15 There is one misstatement above our trivial level, but lower than materiality that we identified in the accounts, which has been discussed with management but remains uncorrected. We request that this is corrected. If you decide not to correct this misstatement, we ask that you provide us with the reasons in writing.

16 Land and building assets on NHS bodies balance sheets have full revaluations every five years and are subject to indexation annually. The District Valuer (DVS) provides the indices in each interim year between the full revaluation exercise. The rates to be used in 2021-22 were provided in August 2021. The index quoted for buildings was 111 compared to a base rate of 100 from 2017-18, when the last full revaluation exercise was completed.

17 Due to movement in building costs in quarter four of 2021-22, the DVS provided an updated index for buildings (113) in March 2022. In line with all other Welsh health bodies and in compliance with instructions from Welsh Government under Technical Update 7, the Trust has not applied the latest rate in their calculation of indexation within the financial statements.

18 This has resulted in the following misstatements:

- an understatement of £395,000 in the indexation (cost) figures;
- an understatement of £71,000 in the indexation (accumulated depreciation) figures;
- an understatement of £324,000 in the net gain on revaluation of property, plant and equipment in the Revaluation Reserve; and
- an understatement of £4,000 in depreciation charged to the Statement of Comprehensive Income.

Corrected misstatements

19 There were initially misstatements in the accounts that have now been corrected by management. However, we consider 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

20 In the course of the audit, we consider a number of matters relating to the accounts and report any significant issues arising to you. There was one issue arising in this area this year as shown in **Exhibit 2**:

Exhibit 2 – significant issues arising from the audit

Area	Issue identified	Recommendation
Contingent liability arising from the ministerial direction relating to senior NHS staff's pension tax liabilities	As was the case last year, the Trust has disclosed additional narrative in Note 24 – Contingent Liabilities, to disclose the potential liability resulting from the ministerial direction to the Welsh Government to fund pensions tax liabilities above the pension savings annual allowance threshold in 2019-20	As set out in paragraphs 11 and 12, this remains a potential issue and the Trust. The Trust should continue to engage with Welsh Government to resolve the issue in 2022-23, so the contingent liability disclosure can be removed, or if a liability has arisen, a provision included in the accounts. If a provision is required, this would result in a regularity qualification.

Recommendations

21 The recommendations arising from our audit are set out in **Appendix 4**. Management has responded to them and we will follow up progress against them 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

Draft Letter of Representation

Auditor General for Wales

Wales Audit Office

24 Cathedral Road

Cardiff

CF11 9LJ

13 June 2022

Representations regarding the 2021-22 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 2022 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 the 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. A summary of these items is set out below:

- The Trust has not applied the latest index rate (113) in the calculation of indexation within the financial statements, in line with all other Welsh NHS bodies and instruction from Welsh Government. This has resulted in the following misstatements.
    - an understatement of £395,000 in the indexation (cost) figures;
    - an understatement of £71,000 in the indexation (accumulated depreciation) figures;
    - an understatement of £324,000 in the net gain on revaluation of property, plant and equipment in the Revaluation Reserve; and
    - an understatement of £4,000 in depreciation charged to the Statement of Comprehensive Income.

Representations by the NHS Trust 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 Trust Board on 13 June 2022.

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	Martin Woodford
Chief Executive	Chair of the Trust
Date: 13 June 2022	Date: 13 June 2022

Appendix 2

Proposed Audit Report

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 NHS Trust for the year ended 31 March 2022 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 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 2022 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 of 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 report. I am 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 report.

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.

Report on other requirements

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 information given in the Governance Statement for the financial year for which the financial statements are prepared is consistent with the financial statements and Governance Statement has been prepared in accordance with Welsh Ministers' guidance;
- the information given in the Foreword, Performance Report and Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements and the Foreword, Performance Report and Accountability Report has been prepared 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 Foreword, Performance Report, Accountability Report and Governance Statement.

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

- 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 Remuneration 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; orI have not received all the information and explanations I require for my audit.

Responsibilities

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 the preparation of financial statements which give a true and fair view and for such internal control 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.

In preparing the financial statements, the Directors and Chief Executive are responsible for 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 deemed inappropriate.

Auditor's responsibilities for the audit of the financial statements

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 an auditor's report 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, the audited entity's head of 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 the following area: management override; and
- 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.

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, the Audit Committee and legal advisors about actual and potential litigation and claims;
- reading minutes of meetings of those charged with governance and the Board;
- 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 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.

Responsibilities for regularity

The Chief Executive is responsible for ensuring the regularity of financial transactions.

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

Report

I have no observations to make on these financial statements.

Adrian Crompton
Auditor General for Wales
15 June 2022

24 Cathedral Road
Cardiff
CF11 9LJ

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.

Exhibit 3: summary of corrections made

Value of correction	Nature of correction	Reason for correction
£Nil impact on the overall financial position	**Annual Governance Statement:** Minor disclosure amendments have been made to the Annual Governance	To comply with the requirements of the Manual for Accounts
£Nil impact on the overall financial position	**Remuneration and staff report:** The following amendments have been made to the remuneration and staff report: • Staff numbers disclosed within the remuneration and staff report have been updated to agree to those disclosed within Note 10.2 of the financial statements; • Remuneration table B has been updated for the employer's contribution to stakeholder pension for one senior manager; • Remuneration table A has been updated for the pensions benefits to show the disclosures to the nearest £1,000 instead of in bands of £2,500. • Remuneration table A has been updated to include full year equivalent salary figures for senior managers who were not in post for the full year.	To comply with the requirements of the Manual for Accounts and ensure disclosures are accurate.

£Nil impact on the overall financial position	**Note 10 - Employee costs and numbers:** The following amendments have been made to Note 10: 'Employee costs and numbers': • Note 10.1: 'Employee costs' has been amended to correctly disclose 'social security costs' as employer's National Insurance costs net of statutory maternity pay deductions, which resulted in an amendment of £346,000 between 'salaries and wages' and 'social security costs'.	To comply with the requirements of the Manual for Accounts and ensure disclosures are accurate.
£Nil impact on the overall financial position	**Note 13 – Property, plant and equipment:** • 'Net book value at 31 March 2022' table has been amended to correctly disclose £155,000 transport equipment and £20,000 plant and machinery as 'donated', which was been incorrectly included as 'purchased'.	To correctly reflect the financing of the assets.
£Nil impact on the overall financial position	**Note 13 – Property, plant and equipment:** • 'Cost of valuation' Reclassifications – Buildings excluding dwellings: decreased from £13,010,000 to £12,710,000; and • 'Cost of valuation' Reclassifications – Land: increased from £0 to £300,000.	To correct the classification of land at Cardiff MRD.
£Nil impact on the overall financial position	**Note 20 – Trade and other payables:** • Non-NHS trade payables – revenue: increased from £3,716,000 to £3,883,000; • Capital payables – tangible: decreased from £10,212,000 to £10,063,000; and • Capital payables – intangible: decreased from £122,000 to £104,000.	To correct the classification of balances within Note 20.

£Nil impact on the overall financial position	**Note 23 - Provisions**: Expected timing of cash flows – personal injury: 'Between 01 April 2023 to 31 March 2027' decreased from £9,571,000 to £1,911,000 and 'Thereafter' increased from £0 to £7,680,000.	To correctly reflect the expected timing of cash flows. This amendment impacts on the disclosure within Note 23 only.
£Nil impact on the overall financial position	**Note 24 - Contingent Liabilities**: Amounts disclosed in the note have been amended as follows: • Secondary care: Increased from £8,172,000 to £9,193,000; • Defence costs: Increased from £241,000 to £316,000; • Total of disputed claims: Increased from £8,413,000 to £9,509,000; • Amount recovered under insurance arrangements in the event of these claims being successful: Increased from (£7,360,000) to (£8,290,000); and • Net contingent liability: Increased from £1,053,000 to £1,219,000.	To ensure the disclosure in Note 24 agrees to supporting documentation.
£Nil impact on the overall financial position	**Note 33 - Related Party Transactions**: The following amendments have been made to the disclosures of transactions with related parties: • Expenditure to related party: WHSSC/EASC increased from £0 to £50,000; Aneurin Bevan University Health Board increased from £290,000 to £348,000 and Digital Health and Care Wales increased from £696,000 to £758,000; and • Interests in related parties table has been updated to include an omitted directorship for one senior manager. The Trust had no transactions in respect of the omitted directorship.	To ensure disclosures are complete and accurate.

There have also been a number of minor amendments and disclosure updates as a result of our work.

Appendix 4

Recommendations

We set out all the recommendations arising from our audit with management's response to them. We will follow up these next year and include any outstanding issues in next year's audit report:

Exhibit 4: matter arising

Matter arising – Defibrillators	
Findings	In our 2020-21 audit of accounts report, we reported that we had been unable to obtain sufficient assurance over the existence of defibrillators with a net book value of £273,000, out of the total value of defibrillators of £5.3 million. The Trust indicated they planning to implement an RFID tagging system to identify where all assets are held, which would enable the Trust to verify the existence of these defibrillators and ensure they are still in operational use. The RFID tagging system is not yet operational, therefore we are still unable to obtain sufficient assurance over the existence of these defibrillators. The net book value of these was £196,000 as at 31 March 2022.
Priority	Medium
Recommendation	The Trust should implement the planned RFID tagging system in 2022-23. If this system is not going to be implemented in 2022-23, the Trust should consider completing a separate exercise to verify the existence and operational status of the defibrillators.
Benefits of implementing the recommendation	Improved controls over the location and status of assets.

Accepted in full by management	Yes
Management response	This project has been impeded and impacted on by Covid-19 over the past two years, as due to restrictions on access to Trust property from a Covid-19 secure point of view it was inappropriate to roll-out this project further and risk unnecessary spread. The Trust will now endeavour to accelerate the delivery and implementation of this system at pace.
Implementation date	31 December 2022

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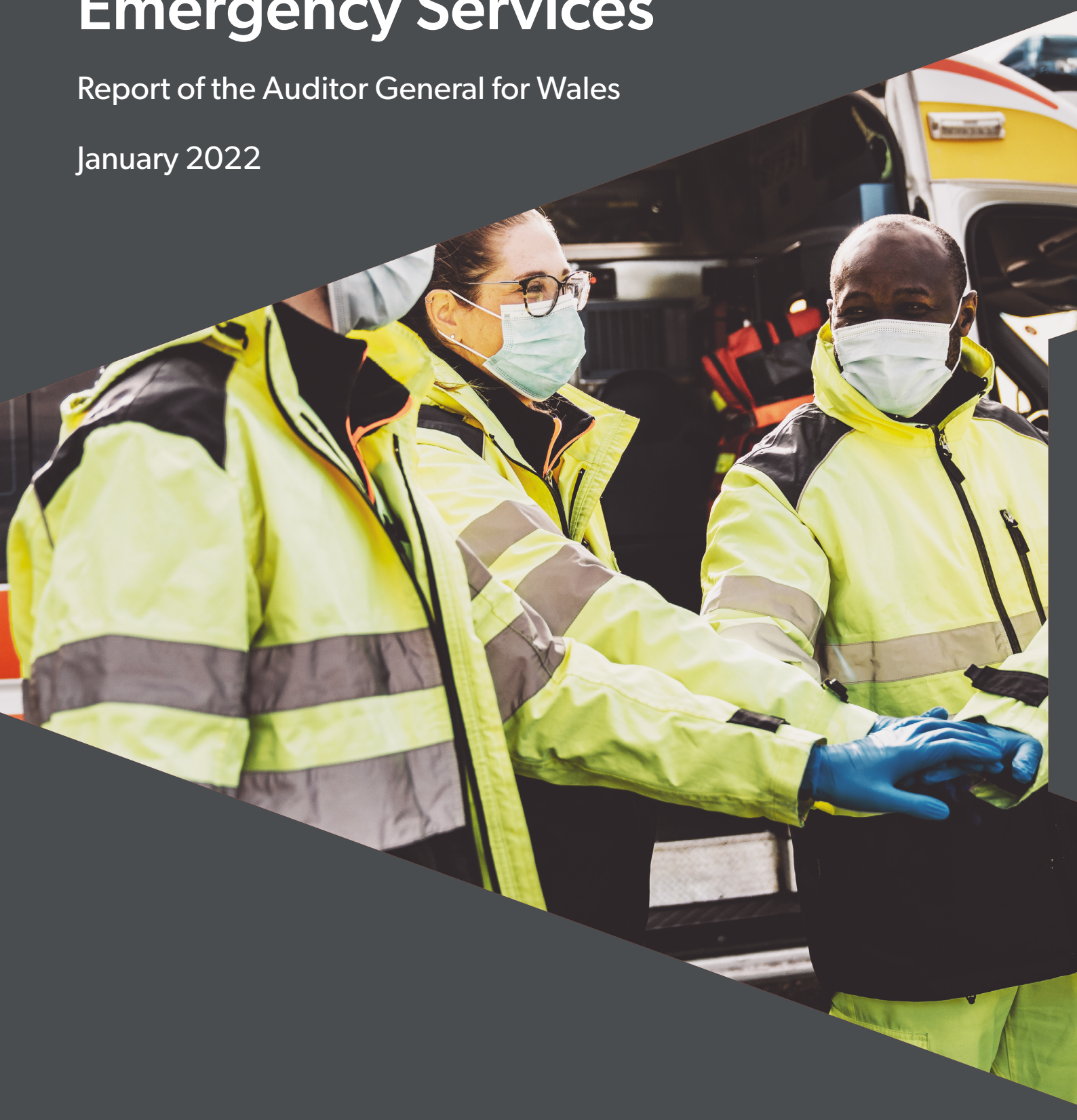
We welcome correspondence and telephone calls in Welsh and English. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Archwilio Cymru
Audit Wales

Joint Working Between Emergency Services

Report of the Auditor General for Wales

January 2022



This report has been prepared for presentation to the Senedd under the Public Audit (Wales) Act 2004.

The Auditor General is independent of the National Assembly and government. He examines and certifies the accounts of the Welsh Government and its sponsored and related public bodies, including NHS bodies. He also has the power to report to the National Assembly on the economy, efficiency and effectiveness with which those organisations have used, and may improve the use of, their resources in discharging their functions.

The Auditor General also audits local government bodies in Wales, conducts local government value for money studies and inspects for compliance with the requirements of the Local Government (Wales) Measure 2009.

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.

For further information, or if you require any of our publications in an alternative format and/or language, please contact us by telephone on 029 2032 0500, or email info@audit.wales. We welcome telephone calls in Welsh and English. You can also write to us in either Welsh or English and we will respond in the language you have used. Corresponding in Welsh will not lead to a delay.

Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

Contents

Summary report

Appendices

Summary report

Background

1 The ‘blue light’ emergency services[1] in Wales consist of the four police services, three fire and rescue services and the Welsh Ambulance Services NHS Trust (**Exhibit 1**). The Welsh Government oversees the fire and rescue services and Welsh Ambulance Services NHS Trust, and the UK Government Home Office oversees the four police forces. When we refer in this report to ‘emergency services’ we mean these eight organisations.

Exhibit 1: the eight Welsh ‘blue light’ emergency service organisations

Police	Fire and Rescue	Ambulance
Dyfed Powys Police	Mid and West Wales Fire and Rescue Service	Welsh Ambulance Services NHS Trust
Gwent Police	North Wales Fire and Rescue Service	
North Wales Police	South Wales Fire and Rescue Service	
South Wales Police		

Source: Audit Wales

1 ‘Blue light’ is a popular term for those services that, in case of an emergency, are allowed to turn on flashing blue lights indicating traffic priority over other motorists.

2 In addition to the 'blue light' services, a range of other organisations are classed as 'emergency responders'; organisations with specialist knowledge and skills who act in an emergency. These include search and rescue services[2], the Royal National Lifeboat Institution, Her Majesty's Coastguard, local authority emergency planning teams and voluntary sector bodies like St John Ambulance Cymru and the British Red Cross.

3 The potential benefits of emergency services collaborating and integrating services broadly fall under two key areas:

- firstly, joint working to ensure emergency services plan for and effectively respond to emergencies and disasters when delivering their responsibilities under the Civil Contingencies Act 2004 (**Appendix 2**); and
- secondly, collaborating and integrating emergency services by removing duplication of effort in the design, commissioning, operation and delivery of activity that helps bodies make better use of resources and deliver seamless services.

4 This report looks at the second of these two areas of work, examining whether emergency services in Wales are working more closely together to make better use of resources. **Appendix 1** provides more detail about our audit approach and methods.

5 We acknowledge the significant pressures emergency services have been under responding to the pandemic in the last 18 months. COVID-19 has generated huge demands on frontline workers who have had to respond creatively and over extended periods of time to keep people in Wales safe and well.

2 For example, the Central Beacons Mountain Rescue Team and the North Wales Mountain Rescue Association.

Key findings

6 Our overall conclusion is that blue light emergency service collaboration is slowly growing but requires a step change in activity to maximise impact and make best use of resources.

7 Joint working across emergency services to make best use of resources is not a new concept. Emergency services have been working closely together to provide a better service to the public for many years. Innovative partnership initiatives have saved money, reduced local response times and have contributed to protecting the public.

8 Despite this, there are growing expectations from government policy and legislation that collaboration needs to happen more deeply and quickly to ensure front line services can meet the challenges facing 21st century Wales. While there are areas where services do not need to collaborate with each other, different lines of accountability and other practical issues can also influence the extent and pace of joint working.

9 The Joint Emergency Services Group, which brings together senior leaders from 'blue light' services, is leading the collaboration agenda. Although collaborating better is acknowledged as essential, fully integrating services is not a priority at this time.

10 In key areas – such as estates and co-location of services, fleet management and workforce – there are examples where collaborative activity is happening, but the overall scale of activity has been limited. In addition, while emergency services effectively share and use data to improve response times and vehicle utilisation, they do not have an effective approach to managing vulnerable people.

11 The Joint Emergency Services Group has established a Strategic Collaboration Board to identify and deliver future joint working opportunities, giving a clear signal that a step change is required. Plans for collaboration are developing but some of these are limited in coverage and not supported by consistent project management arrangements. Clear priorities are still to be identified and project work has not yet been fully costed. The Group have also yet to agree how they will judge the impact and value for money of collaboration.

12 As the Strategic Collaboration Board arrangements develop, there are opportunities to learn from some of the critical factors that support examples of emergency service collaboration elsewhere in Great Britain. Nevertheless, integrated services are not widespread elsewhere and no 'blue light' collaboration board appears to have fully cracked the secret of collaboration.

> The emergency services have a long history of working collaboratively and they continue to help keep people in Wales safe. Their innovative partnership initiatives have saved money, reduced local response times, and have contributed to protecting the public. Despite this, the growing expectations of public policy and legislation mean they need to work together even more to make better use of their resources and truly maximise their impact.
>
> **Adrian Crompton**
> Auditor General for Wales

Key facts

13 The infographic below summarises key facts from our report and supporting data tool about emergency services in Wales.

The budget to run the emergency services in Wales is over **£1 billion annually**.

In 2020-21, the emergency services spent **£71 million** improving assets and upgrading equipment.

Emergency services in Wales had **£151 million** in reserves at the end of March 2021.

In 2020-21, the police had **£658 million** for services, the Welsh Ambulance Services NHS Trust £211 million and the fire and rescue services £156 million.

In 2020-21, the police employed **13,147 people**, the Welsh Ambulance Services NHS Trust 3,274 and the fire and rescue services 3,969.

Roughly **11,500** of the emergency service workforces are 'uniformed'.

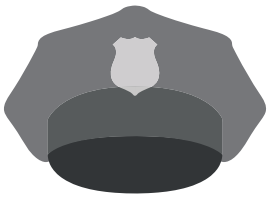
The emergency services employ over **20,000 people**.

Welsh emergency services and emergency responders operate from 684 different buildings.

Of this number:

47 (7%) are co-located – where two or more organisations share facilities.

541 (79%) are stations, where an organisation mobilises from to respond to an incident.



Welsh emergency services used **3,917 vehicles** to deliver their services at the end of March 2020.

In 2019-20, they spent just under **£11 million** maintaining their fleet.

In 2019-20, emergency services travelled over **41.6 million miles**.

4 Recommendations

14 Our recommendations are intended to help support the Joint Emergency Services Group to maximise the opportunities for greater collaboration to both make better use of resources but also continue to protect people and communities throughout Wales.

Recommendations

In **Part 2** we note that while it is important that emergency services comply with relevant data protection legislation, they also need to share data to ensure citizens receive efficient and effective services. While these two things are not mutually exclusive, uncertainty on data protection responsibilities is resulting in some officers not sharing data, even where there is agreement to provide partners with information.

R1 We recommend that the Joint Emergency Services Group provide refresher training to service managers to ensure they know when and what data they can and cannot share.

R2 We recommend that the Joint Emergency Services Group review and update data sharing protocols to ensure they support services to deliver their data sharing responsibilities.

In **Part 3** we review future plans for collaboration between emergency services and identify opportunities to improve project planning and management to maximise the benefit and impact of improved joint working on citizens.

R3 We recommend that the Strategic Collaboration Board review workstream plans to ensure they are SMART and are focused on delivering the right outcomes.

R4 We recommend that the Strategic Collaboration Board introduce and adequately resource project management arrangements for delivery of workstream plans to be able to effectively track performance but also identify where corrective action is required.

Recommendations

In **Part 3** we consider how emergency services are measuring and evaluating their collaborative work, but found systems and data used to judge impact and benefit are yet to be established.

R5 We recommend that the Joint Emergency Services Group agree baselines which show the extent of current joint working and collective spend on collaborative activity.

R6 We recommend that the Joint Emergency Services Group establish targets for future activity to be able to demonstrate delivery of planned savings and improvements in the future.

R7 We recommend that the Joint Emergency Services Group report performance against planned activity to demonstrate the savings and improvements that are being achieved and report this publicly to provide assurance to people in Wales on its work.

In **Part 3** we conclude that much of the good joint working between emergency services is not promoted and broadcast widely and the Joint Emergency Services Group does not have a strong public visibility.

R8 We recommend that the Joint Emergency Services Group undertake a publicity and awareness raising campaign to promote its past work and future plans.

In **Part 3** we highlight critical success factors drawn from a review of emergency service collaborations across Great Britain that can strengthen approaches in Wales.

R9 We recommend that the Strategic Collaboration Board workstreams use our self-reflection tool to evaluate their work programmes and identify where activity needs to improve (the tool is set out in **Appendix 4**).

Emergency services are expected to work collaboratively to make better use of resources

01

15 In this part of the report, we set out expectations and recommendations from recent reviews and government policy that promote collaboration between emergency services. We also highlight the scale of joint working and the limitations on where collaboration and integration can take place.

Joint working across Welsh emergency services to make best use of resources is not a new concept and is growing in importance

16 Emergency services have been working closely together to provide a better service to the public for many years. Innovative partnership initiatives have saved money, reduced local response times and have contributed to protecting the public. Fundamentally, it is only through effective joint working when planning and/or responding to an emergency that blue light services can effectively discharge their statutory responsibilities.

17 The Knight Review[3] published by the UK Government in 2013 and the UK-wide Emergency Services Collaboration Working Group[4] report from 2016 both outlined much of the good work of emergency services in working together. While primarily focused on England, many of the findings relate to Wales. However, they also identified opportunities for improvement to increase efficiency and make better use of resources.

18 The expectation of emergency services in England working more closely together is partly a reflection of the duty to collaborate introduced by the Policing and Crime Act 2017 in England. Under sections 1 – 5 of the Act the police, fire and rescue and ambulance services are required to work together in discharging their functions, and this has encouraged a growth in joint working between emergency services.

19 Similarly, the Fire and Rescue National Framework 2016[5] states that the Welsh Government will promote collaboration between fire and rescue services and other agencies in the interests of improving safety. More recently, in March 2021[6] and December 2021[7] the Welsh Government published written statements on broadening the role of firefighters, both as a means of better utilising the skills and capabilities that firefighters have to secure better health outcomes but also to make more efficient and effective use of resources. Ministers have been clear that they want to see collaboration between the emergency services go further and faster.

