# Bundle Audit Committee (Open) 7 June 2024

Agenda attachments

ITEM 0 Agenda Audit Risk and Assurance Committee Open 7 June 2024

0 09:00 - OPENING ITEMS

1 Chair's welcome; apologies and confirmation of quorum

2 Board Member Register of Interests
*Board Member Register of Interests*

3 Minutes of Audit Committee Meeting: 30 April 2024

ITEM 03 2024-04-30 Audit Committee OPEN Minutes

4 Action Log (None open) and Matters Arising
*ITEM 4.1 AAA Report dated 30 April 2024*

ITEM 04.1 Audit Committee AAA Report April 2024

4.1 ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION

5 09:10 - Internal Audit
*5.1 Draft Head of Internal Audit Annual report and Opinion 2023-24*
*Internal Audit Reports*
*5.2 Follow Up Audit*
*5.3 Clinical Audit*

ITEM 05.1 Draft Head of Internal Audit Annual Report and Opinion_23-24_WAST_for Trust AC
ITEM 05.2 WAST-2324-20_Follow up_Final Internal Audit Report_for Trust issue
ITEM 05.3 WAST_2324-010_Clinical Audit_Final Internal Audit Report

6 10:10 - Audit Wales Update Report

ITEM 06 WAST Audit Committee Update 07062024

6.1 10:30 - COMFORT BREAK

7 10:45 - Risk Management and Board Assurance Framework

ITEM 07 Executive Summary Risk Management Report AC 070624

8 11:05 - Audit Tracker

ITEM 08 SBAR Audit Tracker to Committees - Q4 Reporting - ARAC June 2024
ITEM 08.1
ITEM 08.1a
ITEM 08.2
ITEM 08.2a

9 11:15 - Policy Report

ITEM 09 Executive Summary Policy Report AC 070624

10 11:25 - Review of the Governance Practice Notes

ITEM 10 ARAC SBAR on Governance Practice Notes Review - June 2024
ITEM 10.1 Governance Practice Note 002 April 2023 - Private Board and Committee Business - 2024 EDITS FOR JUNE 2024 ARAC
ITEM 10.2 Governance Practice Note 003 April 2023 - Chair's Action - 2024 EDITS FOR JUNE 2024 ARAC

11 11:30 - Losses and Special Payments - Payments for the Period 1 April 2024 - 30 April 2024

ITEM 11 Executive Summary SBAR Losses Special Payments M01 2024-25
ITEM 11.1 Annex 1 - Losses Special and Payments 2024-25 M1

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

12 Committee Priorities and Cycle of Business Monitoring Report

ITEM 12 Audit Committee Priorities and Cycle Monitoring Report
ITEM 12.1
ITEM 12.1a

13 Committee Terms of Reference and Annual Return 2023/24
*13.1 ARAC Annual Return*

ITEM 13 ARAC Terms of Reference 2024-25 - Approved by Trust Board 30052024
ITEM 13.1 ARAC Annual Return 2023-24

13.1 11:40 - CLOSING ITEMS
14 Reflections & Summary of Decisions and Actions
15 Key Messages for Board
16 Any Other Business
17 Date and time of next meeting: 10 July 2024

Ymddiriedolaeth Brifysgol GIG Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services University NHS Trust

**AGENDA**

**MEETING OF THE OPEN AUDIT, RISK AND ASSURANCE COMMITTEE**

Held in public on **7 June 2024 from 09:00 to 11:45**

***Closed meeting to commence at 12:15***

Meeting held virtually via Microsoft Teams and in person in Cardiff

| No. | Agenda Item | Purpose | Lead | Format | Time |
|---|---|---|---|---|---|
| **OPENING ITEMS** | | | | | |
| 1. | Chair's welcome; apologies and confirmation of quorum | Information | Peter Curran | Verbal | 10 Mins |
| 2. | Board Member Register of Interests | To State Conflicts | Peter Curran | Verbal | |
| 3. | Minutes of Audit Committee Meeting: 30 April 2024 | Approval | Peter Curran | Paper | |
| 4. | Action Log (No open actions) and Matters Arising<br>4.1 30 April 2024 AAA Report | Assurance | Peter Curran | Paper | |
| **ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION** | | | | | |
| 5. | Internal Audit<br>5.1 Draft Head of Internal Audit Annual Report and Opinion 2023-24<br><br>*Internal Audit Reports*<br>5.2 Follow Up Audit<br>5.3 Clinical Audit | Assurance | Osian Lloyd<br><br><br><br>Trish Mills<br>Duncan Robertson | Paper | 60 Mins |
| 6. | Audit Wales Update Report | Assurance | Fflur Jones | Paper | 20 Mins |
| **COMFORT BREAK – 15 Minutes** | | | | | |
| 7. | Risk Management and Board Assurance Framework | Assurance | Julie Boalch | Paper | 20 Mins |
| 8. | Audit Tracker | Assurance | Trish Mills | Paper | 10 Mins |
| 9. | Policy Report | Assurance | Julie Boalch | Paper | 10 Mins |
| 10. | Review of the Governance Practice Notes | Approval | Trish Mills | Paper | 5 Mins |