3 Findings from the review of efficiencies and operations in fire and rescue authorities in England, UK Government Department for Communities and Local Government, May 2013

4 Emergency Services Collaboration Working Group National Overview, 2016

5 Fire and Rescue National Framework 2016, Welsh Government, November 2015

6 Written statement on broadening the role of firefighters, Welsh Government, March 2021.

7 On 6 December 2021 the Chief Fire and Rescue Advisor for Wales published his in-depth review of broadening of the role of firefighters in Wales and the Deputy Minister for Social Partnership published a written statement on broadening the role of firefighters.

20 These and other past reviews and statements have identified several benefits of increasing joint working between emergency services, namely:

- improving communications, emergency response and scheduling of personnel, including reciprocal arrangements for operational support, training, emergency cover and control rooms;
- facilitating the specialisation of skills, services and strengthening capacity in back-office functions and creating opportunities to make better use of and share specialised services or equipment;
- increasing spending power and opportunities to make savings through the joint commissioning and procurement of goods, services and equipment; and
- assisting with 'master-planning' for a wider geographical region and opportunities for making better use of current assets, rationalising bases, planning new joint facilities and modernising communication and ICT systems.

21 The need for better co-ordination and integration stems from some fundamental challenges, such as:

- growing demand driven by demographic change;
- the proliferation of 'wicked issues' where public bodies need to work collectively to address complex needs;
- the fragmentation of public service responsibilities with the growth of local, regional and national planning and delivery bodies;
- limited financial resources; and
- growing public expectations.

22 These changes bring common challenges which in turn means a common response is necessary if better outcomes for people and communities across Wales are to be delivered.

23 In addition, legislation introduced by the Welsh Parliament requires or encourages blue light services to work better together and with other public bodies to address some of the big challenges facing the country. For instance, the Well-being of Future Generations (Wales) Act 2015 and the Social Services and Well-Being (Wales) Act 2014. Such legislation emphasises the key role of emergency services in Welsh public life and their essential contribution to meeting need and keeping people safe.

24 While the Future Generations Act includes Fire and Rescue Authorities as responsible bodies, this is not extended to other emergency services. The police and Police and Crime Commissioners are statutory invitees to Public Service Boards, but not the Welsh Ambulance Services NHS Trust. Meanwhile, the Social Services and Well-being Act does not include fire and rescue services within its remit. Despite these anomalies, all bodies are committed to working to deliver the ambitions of the legislation.

Emergency services have different responsibilities and accountabilities which influences the extent and pace of joint working

25 While collaboration can help resolve some of the challenges facing 21st century public services, achieving such benefits is not easy because of the associated problems of securing accountability, managing complexity, coping with shifting demands and the difficulties of measuring success. In addition, despite coming under the broad umbrella of 'blue light services', the police, ambulance and fire and rescue service are culturally distinct and have different governance models, responsibilities and ways of working.

26 Consequently, we would not expect to see collaboration on everything 'blue light' services do. There are things that they should not work together on as well as things they should. We call this the 'Joint Working Continuum' (**Exhibit 2**).

Exhibit 2: the 'Joint Working Continuum' for emergency services

 **Independent working**	Activity specific to a body which has no bearing on or influence from another emergency service partner. Decisions on how to deliver these functions are determined by the individual organisation. Examples include patient transfer, policing patrols and home fire safety visits.
 **Dependent working**	Recognises the importance of emergency services exchanging information for mutual benefit and working in ways to achieve a common purpose. For instance, in responding to road traffic collisions and incidents of arson.
 **Collaboration**	Where organisations share resources – money, staff and buildings – to help strengthen capacity and for mutual benefit. For example, the creation of joint control rooms, co-located services and operating joint fleet maintenance contracts. While collaborative working brings together different disciplines, professional boundaries, identification and autonomy is maintained. Good collaborative working is often a necessary precondition to integration.
 **Integration**	Where two or more emergency services have been formally combined and work together as part of a single entity under a single governance, management and delivery structure. Consequently, integration will see a deliberate blurring of roles and responsibilities and the creation of common organisational support structures such as management, payments, protocols, policies and support.

Source: Audit Wales

27 There are also some fundamental structural issues which can reduce the potential for joint working. The Welsh Ambulance Services NHS Trust is a commissioned organisation overseen by the Welsh Government and which responds primarily to the requirements of the NHS in Wales and local health boards. This can limit the potential scope and scale of joint working because of differing priorities, funding and commissioning arrangements within the health service. Fire and rescue services are accountable to the Welsh Government and respond to its policy priorities. However, criminal justice and policing is not devolved, and the police services respond to the agenda set by the Home Office which is not always aligned with Welsh Government.

28 In practical terms, the three 'blue light' services:

- operate to different footprints – the Welsh Ambulance Services NHS Trust is an all-Wales body, but the police and fire and rescue services work to regional footprints. Only in North Wales is the boundary for both the police and fire and rescue services the same. While the Welsh Ambulance Services NHS Trust has regional hubs, these do not map neatly onto the footprints for police and fire and rescue services; and
- have different governance models – each police service reports to a Police and Crime Commissioner, the Welsh Ambulance Services NHS Trust has a Board made up of a Chair, Non-Executive Directors, the Chief Executive and four Executive Directors; and the fire and rescue services each have an Authority made up of representatives from their constituent local authorities.

How well emergency services are currently working together

02

29 In this part of the report, we briefly set out the important leadership role of the Joint Emergency Services Group which is providing direction and setting priorities for future collaboration. We review how emergency services in Wales are currently working together to make better use of their resources. We summarise progress to date and highlight where collaboration is taking place in respect of making better use of estates, fleet, joint posts, co-located services and better information sharing. These are the 'big ticket' items that offer the greatest opportunities to realise savings and make best use of resources.

The Joint Emergency Services Group is providing leadership for collaboration, but there is no priority to move towards more fully integrated services

30 The Joint Emergency Services Group brings together the most senior leaders in the emergency services in Wales. The Group consider their contribution to civil contingencies, counterterrorism and focus on addressing the wider cross-service issues of joint interest. The Group consists of key decision makers: the four Chief Constables, the three Chief Fire Officers and the Chief Executive of the Welsh Ambulance Services NHS Trust. Attending in an observer capacity are the Chief Executive of the NHS in Wales, senior Welsh Government officials and senior military leaders in Wales.

31 The Joint Emergency Services Group continues to play a key role in coordinating emergency service responses to the pandemic, and the cooperation between members has helped forge closer working relationships. The importance of strong relationships between senior leaders is evident with the success to date in developing ideas into campaigns in short timescales that have had the buy-in of individual organisations and achieved significant impact. This has been most recently seen with the launch of a joint information campaign in respect of violence against emergency services personnel[8]. Within two months of issues being highlighted, the campaign was set up and introduced to coincide with the reopening of pubs following previous relaxation of COVID-19 lockdown restrictions. The campaign received interest from partners in England.

8 'Work with us, not against us' campaign, Welsh Ambulance Services NHS Trust Article, May 2021.

32 Members of the Joint Emergency Services Group we spoke to also recognise the importance of leadership in making collaboration and integration a reality, and they see the group as fundamental to delivering these ambitions and expectations. It is with this in mind that the Joint Emergency Services Group has recently developed a Joint Strategic Collaboration Plan and has appointed an officer to coordinate the group's civil contingencies and collaboration work. Part 3 of our report considers the work of the Joint Emergency Services Group in more detail.

33 Although there are many benefits to joint working between emergency services, it also comes with challenges, and these cannot be underestimated. It is also clear that the while there is a commitment to strengthen partnerships and deliver more collaborative working, the Joint Emergency Services Group is not pursuing integration at this time.

34 Staff we interviewed from emergency services in Wales, the Welsh Government and other stakeholders highlighted some potential risks of integrating services with different responsibilities and diverting organisations from their core purpose during the pandemic. Several blue light service staff we spoke to also felt that the cost of pursuing integration would not result in meaningful benefits in terms of saving money, nor improving the quality and responsiveness of services to deliver better outcomes for people in Wales.

Emergency Services are collaborating to make better use of their estate, but the scale of collaboration has been limited

35 Sharing offices and buildings is an area often identified as the starting point for better collaboration. It offers emergency services greater flexibility in terms of their estate, the costs associated with managing and running buildings and in organising service delivery. Shared offices also provide the chance for networking, mingling and learning and provides organisations with enhanced access to key partners who can help support your work. There are greater opportunities for information sharing to strengthen resilience in services.

36 In total, there are 597 building owned by the blue light services in Wales and a further 87 by the named emergency responders[9]. Of these buildings, 541 (79%) are stations, where an organisation mobilises from to respond to an incident. Overall, just under 7% of these 684 buildings are currently shared between two or more emergency services and/or emergency responders (**Exhibit 3**). There are opportunities for emergency services and responders to make better use of real estate through greater co-location.

9 This is not an exhaustive list and other bodies who can respond to an emergency will have buildings they operate from. These are the ones identified by blue light services in use of estate.

Exhibit 3: the number of buildings owned, leased and shared by emergency services and emergency responders in Wales at 31 March 2021

Emergency services and emergency responders manage a large number of buildings across Wales, but the level of co-location is limited to date

Organisation	Number of buildings owned	Number of buildings owned or leased by named organisation with one or more other emergency service or responder working from them	Proportion of owned buildings that are shared
Dyfed Powys Police	53	1	1.9%
Gwent Police	52	1	1.9%
North Wales Police	58	6	10.3%
South Wales Police	103	1	1.0%
Mid and West Wales Fire and Rescue Service	122	3	2.5%
North Wales Fire and Rescue Service	49	8	16.3%
South Wales Fire and Rescue Service	50	8	16%
Welsh Ambulance Services NHS Trust	110	15	13.6%
RNLI	30	0	0%
Search and rescue	14	2	14.3%
Coastguard	43	2	4.7%
TOTAL	**684**	**47**	**6.9%**

Source: Audit Wales data tool

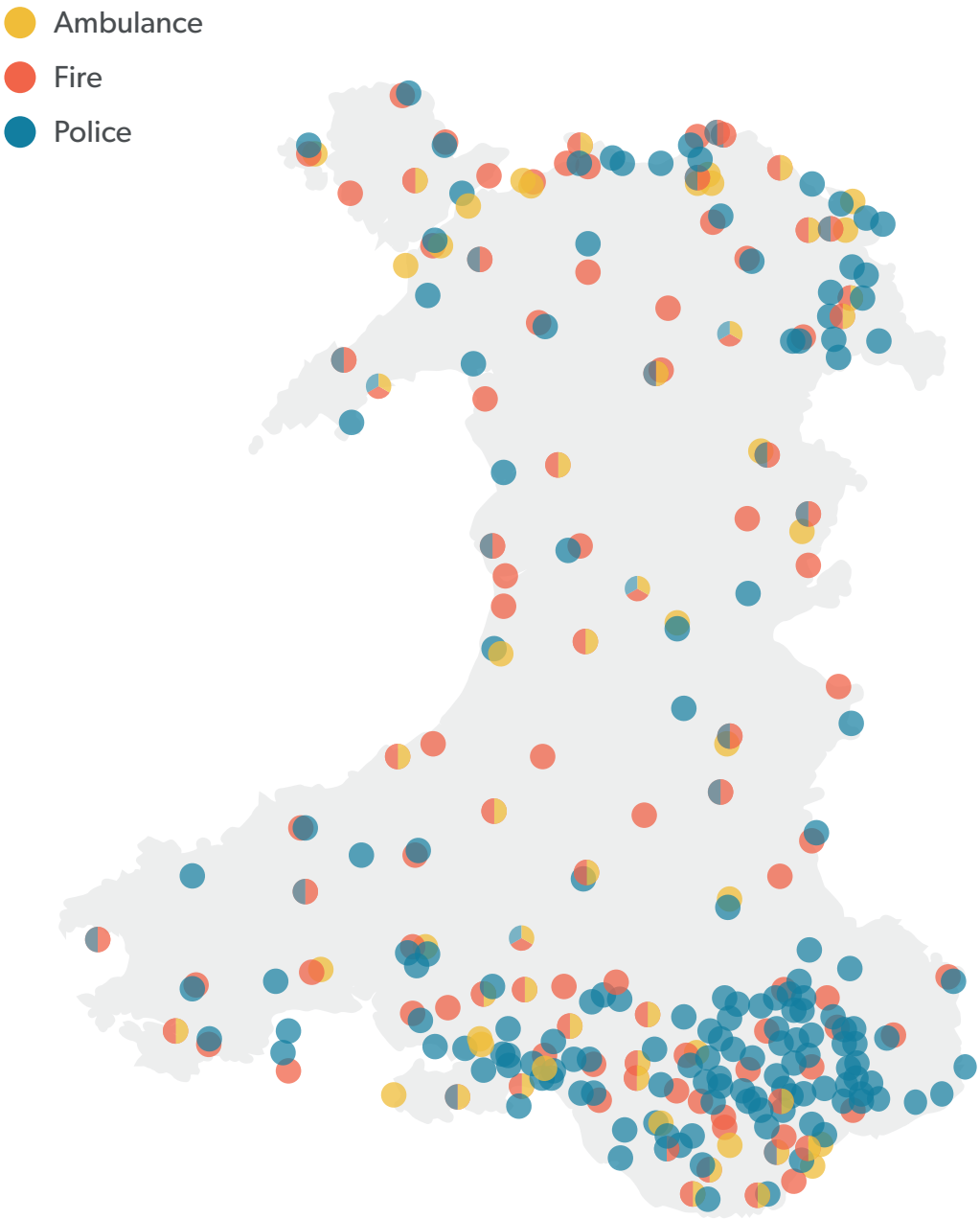
37 There are several examples of the Welsh Ambulance Services NHS Trust co-locating at fire stations using these bases as they would an ambulance station because they offer space to park, fuel and rest areas for crew. For instance, in North Wales the Trust shares fire stations in Wrexham, Bangor, Llandudno and Colwyn; and in South Wales in Maesteg, Pontyclun, Caerphilly, Barry and various locations in Cardiff. A smaller number of co-locations include the police service, which can be vital in rural areas in keeping a local presence. For example, North Wales Police and North Wales Fire and Rescue service share buildings in Tywyn, Nefyn, Deeside and Prestatyn.

38 Similarly, Mid and West Wales Fire and Rescue Service share a facility with Dyfed Powys Police and the Ministry of Justice in Llandrindod Wells and also share facilities with the Welsh Ambulance Services NHS Trust in several locations in Swansea. There are also some good examples of emergency services and responders sharing buildings. The Llantwit Major Joint Emergency Services Station co-locates the South Wales Fire and Rescue Service, Welsh Ambulance Services NHS Trust, South Wales Police and HM Coastguard.

39 Through our geo-mapping tool we have plotted the location of all emergency service buildings in Wales. This shows that in many locations emergency services site buildings are in close proximity to each other. For example, there are 72 emergency service buildings within 10 miles of Pontypridd town centre, 51 within 10 miles of Swansea city centre, 24 within 10 miles of Bangor and 20 within 10 miles of the centre of Wrexham[10]. **Exhibit 4** provides a geographical snapshot of emergency service buildings across Wales.

10 Our analysis is measured as the shortest distance between two points - ‘as the crow flies’.

Exhibit 4: emergency services buildings at 31 March 2021



Source: Audit Wales data tool

40 Not all sites will be suitable for co-location and the positioning of stations should always be driven by operational and risk planning, but opportunities to co-locate emergency services need to become central to these considerations. In addition, the sale of surplus buildings to generate funding for reinvestment needs to be considered as part of this decision making. We believe there are clear opportunities to make better use of the collective emergency services and emergency responders estate going forward.

Joint work on fleet is limited and there are opportunities to make better use of resources

41 Emergency services are responsible for massive fleets of vehicles. As fleet managers modernise their fleets, there are opportunities to work together to share resources and reduce costs. **Exhibit 5** highlights that emergency services were using 3,917 vehicles at 31 March 2020 and collectively spent almost £11 million on maintaining fleet in 2019-20[11]. Of this figure, roughly 50% of the spend is by the Welsh Ambulance Services NHS Trust, but it is not immediately clear from our fieldwork why they are spending significantly higher sums than other emergency services.

11 How emergency services calculate total vehicle maintenance costs and mileage varies. Some exclude the cost of parts, overheads, internal staffing costs and accident repair (due to some of the work being outsourced). Similarly, some emergency services exclude some specialist vehicles, and on occasions estimate mileages due to software limitations.

Exhibit 5: emergency services' fleet, maintenance costs and mileage at 31 March 2020

Emergency services manage a large number of vehicles and invest a significant sum of money annually on maintaining fleet.

Organisation	Total number of vehicles	Total vehicle maintenance cost (annual)	Average annual maintenance cost per vehicle	Total mileage at year end
Dyfed Powys Police	465	£1,352,255	£2,908	5,276,328
Gwent Police	400	£744,405	£1,861	5,695,410
North Wales Police	595	£551,750	£927	10,364,506
South Wales Police	867	£1,625,000	£1,874	10,235,034
Mid and West Wales Fire and Rescue Service	378	£527,011	£1,394	1,990,779
North Wales Fire and Rescue Service	223	£201,726	£905	1,870,533
South Wales Fire and Rescue Service	408	£504,025	£1,235	2,373,689
Welsh Ambulance Services NHS Trust	581	£5,482,775	£9,437	3,814,605
Total	**3,917**	**£10,988,947**	**£2,805**	**41,620,884**

Source: Audit Wales data tool.

42 Collaboration offers benefits beyond achieving financial efficiencies. For instance, sharing knowledge and skills with partners will enhance capability and capacity, and can help drive innovation across emergency services to ensure the fleet is prepared for the future. Joint working on maintenance increases economies of scale and allows for better access to specialists and more comprehensive training and support. Reducing duplication between procurement functions and agreeing common specifications on fleet is one way to save money and improve resilience, particularly given that outside of specialist fleet such as ambulances and fire appliances, services overwhelmingly use the same type of vehicles – cars and vans for instance

43 To date collaborative work between blue light services on fleet has been limited. While the work of the joint fleet group between the three fire and rescue services is progressing well and bulk fuel purchasing is delivering estimated annual savings of between £70,000 and £80,000 for the four police forces, there remain opportunities for emergency services to develop joint approaches to procurement, maintenance, standardised specifications, training and apprenticeships.

There are few joint emergency service posts, and they are not a major feature of service delivery

44 Joint posts and teams can help build a collaborative culture by enabling shared decision-making, regular team building and working towards a common goal. Working together in this way can strengthen the flow of information between organisations, help improve communication and share learning from one another.

45 Overall, there are just over 20,000 emergency service personnel in Wales (**Exhibit 6**). Rather than create joint posts, emergency services have focussed on creating co-located services where teams work together from a single base. For example, the Joint Public Service Centre control room with joint staff operated between South Wales Police, Mid and West and South Wales fire and rescue services based at police headquarters in Bridgend. There, services work together but retain operational independence and report to their respective organisations. The co-location on a single site has allowed partners to reduce call handling duplication and improve intelligence sharing.

Exhibit 6: emergency services' workforce at 31 March 2020

Organisation	Police Special Constables	On call	Support staff	Police Constable Support Officers	Uniformed	Total
Dyfed Powys Police	93		724	139	1,182	2,138
Gwent Police	86		706	163	1,362	2,317
North Wales Police	156		998	185	1,591	2,930
South Wales Police	163		2,037	387	3,174	5,761
Mid and West Wales Fire and Rescue Service		723	214		386	1,323
North Wales Fire and Rescue Service		438	147		297	882
South Wales Fire and Rescue Service		593	325		846	1,764
Welsh Ambulance Services NHS Trust			531		2,743	3,274
Total	**498**	**1,754**	**5,682**	**874**	**11,581**	**20,389**

Source: Audit Wales data tool

46 Similarly, Dyfed Powys Police have created an Operational Planning and Civil Contingencies Unit with its key partners including emergency services. The Unit is co-located with three Local Resilience Forum co-ordinators in the Strategic Co-ordination Centre at police headquarters in Carmarthen. Other joint staffing responses include seconded police officers working in fire crime units and medical response training for firefighters provided by the Welsh Ambulance Services NHS Trust. There is also some good inter-service working taking place. For instance, the joint police firearms teams, the joint police forensic services and counter terrorism activity, and fire and rescue services' joint fire investigation teams. Also, joint work on personal protective equipment, uniform, fleet design and procurement.

Emergency services effectively share and use data to improve response times and vehicle utilisation but do not have an effective approach to managing vulnerable people

47 Reacting to requests for help from citizens often results in a combined intervention by different emergency services. To ensure responders have a full understanding of needs and requests it is essential that emergency services share data appropriately and efficiently. Meaningful and effective communication between responders and responder agencies underpins effective joint working. Sharing information aids understanding and awareness, which is fundamental to good decision making.

48 To do this well requires blue light services to have good systems in place to exchange reliable and accurate information about risks and threats. This information should be jargon free to avoid confusion and misinterpretation, and clarified using terminology that is common to all. Effective data sharing is also essential to support vehicle utilisation[12] and to optimise responses to ensure the right people and organisations attend incidents.

12 The vehicle utilisation rate highlights an emergency services fleet's capacity against logistical needs. Whereas you may not achieve 100% vehicle utilisation, the vehicle use rate will let you identify the excess fleet capacity. Using such data highlights where there are opportunities to widen existing roles for emergency services to do more.

49 Several people we interviewed noted the positive impact of the JIGSO[13] and Multi Agency Incident Transfer (MAIT) initiatives. JIGSO is a digital solution designed to assist the resilience community to plan and respond to a major incident or public health emergency. MAIT is a service which provides emergency services with a robust, virtually instantaneous, secure inter-agency messaging solution. JIGSO and MAIT have helped reduce operational response times by more than three minutes per emergency and reduce the risk of errors and delays, enabling frontline staff to focus on the task at hand, saving time, cost and lives. Both initiatives use address data provided by Geoplace[14] as the recognised definitive source of addressing in the UK.

50 The current arrangements are a vast improvement to the old method of different branches of the emergency services physically dialling 999 to share incident information with other emergency services and has contributed to improved data and information sharing to help improve response times. Within Wales, over 300,000 calls are made per annum across the three emergency services and the use of MAIT is estimated as potentially saving over 18,000 hours of emergency service control room staff time spent telephoning other agencies[15].

51 We also identified some continuing challenges. Data protection legislation is seen as often stopping organisations from undertaking projects that involve the use of personal and sensitive data, especially where it requires sharing information with partners. Most importantly, concern over data protection is encouraging risk-aversion and stifling innovation in using data, because of the fear of being penalised. There remains an enduring cultural resistance to sharing information. Developing joint protocols to share information on vulnerable people is seen as a key priority for the future.

13 ‘JIGSO’ is the Welsh word for ‘Jigsaw’ and is the name given to this initiative.

14 Geoplace uses standardised Unique Property Reference Number (UPRN) address to underpin command and control systems for emergency services in Wales.

15 See The UPRN underpinning the Multi Agency Incident Transfer (MAIT) standard | GeoPlace LLP for further detail.

How emergency services plan to collaborate in the future

03

52 This part of our report considers emergency services' future plans for collaboration through a new Strategic Collaboration Board. It also sets out some opportunities to strengthen this work, including drawing on lessons from collaborative initiatives elsewhere in Great Britain.

The Joint Emergency Services Group has established a Strategic Collaboration Board to identify and deliver future joint working opportunities

53 The Joint Emergency Services Group has agreed an appropriate focus in its strategic collaboration plan to develop, plan and coordinate delivery of actions to make best use of resources through collaboration – **Exhibit 7**. To encourage wider and deeper collaboration, the Joint Emergency Services Group has also created a Strategic Collaboration Board, giving a clear signal that a step change is required to fully realise the benefits of cross-service collaboration. Established in November 2020, the Strategic Collaboration Board consists of senior leaders from across police, fire and ambulance services in Wales.

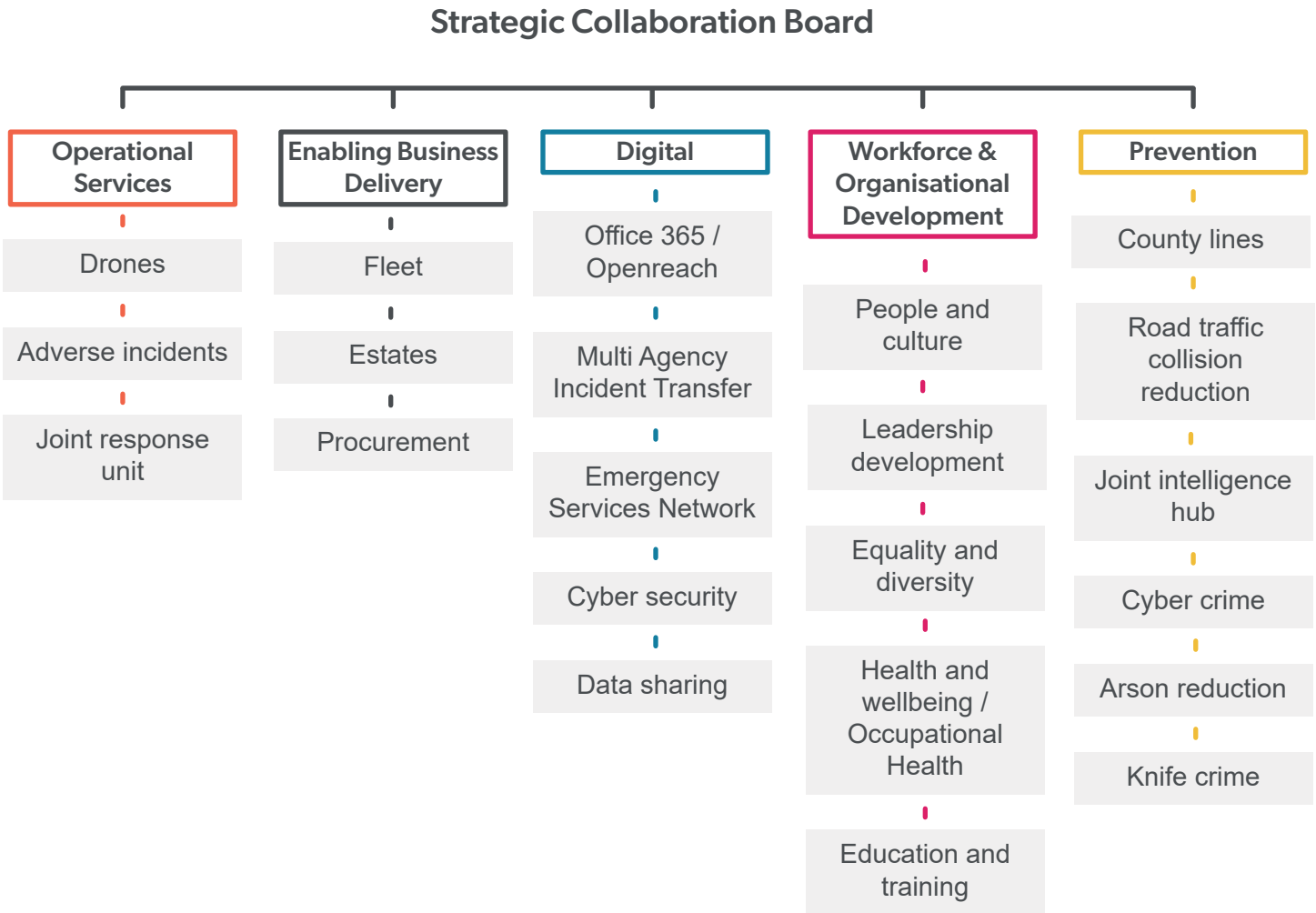
Exhibit 7: Joint Emergency Services Group Strategic Collaboration Plan objectives

- Consider issues of mutual interest and develop joint initiatives which, through collaborative working, enhances the delivery of services across Wales
- Improve co-operation and co-ordination between emergency services
- Exploit opportunities to collaborate and support enhanced emergency services delivery
- Develop new ways of working together
- Promote proactive collaboration initiatives to ensure the public of Wales receive the most appropriate emergency service response
- Reduce the volume and seriousness of adverse incident reporting between emergency services in Wales
- Deliver value for money to the Welsh taxpayer through implementation of cost-effective collaborative initiatives

Source: Joint Emergency Services Group, Joint Strategic Collaboration Plan, Version 1.0, July 2021

54 The Strategic Collaboration Board has also agreed three key principles for successful collaboration that will underpin prioritisation of future activities. These are: reduce risk and harm to our communities; enable service delivery improvement; and provide better value for money. The Board has also agreed and mapped its priorities for the future under five broad workstreams (**Exhibit 8**). Each of these five areas – operational services; enabling business delivery; digital; workforce and organisational development; and prevention – is led by a senior officer from one of the emergency services partners.

Exhibit 8: Strategic Collaboration Board workstreams and key priority areas



Source: Joint Emergency Services Group, Joint Strategic Collaboration Plan, Version 1.0, July 2021

55 The five Strategic Collaboration Board portfolios are in line with national thinking, in particular in the desire to broaden the role of firefighters and for all partners to develop digital services. In addition, important 'big ticket' items of expenditure such as fleet and assets have been prioritised. These are the most likely to yield the biggest benefits. In addition, the five workstreams are building on current practice and are not intending to join up with other national committees and working groups. The priority is to use groups and relationships that are already established and working. Some workstreams will continue to prioritise work within services, while others plan to deliver pan emergency service collaborations.

Plans for collaboration are developing but some of these are limited in coverage and not supported by consistent project management arrangements

56 Each of the five workstreams has been identifying and agreeing potential short-, medium- and long-term areas for action, which in themselves can be small scale adjustments, as well as more significant pan-organisation changes. Some of the activity also builds on, and seeks to strengthen, well-established joint working – for example, the joint work on arson reduction and road safety prevention work – while others are entirely new collaborative opportunities such as joint vehicle maintenance contracts.

57 In principle, the Strategic Collaboration Board is looking to deliver three projects under each workstream per year. Although each of the workstreams is progressing, and some have made good progress, most are still identifying, mapping out and agreeing their priorities for the future. In July 2021:

- the Operational Services workstream had identified potential topics and agreed leads for different activities and actions but was yet to agree a plan of activity or a timeline to deliver against.
- in comparison, Enabling Business Delivery had agreed draft programmes highlighting potential areas for collaboration in relation to fleet, estates and procurement, although timelines are not in place for all activities.
- both the digital and prevention workstreams were scoping baselines and agreeing work to finalise their future collaboration plans.
- while the workforce and organisational development group had identified several potential areas for collaboration, concerns had been raised that progress will be limited without specific resources being dedicated to support activity.

58 The agenda set by the Strategic Collaboration Board is appropriate and is focussed on ensuring ‘togetherness’, but it needs more robust and consistent project management support and could be more ambitious in some areas. For example, some of the activity is focussed on identifying whether there is a case for collaboration with actions described as ‘mapping activity’; ‘sharing information’; ‘creating a baseline’; ‘obtaining advice’; ‘benchmarking’; ‘explore opportunities’; ‘assess competencies’; and ‘produce a list’. These read as a plan to create a plan for collaboration, not delivering improvement through actual collaboration.

59 Consequently, some workstreams are still narrowing down potential actions and have yet to finalise their priorities. While the type of activities appears sound, it is not always clear what outcome is being aimed at. This raises questions as to whether actions will result in meaningful improvements, particularly as much of the detail needed to measure success and evaluate progress have yet to be agreed.

60 While the five workstreams are broadly focussed on the right things they have no consistent, resourced and agreed approach to project management. Establishing a consistent resourced approach is therefore critical because it:

- brings leadership and direction to projects and supports the creation of a proper plan for executing on strategic goals;
- ensures proper expectations are set around what can be delivered, by when, for how much and ensures the quality of whatever is being delivered, consistently hits the mark;
- ensures proper project management processes are followed throughout the project life cycle and enables the right people do the right things, at the right time; and
- enables risks to be properly managed and mitigated against to avoid them becoming issues and supports effective tracking and reporting of a project’s progress.

61 Currently, much of the coordination work falls to the Joint Emergency Services Group coordinator but this is not sufficient to support such a wide and ambitious programme. Overall, workstream capacity is limited with no dedicated staff resource to support Strategic Collaboration Board activity with everyone doing their ‘day job+’. In addition, some important recent inter-agency collaborations such as the fire and rescue services co-responding to medical emergencies and joint response units with the police have not progressed in recent years because of uncertainties in funding.

62 Without a consistent project management approach and ensuring there are adequate resources in place, the ambitions of the Strategic Collaboration Board are unlikely to be realised. This is a major risk to future success.

The Joint Emergency Services Group have yet to agree how they will judge the impact and value for money of collaboration

63 Establishing clear outcomes for collaboration is important to enable partners to understand the impact and value of joint working. However, developing 'whole system' outcomes is complex, especially in a multi-disciplinary environment. Integrating the outcomes and outputs from different services can be as complicated as delivering the collaboration itself. And it can be difficult to know where to start without a clear baseline, or where particular measures are not already in place, and without them, it is impossible to evaluate how well you are doing. It is essential therefore that partners identify outcomes at an early stage of the collaboration process rather than retrospectively fitting them to already agreed and funded activities or interventions to ensure they can undertake a proper evaluation.

64 Importantly, the strategic collaboration plan includes an objective to deliver value for money to the Welsh taxpayer through implementation of cost-effective collaborative initiatives. However, beyond this ambition, there is little information currently reported to judge whether existing and planned future collaborations between 'blue light' services is and will deliver better value for money.

65 For instance, there is no baseline data which shows collectively what organisations currently spend; no information on collaborative activities highlighting the savings that have been made to date; and no agreed targets on improvements that are planned to be delivered in the future. Existing collaborations are yet to be mapped or assessed for impact.

66 In addition, much of the good joint working between emergency services is not promoted and broadcast widely and the Joint Emergency Services Group does not have a strong public visibility. This is a missed opportunity given the Group's positive work in the last 18 months steering their way through the pandemic.

There are opportunities to learn from what is happening elsewhere in Great Britain

67 Nationally, emergency services benefit from being part of service-based networks that operate on a wider basis and have a good track record of encouraging within-sector collaboration. They include the National Fire Chiefs Council, National Police Chiefs Council and the Association of Ambulance Chief Executives. In addition to service specific networks, there are several other national, regional and local 'blue light' strategic collaboration boards in other parts of Great Britain.

The Scottish Emergency Services National Collaboration Strategy 2018-2023 is heavily focused on policy and service integration

68 In 2014, a Reform Collaboration Group was established in Scotland. It comprises the Scottish Fire and Rescue Service, the Police Service of Scotland and the Scottish Ambulance Service. In addition to the chairs of the fire and rescue and ambulance services, the chair of the Scottish Police Authority, the Chief Fire Officer, the Chief Executive of the Scottish Ambulance Service and the Chief Constable of Police Scotland also sit on a separate governance group. The Reform Collaboration Group vision is "working together for a safe and successful Scotland" and they have agreed seven areas for action:

- improve outcomes for people;
- transform by rebalancing how we deploy resources towards prevention activities;
- enhance the skills of our workforce;
- improve how we work in partnership and collaborate with others;
- further build and strengthen community resilience;
- exploit new technology in redesigning our services; and
- develop more flexible service models.

69 Importantly, in January 2018 the Group published the Scottish Emergency Services National Collaboration Strategy[16]. The strategy sets out the collective vision, strategic direction, objectives and working principles which will guide the ongoing development of collaborative working across the three emergency services in Scotland. A joint vision has been agreed, that "through ever closer working and through empowering our staff and communities we will improve the safety and resilience of communities and improve the wellbeing of the people of Scotland".

16 The partners have also developed a separate plan for improving use of data. This supports delivery of the overall National Collaboration Strategy.

70 The strategy includes a brief analysis of the demands that are being placed on emergency services and other public services and makes the case for why collaboration is important. Demographic change, social inequality, reductions in resources and political uncertainty highlight the need for a robust response to enable emergency services to be able to continue to deliver their responsibilities.

71 The strategy takes a logical step by step approach focussing on quick wins and easy choices that build up to longer term benefits focussing on four priority areas: co-location of services; co-responding; policy and data integration; and integration and shared services. They are focussing on these four areas because “Co-location helps us to co-respond which can lead to better sharing of knowledge and information which can help us to integrate services”. The Reform Collaboration Group is also developing a Collaborative Improvement Model to inform future collaborative work and to maximise opportunities, efficiencies and effectiveness.

The Thames Valley Emergency Services Steering Group is overseeing a focused programme of sharing resources and enhancing joint capabilities

72 The Thames Valley Emergency Services Steering Group brings together senior officers from the emergency services. The main differences with the Joint Emergency Services Group in Wales are the inclusion of the Thames Valley Police and Crime Commissioner and local authorities as members. There is a Programme Support officer, and a triage mechanism for focusing and reducing workstreams so they remain achievable and realistic. The Thames Valley Emergency Services Steering Group provides overall guidance, challenge, and direction on the implementation of the Collaboration Programme. Strategic priorities are focused on:

- demand analysis and reduction;
- enabling services through joint procurement;
- sharing specialist capabilities;
- identifying and collaborating on workforce recruitment and development; and
- operational integration.

73 Significant progress has been made including Buckinghamshire Fire

Authority, South Central Ambulance Trust and Thames Valley Police co-locating in a new purpose built 'Hub' with all three services operating from one site. Other developments include the joint procurement of standardised fire appliances and using a single supplier for personal protective equipment across the three fire and rescue services in the region. A collaboration register and monitoring report has been developed and is used to track progress[17].

Emergency services in the East of England are starting to quantify the return on investment from collaborations

74 An evaluation report of current collaborative activity between Bedfordshire Fire and Rescue Service and the East of England Ambulance Service Trust estimated a total return on investment of £5.09 million in social value, or £7 for every £1 invested[18]. This includes:

- the return on investment and social value of the Fire and Rescue Service's support during the pandemic from firefighter secondments into Ambulance Service Trust of £0.448 million;
- the social value of the Fire and Rescue Service's falls team in 2020-21 of £1.053 million;
- bariatric complex patient rescue service with an added social value to Bedfordshire of £0.384 million;
- co-responding with an added social value to Bedfordshire of £2.244 million; and
- effecting entry[19] has added social value to Bedfordshire of £0.960 million.

75 Due to collaborative efforts, the evaluation highlights that COVID-19 has been less impactful on the Ambulance Service Trust and since April 2020 the support of the Fire and Rescue Service has enabled an extra 600 emergency ambulances to be available and more than 22,332 patient-facing hours have been provided. As a result, in 2020-21 the Ambulance Service Trust met all its category 1 life threatening incident response standards[20] in the Bedfordshire area for the first time since 2010. The Trust have since reported the third best performance in England within their 7-minute target during 2020-21.

17 Thames Valley Collaboration Report

18 BFRS and EEAST Collaboration Evaluation 2021.

19 Effecting entry is where the fire and rescue service break into a property where there is a concern for the life of a patient in a premises and ambulance or police crews are unable to make entry.

20 In 2017, NHS England implemented new ambulance standards across the country. This was to ensure the sickest patients get the fastest response and that all patients get the right response first time. A set of pre-triage questions were introduced to identify those patients in need of the fastest response. There are four categories of call and Category 1 covers calls from people with life-threatening illnesses or injuries and requires a response within 7 minutes.

What can Wales learn from this?

76 From the examples we have reviewed in other parts of Great Britain, we conclude that collaboration is mostly operationally focused, prioritised locally not nationally and is often a tactical response to address a problem or circumstance. Activity is also often invisible to the public. Integrated services are not widespread elsewhere and no 'blue light' collaboration board appears to have fully cracked the secret of collaboration.

77 Drawing from the examples above and others – **Appendix 3** provides a summary of some additional partnerships – there are clearly some key principles that can help make 'blue light' collaboration work. In taking this agenda forward in Wales, **Exhibit 9** highlights some likely critical factors of success. Building on this, **Appendix 4** provides a self-evaluation checklist.

Exhibit 9: making collaboration work – critical success factors

- Visible leadership that prioritises the importance of collaboration.
- Being clear how collaboration contributes in a meaningful way to taking forward each agencies vision and strategy.
- Contextualising the reasons for change – how demographic, societal, financial and political issues require different responses from services in the 21st Century.
- Being open about the potential areas of conflict and confronting these head on by openly discussing, assessing and managing them.
- Establishing clear protocols around behaviours, regularity of meetings, information and data sharing, finances, and accountabilities.
- Establishing a shared understanding, and an appreciation, of the remit and limitations of collaboration.
- Ability to commit time, energy and resource (including senior leaders time) to sustain momentum and delivery.
- Appreciating the service user's perspective and involving them in identifying where collaboration can improve their experience.
- Promoting the importance and benefits of collaborative working at the 'front line' and communicating/explaining why it is important.
- Creating measures of success that enable you to demonstrate impact and value for money, and regularly evaluating and reporting performance against these.

Source: Audit Wales

Appendices

1 Audit methods and approach

2 The Civil Contingencies Act 2004 and responding to disasters in Wales

3 Examples of emergency services and responders collaborations elsewhere in Great Britain

4 Positive characteristics of emergency services who collaborate effectively

1 Audit methods and approach

Methods

We completed our review between March 2020 and October 2021 and used a range of methods in delivering the review:

- **document review:** we reviewed Welsh Government documentation, guidance and announcements, a range of materials on approaches in other parts of Great Britain and reports and information published by the UK Government;
- **interviews:** we interviewed senior leaders from each of the emergency services, officers with responsibility for delivering collaboration initiatives in Welsh emergency services, staff of the Welsh Government and a small number of people working in emergency services in England; and
- **data analysis:** we undertook a detailed data collection and analysis exercise drawing on information included in published accounts and data held by each of the emergency services. The data requested covered the following:
  - stations/bases, control rooms and location of each organisations buildings – we had all of this information.
  - workforce by role - uniformed and non-uniformed – we had all of this information.
  - revenue and capital spend – we had all of this information.
  - reserves – we had all of this information.
  - number of vehicles, annual mileage and spend on maintaining fleet – we had most of this information.
  - spend on overtime – we had most of this information.
  - sickness absence levels – we had some of this information.
  - board remuneration – we had all of this information.

We have only drawn on data sets which are fully or mostly complete in our analysis and have checked the validity and accuracy of the information with each body. Because of these differences in data, the analysis in the report varies between financial years.

Approach

Following previous local audit work on collaboration between police forces in Wales, we launched this review looking more widely at all Welsh 'blue light' services in March 2020. We originally planned this work as a '2 stage' audit:

- Stage 1 desktop review of resources, budgets, fleet and assets, to identify from where and how services currently work together.
- Stage 2 opportunities to improve resilience through better collaboration, integration and use of resources.

We revised our plans to take account of the challenges facing emergency services in dealing with the impact of COVID-19. We reduced the scope and coverage of our fieldwork. For instance, we did not process map how each emergency service responds to emergency 999 calls, including resolution and recovery at the Bridgend Joint Emergency Services Centre; we did not hold focus groups of frontline emergency workers; and we did not review risk registers and risk management arrangements. We also completed the review as a single stage audit.

2 The Civil Contingencies Act 2004 and responding to disasters in Wales

The Civil Contingencies Act 2004, and accompanying non-legislative measures, provides a single framework for civil protection in Wales[21]. Part 1 of the Act and supporting regulations and statutory guidance establish a clear set of roles and responsibilities for those involved in emergency preparation and response at the local level. We reported on the operation of the Act in 2012[22].

The Act divides local responders into 2 categories, imposing a different set of duties on each. Those in Category 1 are organisations at the core of the response to most emergencies (the emergency services, local authorities and NHS bodies). Category 1 responders are subject to the full set of civil protection duties. They will be required to:

- assess the risk of emergencies occurring and use this to inform contingency planning;
- put in place emergency plans;
- put in place business continuity management arrangements;
- put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency;
- share information with other local responders to enhance co-ordination;
- co-operate with other local responders to enhance co-ordination and efficiency; and
- provide advice and assistance to businesses and voluntary organisations about business continuity management (local authorities only).

21 Under Section 41 of the Transfer of Functions Order in 2018, key provisions of the Civil Contingencies Act 2004 ('the Act') were transferred to Welsh Ministers.

22 Civil Emergencies in Wales, Auditor General for Wales, December 2012.

Category 2 organisations (the Health and Safety Executive, transport and utility companies) are ‘co-operating bodies’. They are less likely to be involved in the heart of planning work, but will be heavily involved in incidents that affect their own sector. Category 2 responders have a lesser set of duties - co-operating and sharing relevant information with other Category 1 and 2 responders. Category 1 and 2 organisations come together to form ‘local resilience forums’ (based on police areas) which help co-ordination and co-operation between responders at the local level.

Emergency services in Wales have taken the lead in keeping people and property safe in response to a wide variety of incidents. For instance, severe storms and floods as well as transportation accidents, riots, civil protests, massive fires and oil pollution.

3 Examples of emergency services and responders collaborations elsewhere in Great Britain

Joint working between emergency services is growing in importance across Great Britain and there are numerous approaches in place or under development. For further information on the work of the Reform Collaboration Group in Scotland, Thames Valley Collaboration Steering Group and Bedfordshire Blue Light Collaboration Strategic Board see paragraphs 67 to 75 in the main body of this report.

Collaboration	Wider Membership	Performance management framework in place	Evaluation of existing joint working arrangements	Work programme prioritised	Additional and separate Tri Service strategies and approaches developed
Scotland Reform Collaboration Group	N/A	Yes	No	Yes	Data
Thames Valley Collaboration Steering Group	Police and Crime Commissioner County Councils Local Resilience Forum Local Economic Partnership NHS CCG	Yes	Yes	Yes	Estates Fleet Procurement Emergency Services Hubs Operational rotas Apprentices

Collaboration	Wider Membership	Performance management framework in place	Evaluation of existing joint working arrangements	Work programme prioritised	Additional and separate Tri Service strategies and approaches developed
Bedfordshire Blue Light Collaboration Strategic Board	Police and Crime Commissioner Local Resilience Forum	Yes	Yes	Yes	Estates Fleet Procurement Workshops
Southwest Emergency Services Collaboration Group	Cornwall Council Local Resilience Forum	Yes	Yes	Yes	Tri Force Specialist Operations Digital Storage and Management Emergency Services Mobile Communication Programme (ESMCP)
Warwickshire Blue Light Collaboration Joint Advisory Board	Police and Crime Commissioner County Council	Yes	No	Yes	Fire crime scene investigation Real Time Demand Management

Collaboration	Wider Membership	Performance management framework in place	Evaluation of existing joint working arrangements	Work programme prioritised	Additional and separate Tri Service strategies and approaches developed
Cheshire	Air ambulance	Yes	No	No	People Development professional elements Facilities and Estates Strategic Change Improvement Courier Services Legal Services Print Services Corporate Communications
Cumbria Blue Light Executive Leaders Board	County Council Mountain Rescue	Yes	No	Yes	Data sharing District level Local Focus Hubs Strategy Joint Command and Control Centre Mobile working strategy

Collaboration	Wider Membership	Performance management framework in place	Evaluation of existing joint working arrangements	Work programme prioritised	Additional and separate Tri Service strategies and approaches developed
Essex Strategic Board	Thurrock Council Southend on Sea Council	Yes	Yes	Yes	Estates Fleet Procurement Safer Essex Roads Strategy
Merseyside Blue Light Collaboration Board	Local Resilience Forum Liverpool City Council	Yes	No	Yes	Joint training for commanders and control room supervisor Common debrief process

Source: Audit Wales

We have developed this self-assessment checklist drawing on our review of

4 Positive characteristics of emergency services who collaborate effectively

emergency service collaborations across Great Britain. We have recommended that it is used by the emergency services in Wales to evaluate and strengthen their collaborative work programmes.