| No. | Agenda Item | Purpose | Lead | Format | Time |
|---|---|---|---|---|---|
| 11. | Losses and Special Payments – Payments for the Period 1 April 2024 – 30 April 2024 | Assurance | Chris Turley | Paper | 10 Mins |
| **CONSENT ITEMS**<br>**The items that follow are for information only. Should a member wish to discuss any of these items they are requested to notify the Chair so that time may be allocated to do so.** | | | | | |
| 12. | Committee Priorities and Cycle of Business Monitoring Report | Information | Trish Mills | Paper | - |
| 13. | Committee Terms of Reference<br><br>13.1Annual Return 2023/24 | Information | Peter Curran | Paper | |
| **CLOSING ITEMS** | | | | | |
| 14. | Reflections & Summary of Decisions and Actions | Information | Peter Curran | Verbal | 5 Mins |
| 15. | Key Messages for Board | Information | Peter Curran | Verbal | |
| 16. | Any Other Business | Discussion | Peter Curran | Verbal | |
| 17. | Date and time of next meeting:<br>10 July 2024 | Information | Peter Curran | Verbal | |

## Lead Presenters

| Name of Lead | Position of Lead |
|---|---|
| Peter Curran | Non-Executive Director and Committee Chair |
| Julie Boalch | Head of Risk/Deputy Board Secretary |
| Fflur Jones | Audit Wales |
| Osian Lloyd | Head of Internal Audit |
| Trish Mills | Director of Corporate Governance/Board Secretary |
| Duncan Robertson | Assistant Director for Clinical Development |
| Chris Turley | Executive Director of Finance and Corporate Resources |

**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 30 APRIL 2024 IN VANTAGE POINT HOUSE, CWMBRAN, AND VIA TEAMS**

**Meeting Commenced at 09:30**

**PRESENT:**

| | |
|---|---|
| Peter Curran | Non-Executive Director and Committee Chair |
| Ceri Jackson | Non-Executive Director and Vice Chair of the Trust Board |
| Kevin Davies | Non-Executive Director |
| Joga Singh | Non-Executive Director (Left after Minute 20/24) |

**IN ATTENDANCE:**

| | |
|---|---|
| Julie Boalch | Head of Risk/Deputy Board Secretary |
| Judith Bryce | Assistant Director of Operations |
| Christian Fox | Trade Union Partner |
| Jill Gill | Head of Financial Accounting |
| Darren Griffiths | Audit Wales |
| Fflur Jones | Audit Wales |
| Angela Lewis | Director of People and Culture |
| Osian Lloyd | Head of Internal Audit, NWSSP |
| Amy Lord | Audit Wales |
| Trish Mills | Director of Corporate Governance/Board Secretary |
| Steve Owen | Corporate Governance Officer |
| Felicity Quance | Deputy Head of Internal Audit, NWSSP |
| Jonny Sammut | Director of Digital Services |
| Chris Turley | Executive Director of Finance and Corporate Resources |
| Damon Turner | Trade Union Partner |
| Carl Window | Counter Fraud Manager |

**APOLOGIES:**

| | |
|---|---|
| Liam Williams | Executive Director of Quality and Nursing |

**15/24 PROCEDURAL MATTERS**

The Chair welcomed all to the meeting.

Members noted that any declarations of interest were contained within the Trust's Register of Interests. Peter Curran added he was no longer the Interim Finance Director for Turbine Leisure Trust and that there was a minor spelling mistake in respect of Jonny Sammut's name. Trish Mills advised these two issues had already been resolved.

**Minutes:**

The Minutes of the Audit Committee meeting held on 1 March 2024 were approved.

**Action Log**

Minute Reference 02-24: *It was requested that a comparison of Audit Fees with other organisations be provided along with the reasons for increase.* An explanatory letter was attached to action log. Action closed.

Minute Reference 03-24: *To consider the placement of the extra AC/TB meetings and the process for drafting of the accounts from an AC point of view and the oversight.* Dates have been confirmed and published. Action closed.

Minute Reference 06-24: *It was asked that reference be made to specifically include Volunteers within the Risk Management policy to assist in ensuring clarity and accountability for everyone involved. It was agreed that the policy would be approved subject to including the relevant wording regarding Volunteers.* The policy amended to reflect the change; Action closed.

Minute Reference 10/24: *It was asked that reference be made to specifically include Volunteers within the Counter Fraud, Bribery and Corruption policy to assist in ensuring clarity and accountability for everyone involved. It was agreed that the policy would be approved subject to including the relevant wording regarding Volunteers.* Policy amended to reflect the change; Action closed.