Characteristic	Always	Sometimes	Never
We have visible leadership that prioritises the importance of collaboration			
I trust others within the collaboration, and others trust me			
We are clear how collaboration contributes in a meaningful way to taking forward each agencies vision and strategy			
We know why and can contextualise the reasons for change – how demographic, societal, financial and political issues require different responses from services in the 21st Century			
We are open about the potential for conflict and confront these head on by openly discussing, assessing and managing them			
We know who will hold the partners together during challenging times			
Individuals are taking specific actions to move the collaboration forward			
The most difficult issues are being addressed			
We have clear and effective protocols around behaviours, regularity of meetings, information and data sharing, finances, and accountabilities			
Responsibility for coordinating the collaboration process is clear and partners are committed to sharing responsibility for the collaboration			
We have a shared understanding, and an appreciation, of the remit and limitations of collaboration			
We can commit sufficient time, energy and resource (including senior leaders time) to sustain momentum and delivery of our collaborative work			

Characteristic	Always	Sometimes	Never
I and my organisation is prepared to create and sustain capacity, and all other partners are committed to doing the same			
We value the service user's perspective and involve them in identifying where collaboration can improve their experience			
We promote the importance and benefits of collaborative working at the 'front line' and communicate and explain why this is important			
We have measures of success that enable us to demonstrate impact and value for money, and regularly evaluate and report performance against these			

Source: Audit Wales

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2022 Audit Plan – Welsh Ambulance Services NHS Trust

Audit year: 2022-23

Date issued: April 2022

Document reference: 2870A2022

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.

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

Contents

2022 Audit Plan

About this document

1 This document sets out the work I plan to undertake during 2022 to discharge my statutory responsibilities as your external auditor and to fulfil my obligations under the Code of Audit Practice.

Impact of COVID-19

2 The COVID-19 pandemic has had an unprecedented impact on the United Kingdom and the work of public sector organisations.

3 While Wales is currently at Coronavirus Alert Level 0, Audit Wales will continue to monitor the position and will discuss the implications of any changes in the position with your officers.

Audit of financial statements

4 I am required to issue a report on Trust's financial statements which includes an opinion on their 'truth and fairness' and the regularity of income and expenditure. In preparing such a report, I will:

- give an opinion on your financial statements;
- give an opinion on the proper preparation of key elements of your Remuneration and Staff Report; and
- assess whether other information presented with the financial statements are prepared in line with guidance and consistent with the financial statements.

5 I will also report by exception on a number of matters which are set out in more detail in our Statement of Responsibilities, along with further information about our work.

6 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 will be reported to the Audit Committee prior to completion of the audit.

7 Any misstatements below a trivial level (set at 5% of materiality) I judge as not requiring consideration by those charged with governance and therefore will not report them.

8 There have been no limitations imposed on me in planning the scope of this audit.

Audit of financial statement risks

9 The following table sets out the significant risks that have been identified for the audit of your financial statements.

Exhibit 1: audit of financial statement risks

Financial audit risks	Proposed audit response
Significant risks	
The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.31-33].	We will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for biases; and • evaluate the rationale for any significant transactions outside the normal course of business.
The implementation of the 'scheme pays' initiative in respect of the NHS pension tax arrangements for clinical staff is ongoing. Last year we included an Emphasis of matter paragraph in the audit opinion drawing attention to your disclosure of the contingent liability. Applications to the scheme will close on 31 March 2022, and if any expenditure is made in-year, we would consider it to be irregular as it contravenes the requirements of Managing Welsh Public Money.	We will review the evidence one year on around the take-up of the scheme and the need for a provision, and the consequential impact on the regularity opinion.
NHS Trusts have a financial duty to break even over a three-year rolling period. Although the Trust is forecasting a break-even position, this duty increases the risk that management judgements and estimates included in	We will focus our testing on areas of the financial statements which could contain reporting bias

Financial audit risks	Proposed audit response
the financial statements could be biased in help achieve this financial duty. Where the Trust fails this financial duty, I will place a substantive report on the financial statements highlighting the failure.	
Other areas of audit attention	
Introduction of IFRS 16 Leases has been deferred until 1 April 2022. There may be considerable work required to identify leases and the COVID-19 national emergency may pose additional implementation risks. The 2021-22 accounts will need to disclose the potential impact of implementing the standard.	We will review the completeness and accuracy of the disclosures.
We audit some of the disclosures in the Remuneration Report, such as the remuneration of senior officers and independent members, to a lower level of materiality. The disclosures are therefore inherently more prone to material misstatement. A number of changes have taken place to the senior management team and non-executive directors during the financial year. There is a risk that these changes are not correctly disclosed within the Trust's Remuneration Report.	We will review all entries in the Remuneration Report to verify that the Trust has reflected all known changes to senior positions, and that the disclosures are complete and accurate.
There continues to be increased funding streams and expenditure in 2021-22 to deal with the COVID-19 pandemic. These could have an impact on the risks of misstatement and the shape and approach to our audit. Examples of issues include fraud, error and regularity risks of additional spend; valuation	We will identify the key issues and associated risks and plan our work to obtain the assurance needed for our audit.

Financial audit risks	Proposed audit response
(including obsolescence) of year-end inventory including PPE; and estimation of annual leave balances.	
Although COVID-19 restrictions have now been removed, there have been ongoing pressures on staff resource and of remote working that may impact on the preparation, audit and publication of accounts. There is a risk that the quality of the accounts and supporting working papers may be compromised leading to an increased incidence of errors. Quality monitoring arrangements may be compromised due to timing issues and/or resource availability.	We will discuss your closedown process and quality monitoring arrangements with the accounts preparation team and make arrangements to monitor the accounts preparation process. We will help to identify areas where there may be gaps in arrangements.

10 In addition to my responsibilities in respect of the audit of the body's statutory financial statements set out above, I am also required to certify a return to the Welsh Government which provides information about Welsh Ambulance Services Trust to support preparation of Whole of Government Accounts.

Performance audit work

11 In addition to my Audit of Financial Statements, I must also 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.

12 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.

13 **Exhibit 2** sets out my current plans for performance audit work in 2022.

Exhibit 2: My planned 2022 performance audit work at the Trust

Theme	Approach/key areas of focus
NHS Structured Assessment	Structured assessment will continue to form the basis of the work auditors do at each NHS body to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. My 2022 structured assessment work will review the corporate arrangements in place at the Trust in relation to: • Governance and leadership; • Financial management; • Strategic planning; and • Use of resources (such as digital resources, estates, and other physical assets).
All-Wales Thematic work	As part of my 2022 plan, I intend to undertake an assessment of the workforce risks that NHS bodies are experiencing currently and are likely to experience in the future. It 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. I will tailor this work to align to the responsibilities of individual NHS bodies in respect of workforce planning.

Theme	Approach/key areas of focus
Implementing previous audit recommendations	My structured assessment work will 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.

14 In March 2022, I published a consultation inviting views to inform our future audit work programme for 2022-23 and beyond. In particular, it considers topics that may be taken forward through my national value for money examinations and studies and/or through local audit work across multiple NHS, central government, and local government bodies. As we develop and deliver our future work programme, we will be putting into practice key themes in our new five-year strategy, namely:

- the delivery of a strategic, dynamic, and high-quality audit programme; supported by
- a targeted and impactful approach to communicating and influencing.

15 The possible areas of focus for future audit work that we set out in the consultation were framed in the context of three key themes from our Picture of Public Services analysis in autumn 2021, namely: a changing world; the ongoing pandemic; and transforming service delivery. We also invited views on possible areas for follow-up work.

16 We will provide updates on the performance audit programme though our regular updates to the Audit Committee.

Fee, audit team and timetable

17 My fees and the planned timescales for completion of the audit are based on the following assumptions:

- the financial statements are provided to the agreed timescales, to the quality expected and have been subject to quality assurance review;
- information provided to support the financial statements is in accordance with the agreed audit deliverables document[1];
- appropriate facilities and access to documents are provided to enable my team to deliver our audit in an efficient manner;
- all appropriate officials will be available during the audit;
- you have all the necessary controls and checks in place to enable the Accounting Officer to provide all the assurances that I require in the Letter of Representation addressed to me; and
- Internal Audit's planned programme of work is complete, and management has responded to issues that may have affected the financial statements.

Fee

18 As set out in our Fee Scheme 2022-23 our fee rates for 2022-23 have increased by 3.7% as a result of the need to continually invest in audit quality and in response to increasing cost pressures.

19 The estimated fee for 2022 is set out in **Exhibit 3**. This represents a 5.4% increase compared to your actual 2021 fee. This increase reflects both the change in fee rates and the thematic work we feel we need to do in response to the risks and challenges facing the Trust and wider NHS.

Exhibit 3: audit fee

Audit area	Proposed fee for 2022 (£)[2]	Actual fee for 2021 (£)
Audit of Financial Statements	93,686	89,750
Charitable funds – independent examination[3]		1,500

[1] The agreed audit deliverables documents set out the expected working paper requirements to support the financial statements and include timescales and responsibilities.

[2] The fees shown in this document are exclusive of VAT, which is not charged to you.

[3] The Trust has requested a full audit of the charitable funds financial statements for 2021-22. A separate audit plan will be issued for this later in the year, including the proposed fee.

Performance audit work:		
• Structured Assessment	40,602	53,352
• National and local thematic work[4]	25,464	7,016
Performance work total	66,066	60,368
Total fee	159,752	151,618

20 Planning will be ongoing, and changes to our programme of audit work and therefore the fee, may be required if any key new risks emerge. We shall make no changes without first discussing them with the Director of Finance.

21 Further information on my fee scales and fee setting can be found on our website.

Audit team

22 The main members of the audit team, together with their contact details, are summarised in **Exhibit 4**.

Exhibit 4: my local audit team

Name	Role	Contact number	E-mail address
Clare James	Audit Director (Financial Audit)	02920 829330	Clare.James@audit.wales
Dave Thomas	Engagement Director (Performance Audit)	02920 320604	Dave.Thomas@audit.wales
Mike Whiteley	Audit Manager (Financial Audit)	02920 829389	Mike.whiteley@audit.wales
Andrew Doughton	Audit Manager (Performance Audit)	02920 829342	Andrew.Doughton@audit.wales

[4] As detailed in the respective audit plans.

Name	Role	Contact number	E-mail address
Sioned Owen	Audit Lead (Financial Audit)	02920 829338	Sioned,owen@audit.wales
Fflur Jones	Audit Lead (Performance Audit)	07773 193627	Fflur.Jones@audit.wales

23 We can confirm that team members are all independent of you and your officers. In addition, we are not aware of any potential conflicts of interest that we need to bring to your attention.

Timetable

24 The key milestones for the work set out in this plan are shown in **Exhibit 5**. As highlighted earlier, there may be a need to revise the timetable in light of developments with COVID-19.

Exhibit 5: Audit timetable

Planned output	Work undertaken	Report finalised
2022 Audit Plan	December 2021 to March 2022	April 2022
Audit of Financial Statements work: • Audit of Financial Statements Report • Opinion on Financial Statements • Final accounts action plan	February to June 2022	June 2022 June 2022 August 2022

Planned output	Work undertaken	Report finalised
Performance audit work: • Structured Assessment • All-Wales thematic work	Timescales for individual projects will be discussed with you and detailed within the specific project briefings produced for each study.	

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

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

MEETING	Audit Committee
DATE	7th June 2022
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Julie Boalch, Head of Risk, Deputy Board Secretary
CONTACT	Julie.Boalch@wales.nhs.uk

EXECUTIVE SUMMARY

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

2. In addition, it provides a progress update in respect of the Risk Transformation Programme which was supported as the direction of travel at the Audit Committee in December 2021 and has been included in the Integrated Medium Term Plan (IMTP) (2022/25).

RECOMMENDATION:

3. **Members are asked to consider and discuss the contents of the report and:**
   a. **Receive the improved Board Assurance Framework.**
   b. **Approve the adoption of the new nationally agreed Risk Matrix including scoring levels, review schedules and risk descriptors.**
   c. **Note the Risk Transformation Programme project plan and reporting arrangements.**
   d. **Agree the 2022/23 Risk reporting timetable.**

KEY ISSUES/IMPLICATIONS

4. This paper sets out the outcome of the work that has been undertaken to date to strengthen and rearticulate the Trust's Corporate Risks including new titles, summary descriptions and scores which Members are asked to note.

5. A review of each Corporate Risk score has been undertaken by mapping each control to related assurances and by identifying any gaps in these as well as any actions that can be taken to further mitigate the risk. As a result of this, 3 scores have increased.

6. Members are asked to agree the proposed risk reporting timetable.

7. The nationally agreed Risk Matrix is included in this paper for approval.

8. The Trust has recently undergone an Internal Audit review on Risk Management & Assurance and received a Reasonable Assurance rating.

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

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

    a) **People & Culture Committee** (10th May 2022)
    b) **Quality, Safety & Patient Experience** (12th May 2022)
    c) **Finance & Performance Committee** (16th May 2022)

REPORT APPROVAL ROUTE

11. The report has been considered by:
    - ADLT – 21st March 2022
    - ADLT – 22nd April 2022
    - EMT – 11th May 2022

REPORT ANNEXES

12. SBAR report.

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

14. Annex 2 - Risk Matrix

15. Annex 3 – Risk Reporting Timetable

16. Annex 4 - Board Assurance Framework

REPORT CHECKLIST

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

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

SITUATION

1. The purpose of this report is to provide an update in relation to the Trust's Corporate Risks with a particular focus on the work that has taken place to rearticulate and strengthen these

2. A summary report describing each of the corporate risks as of 12th May 2022 is detailed in Annex 1 as an extract from the Corporate Risk Register (CRR).

3. A proposed National Risk Matrix is included in Annex 2 for Members approval.

4. A revised Risk Reporting Schedule is included in Annex 3 for agreement.

5. The improved Board Assurance Framework (BAF) report is included in the paper in Annex 4.

BACKGROUND

6. The Risk Management and Board Assurance Framework Transformation Programme was supported as the direction of travel at the Audit Committee in December 2021 and has been included in the IMTP. It was agreed that a progress report would be submitted to the Audit Committee meeting in June 2022.

7. The immediate priority was for a detailed review of the Trust's 5 highest scoring risks with the remaining corporate risks to follow. A programme of work has been undertaken to strengthen the articulation of the corporate risks and any new risks including title, summary descriptions, controls, assurances and any gaps or additional actions required.

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

ASSESSMENT

9. There are currently 16 Corporate Risks on the register which are described in the summary table in Annex 1. The table sets out the rearticulation of each of the Corporate Risks including new titles and summary descriptions, utilising an '*if, then, resulting in*' approach, the Executive Owner of the Risk and the Risk score with any changes that have occurred during the period.

<u>Highest Scoring Risks</u>

10. The immediate priority of the transformation programme was to undertake a full review of the Trust's highest scoring risks: Risks 223, 224, 199, 316 and 160

which has been completed. New titles were determined, and the risks clearly articulated with new summary descriptions. The controls and assurances have been mapped together and any gaps identified. Further actions have been identified to mitigate the risks in addition to reviewing the scores and controls rating assurances.

11. The EMT has approved the rearticulation of each of the highest scoring Corporate Risks, which are included in the summary table in Annex 1.

12. The same process has been applied to the remaining Corporate Risks on the CRR and these are described in the table in Annex 1 focussing on titles, summary descriptions and scores only. The full Risk detail, including controls, assurances, gaps and mitigating actions form part of the improved Board Assurance Framework (BAF) detailed in Annex 3; however, whilst significant progress has been made, this work is not fully complete with a number of risks still a work in progress.

Closure and De-Escalation of Risks

13. No risks have been closed from the CRR or de-escalated to Directorate Registers since the last meeting in March 2022.

Changes to Risk Scores

14. Members are asked to note that 3 Corporate Risk scores have increased due to the rearticulation of the risks and subsequent review of the controls, assurances, gaps and mitigating actions.

15. The Risks that have increased in score are Risks 160, 201 and 245 and these are described below. To support this, the new nationally agreed Risk Matrix is included in Annex 2; however, the rationale for the change, made by the Risk Owner, is described below.

16. **Risk 160** - *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 of a reduced resource capacity*

    ***RESULTING IN** an inability to deliver services which adversely impacts on quality, safety and patient/staff experience.*

17. The Risk Owner and ADLT recommended the risk score be increased from 16 (4x4) to 20 (5x4) to reflect the significant, negative impact of absence on service delivery which impedes the Trust's ability to reach patients. The increase in score was approved by the EMT.

18. **Risk 201** - *Damage to Trust reputation following a loss of stakeholder confidence.* The previous title was *Trust Reputation.*

***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.*

19. The Risk Owner and ADLT recommended the risk score be increased to 20 (4x5) from 15 (3x5) as the ability to mitigate issues outside of the organisation are not within WAST's control these are contributing to the effects on the Trust's reputation. The increase in score was approved by the EMT.

20. **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).*

21. The Risk Owner and ADLT recommended the risk score be increased to 16 (4x4) from 15 (3x5) given the potential impact on patients and staff. The increase in score was approved by the EMT.

Further Review of Risks

22. Work is ongoing to consider and develop potential new Risks for inclusion on the CRR and consideration will be given during the coming weeks to the following:

    - *Patient Safety/Putting Things Right Team*
    - *NHS Decarbonisation*
    - *Supply Chain Issues – Digital Equipment*
    - *Securing Stakeholder Support to Deliver the Strategy and IMTP*
    - *Capacity to deliver change (IMTP)*
    - *Ongoing Impact of CoVID and Increasing Demand for Services (IMTP)*
    - *Staff health and wellbeing in the face of continued pressure (IMTP)*

Board Assurance Framework

23. The Audit Committee approved a request to suspend reporting of the BAF for a period of 3 months, at its March meeting, to enable the Governance team time to develop a transitional BAF that will be presented at the Audit Committee in June 2022 and the Trust Board in July 2022.

24. By way of assurance, a high level report was provided to the Trust Board and each scrutiny Committee during May 2022 on each of the corporate risks with a particular focus on the developing controls and assurances of the Trust's 5 highest scoring risks.

25. One element of the Risk Transformational Programme was to develop a transitional BAF that focusses the Board on the key risks that are mapped to the IMTP deliverables and that might compromise the achievement of the Trust's strategic objectives.

26. This improved BAF has been populated with the 16 Corporate Risks and is presented to the Audit Committee as agreed for review (Annex 4). As the Trust's risk maturity advances this template will be used to capture the risks to the strategic objectives and will be cross-referenced to the principal corporate risks.

27. This BAF will be presented to the Trust Board and each of the Committees as a standing Agenda item throughout the reporting cycles.

Internal Audit Review

28. The Trust has recently undergone an Internal Audit review on Risk Management & Assurance which received a Reasonable Assurance rating.

Risk Transformation Programme Progress Update

29. Risk management is an integral part of the Trust's governance arrangements, and the Trust Board has a responsibility to ensure that the principles of good governance are underpinned by such frameworks for risk and assurance, performance, and quality improvement to provide safe and effective care for patients and staff and ensure the safety of the environment around them.

30. To support this, a risk management transformation programme has been developed and included in the Integrated Medium Term Plan (2022-25) (IMTP).

31. 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.

32. The Trust will deliver strong risk management processes and embed an enterprise wide risk culture that underpins the principles of good governance by rolling out and embedding the transformation programme deliverables as described in the project plan, starting on page 7, below:

No.	IMTP Deliverable	Date
1.	Once for Wales Datix Risk Module implementation	January 2023 to March 2023
2.	Detailed review of each Corporate Risk	July 2022 Each Risk has been rearticulated (para 12). The work to finalise the mapping of assurances, controls and gaps will be finalised in July 2022.
3.	Develop Risk Management Policy and procedures	• Policy Group – 23rd August 2022 • Consultation - 24th August to 21st September 2022 • Policy Group – 25th September 2022 • ADLT, EMT and WASPT – November 2022 • Audit Committee – 1st December 2022 • Trust Board – 26th January 2023 for approval
4.	Develop and deliver a programme of training and education to the organisation	• Level 1 national package on ESR – December 2022 • Induction and bespoke packages – December 2022 • Level 2 mandatory packages aligned to the Once for Wales Datix Module – March 2023
5.	Board education on Risk Management and	Scope and plan with Chair – January 2023 to March 2023
6.	Development of Risk Appetite Statements	Scope and plan with Chair – January 2023 to March 2023
7.	Develop a new BAF aligned to the 2030 Delivering Excellence 7 objectives	Roadmap and plan complete – March 2023

33. The Risk Management Strategy (2018-21) will not be refreshed; however, as the above project plan indicates, a clear Risk Management Framework is in development which incorporates the IMTP deliverables described above, a Risk Management Policy, associated procedures, and Board and organisational risk management training.

34. The Governance Team are members of national Risk Management Groups who are currently working with RL Datix on the design phase of the new Once for Wales Datix Risk Module. This is expected to be implemented by March 2023; however, there have been delays in receiving the agreed updates to the system from RL Datix which incorporate the group's requested amendments and improvements.

35. RL Datix have advised that it will be September 2022 before they are able to showcase the revised system including our amendments as part of the design phase.

36. The Risk Team's plan to roll out the new Once for Wales Datix Module is to manually migrate the Corporate Risks with a planned approach to Directorate Risks including data cleansing and migration. It is intended that these will be manually input by each Directorate as part of a phased implementation.

37. There are a total of 312 risks currently open on Datix that need to be cleansed prior to migration; however, with a planned approach to achieve this is being developed to ensure that this is manageable for the Trust within the timeframe. RL Datix have said that there will be no additional charge to the Trust to hold both systems open until all risks have been migrated to the new system and the old one closed down.

38. The Board Risk Maturity matrix 2023/24 (3 year) will be reported through the IMTP to the Strategic Transformation Board (STB) for monitoring later.

39. Each of the IMTP deliverables and delivery timeframes will be monitored at the STB with regular update reports presented on progress. The first of these reports will be presented to the STB in June 2022.

40. In addition, regular update reports will be presented to Audit Committee and Trust Board during each meeting cycle.

National Approach and Risk Matrices

41. Members are asked to approve the adoption of nationally agreed Risk Scoring Matrices (Annex 2). These have been developed in partnership across Health Boards and Trusts to align the approach to Risk Management across the NHS in Wales wherever possible.

42. It should be noted that some of the likelihood and consequence descriptors have been improved by the inclusion of additional narrative and are highlighted in yellow on the matrix in Annex 2. None of the existing narrative has been removed. Two additional rows have been included to describe the *Environment, Estate and Infrastructure* as well as a separate row for *Health Inequalities and Equity.*

43. The specific changes to the other individual elements of the matrix are described in paragraphs 44 to 47 below.

New Risk Scoring Matrices

44. The Trust's current risk scoring matrix has 4 levels of *Red, Amber, Yellow and Green* as described in the table below:

Current Risk Scoring Matrix

Risk Score	Review Frequency	Risk Rating
15 – 25 Red	Review monthly	Extreme
8 – 12 Amber	Review quarterly	High
4 – 6 Yellow	Review every 6 months	Moderate
1 - 3 Green	Review at least annually	Low

45. The national proposal is for only 3 levels, and this has been achieved by removing the existing *Yellow* level and in addition to this, the *Extreme* risk rating has been removed and the levels recategorized as per the proposed new matrix in the table below:

Proposed Risk Scoring Matrix

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

46. The Trust's current risk descriptors are *Rare, Unlikely, Possible, Likely and Almost Certain* as described in the table below

Current Risk Descriptors

1	Rare	Will probably never happen/recur
2	Unlikely	Do not expect it to happen/recur but it is possible
3	Possible	It might happen/recur occasionally
4	Likely	Will probably happen/recur, but is not a persisting issue
5	Almost Certain	Will undoubtedly happen/recur, maybe frequently

47. The nationally proposed risk descriptors are described in the table below:

Proposed Risk Descriptors

1	Highly Unlikely	Will probably never happen/recur
2	Unlikely	Do not expect it to happen/recur but it is possible
3	Likely	It might happen/recur occasionally
4	Highly Likely	Will probably happen/recur, but is not a persisting issue
5	Almost Certain	Will undoubtedly happen/recur, maybe frequently

48. Additionally, the national groups have agreed to move from *Initial* to *Inherent* as a Risk Level and Members are asked to approve this as described in the table below:

Inherent	**Current**	**Target**
Risk level before any controls/mitigations implemented, in its initial state.	***Risk level after initial controls/mitigations have been implemented.***	***Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.***

Reporting Timetable

49. Members are asked to agree the proposed risk reporting timetable described in annex 3.

50. Each of the red and high scoring risks will be reviewed monthly by the Risk Owners with the support of the Risk Team as part of the agreed review frequency matrices; however, these will be reported to Trust Board on a quarterly basis and any additional actions included where possible.