**Committee Highlight Report**

The report was received for information.

**RESOLVED: The Committee.**

**(1) Noted the apologies received from Liam Williams who was engaged with the CAS implementation along with other members of his team and was unable to send a deputy.**

**(2) Approved the Minutes of 1 March 2024.**

**(3) Considered the action log and closed the actions as described; and**

**(4) Received the Committee highlight report.**

## 16/24 INTERNAL AUDIT REPORTS

The Committee received a progress update from Osian Lloyd against the 2023/24 Internal Audit Plan, revealing five remaining audits to be completed by the June meeting. The progress report covers the training plan for 24 weeks and provides an overview of other activities. The most recent Key Performance Indicator (KPI) for audits reporting deadlines continues to show an improvement. Two completed audits were presented to the Committee during the quarter:

Comments:

Trish Mills added that she would be presenting a report to the Executive Leadership Team (ELT) which will focus on ensuring clarity regarding timing in terms of when the 15 day period begins to run to ensure clarity in respect of the management response to audits. Furthermore, there will be continuing efforts to schedule sessions with ELT during the audit scoping phase to coordinate timelines and avoid scheduling conflicts.

Members noted the emphasis place on ensuring that the narrative regarding the Estate Audit of limited assurance reflects systemic challenges rather than solely internal challenges. This approach aims to provide a comprehensive understanding of the issues at hand, considering broader systemic factors that may contribute to the challenges faced.

1. **Seatbelt Action Plan:** Felicity Quance stated that this audit received reasonable assurance. Its aim was to evaluate the implementation of the seatbelt action plan, ensuring the safety of both crews and patients aboard Trust vehicles, and assessing compliance. An incident in North Wales in April 2021 prompted a review of the seatbelt action plan to enhance the safety of crews and patients aboard Trust vehicles. The Trust conducted assessments to ensure compliance with safety protocols and standards. Following the incident, the Trust responded promptly by establishing a Road Traffic Collision Cross Directorate Group. Additionally, an internal health and safety investigation was initiated. Subsequently, an action plan was developed, which has been evolving as the investigation progresses. It is important to note that the action plan was implemented prior to the completion of the investigation, emphasising the timeliness of the response.

   It is also important to acknowledge that the coroner's report identified three aspects requiring further consideration, details of which were still awaited from the coroner.

Quality assurance arrangements were established with both external providers, including due diligence checks to ensure they meet the required standards, as well as internal inspections of Trust-owned vehicles. It was noted that the number of inspections to be undertaken across the 76 Trust Non-Emergency Patient Transport Services (NEPTS) sites is limited to four stations per year. Resourcing issues have impacted on the number of internal inspections being completed which was currently two.

The Quality, Patient Experience, and Safety Committee, along with the People and Culture Committee, will review this audit in more detail in May, given its relevance to patient safety and health and safety.

Judith Bryce welcomed the report and acknowledged that the additional actions have been implemented to enhance safety for patients, staff, and the Trust. The quality and support days referred to in the report were deemed successful, and their reporting will be presented to the Joint Senior Leadership Team Day on 17 May.

Following a query in terms of the number of internal inspections being undertaken, Judith Bryce added that she was relatively comfortable that these checks are in place, and if capacity allows, will do more. However, four will be maintained as a minimum and did not see any significant risk with this approach. She was comfortable with what has been outlined in the management response.

2. **ICT Contract Management:** Felicity Quance advised the Committee this audit also received reasonable assurance. Its objective was to assess whether the Trust has appropriate contract management arrangements in place to ensure the achievement of value for money. The Finance and Performance Committee reviewed this audit at its March meeting.

   At the time of the audit, there was a lack of structure in the supplier and contract function, especially regarding additional services. However, actions had been taken to address this, including the appointment of a contract manager. Additionally, a standard operating procedure was approved to close off this issue.

   An ICT contract register was in place for current contracts, but it was observed that it did not include all suppliers, particularly those used for single capital orders or contracts where ICT requirements fell outside of digital services' budgetary responsibility.

   Additionally, it was noted that while there is an ongoing contract management process to review performance reports, it is not fully documented. There was no evidence found for the management of instances of poor performance or escalation procedures if required.

The monitoring of contracts before their term ends is conducted at the Digital Services Senior Management Team meeting. However, since there were no minutes from these meetings in place, it remained unclear what requirements were determined for relevant procurement processes or what the next steps needed to be in relation to that.

Jonny Sammut added that it might be disproportionate to include all contracts in the contract register. Therefore, as part of the management action, he has agreed to document any recurrent spend via the contract register. For anything else, he will continue to monitor using the single one-off spend in Oracle, as it provides sufficient detail while balancing time and effort. Additionally, many of the actions are already in progress in terms of evidence gathering for performance meetings.