RECOMMENDED:

51. **Members are asked to consider and discuss the contents of the report and:**
    - **a) Receive the improved Board Assurance Framework.**
    - **b) Approve the adoption of the new nationally agreed Risk Matrix including scoring levels, review schedules and risk descriptors.**
    - **c) Agree the Risk Transformation Programme project plan and reporting arrangements.**
    - **d) Note the 2022/23 Risk reporting timetable.**

Annex 1 – Corporate Risk Register Summary

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
223	The Trust's inability to reach patients in the community causing patient harm and death Previous title: *Unable to attend patients in community who require See & Treat*	**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	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 Previous title: *Patients delayed on ambulances outside A&E Departments*	**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	High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service Previous title: *High Sickness Absence Rates*	**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)** ↑ **New score up from 16 (4x4)**
199	Failure to embed an interdependent and mature health and safety culture which could cause harm and a breach in compliance with Health & Safety statutory legislation	**IF** there is a failure to embed an interdependent and mature health and safety culture, effective arrangements and associated governance **THEN** there is a risk of a potential breach in compliance with the requirements of the Health & Safety at Work etc. Act 1974 and	Director of Quality & Nursing	**20 (4x5)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
	Previous title: *Compliance with Health and Safety legislation*	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		
201	Damage to Trust reputation following a loss of stakeholder confidence Previous title: *Trust Reputation*	**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)** ↑ **New Score up from 15 (3x5)**
139	Failure to Deliver our Statutory Financial Duties in accordance with legislation Previous title: *Non Delivery of Financial Balance*	**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)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
244	Estates accommodation capacity limitations impacting on EMS Clinical Contact Centre's (CCC) ability to provide a safe and effective service Previous title: *Impact on EMS CCC service delivery due to estates constraints*	**IF** the Trust is unable to increase accommodation capacity **THEN** there is a risk that EMS CCC will not be able to accommodate all roles during periods of escalation and surge management or expand operations to support new initiatives **RESULTING IN** EMS CCC being unable to deliver services effectively which adversely impacts on quality, safety and patient/staff experience	Director of Operations	**16 (4x4)** →
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 Previous title: *Inability to maintain safe and effective services during a disruptive challenge due to insufficient capacity in EMS CCCs*	**IF** CCCs are unable to accommodate additional core functions and do not have alternative site arrangements in place in the event of a business continuity incident **THEN** there is a risk that EMS CCCs cannot utilise other CCC's space, accommodation and facilities **RESULTING IN** potential patient harm and a breach of the requirements of the Civil Contingencies Act (2004) and Contingency Planning Regulations (2005)	Director of Operations	**16 (4x4)** ↑ **New Score Up from 15 (3x5)**
311	Inability of the Estate to cope with the increase in FTEs Previous title: *Failure to manage the cumulative impact on estate of the EMS Demand & Capacity Review, the NEPTS Review and GUH*	**IF** the cumulative impact on the estate of the EMS Demand & Capacity Review and the NEPTS Review is not adequately managed **THEN** there is a risk that the Estate will not be able to cope with the increase in FTEs **RESULTING IN** potential failure to achieve the benefits/outcomes of the programme and reputational damage to the Trust	Director of Finance & Corporate Resources	**16 (4x4)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
458	A confirmed commitment from EASC and/or Welsh Government is required in relation to funding for recurrent costs of commissioning Previous title: *Confirmed commitments from EAST and/or Welsh Government required regarding funding for recurrent costs of commissioning to deliver the IMTP and/or additional services*	**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)** →
260	A significant and sustained cyber-attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems Previous title: *Cyber Risk*	**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)** →
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	**IF** WAST fails to persuade EASC/Health Boards about WAST ambitions **THEN** there is a risk of a delay or failure to receive funding and support	Director of Strategy Planning & Performance	**12 (3x4)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
	Previous title: *Failure to collaborate, engage and reach agreement with EASC on ambitions and plans for WAST*	**RESULTING IN** a catastrophic impact on services to patients and staff and key outcomes within the IMTP not being delivered		
163	Maintaining Effective & Strong Trade Union Partnerships Previous title: *Trade Unions/Partnership Working*	**IF** the response to tensions and challenges in the relationships with Trade Union partners is not effectively and swiftly addressed and trust and (early) engagement is not maintained **THEN** there is a risk that Trade Union partnership relationships increase in fragility and the ability to effectively deliver change is compromised **RESULTING IN** a negative impact on colleague experience and/or services to patients.	Director of Workforce & Organisational Development	**12 (3x4)** →
283	Failure to implement the EMS Operational Transformation Programme Previous title: *EMS Demand & Capacity Review Implementation 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)** →
424	Prioritisation or Availability of Resources to Deliver the Trust's IMTP Previous title: *Resource availability (capital) to deliver the organisation'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	Director of Strategy Planning and Performance	**12 (3x4)** →

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

Annex 2 – Proposed National Risk Matrix begins at the top of the next page (17)

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.	Local media coverage - short-term reduction in public confidence/trust. Short-term negative social media. Public expectations not met.	Local media coverage - long-term reduction in public confidence & trust. Prolonged negative social media. Reported in local media.	National media coverage <3 days, service well below reasonable public expectation. Prolonged negative social media, reported in national media, long-term reduction in public confidence & trust. Increased scrutiny: inspectorates, regulatory bodies and WG.	National/social media coverage >3 days, service well below reasonable public expectation. Extensive, prolonged social media. MP/MS questions in House/Senedd. Total loss of public confidence/trust. Escalation of scrutiny status by WG.
Business Objectives or Projects	Insignificant cost increase/ schedule slippage.	<5 per cent over project budget. Schedule slippage.	5–10 per cent over project budget. Schedule slippage.	Non-compliance with national targets.10-25 per cent over project budget. Schedule slippage. Key objectives not met.	>25 per cent over project budget. Schedule slippage. Key objectives not met.
Financial Stability & Impact of Litigation	Small loss. Risk of claim remote.	Loss of 0.1–0.25% of budget Claim less than £10,000.	Loss of 0.25–0.5% of budget. Claim(s) between £10,000 and £100,000.	Uncertain delivery of key objective. Loss of 0.5-1.0% of budget. Claim(s) between £100,000 and £1 million. Purchasers failing to pay on time.	Non-delivery of key objective. Loss of >1 per cent of budget. Failure to meet specification. Claim(s) >£1 million. Loss of contract/payment by results.
Service/ Business Interruption	Loss/interruption of >1 hour. Minor disruption.	Loss/interruption of >8 hours. Some disruption manageable by altered operational routine.	Loss/interruption of >1 day. Disruption to a number of operational areas in a location, possible flow to other locations.	Loss/interruption of >1 week. All operational areas of a location compromised; other locations may be affected.	Permanent loss of service or facility. Total shutdown of operations.
Environment/Estate / Infrastructure	Minimal or no impact on environment/service/property.	Minor impact on environment/ service/property.	Moderate impact on environment/ service/property.	Major impact on environment/ service/property.	Catastrophic impact on environment/service/property.
Health Inequalities/ Equity	Minimal or no impact on attempts to reduce health inequalities/improve health equity.	Minor impact on attempts to reduce health inequalities or lack of clarity on the impact on health equity.	Lack of sufficient information to demonstrate reducing equity gap, no positive impact on health improvement or health equity.	Validated data suggests no improvement in the health of the most disadvantaged, whilst supporting the least disadvantaged, no impact on health improvement and/or equity.	Validated data demonstrates a disproportionate widening of health inequalities, or negative impact on health improvement and/or equity.

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)		Consequence:				
Likelihood:	Frequency:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
1 Highly Unlikely: Will probably never happen/recur	Not for years	1	2	3	4	5
2 Unlikely: Do not expect it to happen/recur but it is possible	At least annually	2	4	6	8	10
3 Likely: It might happen/recur occasionally	At least monthly	3	6	9	12	15
4 Highly Likely: Will probably happen/recur, but not a persisting issue	At least weekly	4	8	12	16	20
5 Almost Certain: Will undoubtedly happen/recur, maybe frequently	At least daily	5	10	15	20	25

Annex 3 - Risk Reporting Timetable

	ADLT	EMT	Deadline for Papers	Audit Committee	FPC	QuEST	PCC
1	5th May 2022	11th May 2022	31st May 2022	7th June 2022	18th July 2022	11th August 2022	6th September 2022
2	8th August 2022	24th August 2022	8th September 2022	15th September 2022	19th September 2022	10th November 2022	29th November 2022
3	31st October 2022	9th November 2022	24th November 2022	1st December 2022	16th January 2023	9th February 2023	21st February 2023
4	23rd January 2023	8th February 2023	23rd February 2023	2nd March 2023	20th March 2023		

Risk Register locked and no further changes will be made apart from any amendments agreed at EMT.

No risk report to FPC on 14th November 2022 (duplicate of 19th September 2022 report).

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	11/05/2022	TREND	25 (5x5)
		Date of Next Review:	09/06/2022	➡	

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

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

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

CONTROLS

a. Hospital Ambulance Liaison Officer (HALO)
b. Regional Escalation Protocol
c. Immediate release protocol
d. Resource Escalation Action Plan (REAP)
e. 24/7 Operational Delivery Unit (ODU)
f. Incident Response Plan (IRP)
g. Gold/Strategic, Silver/Tactical and Bronze/Operational 24 hour/ 7 day per week system to manage escalation plans
h. Alternative care pathways in place
i. Hear and Treat
j. Consult and Close
k. Advanced Paramedic Practitioner (APP) deployment model
l. Clinical Safety Plan
m. Volunteers getting to patients
n. Extended cohorting arrangements at Morriston and Grange hospitals to end of July 2022
o. ETA scripting
p. Clinical Contact Centre (CCC) emergency rule
q. Protocol 36 (dealing with pandemic flu symptoms)
r. BT duplicate call filter
s. Escalation forums to discuss reducing and mitigating system pressures
t. SCIF to discuss patient incidents that have triggered a certain risk level which have a potential of being reported to the Welsh Government

ASSURANCES

Internal

Management (1st Line of Assurance)

a. Patient Flow Coordinators (PFCs) are a commissioned service by the Health Board (x2 in ABUHB specifically for GUH) with a bespoke job description, these link directly with the National Delivery Managers in ODU
b. Daily conference calls to agree RE levels in conjunction with Health Boards
c. 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)
d. Weekly review by Senior Operations team. 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.
e. Shift reports from ODU & ODU Dashboard received by Exec, SOT and On-Call Team at start/end
f. The Incident Report Plan has been ratified via EMT
g. Same as e
h. Health Informatics reports, APP dashboard monitors, reports on app use by Consultant Connect
i. Monitoring CSD rates through AQIs
j. Consult and Close volumes form part of EMS CCC weekly reports to SPT. 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)
k. 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
l. Clinical agreement – agreeing escalation to higher levels, ODU dashboard, AACE paper through National Director of Operations group
m. Volunteers are another resource for response, Volunteer
n. Service level agreement in place
o. 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
p. CCC Emergency Rule is policy that has been signed off by Execs.
q. There is a regular review of levels through SPT ratified at EPT.
r. This is a tactic contained in REAP ratified through SPT and EPT
s. Daily risk huddles are recorded, and documented actions are shared with stakeholders and progress monitored via the ODU
t. Occurs on a weekly basis and meetings are minuted

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	11/05/2022	TREND	25 (5x5)
		Date of Next Review:	09/06/2022	➡	

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

GAPS IN CONTROLS	GAPS IN ASSURANCE
• Acknowledgement and acceptance of risk by Health Boards and balancing the risks across the whole system • Blockages in system e.g internal capacity within Health Boards which affect patient flow • Covid capacity streaming • Transition Plan/Inverted Triangle – bid for transition plan has been put in and is now subject to funding • Local delivery units mirroring WAST ODU • Handover delays link to risk 224 • Tolerance in Health Boards has become the norm. As delays have increased, there appears to be no visible appetite to address these issues • There appears to be a lack of leadership, ownership, responsibility by external stakeholders e.g EASC have stated that no delay should exceed 4 hours although WAST is yet to see any demonstrable plans to support this • Outputs from the NHS System Reset – it is a closer collaboration to address some of the system blockages and reduce system pressures. This is the aspiration *Please note that the gaps listed are not WAST's and are therefore outside of the control of WAST*	None immediately identified but subject to continual review

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	Assistant Director of Operations EMS / Assistant Director of Operations – National Operations & Support	Subject to funding - no timeframe for this	
2. Leading Change Together (forum to progress workforce related work streams jointly with TUPs)	ADLT Sub-Group	30.09.22	
3. EMS Demand & Capacity i.e. review and implementation of new EMS rosters	Assistant Director of Operations EMS	30.09.22	
4. Transition arrangements post pandemic	Executive Pandemic Team	30.09.22	

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:	20/05/2022	TREND	25 (5x5)
		Date of Next Review:	30/06/2022	→	

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

	Likelihood	Consequence	Score
Inherent	5	5	25
Current	5	5	25
Target			

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

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

CONTROLS

a. WAST Serious Clinical Incident Forum (SCIF) is in place to discuss patient safety incidents, learning and improvement actions to prevent future harm, working in collaboration with Health Boards / NHS Wales Delivery Unit under the *Framework for the Investigation of Patient Safety Serious Incidents (SIs)* V2.2, dated July 2019.
b. WAST membership of the working group to reform the Framework for the Investigation of Patient Safety Serious Incidents (SIs) national investigation framework with system partners. To be chaired by the Deputy Chief Ambulance Commissioner.
c. WAST and system compliance with National Standards - 15-minute handover (NHS Wales Hospital Handover Guidance v2 (May 2016)
d. 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.
e. 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 on the workstream in place looking at handover of care delays which includes the implementation of Fit2Sit programme and handover of care checklist pan NHS Wales. Additionally, the Emergency Ambulance Services Committee (EASC) have stated that no delay should exceed 4 hours.
f. Hospital Ambulance Liaison Officer (HALO) (Some health Boards).
g. Regional Escalation Protocol and Resource Escalation Action Plan (REAP).
h. Staff from WAST, Health Boards and third sector organisations assisting to meet patient's Fundamentals of Care as best they can in the circumstances.
i. 24/7 Operational Delivery Unit (ODU) escalating handover delays / patient condition to Health Board colleagues.
j. Gold/Strategic, Silver/Tactical and Bronze/Operational 24 hour/ 7 day per week system to manage escalation plans.
k. Escalation forums to discuss reducing and mitigating system pressures.
l. WAST Education and training programmes include deteriorating patient (NEWs), tissue viability, dementia awareness, mental health.
m. Clinical audit programme
n. 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.

ASSURANCES

Internal
Management (1st Line of Assurance)

a.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
e. Monitoring of Ambulance Quality Coordinators
f. Patient Flow Coordinators (PFCs) are a commissioned service by the Health Board (x2 in ABUHB specifically for GUH) with a bespoke job description, these link directly with the National Delivery Managers in ODU
g. 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
h. Confirmed through HIW workshops
i. Shift reports from ODU & ODU Dashboard received by Exec, SOT and On-Call Team at start/end
j. Same as i
k. Daily risk huddles are recorded, and documented actions are shared with stakeholders and progress monitored via the ODU
l. Integrated Quality and Performance Report, Health Informatics reports, APP dashboard monitors, reports on app use by Consultant Connect (I) and shared at local and corporate meetings regarding patient safety and handover of care position across NHS Wales and NHS England
m. *TBC via meeting with Assistant Director Research, Audit and Service Improvement*
n. HIW approve and sign off WAST elements of recommendations

External
Management (1st Line of Assurance)

a. Monitoring and oversight of the Ambulance Quality Indicators (AQIs) including handover of care timeliness and Commissioning Framework by the Chief Ambulance Services Commissioner (CASC) and Joint Executive Team meeting Welsh Government (I&E).
b. Healthcare Inspectorate Wales (HIW) 'Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover' Report and system wide improvement plan with working group in place with WAST senior representation. Oversight by HIW and CASC

GAPS IN CONTROLS

- Inconsistent review of potentially serious / catastrophic patient safety incidents in line with the Framework for the Investigation of Patient Safety Serious Incidents (SIs) V2.2, dated July 2019 (frequently referenced as 'Appendix B' Reports) by Health Boards pan NHS Wales and lack of ownership of system risks* (covering control a)
- Lack of pace in the formation of a working group (pan Wales) to address the findings of the NHS Wales Delivery Unit Report on the implementation of the Framework for the Investigation of Patient Safety Serious Incidents (SIs)* (covering control b)
- 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* (covering control c)
- Variation in responsiveness at Emergency Departments to the escalating concerns regarding patients' NEWS* (covering control d)
- Internally WAST require rapid access to collective patient safety data including NEWs at Emergency Department level for local managers, the Operational Delivery Unit, senior managers, and patient safety / quality improvement teams to support quality and patient safety conversations and reporting (covering control d)

GAPS IN ASSURANCE

- Lack of live collective patient safety metrics and look back data at ED level for in baseline data for improvement projects and WAST reports (covering assurance a)
- Strengthen current quality, safety and patient experience reports to include collective data over time and use statistical process charts where appropriate (covering assurance b)
- 15-minute handover target is not being achieved pan-Wales * (covering assurance c)
- TBC via discussion with Assistant Director Research, Audit and Service Improvement (covering assurance d)
- Planning and performance teams are preparing workstreams. Lack of escalation and response to AQIs by the wider urgent care system and regulators * (covering assurance e)
- Lack of escalation and response to AQIs by the wider urgent care system and regulators* (covering assurance a)
- Lack of collective system response to HIW 'Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover' Report. Meetings cancelled x 2 in May 2022. WAST has representation on the working group* (covering assurance b)

*(*WAST can influence but the gap is out of WAST's control).*

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:	20/05/2022	TREND	25 (5x5)
		Date of Next Review:	30/06/2022	➡	

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

	Likelihood	Consequence	Score
Inherent	5	5	25
Current	5	5	25
Target			

- Variation in appetite across the Health Boards to implement Fit2Sit, citing overcrowded emergency department waiting rooms as the reason. Quality Improvement approach required to engage and influence, led by WAST (WAST have some control on this). Limited confidence in system engagement to address Goal 4 (covering control e)
- Protracted timescales in the *Right care, right place, first time Six Goals for Urgent and Emergency Care - A policy handbook 2021–2026.* Goal 4 'Improving ambulance patient handover, ensuring no one arriving by ambulance at an Emergency Department waits more than 60 minutes from arrival to handover to a clinician – by the end of **April 2025**. The number of people waiting over this period for ambulance patient handover will reduce on an annual basis until that point'. No detail on incremental improvements required at emergency department level or oversight mechanisms. EASC have stated that no delay should exceed 4 hours although WAST is yet to see any demonstrable plans to support this*.
- Position not implemented across all emergency departments* (covering control f)
- Variable depending on staff resources and facilities at each ED. WAST have minimal control on this at patient level* (covering control h)
- Mandatory training compliance lower than required. Recovery plan in place (covering control i)
- Lack of pace and engagement from system partners. Second meeting cancelled on two occasions in May 2022* (covering control n)
- 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* (covering control n)

*(*WAST can influence but the gap is out of WAST's control).*

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1.Right care, right place, first time Six Goals for Urgent and Emergency Care A policy handbook 2021–2026 Goal 4: Rapid response in physical or mental health crisis.	TBC	Awaiting internal programme details	
2. Fit 2 Sit implementation – through the Emergency Department Quality Delivery Framework (EDQDF).	Head of Quality (QSPE)	Timeframes awaited via EDQDF	
3. Develop and implement patient safety dashboards at Emergency Department level (NHS Wales & NHS England). With a handful key quality metrics / KPIs which may include: - NEWs - Age - Waiting times (Live) (Call to current time) - Existing long-term condition - Immediate release data (Links to 223)	Head of Patient Safety	October 2022	
3. Incrementally strengthen the look back collective intelligence data in the Patient Safety Highlight Report over the next six months to include as relevant: - 'Call to definitive care' time - 'Number of patients ROLED at scene – outside of response time' - Safeguarding referrals - Patient experience data - Clinical audit data - SCIF (NRIs) / Appendix Bs numbers - Pressure damage – whole pathway (grade 3 /4 – ambulance transfers) - Regulation 28 Prevention of Future Deaths Reports issued - Concerns data - Medical examiner / mortality review outcomes	Head of Patient Safety	Develop during Quarter 2 2022 data period	
4. HIW Improvement Workshop and Task & Finish Group (coordinated by CASC). WAST actions required and also influencing improvements across the system in response to the 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 Quality & Nursing	Quarterly updates on progress to QuEST commencing August 2022	
5. Participation in the CASC led workshop to reform *the Framework for the Investigation of* Patient *Safety Serious Incidents (SIs) V2.2, dated July 2019*	Assistant Director Quality & Nursing	Timeframes awaited from CASC / NHS Wales Delivery Unit	

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:	11/04/2022	TREND	20 (5x4)
		Date of Next Review:	30/06/2022	⬆	

IF there are high levels of absence e.g. sickness and alternative duties	THEN there is a risk that there is reduced resource capacity	RESULTING IN an inability to deliver services which adversely impacts on quality, safety and patient/staff experience

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

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

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

CONTROLS

a. Managing Attendance at Work Policy/Procedures in place
b. Respect and Resolution Policy
c. Raising Concerns Policy
d. Health and Wellbeing Strategy
e. Operational Workforce Recruitment Plans
f. Roster Review & Implementation
g. Return to Work interviews are undertaken
h. Training
i. Directors receives monthly email with setting out ESR sickness data
j. Operational managers receive daily sickness absence data via GRS
k. People Services & Occupational Health & Wellbeing support/Employee Assistance Programme
l. WAST Keep Talking (mental health portal)
m. Suicide first aiders
n. TRiM
o. Peer Support network
p. Coaching and mentoring framework
q. Staff surveys
r. Stress risk assessments
s. Sickness statistics are reported to SLT, SOT, People & Culture Committee, Trust Board and the CASC
t. External agency support e.g. St John Ambulance, Fire and Rescue
u. Strategic Equality Objectives
v. Volunteers
w. Monthly reviews of colleagues on Alternative duties
x. Manager guidance on managing Alternative duties
y. Fortnightly report on absence to EMT and report to every meeting of People & Culture Committee

ASSURANCES

Internal

Management (1st Line of Assurance)

'a.Policy reviews to ensure policies and procedures are fit for purpose (covering a – c)
a. Audits by People Services on sickness (covering a)
b. Sickness forms part of Workforce Scorecard to People & Culture Committee (covering s)
c. Action plans arising from meetings with colleagues implemented through monthly diarised meetings (covering w)
d. Minuted meetings and action logs for EMT & People & Culture Committee (covering y)

External

Management (1st Line of Assurance)

e. All Wales review of All Wales Attendance at Work Policy (covering a)

Independent Assurance (3rd Line of Assurance)

f. Internal Audits scheduled through Shared Services Partnership (covering controls a – x)
g. Audit Wales – Taking Care of the Carers report in October 2021 (covering controls a – x)

GAPS IN CONTROLS

- Wellbeing policy currently being produced (covering control d)
- There is no steering group for Health and Wellbeing – there are plans to restart the group (covering control d)
- Consistency and Application in Managing Attendance at Work Policy (covering control a)
- Education and communication with managers about resources available and how to implement it e.g. stress risk assessments (cover controls a – v)
- It is not known what is undertaken with respect to the data covered in assurances i and j once it is received

GAPS IN ASSURANCE

Internal

- Reporting on training compliance (covering control h)
- Absence data is not updated in a timely manner into ESR by managers (covering controls i, j and s)
- There are other factors that impact on sickness which can't be controlled

External

None identified at the present moment

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:	11/04/2022	TREND	20 (5x4)
		Date of Next Review:	30/06/2022	⬆	

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

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

Risk ID 199	Failure to embed an interdependent and mature health and safety culture which could cause harm and a breach in compliance with Health & Safety statutory legislation	Date of Review:	24/05/2022	TREND	20 (4x5)
		Date of Next Review:	30/06/2022	➡	

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

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

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

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

CONTROLS

a. Systematic review and assessment of Health and Safety arrangements and Governance (Health & Safety Management system)
b. Health & Safety Governance and reporting arrangements e.g. committees and sub-groups
c. Provision of dedicated health and safety expertise and advice
d. Health & Safety Policy and procedures
e. Mandatory Health and Safety training
f. Scheduled H&S visits and inspections
g. Risk assessments (including local risk assessments -Covid 19, workplace risk assessments, risk assessments covering EMS and NEPTs activities)
h. Working Safely Programme Board, Dynamic Delivery Action Group & Programme Manager to provide oversight of Working Safely Action Plan
i. IOSH Managing Safely for Managers training in place
j. IOSH Leading Safely for Directors and Senior Managers training in place

ASSURANCES

Internal

Management (1st Line of Assurance)

a. Assessment criteria set for management system (all Wales system)
b. Monthly H&S report to ADLT, quarterly report and annual report to ADLT, H&S committee, EMT, PCC
c. Working Safely team in place until end of September 2022
d. H&S Policy approved in 2018
e. Quarterly statistics available from ESR and this forms part of Head of Health and Safety's quarterly report
f. Head of Health and Safety's monthly report to ADLT
g. Covid 19 assessments are monitored by Business Continuity and Recovery Cell Team (BCRT) on a weekly basis. Other risk assessments and SOPs are held on Sharepoint and have been submitted to SOT for approval
h. Working Safely Action Plan has been agreed and this is being held to account by Strategic Transformation Board. Deliverables are being monitored fortnightly through Dynamic Delivery Group meeting. Terms of reference for Dynamic Delivery Group are approved.
i. Attendance and competency figures provided in a monthly report to ADLT and quarterly report to committees and above
j. Attendance and figures provided in monthly report to ADLT. Personal safety commitments are being monitored on a quarterly basis

External

Independent Assurance (3rd Line of Assurance)

Internal Audit to be undertaken in Q4 22/23(covering a – j)

GAPS IN CONTROLS

- Baseline audit for (a) not to be commenced till Q1 2022 (***being addressed in Actions 1 & 7)***
- The Health and Safety Policy and some procedures are due to be reviewed by the end of Q1 2022 (covering control d in Q1 2022 (***being addressed in Action 1***)
- Effective learning from events to be documented ***(being addressed in Action 1)***
- Operational pressures on service impacting on Working Safely Programme delivery (covering control h) (***being addressed in Action 1***)
- Staff available to deliver training (covering control i). There is an aim to commence training in May 2022 (***being addressed in Action 4***)
- Staff availability to provision and schedule training (covering control j) ***(being addressed in Actions 2 & 3)***
- 2 live vacancies for H&S Business Partners will be advertised week commencing 3.05.22. This will need to be filled (covering control c) ***(being addressed in Action 4)***
- Poor uptake in H&S training due to sustained pressures and under capacity to deliver in H&S (covering control e) ***(being addressed as part of Actions 2 – 3)***
- Lack of cultural baseline to demonstrate H&S awareness (covering control a) ***(being addressed in Action 5)***
- A compliance register is under construction that describes the requirements of the various Health & Safety legislation that we need to comply with (covering control a) ***(being addressed in Action 6)***
- An assessment section will provide assurance on how we are complying with the legislation (covering control d) ***(being addressed in Action 7)***

GAPS IN ASSURANCE

Internal

- Capacity issues in assessing management system (covering assurance a)
- Subgroups of H&S committee currently under review (covering assurance b)
- After September 2022, uncertainty over capacity to deliver to the Working Safely programme (covering assurance c)
- Review of H&S Policy is due at end of Q1 2022 (covering assurance d)
- Workforce Transformational change will influence content within H&S policy (covering assurance d)
- Developing schedule for H&S inspections and visits. Once this is undertaken, metrics to be developed (covering assurance f)
- Current copies of risk assessments and SOPs are not available at all stations (covering assurance g)
- Do not know how many SOPs are required until baseline audit completed (covers assurance g)
- H&S team in discussions with best way of monitoring Personal safety commitments (covering assurance j)
- Do not have a schedule of training in place but expecting to complete this in Q1 2022 (covering assurance j)

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:	24/05/2022	TREND	20 (4x5)
		Date of Next Review:	30/06/2022	➡	

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

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

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Delivery of the Working Safely Action Plan (WSAP) (Priority top 25)	Head of Health & Safety	31.08.22	
2. IOSH Leading Safely training to be delivered to Exec Team and Board (forms part of WSAP)	Head of Health & Safety	31.12.22	
3. WAST Leading Safely Behavioural Audit training to Exec Team and Board (forms part of WSAP)	Head of Health & Safety	31.12.22	
4. H&S team workforce review (accompanying Business Case forms part of this) (this forms part of WSAP)	Head of Health & Safety	31.03.22	Completed H&S Workforce report was presented and discussed at EMT on 6.04.22. Director of Finance and Corporate Resources would be formulating a paper for discussion at the ADLT/EMT meeting on 13.04.22 to discuss the issue of investment in Corporate Services based on the evidence provided in H&S Workforce report.
5. Culture survey to all members of staff (forms part of WSAP)	Head of Health & Safety	30.06.22	
6. A compliance register that describes the requirements of the various Health & Safety legislation that the Trust needs to comply with (part of WSAP)	Working Safely Programme Manager	30.06.22	
7. An initial assessment will provide assurance on how we are complying with the legislation.	Working Safely Programme Manager	Assurance - 30.06.22 Rolling programme of audits – 31.12.22 (Checkpoint date)	

Risk ID 201	Damage to Trust reputation following a loss of stakeholder confidence	Date of Review:	19/04/2022	TREND	20 (4x5)
		Date of Next Review:	30/06/2022	⬆	

IF the stability of the Trust deteriorates to a level where service delivery fails to meet patient safety, national standards and contractual obligations	THEN there is a risk of a loss of stakeholder confidence in the Trust	RESULTING IN damage to reputation and increased external scrutiny

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

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

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

CONTROLS	ASSURANCES
a. Regular engagement with senior stakeholders e.g. Ministers, senior Welsh Government officials, commissioners, elected politicians and NHS Wales organisational system leaders b. Challenging of media reports to ensure accuracy c. Media liaison to ensure relationships developed with key media stakeholders d. Board approved Engagement Framework e. Engagement Framework Delivery Plan f. Engagement governance and reporting structures are in place g. Escalation procedure for issues to the Board	**Internal** **Management (1st Line of Assurance)** a. Agendas, minutes and documents of engagement events b. Programme of daily media engagement c. Same as b d. Issues of reputation monitored at EMT – minuted meetings and action logs. 'f. 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 'g. Minuted meetings, action logs and Board papers **External** Not applicable
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
a. Inability to control external environment b. Dependency on Commissioners' decisions c. Unpredictable external environment affecting the way the Trust operates d. Engagement Framework is due to be submitted to the Board for approval in May 2022 (covering control d) e. Engagement Framework Delivery Plan suspended due to Covid-19 and will be reinstated subject to the Engagement Framework being approved by the Board (covering control e) f. Lack of resilience in the function – team is very small so any absences would have an impact on ability to respond	**Internal** • Engagement Framework Delivery Plan suspended due to Covid-19 and will be reinstated subject to the Engagement Framework being approved by the Board (covering control e) **External** Not applicable

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	
2. Report progress on Engagement Framework Delivery Plan to the People and Culture Committee	Director of Partnerships & Engagement	30.09.22 – Checkpoint Date	
3. Monitoring internal Quality and Performance of Trust	Executive Management Team Finance and Performance Committee Quality, Safety and Patient Experience Committee People and Culture Committee Audit Committee	31.03.23 – Checkpoint Date	
4. Engaging with internal and external stakeholders to develop confidence	CEO & Director of Partnerships & Engagement	31.03.23- Checkpoint Date	
5. Monitoring external factors that may affect the Trust	CEO & Director of Partnerships & Engagement	31.03.23 – Checkpoint date	

Risk ID 139	Failure to deliver our Statutory Financial Duties in accordance with Legislation	Date of Review:	01/04/2022	TREND	16 (4x4)
		Date of Next Review:	30/06/2022	➡	

IF the Trust does:	THEN there is a risk that the Trust will fail to achieve all of its statutory financial obligations and the requirements as set out within the Standing Financial Instructions (SFIs)	RESULTING IN potential interventions by the regulators, qualified accounts and impact on delivery of services and reputational damage

- 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	Director of Finance and Corporate Resources	ASSURANCE COMMITTEE	Finance and Performance Committee

CONTROLS

a. Financial governance and reporting structures in place
b. Financial policies and procedures in place
c. Budget management meetings
d. Regular financial reporting to ADLT, EFG, EMT, FPC and Trust Board in place
e. Welsh government reporting
f. Monthly review of savings targets
g. Regular review monitoring and challenge via WAST and CASC quality and delivery meeting with commissioners.
h. Monthly ICMB (Internal Capital Monitoring Board) meetings to monitor and review progress against capital programme and engagement with WG and capital leads.
i. PSPP monthly reporting and regular engagement with P2P colleagues and periodic Trust Wide communications
j. Forecasting of revenue and capital budgets
k. Business cases and benefits realisation (both revenue and capital)

ASSURANCES

Internal

Management (1st Line of Assurance)

'a. Risk is reviewed quarterly at F&P and a report is submitted bi-monthly to Trust Board
'c. Diarised dates for budget management meetings
d. Diarised dates for EFG and FPC and monthly reports
f. ADLT monthly review
h. Diarised dates for ICMB meetings with regular monthly reports
i. Regular PSPP communications (Trust wide) on Siren
j. Monthly monitoring returns to ADLT, EFG, EMT and FPC
j. Reliance on available intelligence to inform future forecasting.
k. 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

Management (1st Line of Assurance)

e. Monthly Monitoring Returns to Welsh Government
g. EASC management meetings. Monthly meetings with EASC and DAG for NEPTS.
h. Bi-monthly Capital CRL meetings with Trust and WG capital leads
i. Regular P2P meetings diarised (bi-monthly)
j. Monthly monitoring returns into Welsh Government

Independent (3rd Line of Assurance)

- Internal audit reviews covering controls a – j
- External audit reviews covering controls a – j

Risk ID 139	Failure to deliver our Statutory Financial Duties in accordance with Legislation	Date of Review:	01/04/2022	TREND	16 (4x4)
		Date of Next Review:	30/06/2022	➡	

IF the Trust does:	**THEN** there is a risk that the Trust will fail to achieve all of its statutory financial obligations and the requirements as set out within the Standing Financial Instructions (SFIs)	**RESULTING IN** potential interventions by the regulators, qualified accounts and impact on delivery of services and reputational damage

- 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

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

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

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

IF the Trust is unable to increase accommodation capacity	THEN there is a risk that EMS CCC will not be able to accommodate all roles during periods of escalation and surge management or expand operations to support new initiatives	RESULTING IN EMS CCC being unable to deliver services effectively which adversely impacts on quality, safety and patient/staff experience		Likelihood	Consequence	Score
			Inherent	5	4	20
			Current	4	4	16
			Target	3	4	12

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

EXECUTIVE OWNER	Director of Operations	ASSURANCE COMMITTEE	Finance and Performance Committee

CONTROLS	ASSURANCES
a. Temporary call handling provision in Carmarthen b. Maximum use of space at the Bryn Tirion site c. Maximum use of space at the Vantage Point House (VPH) site d. Prioritisation of space utilisation for each shift by CCC management team and alignment to priorities associated with safe service delivery	**Internal** **Management (1st Line of Assurance)** a. Monitoring of Performance standards for call handling (daily) and dispatch (weekly) to identify impacts on service with further investigation on a monthly basis b. All desks have been realigned to 2m physical distancing as part of covid preparations c. Review of VPH undertaken – November 2021 Staffing levels are managed according to maximum desk space on each centre. In VPH, because of agile working there is capacity for non-dispatch functions. d. Business continuity tracker for staffing levels updated daily **External** Not applicable
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
• Call handling provision is a short-term solution and not fully resilient • Lack of resilience in temporary accommodation may trigger risk if business continuity plans are invoked • Current social distancing plans for EMS CCC do not provide solutions for the dispatch environment in Carmarthen • Current social distancing plans for EMS CCC provide limited solutions for call handling and dispatch in Bryn Tirion • Current social distancing plans for EMS CCC provide limited solutions for dispatch environment in VPH. • Estates Strategy is silent on risk associated with CCC environment	• Carmarthen solution for call handling is temporary • Reconfiguration work reviewed by architects during pandemic preparation and earlier have yet to be delivered. • Agile working solution would be compromised in an ICT outage and paper-based approach would be used

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

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

IF 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)

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

IMTP Deliverable Numbers: 1, 5, 9

EXECUTIVE OWNER	Director of Operations	ASSURANCE COMMITTEE	Finance and Performance Committee

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

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

Risk ID 311	Inability of the Estate to cope with the increase in FTES	Date of Review:	20/05/2022	TREND	9 (3x3)
		Date of Next Review:	26/05/2022	⬇	

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

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

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

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

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

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

Risk ID 458	A confirmed commitment from EASC and/or Welsh Government is required in relation to funding of recurrent costs of commissioning services to deliver the IMTP and/or any additional services	Date of Review:	17/03/2022	TREND	16 (4x4)
		Date of Next Review:	30/06/2022		

				Likelihood	Consequence	Score
IF sufficient recurrent funding is not forthcoming there is a risk that the Trust will be committed to additional expenditure through delivery of the IMTP and in year developments which are only recognised by commissioners on a cost recovery basis.	**THEN** there is a risk that the Trust may not be able to deliver services and there will be a lack of funding certainty when making recurrent cost commitments. Any potential 'exit strategies' from developed services could be challenging and harmful to patients.	**RESULTING IN** patients not receiving services, the Trust not achieving financial balance and a potential failure to meet statutory obligations causing reputational damage	**Inherent**	3	4	12
			Current	4	4	16
			Target	2	4	8

IMTP Deliverable Numbers: 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**
a. Financial governance and reporting structures in place b. Financial policies and procedures in place c. Setting and agreement of recurrent resources d. Budget management meetings e. Budget holder training f. Annual Financial Plan g. Regular financial reporting to EFG & FPC in place h. Regular engagement with commissioners of Trust's services i. Welsh Government reporting on a monthly basis	**Internal** **Management (1st Line of Assurance)** a. Risk is reviewed quarterly at F&P and a report is submitted bimonthly to Trust Board d. 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. e. Diarised dates for budget holder training f. Submission to Trust Board in March annually g. Diarised dates for EFG and FPC with full financial reports **External** **Management (1st Line of Assurance)** a. Accountability Officer letter to Welsh Government e.g. November 2021 c & h EASC management meetings. Monthly meetings with EASC and DAG meetings for NEPTS. Meetings are diarised i.Monthly monitoring returns **Independent Assurance (3rd Line of Assurance)** b. 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	• Dialogue with EASC and DAG does not always result in recurrent arrangements (outside of WAST control)

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

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:	19/04/2022	TREND	15 (3x5)
		Date of Next Review:	24/06/2022	➡	

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

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

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

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

CONTROLS

a. Appropriate policy and procedures in place for Information/Cyber Security
b. Trust Business Continuity Procedure and Incident Response Plan
c. IT Disaster Recovery Plan
d. Relevant expertise in Trust with respect to information security
e. Data Protection Officer in post
f. Cyber and information security training and awareness
g. Mandatory Information Governance training which includes GDPR
h. ICT tests and monitoring on networks & servers
i. Information Governance framework
j. Internal and NHS Wales governance reporting structures in place
k. Checks undertaken on inactive user accounts
l. Business Continuity exercises
m. Operational ICT controls e.g. penetration testing, firewalls, patching
n. Security alerts

ASSURANCES

Internal

Management (1st Line of Assurance)

a. Information Security Policy reviewed every 3 years (currently due for renewal). Incident Policy and Procedure put in place in February 2022 – renewed annually.
b. 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
c. Organisation-wide tabletop exercise undertaken in March 2022 with all BC leads and Digital teams.
d. Staff undertake relevant training courses e.g. CISSP to increase knowledge and expertise
e. In job description of Head of ICT
f. Training statistics are available on ESR and from Phish threat module
g. Training statistics reported on by Information Governance department
h. Any issues would be identified and flagged and actioned
i. WAST self-assesses its Information Governance Framework against the Welsh Information Governance toolkit.
j. 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.
k. Software in place to run check on inactive accounts as and when
l. Annual schedule of testing
m. 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.
n. 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 a, c – k, m – n)

GAPS IN CONTROLS

- Not all information security procedures are documented
- Lack of understanding and compliance with policy and procedures by all staff members
- No organisational information security management system in place
- IT Disaster Recovery Plan does not include a cyber response
- 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

GAPS IN ASSURANCE

- No regular Cyber/Info Security KPIs are reported to senior management committees
- Cyber awareness campaigns could be undertaken more regularly e.g. bi-monthly

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

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:	19/04/2022	TREND	15 (3x5)
		Date of Next Review:	24/06/2022	➡	

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

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

5.Formalise Cyber Incident Response Plan	Head of ICT	31.12.22 – Checkpoint Date	
6.Implement Meta Compliance Policy Solution	Senior ICT Security Specialist	31.12.22 – Checkpoint Date	

Risk ID 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:	20/05/2022	TREND	12 (3x4)
		Date of Next Review:	31/08/2022		

IF	THEN	RESULTING IN		Likelihood	Consequence	Score
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	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
a. EASC/WAST Forward Plan b. EASC and its 2 sub-committees c. Weekly catch up between CASC/CEO d. Collaboration between EASC and WAST on specific projects e.g. Amber Review, EMS Operational Transformation Programme, Ambulance Care Programme e. Monthly CASC Quality and Delivery Meeting f. Patient Safety information e.g. Appendix B incidents, weekly/monthly patient safety reports	**Internal & External** **Management (1st Line of Assurance)** 'c. Meetings are diarised every week d. Representatives are co-opted onto meetings and frequency is between 3 – 6 weeks. Set agendas with NCCU reps co-opted. e. Formal meeting with agendas, minutes and action logs available. f. Information is going to Director of Quality and Nursing in Health Boards and other senior stakeholders **External** **Management (1st Line of Assurance)** a. Plans go to every bi-monthly meeting b. Meet bi-monthly and agendas, minutes and action logs available
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
• WAST's ability to influence hospital handover delays (this is outside of the Trust's control and a Health Board responsibility) • Funding does not flow in a manner to balance demand with capacity (this is outside of WAST's control)	• Health Boards are not sending Patient Safety Incidents that are National Reportable Incidents to the Delivery Unit (identified within a Delivery Unit audit) • Identified need for a governance meeting between NCCU and WAST to manage the overall commissioner/provider interface

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Persuade EASC/Health Boards that sufficient funding to be provided to WAST	CEO WAST	30.06.22 – Checkpoint Date	
2. Persuade EASC/Health Board of the need for significant reduction in hospital handover hours	CEO WAST	30.06.22 – Checkpoint Date	
3. Increased understanding of NEPTS by EASC	Director of Strategy Planning and Performance	30.06.22 – Checkpoint Date	
4. Governance meeting between NCCU and WAST to manage the commissioner provider interface	Assistant Director Commissioning & Performance	30.06.22 – Checkpoint Date	

Risk ID 163	Maintaining Effective & Strong Trade Union Partnerships	Date of Review:	18/05/2022	TREND	12 (4x3)
		Date of Next Review:	31/08/2022	➡	

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

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

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

CONTROLS	**ASSURANCES**
a. Agreed (Refreshed) TU Facilities Agreement developed in partnership b. Go Together Go Far (GTGF) statement and CEO/TU Partners statement c. IPA Workshops d. Trade Union representation at Trust Board, Committees e. Monthly Informal Lead TU representatives and Chief Executive meetings f. Staff representative management in Task & Finish Groups g. Fortnightly TUP Cell meetings h. Local Co-Op Forums, and informal monthly meetings between TUs and Senior Operations Team i. Quarterly Report on TU activity to People and Culture Committee	**Internal** **Management (1st Line of Assurance)** a. Agreed document which states governance arrangements and the criteria for time off for TU activity etc. b. Both parties refer to the documents and are signed up/committed to it c. Meetings completed with participation from TUs and senior managers. Attendance lists are available d. 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 e. Diarised meetings f. Good attendance and commitment is observed at the meetings. TU partners listed as members in terms of reference g. Diarised meetings with a formal agenda. Any business needed to be discussed is included in the agenda. Good attendance and commitment observed at meetings. h. Consistency of invitation and good attendance/commitment observed at meetings. Trade Union representations on SOT meetings i. Report at every P& C committee meeting regarding activities TUPs involved with which is noted. Whenever Partnerships are discussed, the value of these is formally minuted in the Board and Committee minutes **External** Not applicable

GAPS IN CONTROLS	**GAPS IN ASSURANCE**
• Need to move back to business-as-usual footing • Facility to manage situations where there is a failure to agree, to avoid grievance and disputes from occurring	None identified

Actions to reduce risk score or address gaps in controls and assurances	**Action Owner**	**By When/Milestone**	**Progress Notes:**
1.Clarify the formal and informal consultation and engagement framework and definitions	Deputy Director of Workforce & Organisational Development	31.05.22	
2.Agree the ToR for refreshed Partnership Forum meeting and move back to a business-as-usual footing	Deputy Director of Workforce & Organisational Development	31.05.22	
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	30.06.22	
4.Minutes of formal Partnership Forum should be reported to PCC or Board in future (return to BAU).	Deputy Director of Workforce & Organisational Development	30.09.22	

Risk ID 283	Failure to implement the EMS Operational Transformation Programme	Date of Review:	19/05/2022	TREND	12 (3x4)
		Date of Next Review:	31/08/2022	➡	

IF there are issues and delays in the planning and organisation of the EMS Demand & Capacity Review Implementation Programme	**THEN** there is a risk that WAST will fail to implement the EMS Operational Transformation Programme to the agreed performance parameters	**RESULTING IN** potential patient harm, deterioration in staff wellbeing and reputational damage

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

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

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

CONTROLS

a. Implementation Programme Board in place – meetings held every 3 weeks
b. Executive sponsor and Senior Responsible Owner (SRO) for programme in place
c. Programme Manager and Programme support office in place (for delivery of the programme)
d. Programme risk register
e. Assurance meetings held with Strategic Transformation Board (STB) every 6 weeks and with CEO every 3 weeks
f. Programme budget in place
g. Programme documentation and reporting is in place
h. Regular engagement with the Commissioner and Trade Unions
i. Management of external stakeholder and political concerns

ASSURANCES

Internal

Management (1st Line of Assurance)

a. Minutes and papers of Implementation Programme Board
b. Project Initiation Document (PID) detailing structure and minutes of Implementation Programme Board
c. Same as b
d. Highlight reports showing key risks reported to STB every 6 weeks
e. Highlight reports presented to STB every 6 weeks
f. Programme budget monitoring report is provided to the Implementation Programme Board – every 6 weeks
g. 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.
h. Commissioner and TU participation at the Implementation Programme Board
i. Communications and Engagement Plan sets out WAST's arrangements for engagement with stakeholders

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
e. EASC receives an update every 2 months on the programme as part of the WAST Provider Report

GAPS IN CONTROLS

- Lack of workforce buy in due to changes in working practices
- System pressures – patient handover delays at hospitals (link to risks 223 & 224)

GAPS IN ASSURANCE

- Project Initiation Document (PID) needs to be updated to reflect 22/23 budget position
- No prompts from STB for programme PID or risk register updates

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Increase in engagement on the specifics of change at a locality level	Assistant Director – Commissioning & Performance	31.05.22 – Checkpoint Date	
2. More capacity requested (transition plan)	Assistant Director of Planning & Transformation	31.05.22 – Checkpoint Date	
3. Engage with key stakeholders to reduce handover delays	CASC	31.05.22 – Checkpoint Date	
4. Reduce abstractions in particular sickness absence	Deputy Director of Workforce & OD	30.09.22 – Checkpoint Date	
5. Engage with Assistant Director of Planning and Transformation on process for PID updates	Assistant Director – Commissioning & Performance	30.06.22 - Checkpoint Date	

Risk ID 424	Resource availability (capital) to deliver the organisation's Integrated Medium-Term Plan (IMTP)	Date of Review:	19/05/2022	TREND	12 (3x4)
		Date of Next Review:	31/08/2022	➡	

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

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

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

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

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

Risk ID 303	Delayed administration of chest compressions to patients as part of resuscitation	Date of Review:	26/04/2022	TREND	10 (2x5)
		Date of Next Review:	05/07/2022	➡	

IF there is no universal guidance issued in relation to the level of PPE required when administrating chest compressions and no reduction in infection rates of Covid-19	**THEN** there is a risk of delayed administration of chest compressions to patients as part of resuscitation due to WAST ambulance crews continuing to wear level 3 PPE	**RESULTING IN** potential patient harm and damage to the Trust's reputation

	Likelihood	Consequence	Score
Inherent	3	5	15
Current	2	5	10
Target	1	5	5

IMTP Deliverable Numbers: 7,12,16, 36

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

CONTROLS	ASSURANCES
a. PPE provision to frontline staff b. Mandatory PPE training for frontline staff c. Clear Trust guidelines for PPE to be used during resuscitation d. PPE guidance to staff on intranet – this clearly states what level 3 PPE consists of e. Communication to caller via CCC call handler regarding Basic Life Support (BLS) f. Guidance updates relating to IPC/PPE/Resuscitation guidelines provided to Clinical Advisory Cell g. Monitoring and reporting of patient safety incidents via Executive Pandemic Team/Senior Pandemic Team (SPT) h. Dissemination of process for rapidly donning PPE. This includes briefing of bank staff, volunteers and military for donning and doffing PPE i. PPE breach reporting process j. Covid 19 vaccination of staff members k. Monitoring return of spontaneous circulation rates l. Chest compression advice provided to callers by call handlers	**Internal** **Management (1st Line of Assurance):** a. Staff have emergency PPE wallet if caught unawares. All PPE is ordered via logistics in local area. All staff are fit tested for FFP3 protection. Fit testing and Respiratory Protection Equipment (RPE) SOPs – these go through WAST governance structures. Training and videos available for staff on use of PPE which is captured on ESR b. Mandatory training is recorded on ESR c. Coronavirus update section which details Trust guidelines. Frontline EMS staff issued with iPads to be able to access the intranet d. PPE guidance available on the intranet and regularly reviewed and updated at the Clinical Advisory Cell and signed off at SPT as required e. CCC call handling protocol f. All meetings of the Clinical Advisory Cell are minuted and upwardly reported to SPT via a Common Recognised Information Picture (CRIP) g. Incidents recorded on Datix h. Coronavirus update section which details Trust guidelines. Frontline EMS staff issued with iPads to be able to access the intranet. Register for donning and doffing PPE training i. Breaches recorded on Datix j. Essential register reported to SPT k. Monthly clinical indicators l. Calls are subject to auditing **External** Not applicable
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
• If the right level of PPE is not used, there is no way of knowing unless the team or part of the team report it. • Impact of new variants	• Difficult to obtain a true picture, if incidents are not reported • Difficult to plan against future environmental factors which are outside WAST's control

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Monitor vaccinations / booster rates of staff	Occupational Health team	31.03.23 – Checkpoint Date	
2. Monitor changes to changes to resuscitation guidelines	Cardiac Lead – Clinical Directorate	31.03.23 – Checkpoint Date	
3. Monitoring any move from pandemic to endemic	SPT / Business Continuity and Recovery Team	31.03.23 – Checkpoint Date	
4. Monitoring changes to the national guidance for PPE	IPC team who report to BCRT who report to EPT	31.05.22	

IMTP Deliverable Key

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

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

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

AUDIT REPORT

MEETING	Audit Committee
DATE	7th June 2022
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Julie Boalch, Head of Risk and Corporate Governance
CONTACT	Julie.Boalch@wales.nhs.uk

EXECUTIVE SUMMARY

1. The purpose of the report is to provide the Audit Committee with an update in respect of internal and external reviews and an update in respect of activity since the las meeting.

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

KEY ISSUES/IMPLICATIONS

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

4. This paper was discussed by the Executive Management Team and particular consideration was given to the overdue recommendations and any outliers to agree the proposals to address them including extensions to previously agreed deadlines.

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

   a. **People & Culture Committee** (10th May 2022)
   b. **Quality, Safety & Patient Experience Committee** (12th May 2022)
   c. **Finance & Performance Committee** (16th May 2022)

REPORT APPROVAL ROUTE
6. The details of the report have been submitted to: • ADLT – 22nd April 2022 • ADLT - 16th May 2022 • EMT – 1st June 2022

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

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

WELSH AMBULANCE SERVICES NHS TRUST
EXECUTIVE MANAGEMENT TEAM
AUDIT REPORT

SITUATION

1. This paper provides an update in respect of audit recommendations made resulting from internal and external audit reviews.

BACKGROUND

2. The audit recommendation tracker is in place for the purpose of tracking progress across the Trust to ensure that recommendations contained in internal and external audit review reports were actioned and in a timely manner.

3. This tracker provides Senior Managers with a workable tool that allows for closer scrutiny of audit recommendations and is designed to provide a more detailed focus as to the reasons why recommendations are overdue or have not progressed within the agreed timeframes. This will highlight areas that may require additional support and ensures there are clear mechanisms in place to escalate any issues.

ASSESSMENT

Internal Audit Highlights

4. The Trust continued to face significant operational pressures resulting from the pandemic and REAP level 4 during the period and as such expects to be carrying a slightly higher number of overdue recommendations.

5. At the time of issuing the paper, there were a total of 89 current internal audit recommendations on the tracker. 21 recommendations were marked as complete at the March 2022 Audit Committee and removed from the tracker.

6. 27 recommendations were added to the tracker resulting from 5 Internal Audit Reports which were presented to the Audit Committee in March 2022.

7. The status of each of the current internal audit recommendations is described in the table below.

Status	Total Number of Recommendations on the tracker	High Priority	Medium Priority	Low Priority
Overdue	48	6	28	14
Not yet due*	26	3	21	2
Complete	15	4	8	3
Total	89	13	57	19

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

8. The 6 high priority recommendations showing as overdue relate to the following Reasonable Assurance rated reports:

- 20/21 Clinical Contact Centres Performance Management. These are proposed to be completed between July and December.
- 2021/22 Asset Management - RAM System. These are proposed to be completed between June and July.
- 2021/22 Role of Advanced Paramedic Practitioner – Proposed to be completed by July 2022.

9. The total number of recommendations, separated by financial year, and status this period is described below.

Financial Year	Total No. of Recommendations on the tracker	Complete	Overdue	Not Yet Due
2019/20	4	1	3	0
2020/21	29	6	23	0
2021/22	56	8	22	26
Total	89	15	48	26

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

11. The remaining two recommendations outstanding from 2019/20 relate to the Information Systems Security Leavers Reasonable Assurance Follow Up Review, both of which were expected to be completed by the end of March 2022; however, this is now proposed to be extended until the end of September 2022.

12. The number of recommendations by assurance rating and level of priority are described below.

Assurance Ratings	Total No. of Recommendations on the tracker	High Priority	Medium Priority	Low Priority
Limited	6	3	3	0
Reasonable	72	10	54	8
Substantial	1	0	0	1
Not Rated	10	0	0	10
Total	89	18	57	19

13. Each of the 89 recommendations were subject to a monthly review by the Assistant Directors Leadership Team since the last Audit Committee in March 2022 to ensure that realistic timescales were proposed where necessary and any new completion dates assigned with a strong narrative and rationale to support this.

14. The Governance team continue to seek assurance from Executives to ensure that:

- Recommendations have been considered and completed within agreed timeframes and,

- All is being done to ensure that the follow up of recommendations will not result in further *Limited* or *No Assurance* rated reports.

External Audit Reviews

15. Section 2 on the tracker describes 20 recommendations made as a result of the following reports:
    - 2018 and 2019 Structured Assessments
    - Effectiveness of Counter Fraud Arrangements Report
    - Taking Care of the Carers

16. No new recommendations were made as part of the 2020 Structured Assessment work; however, improvement opportunities were made throughout the report and these form part of the CoVID-19 tab described on the Audit Tracker. In addition, this section includes considerations made within the Internal Audit Governance Arrangements During CoVID-19 Pandemic Advisory Review 20/21.

17. The CoVID-19 tab will be fully reviewed during this quarter to ensure evidence of action is available and full assurance can be provided that improvement actions have been considered and acted upon.

18. There are several recommendations outstanding from external audit reviews, and these are described in the table below and revised dates are included on the tracker:

Status	Number of Recommendations
Overdue	2
Not yet due	10
Complete during this period	8
Total	20
Overdue from 2021/22 reports	2
Total	2

RECOMMENDED:

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

AGENDA ITEM No	**11**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**3**

LOSSES AND SPECIAL PAYMENTS - PAYMENTS FOR THE PERIOD FROM 1st APRIL 2021 TO 31st March 2022 & 1ST APRIL 2022 TO 30th APRIL 2022

MEETING	**Audit Committee**
DATE	**7th June 2022**
EXECUTIVE	**Director of Finance and Corporate Resources**
AUTHOR	**Jill Gill**
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 2022 (**Annex 1**) and the month of April 2022 (**Annex 2**).

KEY ISSUES/IMPLICATIONS

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

- period 1st April 2021 to 31st March 2022 - £1.849m
- one month to 30th April 2022 - £0.109m

REPORT APPROVAL ROUTE
Audit Committee 7th June 2022 – no action required for information under SFI's only

REPORT APPENDICES
Annex 1 – Summary of payments made for the twelve months to 31st March 2022, along with details of those made in February and March 2022 Annex 2 – Summary and details of payments made for the one month to 30th April 2022

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

WELSH AMBULANCE SERVICES NHS TRUST
AUDIT COMMITTEE
LOSSES AND SPECIAL PAYMENTS - PAYMENTS FOR THE PERIOD FROM 1st APRIL 2021 TO 31st MARCH 2022 & ONE MONTH TO 30TH APRIL 2022

SITUATION

1. In accordance with SFI's all losses and special payments made are to be reported to the Audit Committee on a regular basis.

BACKGROUND

2. This report presents to the Committee details of Losses and Special Payments made during the twelve months from 1st April 2021 to 31st March 2022 (**Annex 1**) and one month to 30th April 2022 (**Annex 2**)

ASSESSMENT

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

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 2022 payments made exceeded reimbursements received by £1.849m.

5. During February you will note that payments in relation to damages amounted to £0.325m. The majority of the damages payments incurred in February £0.315m relate to the finalisation and settlement of a medical negligence case against the Trust due to patient's recovery being effected as a result of an ambulance delay.

6. During February you will also note claimant's solicitors costs incurred of £0.100m, these also relate to the same medical negligence case referred to above.

RECOMMENDED: 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 2022:

	£
April 2021	161,584.84
May 2021	154,976.08
June 2021	102,494.93
July 2021	- 584,439.92
August 2021	17,140.47
September 2021	15,038.63
October 2021	257,603.45
November 2021	585,381.42
December 2021	23,527.99
January 2022	652,063.06
February 2022	461984.39
March 2022	2336.91
	£1,849,692.25

Losses and Special Payments Breakdown:

Payment Type	April	May		**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Total**
	£	£	£	£	£	£	£	£	£	£	£	£	£	
Claimants Solicitor Costs		77749.6	65172.7	47,454.40	17,113.20	6,000.00	1,208.50	4,434.00	26,056.00	960.00	112,110.00	100,000.00	37,969.90	£496,228.30
Counsel fees		7932.5	14885	3,270.16	7,289.59	8,625.00	700.00	2,245.83	19,981.25	1,470.00	19,220.00	5,795.00	4,618.75	£96,033.08
CRU		1376	0	9,009.43	3,068.00	0.00	1,376.00	688.00	17,860.22	0.00	86,101.46	1,183.18	-51,441.46	£69,220.83
Damages		32755	63600	16,985.00	36,732.00	-3,598.20	1,898.80	235,162.00	495,051.26	500.00	408,280.00	325,650.00	-13,381.63	£1,599,634.23
Defence Costs		3773.2	486.02	3,235.10	2,187.10	918.23	920.58	89.25	1,532.00	46.26	3,700.65	50,288.82	1,842.80	£69,020.01
Expert Witness		21795.85	316.8	12,245.00	15,257.40	4,764.50	2,800.00	0.00	9,779.90	10,087.10	10,938.40	10,627.50	2,560.00	£101,172.45
Vehicle Repairs		15992.69	14505.56	9,655.84	21,970.54	19,642.94	9,015.10	14,536.67	15,120.79	8,644.63	11,712.55	6,116.79	5,653.55	£152,567.65
WRP Refund		210	-3990	640.00	-688,057.75	-10,000.00	-3,956.35	447.70	0.00	0.00	0.00	-37,676.90	0.00	-£742,383.30
Court Refund		0	0	0.00	0.00	-9,212.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-£9,212.00
Property Repairs		0	0	0.00	0.00	0.00	1,076.00	0.00	0.00	1,820.00	0.00	0.00	14,515.00	£17,411.00
Total		**£161,584.84**	**£154,976.08**	**£102,494.93**	**-£584,439.92**	**£17,140.47**	**£15,038.63**	**£257,603.45**	**£585,381.42**	**£23,527.99**	**£652,063.06**	**£461,984.39**	**£2,336.91**	**£1,849,692.25**

Welsh Ambulance Services NHS Trust

Losses and Special Payments

Key

MN Medical Negligence
PI Personal Injury
DP Damage To Property

Summary of payments for the twelve months to 31st March 2022:		
	£	
PI cases < £1,000	4,577.18	10 Cases
DP cases < £1,000	20,440.91	45 CASES
16RT4MN0009	609,372.78	
17RT4MN0007	539,206.51	
18RT4MN0005	436,850.00	
18RT4MN0023	238,530.00	
20RT4MN0010	120,820.00	
19RT4PI0053	81,084.01	
15RT4MN0010	67,418.20	
19RT4PI0029	46,096.60	
22RT4DP0025	24,300.80	
20RT4MN0006	20,432.00	
20RT4PI0014	17,648.00	
20RT4MN0011	16,770.00	
22RT4DP0080	14,497.50	
21RT4PI0001	13,258.10	
19RT4PI0023	12,797.70	
20RT4MN0008	12,750.00	
22RT4PI0015	11,114.20	
18RT4MN0015	10,890.00	
21RT4PI0034	10,832.00	
20RT4PI0025	10,400.00	
21RT4DP0086	9,994.87	
20RT4PI0044	9,896.50	
18RT4MN0012	9,542.50	
22RT4DP0022	9,354.79	
19RT4PI0008	9,036.90	
19RT4PI0044	8,000.00	
19RT4PI0038	7,733.40	
18RT4MN0011	7,000.00	
22RT4DP0049	6,928.65	
22RT4DP0070	6,867.66	
22RT4DP0028	6,801.53	
22RT4PI0037	6,750.00	
19RT4FE0004	6,021.15	
19RT4PI0028	5,955.00	
22RT4MN0002	5,701.25	
20RT4MN0019	5,612.62	
21RT4PI0024	5,453.00	
22RT4DP0055	5,091.11	
21RT4DP0098	5,027.78	
21RT4MN0013	4,915.00	
22RT4PI0004	4,640.00	
22RT4DP0048	4,582.69	
22RT4DP0040	4,290.00	
19RT4PI0005	4,252.00	
22RT4DP0026	4,231.97	
22RT4DP0019	4,071.28	
22RT4DP0033	3,930.00	
22RT4MN0012	3,831.25	
22RT4GN0007	3,670.00	
22RT4DP0011	3,359.68	
22RT4DP0072	3,081.79	
18RT4MN0016	3,076.75	
15RT4PI0040	3,006.25	
19RT4EG0005	2,991.67	
21RT4DP0054	2,934.00	
21RT4GN0016	2,850.00	
21RT4DP0073	2,774.15	
21RT4GN0014	2,560.00	
21RT4GN0012	2,446.50	
21RT4DP0093	2,428.43	
22RT4DP0015	2,352.42	
19RT4PI0040	2,339.52	
22RT4DP0057	2,300.00	
22RT4DP0009	2,256.86	
22RT4DP0064	2,244.00	
22RT4DP0047	2,227.87	
22RT4DP0052	2,200.00	
21RT4DP0045	2,179.82	
19RT4PI0060	2,168.75	
22RT4MN0001	2,145.83	
22RT4DP0051	2,140.26	
22RT4DP0078	2,101.49	
22RT4GN0008	2,100.00	
22RT4DP0046	2,058.67	
19RT4PI0051	2,050.00	
22RT4DP0038	1,990.51	
20RT4PI0034	1,987.70	
22RT4DP0001	1,860.50	
22RT4DP0083	1,858.80	
22RT4DP0062	1,820.00	
22RT4DP0007	1,764.15	
21RT4DP0106	1,725.37	
19RT4PI0037	1,705.50	
22RT4DP0054	1,639.10	
21RT4DP0104	1,605.00	
22RT4DP0010	1,598.46	
20RT4MN0018	1,590.00	
22RT4DP0050	1,569.54	
22RT4DP0075	1,554.11	
22RT4DP0042	1,524.49	
22RT4DP0071	1,511.10	
22RT4GN0033	1,500.00	
21RT4DP0075	1,456.02	
22RT4DP0030	1,422.72	
19RT4MN0006	1,375.00	
22RT4DP0061	1,360.68	
22RT4MN0010	1,300.00	
21RT4EG0006	1,200.00	
21RT4GN0011	1,200.00	
21RT4DP0042	1,128.60	
20RT4MN0005	1,100.00	
22RT4DP0014	1,076.21	
22RT4DP0044	1,076.00	
22RT4DP0053	1,038.81	
22RT4DP0076	1,030.00	
20RT4PI0007	1,000.00	
20RT4MN0017	872.00	
18RT4MN0001	795.00	
21RT4MN0012	646.80	
22RT4MN0003	520.00	
22RT4MN0016	72.65	
22RT4MN0011	68.00	
22RT4MN0013	46.26	
22RT4MN0009	36.00	
18RT4PI0060	- 30,981.63	WRP REFUND
15RT4MN0010	- 681,645.75	WRP REFUND
19RT4PI0029	- 30,685.40	WRP REFUND
20RT4EG0017	- 10,000.00	WRP REFUND
21RT4GN0006	- 5,714.30	WRP REFUND
19RT4PI0020	- 4,881.50	WRP REFUND
21RT4GN0001	- 3,200.00	WRP REFUND
15RT4PI0040	- 3,006.35	WRP REFUND
19RT4MN0010	- 1,860.00	WRP REFUND
21RT4GN0020	- 500.00	WRP REFUND
21RT4EG0003	- 250.00	WRP REFUND
21RT4GN0017	- 250.00	WRP REFUND
21RT4GN0010	- 250.00	WRP REFUND
21RT4GN0024	- 250.00	WRP REFUND
21RT4GN0009	- 200.00	WRP REFUND
21RT4GN0003	210.00	WRP REFUND RETURN
15RT4PI0032	100.00	WRP REFUND RETURN
19RT4PI0051	- 9,212.00	COURT REFUND
Total	**1,849,692.25**	

Feb-22

Case Reference	Details	Amount (£)
16RT4MN0009	Defence costs	255.00
16RT4MN0009	Defence costs	275.00
16RT4MN0009	Expert witness	1,500.00
16RT4MN0009	Defence costs	48,000.00
18RT4MN0001	Defence costs	100.00
18RT4MN0001	Counsel fees	70.00
18RT4MN0005	Counsel fees	1,200.00
18RT4MN0005	Expert witness	780.00
18RT4MN0005	Claimants solicitors fees	100,000.00
18RT4MN0005	Damages	315,000.00
18RT4MN0015	Defence costs	390.00
18RT4MN0016	Expert witness	390.00
19RT4MN0010	WRP refund	- 1,860.00
19RT4PI0020	WRP refund	- 4,881.50
19RT4PI0029	WRP refund	- 30,315.40
19RT4PI0029	WRP refund	- 370.00
19RT4PI0037	Counsel fees	1,237.50
19RT4PI0053	CRU	701.58
20RT4MN0019	Expert witness	750.00
20RT4MN0019	Counsel fees	2,200.00
20RT4MN0019	Counsel fees	1,087.50
20RT4MN0019	Defence costs	275.12
21RT4DP0042	Defence costs	326.70
21RT4GN0016	Damages	150.00
21RT4GN0024	WRP refund	- 250.00
21RT4MN0013	Expert witness	625.00
21RT4PI0001	Damages	3,500.00
21RT4PI0001	CRU	240.80
21RT4PI0001	Defence costs	667.00
21RT4PI0001	Damages	7,000.00
21RT4PI0001	CRU	240.80
22RT4DP0026	Vehicle repairs	3,095.18
22RT4DP0075	Vehicle repairs	1,554.11
22RT4DP0076	Vehicle repairs	1,030.00
22RT4DP0077	Vehicle repairs	437.50
22RT4MN0002	Expert witness	1,430.00
22RT4MN0002	Expert witness	2,172.50
22RT4MN0002	Expert witness	98.75
22RT4MN0012	Expert witness	1,300.00
22RT4MN0012	Expert witness	1,581.25
Total		**461,984.39**

Mar-22

Case Reference	Details	Amount (£)
16RT4MN0009	Defence costs	275.00
16RT4MN0009	CRU	-53,481.29
18RT4MN0005	Counsel fees	600.00
18RT4MN0005	Counsel fees	225.00
18RT4MN0005	CRU	10,780.00
18RT4MN0015	Claimants solicitors fees	5,500.00
18RT4MN0016	Defence costs	100.00
18RT4MN0023	Defence costs	680.00
18RT4MN0023	Claimants solicitors fees	33,000.00
18RT4PI0060	CRU	-8,740.17
18RT4PI0060	Claimants solicitors fees	-5,000.00
18RT4PI0060	Defence costs	-1,765.80
18RT4PI0060	Damages	-30,981.63
19RT4PI0008	Claimants solicitors fees	219.90
19RT4PI0008	Defence costs	42.00
19RT4PI0044	Counsel fees	1,375.00
19RT4PI0060	Counsel fees	2,168.75
20RT4MN0008	Counsel fees	250.00
20RT4PI0025	Damages	10,000.00
21RT4DP0042	Defence costs	386.10
21RT4GN0011	Damages	1,200.00
21RT4GN0014	Expert witness	2,560.00
21RT4GN0016	Defence costs	1,600.00
21RT4PI0001	Defence costs	275.50
22RT4DP0078	Vehicle repairs	2,101.49
22RT4DP0079	Vehicle repairs	600.00
22RT4DP0079	Vehicle repairs	142.08
22RT4DP0080	Property Repairs	14,497.50
22RT4DP0081	Vehicle repairs	951.18
22RT4DP0082	Property Repairs	17.50
22RT4DP0083	Vehicle repairs	1,858.80
22RT4EG0004	Defence costs	250.00
22RT4GN0011	Damages	400.00
22RT4GN0015	Damages	500.00
22RT4GN0019	Damages	350.00
22RT4GN0020	Damages	500.00
22RT4GN0021	Damages	250.00
22RT4GN0027	Damages	400.00
22RT4GN0033	Damages	1,500.00
22RT4PI0037	Claimants solicitors fees	4,250.00
22RT4PI0037	Damages	2,500.00
Total		**2,336.91**

Welsh Ambulance Services NHS Trust
Losses and Special Payments

Annex 1

Summary of payments for the one month to 30th April 2022:

	£
April 2021	£109,893.12
May 2021	-
June 2021	-
July 2021	-
August 2021	-
September 2021	-
October 2021	-
November 2021	-
December 2021	-
January 2022	-
February 2022	-
March 2022	-
	£109,893.12

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	0	0	0	0	0	0	0	0	0	0	0	£40,455.00
Counsel fees	10,825.00	0	0	0	0	0	0	0	0	0	0	0	£10,825.00
CRU	0	0	0	0	0	0	0	0	0	0	0	0	£0.00
Damages	12,875.00	0	0	0	0	0	0	0	0	0	0	0	£12,875.00
Defence Costs	4,061.02	0	0	0	0	0	0	0	0	0	0	0	£4,061.02
Expert Witness	15,024.00	0	0	0	0	0	0	0	0	0	0	0	£15,024.00
Vehicle Repairs	12,155.60	0	0	0	0	0	0	0	0	0	0	0	£12,155.60
WRP Refund	0.00	0	0	0	0	0	0	0	0	0	0	0	£0.00
Court Refund	0.00	0	0	0	0	0	0	0	0	0	0	0	£0.00
Property Repairs	14,497.50	0	0	0	0	0	0	0	0	0	0	0	£14,497.50
Total	**£109,893.12**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**£109,893.12**

Welsh Ambulance Services NHS Trust

Losses and Special Payments

Key

MN Medical Negligence

PI Personal Injury

DP Damage To Property

Summary of payments for the one month to 3oth April 2022:		
	£	
PI cases < £1,000	750.00	1 Case
DP cases < £1,000	3,452.46	8 Cases
22RT4MN0018	20.09	
18RT4MN0016	672.50	
19RT4PI0008	1,000.00	
20RT4PI0025	1,100.00	
22RT4DP0097	1,113.36	
22RT4DP0091	1,213.84	
22RT4MN0002	1,430.73	
22RT4DP0099	1,500.40	
20RT4MN0019	1,540.00	
22RT4DP0085	1,866.60	
22RT4DP0090	3,008.94	
18RT4MN0012	3,552.50	
20RT4PI0028	4,998.00	
16RT4MN0009	5,500.00	
21RT4PI0001	6,125.00	
22RT4PI0008	7,207.00	
18RT4MN0005	10,359.00	
22RT4DP0080	14,497.50	
20RT4MN0010	38,985.20	
Total	**109,893.12**	

Apr-22

Case Reference	Details	Amount (£)
16RT4MN0009	Counsel fees	5,500.00
18RT4MN0005	Expert Witness	4,224.00
18RT4MN0005	Expert Witness	4,410.00
18RT4MN0005	Counsel fees	1,725.00
18RT4MN0012	Expert Witness	1,975.00
18RT4MN0012	Expert Witness	787.50
18RT4MN0012	Expert Witness	790.00
18RT4MN0016	Expert Witness	297.50
18RT4MN0016	Counsel fees	225.00
18RT4MN0016	Counsel fees	150.00
19RT4PI0008	Expert Witness	1,000.00
20RT4MN0010	Defence Costs	3,985.20
20RT4MN0010	Claimants Solicitor Costs	35,000.00
20RT4MN0019	Expert Witness	1,540.00
20RT4PI0025	Counsel fees	1,100.00
20RT4PI0028	Claimants Solicitor Costs	2,598.00
20RT4PI0028	Damages	2,400.00
21RT4PI0001	Damages	6,125.00
22RT4DP0075	Vehicle Repairs	600.00
22RT4DP0080	Property Repairs	14,497.50
22RT4DP0084	Vehicle Repairs	637.15
22RT4DP0085	Vehicle Repairs	1,866.60
22RT4DP0086	Vehicle Repairs	702.00
22RT4DP0086	Vehicle Repairs	250.00
22RT4DP0087	Vehicle Repairs	350.00
22RT4DP0088	Vehicle Repairs	175.00
22RT4DP0089	Vehicle Repairs	49.99
22RT4DP0090	Vehicle Repairs	3,008.94
22RT4DP0091	Vehicle Repairs	250.00
22RT4DP0091	Vehicle Repairs	963.84
22RT4DP0092	Vehicle Repairs	412.32
22RT4DP0093	Vehicle Repairs	3,598.37
22RT4DP0093	Vehicle Repairs	-3,598.37
22RT4DP0095	Vehicle Repairs	2,551.85
22RT4DP0095	Vehicle Repairs	-2,551.85
22RT4DP0096	Vehicle Repairs	1,491.44
22RT4DP0096	Vehicle Repairs	-1,491.44
22RT4DP0097	Vehicle Repairs	1,113.36
22RT4DP0099	Vehicle Repairs	1,500.40
22RT4DP0100	Vehicle Repairs	276.00
22RT4MN0002	Defence Costs	55.73
22RT4MN0002	Counsel fees	1,375.00
22RT4MN0018	Defence Costs	20.09
22RT4PI0008	Claimants Solicitor Costs	2,857.00
22RT4PI0008	Damages	4,350.00
22RT4PI0024	Counsel fees	750.00
Total		**109,893.12**

AGENDA ITEM No	**11**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**3**

LOSSES AND SPECIAL PAYMENTS - PAYMENTS FOR THE PERIOD FROM 1st APRIL 2021 TO 31st March 2022 & 1ST APRIL 2022 TO 30th APRIL 2022

MEETING	**Audit Committee**
DATE	**7th June 2022**
EXECUTIVE	**Director of Finance and Corporate Resources**
AUTHOR	**Jill Gill**
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 2022 (**Annex 1**) and the month of April 2022 (**Annex 2**).

KEY ISSUES/IMPLICATIONS

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

- period 1st April 2021 to 31st March 2022 - £1.849m
- one month to 30th April 2022 - £0.109m

REPORT APPROVAL ROUTE
Audit Committee 7th June 2022 – no action required for information under SFI's only

REPORT APPENDICES
Annex 1 – Summary of payments made for the twelve months to 31st March 2022, along with details of those made in February and March 2022 Annex 2 – Summary and details of payments made for the one month to 30th April 2022

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

WELSH AMBULANCE SERVICES NHS TRUST
AUDIT COMMITTEE
LOSSES AND SPECIAL PAYMENTS - PAYMENTS FOR THE PERIOD FROM 1st APRIL 2021 TO 31st MARCH 2022 & ONE MONTH TO 30TH APRIL 2022

SITUATION

1. In accordance with SFI's all losses and special payments made are to be reported to the Audit Committee on a regular basis.

BACKGROUND

2. This report presents to the Committee details of Losses and Special Payments made during the twelve months from 1st April 2021 to 31st March 2022 (**Annex 1**) and one month to 30th April 2022 (**Annex 2**)

ASSESSMENT

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

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 2022 payments made exceeded reimbursements received by £1.849m.

5. During February you will note that payments in relation to damages amounted to £0.325m. The majority of the damages payments incurred in February £0.315m relate to the finalisation and settlement of a medical negligence case against the Trust due to patient's recovery being effected as a result of an ambulance delay.

6. During February you will also note claimant's solicitors costs incurred of £0.100m, these also relate to the same medical negligence case referred to above.

RECOMMENDED: 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 2022:

	£
April 2021	161,584.84
May 2021	154,976.08
June 2021	102,494.93
July 2021	- 584,439.92
August 2021	17,140.47
September 2021	15,038.63
October 2021	257,603.45
November 2021	585,381.42
December 2021	23,527.99
January 2022	652,063.06
February 2022	461984.39
March 2022	2336.91
	£1,849,692.25

Losses and Special Payments Breakdown:

Payment Type	April	May		**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Total**
	£	£	£	£	£	£	£	£	£	£	£	£	£	
Claimants Solicitor Costs		77749.6	65172.7	47,454.40	17,113.20	6,000.00	1,208.50	4,434.00	26,056.00	960.00	112,110.00	100,000.00	37,969.90	£496,228.30
Counsel fees		7932.5	14885	3,270.16	7,289.59	8,625.00	700.00	2,245.83	19,981.25	1,470.00	19,220.00	5,795.00	4,618.75	£96,033.08
CRU		1376	0	9,009.43	3,068.00	0.00	1,376.00	688.00	17,860.22	0.00	86,101.46	1,183.18	-51,441.46	£69,220.83
Damages		32755	63600	16,985.00	36,732.00	-3,598.20	1,898.80	235,162.00	495,051.26	500.00	408,280.00	325,650.00	-13,381.63	£1,599,634.23
Defence Costs		3773.2	486.02	3,235.10	2,187.10	918.23	920.58	89.25	1,532.00	46.26	3,700.65	50,288.82	1,842.80	£69,020.01
Expert Witness		21795.85	316.8	12,245.00	15,257.40	4,764.50	2,800.00	0.00	9,779.90	10,087.10	10,938.40	10,627.50	2,560.00	£101,172.45
Vehicle Repairs		15992.69	14505.56	9,655.84	21,970.54	19,642.94	9,015.10	14,536.67	15,120.79	8,644.63	11,712.55	6,116.79	5,653.55	£152,567.65
WRP Refund		210	-3990	640.00	-688,057.75	-10,000.00	-3,956.35	447.70	0.00	0.00	0.00	-37,676.90	0.00	-£742,383.30
Court Refund		0	0	0.00	0.00	-9,212.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-£9,212.00
Property Repairs		0	0	0.00	0.00	0.00	1,076.00	0.00	0.00	1,820.00	0.00	0.00	14,515.00	£17,411.00
Total		**£161,584.84**	**£154,976.08**	**£102,494.93**	**-£584,439.92**	**£17,140.47**	**£15,038.63**	**£257,603.45**	**£585,381.42**	**£23,527.99**	**£652,063.06**	**£461,984.39**	**£2,336.91**	**£1,849,692.25**

Welsh Ambulance Services NHS Trust

Losses and Special Payments

Key

MN Medical Negligence
PI Personal Injury
DP Damage To Property

Summary of payments for the twelve months to 31st March 2022:		
	£	
PI cases < £1,000	4,577.18	10 Cases
DP cases < £1,000	20,440.91	45 CASES
16RT4MN0009	609,372.78	
17RT4MN0007	539,206.51	
18RT4MN0005	436,850.00	
18RT4MN0023	238,530.00	
20RT4MN0010	120,820.00	
19RT4PI0053	81,084.01	
15RT4MN0010	67,418.20	
19RT4PI0029	46,096.60	
22RT4DP0025	24,300.80	
20RT4MN0006	20,432.00	
20RT4PI0014	17,648.00	
20RT4MN0011	16,770.00	
22RT4DP0080	14,497.50	
21RT4PI0001	13,258.10	
19RT4PI0023	12,797.70	
20RT4MN0008	12,750.00	
22RT4PI0015	11,114.20	
18RT4MN0015	10,890.00	
21RT4PI0034	10,832.00	
20RT4PI0025	10,400.00	
21RT4DP0086	9,994.87	
20RT4PI0044	9,896.50	
18RT4MN0012	9,542.50	
22RT4DP0022	9,354.79	
19RT4PI0008	9,036.90	
19RT4PI0044	8,000.00	
19RT4PI0038	7,733.40	
18RT4MN0011	7,000.00	
22RT4DP0049	6,928.65	
22RT4DP0070	6,867.66	
22RT4DP0028	6,801.53	
22RT4PI0037	6,750.00	
19RT4FE0004	6,021.15	
19RT4PI0028	5,955.00	
22RT4MN0002	5,701.25	
20RT4MN0019	5,612.62	
21RT4PI0024	5,453.00	
22RT4DP0055	5,091.11	
21RT4DP0098	5,027.78	
21RT4MN0013	4,915.00	
22RT4PI0004	4,640.00	
22RT4DP0048	4,582.69	
22RT4DP0040	4,290.00	
19RT4PI0005	4,252.00	
22RT4DP0026	4,231.97	
22RT4DP0019	4,071.28	
22RT4DP0033	3,930.00	
22RT4MN0012	3,831.25	
22RT4GN0007	3,670.00	
22RT4DP0011	3,359.68	
22RT4DP0072	3,081.79	
18RT4MN0016	3,076.75	
15RT4PI0040	3,006.25	
19RT4EG0005	2,991.67	
21RT4DP0054	2,934.00	
21RT4GN0016	2,850.00	
21RT4DP0073	2,774.15	
21RT4GN0014	2,560.00	
21RT4GN0012	2,446.50	
21RT4DP0093	2,428.43	
22RT4DP0015	2,352.42	
19RT4PI0040	2,339.52	
22RT4DP0057	2,300.00	
22RT4DP0009	2,256.86	
22RT4DP0064	2,244.00	
22RT4DP0047	2,227.87	
22RT4DP0052	2,200.00	
21RT4DP0045	2,179.82	
19RT4PI0060	2,168.75	
22RT4MN0001	2,145.83	
22RT4DP0051	2,140.26	
22RT4DP0078	2,101.49	
22RT4GN0008	2,100.00	
22RT4DP0046	2,058.67	
19RT4PI0051	2,050.00	
22RT4DP0038	1,990.51	
20RT4PI0034	1,987.70	
22RT4DP0001	1,860.50	
22RT4DP0083	1,858.80	
22RT4DP0062	1,820.00	
22RT4DP0007	1,764.15	
21RT4DP0106	1,725.37	
19RT4PI0037	1,705.50	
22RT4DP0054	1,639.10	
21RT4DP0104	1,605.00	
22RT4DP0010	1,598.46	
20RT4MN0018	1,590.00	
22RT4DP0050	1,569.54	
22RT4DP0075	1,554.11	
22RT4DP0042	1,524.49	
22RT4DP0071	1,511.10	
22RT4GN0033	1,500.00	
21RT4DP0075	1,456.02	
22RT4DP0030	1,422.72	
19RT4MN0006	1,375.00	
22RT4DP0061	1,360.68	
22RT4MN0010	1,300.00	
21RT4EG0006	1,200.00	
21RT4GN0011	1,200.00	
21RT4DP0042	1,128.60	
20RT4MN0005	1,100.00	
22RT4DP0014	1,076.21	
22RT4DP0044	1,076.00	
22RT4DP0053	1,038.81	
22RT4DP0076	1,030.00	
20RT4PI0007	1,000.00	
20RT4MN0017	872.00	
18RT4MN0001	795.00	
21RT4MN0012	646.80	
22RT4MN0003	520.00	
22RT4MN0016	72.65	
22RT4MN0011	68.00	
22RT4MN0013	46.26	
22RT4MN0009	36.00	
18RT4PI0060	- 30,981.63	WRP REFUND
15RT4MN0010	- 681,645.75	WRP REFUND
19RT4PI0029	- 30,685.40	WRP REFUND
20RT4EG0017	- 10,000.00	WRP REFUND
21RT4GN0006	- 5,714.30	WRP REFUND
19RT4PI0020	- 4,881.50	WRP REFUND
21RT4GN0001	- 3,200.00	WRP REFUND
15RT4PI0040	- 3,006.35	WRP REFUND
19RT4MN0010	- 1,860.00	WRP REFUND
21RT4GN0020	- 500.00	WRP REFUND
21RT4EG0003	- 250.00	WRP REFUND
21RT4GN0017	- 250.00	WRP REFUND
21RT4GN0010	- 250.00	WRP REFUND
21RT4GN0024	- 250.00	WRP REFUND
21RT4GN0009	- 200.00	WRP REFUND
21RT4GN0003	210.00	WRP REFUND RETURN
15RT4PI0032	100.00	WRP REFUND RETURN
19RT4PI0051	- 9,212.00	COURT REFUND
Total	**1,849,692.25**	

Feb-22

Case Reference	Details	Amount (£)
16RT4MN0009	Defence costs	255.00
16RT4MN0009	Defence costs	275.00
16RT4MN0009	Expert witness	1,500.00
16RT4MN0009	Defence costs	48,000.00
18RT4MN0001	Defence costs	100.00
18RT4MN0001	Counsel fees	70.00
18RT4MN0005	Counsel fees	1,200.00
18RT4MN0005	Expert witness	780.00
18RT4MN0005	Claimants solicitors fees	100,000.00
18RT4MN0005	Damages	315,000.00
18RT4MN0015	Defence costs	390.00
18RT4MN0016	Expert witness	390.00
19RT4MN0010	WRP refund	- 1,860.00
19RT4PI0020	WRP refund	- 4,881.50
19RT4PI0029	WRP refund	- 30,315.40
19RT4PI0029	WRP refund	- 370.00
19RT4PI0037	Counsel fees	1,237.50
19RT4PI0053	CRU	701.58
20RT4MN0019	Expert witness	750.00
20RT4MN0019	Counsel fees	2,200.00
20RT4MN0019	Counsel fees	1,087.50
20RT4MN0019	Defence costs	275.12
21RT4DP0042	Defence costs	326.70
21RT4GN0016	Damages	150.00
21RT4GN0024	WRP refund	- 250.00
21RT4MN0013	Expert witness	625.00
21RT4PI0001	Damages	3,500.00
21RT4PI0001	CRU	240.80
21RT4PI0001	Defence costs	667.00
21RT4PI0001	Damages	7,000.00
21RT4PI0001	CRU	240.80
22RT4DP0026	Vehicle repairs	3,095.18
22RT4DP0075	Vehicle repairs	1,554.11
22RT4DP0076	Vehicle repairs	1,030.00
22RT4DP0077	Vehicle repairs	437.50
22RT4MN0002	Expert witness	1,430.00
22RT4MN0002	Expert witness	2,172.50
22RT4MN0002	Expert witness	98.75
22RT4MN0012	Expert witness	1,300.00
22RT4MN0012	Expert witness	1,581.25
Total		**461,984.39**

Mar-22

Case Reference	Details	Amount (£)
16RT4MN0009	Defence costs	275.00
16RT4MN0009	CRU	-53,481.29
18RT4MN0005	Counsel fees	600.00
18RT4MN0005	Counsel fees	225.00
18RT4MN0005	CRU	10,780.00
18RT4MN0015	Claimants solicitors fees	5,500.00
18RT4MN0016	Defence costs	100.00
18RT4MN0023	Defence costs	680.00
18RT4MN0023	Claimants solicitors fees	33,000.00
18RT4PI0060	CRU	-8,740.17
18RT4PI0060	Claimants solicitors fees	-5,000.00
18RT4PI0060	Defence costs	-1,765.80
18RT4PI0060	Damages	-30,981.63
19RT4PI0008	Claimants solicitors fees	219.90
19RT4PI0008	Defence costs	42.00
19RT4PI0044	Counsel fees	1,375.00
19RT4PI0060	Counsel fees	2,168.75
20RT4MN0008	Counsel fees	250.00
20RT4PI0025	Damages	10,000.00
21RT4DP0042	Defence costs	386.10
21RT4GN0011	Damages	1,200.00
21RT4GN0014	Expert witness	2,560.00
21RT4GN0016	Defence costs	1,600.00
21RT4PI0001	Defence costs	275.50
22RT4DP0078	Vehicle repairs	2,101.49
22RT4DP0079	Vehicle repairs	600.00
22RT4DP0079	Vehicle repairs	142.08
22RT4DP0080	Property Repairs	14,497.50
22RT4DP0081	Vehicle repairs	951.18
22RT4DP0082	Property Repairs	17.50
22RT4DP0083	Vehicle repairs	1,858.80
22RT4EG0004	Defence costs	250.00
22RT4GN0011	Damages	400.00
22RT4GN0015	Damages	500.00
22RT4GN0019	Damages	350.00
22RT4GN0020	Damages	500.00
22RT4GN0021	Damages	250.00
22RT4GN0027	Damages	400.00
22RT4GN0033	Damages	1,500.00
22RT4PI0037	Claimants solicitors fees	4,250.00
22RT4PI0037	Damages	2,500.00
Total		**2,336.91**

Welsh Ambulance Services NHS Trust
Losses and Special Payments

Annex 1

Summary of payments for the one month to 30th April 2022:

	£
April 2021	£109,893.12
May 2021	-
June 2021	-
July 2021	-
August 2021	-
September 2021	-
October 2021	-
November 2021	-
December 2021	-
January 2022	-
February 2022	-
March 2022	-
	£109,893.12

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	0	0	0	0	0	0	0	0	0	0	0	£40,455.00
Counsel fees	10,825.00	0	0	0	0	0	0	0	0	0	0	0	£10,825.00
CRU	0	0	0	0	0	0	0	0	0	0	0	0	£0.00
Damages	12,875.00	0	0	0	0	0	0	0	0	0	0	0	£12,875.00
Defence Costs	4,061.02	0	0	0	0	0	0	0	0	0	0	0	£4,061.02
Expert Witness	15,024.00	0	0	0	0	0	0	0	0	0	0	0	£15,024.00
Vehicle Repairs	12,155.60	0	0	0	0	0	0	0	0	0	0	0	£12,155.60
WRP Refund	0.00	0	0	0	0	0	0	0	0	0	0	0	£0.00
Court Refund	0.00	0	0	0	0	0	0	0	0	0	0	0	£0.00
Property Repairs	14,497.50	0	0	0	0	0	0	0	0	0	0	0	£14,497.50
Total	**£109,893.12**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**£109,893.12**

Welsh Ambulance Services NHS Trust

Losses and Special Payments

Key

MN Medical Negligence

PI Personal Injury

DP Damage To Property

Summary of payments for the one month to 3oth April 2022:		
	£	
PI cases < £1,000	750.00	1 Case
DP cases < £1,000	3,452.46	8 Cases
22RT4MN0018	20.09	
18RT4MN0016	672.50	
19RT4PI0008	1,000.00	
20RT4PI0025	1,100.00	
22RT4DP0097	1,113.36	
22RT4DP0091	1,213.84	
22RT4MN0002	1,430.73	
22RT4DP0099	1,500.40	
20RT4MN0019	1,540.00	
22RT4DP0085	1,866.60	
22RT4DP0090	3,008.94	
18RT4MN0012	3,552.50	
20RT4PI0028	4,998.00	
16RT4MN0009	5,500.00	
21RT4PI0001	6,125.00	
22RT4PI0008	7,207.00	
18RT4MN0005	10,359.00	
22RT4DP0080	14,497.50	
20RT4MN0010	38,985.20	
Total	**109,893.12**	

Apr-22

Case Reference	Details	Amount (£)
16RT4MN0009	Counsel fees	5,500.00
18RT4MN0005	Expert Witness	4,224.00
18RT4MN0005	Expert Witness	4,410.00
18RT4MN0005	Counsel fees	1,725.00
18RT4MN0012	Expert Witness	1,975.00
18RT4MN0012	Expert Witness	787.50
18RT4MN0012	Expert Witness	790.00
18RT4MN0016	Expert Witness	297.50
18RT4MN0016	Counsel fees	225.00
18RT4MN0016	Counsel fees	150.00
19RT4PI0008	Expert Witness	1,000.00
20RT4MN0010	Defence Costs	3,985.20
20RT4MN0010	Claimants Solicitor Costs	35,000.00
20RT4MN0019	Expert Witness	1,540.00
20RT4PI0025	Counsel fees	1,100.00
20RT4PI0028	Claimants Solicitor Costs	2,598.00
20RT4PI0028	Damages	2,400.00
21RT4PI0001	Damages	6,125.00
22RT4DP0075	Vehicle Repairs	600.00
22RT4DP0080	Property Repairs	14,497.50
22RT4DP0084	Vehicle Repairs	637.15
22RT4DP0085	Vehicle Repairs	1,866.60
22RT4DP0086	Vehicle Repairs	702.00
22RT4DP0086	Vehicle Repairs	250.00
22RT4DP0087	Vehicle Repairs	350.00
22RT4DP0088	Vehicle Repairs	175.00
22RT4DP0089	Vehicle Repairs	49.99
22RT4DP0090	Vehicle Repairs	3,008.94
22RT4DP0091	Vehicle Repairs	250.00
22RT4DP0091	Vehicle Repairs	963.84
22RT4DP0092	Vehicle Repairs	412.32
22RT4DP0093	Vehicle Repairs	3,598.37
22RT4DP0093	Vehicle Repairs	-3,598.37
22RT4DP0095	Vehicle Repairs	2,551.85
22RT4DP0095	Vehicle Repairs	-2,551.85
22RT4DP0096	Vehicle Repairs	1,491.44
22RT4DP0096	Vehicle Repairs	-1,491.44
22RT4DP0097	Vehicle Repairs	1,113.36
22RT4DP0099	Vehicle Repairs	1,500.40
22RT4DP0100	Vehicle Repairs	276.00
22RT4MN0002	Defence Costs	55.73
22RT4MN0002	Counsel fees	1,375.00
22RT4MN0018	Defence Costs	20.09
22RT4PI0008	Claimants Solicitor Costs	2,857.00
22RT4PI0008	Damages	4,350.00
22RT4PI0024	Counsel fees	750.00
Total		**109,893.12**