Members queried if, across the NHS, there was any shared learning or best practice that the Trust could adopt, specifically on any areas where improvement can be identified. Jonny Sammut added that following benchmarking against other ambulance services it revealed that there are only two other ambulance services in the UK that have established a contract manager role. In the ambulance sector, the Trust is progressing and maturing compared to the wider industry. While there is still work to be done, it is noteworthy that the Trust is in a relatively good place within the sector.

**RESOLVED: The Committee noted the update and received the Seatbelt Action plan audit and the ICT Contract Management audit reports.**

**17/24 AUDIT WALES REPORTS**

**Audit Wales Progress Report**

Fflur Jones presented the 2023 Audit Wales Annual Report for the Trust, which had been summarised in an accompanying report and this outlined findings from various audit activities, including the audit of the 2022/23 accounts, 2023 structured assessment, national workforce review, and the Trust's workforce planning arrangements. These reports underwent review by both the Committee and the Board.

The Review of Unscheduled Care Part Two, focusing on accessing urgent and emergency care, has begun, with the Trust formally engaged in this phase. This review is part of a broader examination that includes Part One (flow out of hospital), completed and currently under clearance with the Regional Partnership Boards, and Part Three (national arrangements and leadership structures), which will begin in the coming months.

**Audit Wales Annual Report**

Fflur Jones explained that the annual audit report provides a comprehensive summary of all the work conducted over the past year. The findings contained within this report have been previously reviewed and discussed by the Committee. The report covers various aspects, including the work on the accounts and performance audits, such as the workforce planning report and structured assessment work.

**Audit Wales Annual Audit Plan 2024**

Amy Lord presented the 2024 Audit Plan which covers both accounts work and performance audit work. Key highlights included:

1. Accounts Audit Planning: The plan identifies risks identified during planning procedures, outlines the timetable, team composition, and fee.

2. Significant Audit Risks: The significant audit risk of management override is highlighted, as mandated by international auditing standards. Other identified risks include duty to break even over a three year period, new systems for calculating provisions, and the impact of International Financial Reporting Standard (IFRS) 16 on leasing standards.

3. Trust-Specific Risks: Risks specific to the Trust include expenditure recognition, capital expenditure classification, senior officer remuneration, and related parties.

4. Audit Timetable: The audit is scheduled to conclude in July, with today's presentation marking the start of the audit planning process.

Overall, the plan provides an overview of the audit approach, risks, and timetable for completing the audit of the 2023/24 accounts.

The audit fee for the 2024/25 year was noted at £200,483. This is in line with the Fee Scheme as approved by the Senedd Finance Committee and represents a 6.4% increase.

In terms of the planned performance work the Committee were updated by Fflur Jones.

This will include the annual structured assessment which will incorporate both a core element and a deep dive element. The core element covers governance, planning, and use of resources, while the deep dive this year focuses on digital systems to support service resilience and transformation.

Originally, the plan was to conduct a deep dive into digital systems this year, but it has been deferred to next year to prioritise financial resilience. The deep dive will begin later in the year.

Additionally, substantial work is being done on the urgent and emergency care review at the Trust.

Comments:

Chris Turley commented that the upcoming audit will address risks identified, including those mandated by auditing standards and common across many NHS organisations.

He added that everything is proceeding according to plan in terms of the draft accounts which will be submitted this week, and then initiating the audit process with Audit Wales colleagues next week.

The request from Audit Wales for responses regarding statements of responsibilities for those charged with governance has been received. The team is currently working on drafting the responses, which will then be reviewed before submission. It is noted that there may not be significant changes from previous years, but a detailed review will be conducted to ensure accuracy and relevance.

Jonny Sammut highlighted a potential challenge regarding readiness for the digital work, mentioning that the team might face capacity constraints due to the ongoing digital plan refresh. Towards the end of the year, there could be significant demands and programs of work, which may impact the team's availability for the required fieldwork.

The Committee recognised that the focus on digital systems investment is crucial, not only in terms of its impact but also from a risk perspective. Understanding the return on investment and how these systems are utilised across different areas is essential. For instance, the variation in usage of digital healthcare records among health boards underscores the importance of assessing whether these systems are being effectively used as intended and how they contribute to managing risk and harm within the healthcare system. Further details on the scoping of the digital audit work were requested.

Darren Griffiths from Audit Wales thanked Members for their comments and agreed to incorporate those points as part of the scoping work going forward. He added that Audit Wales will be adjusting the scope of their work for the Digital Healthcare Wales organisation (DHCW) to reflect its system leadership role in Wales and its importance in developing and delivering digital systems and solutions to NHS Wales. This adjustment will involve focusing on capturing pan-Wales national issues. The work is still in the process of being scoped, with plans to deliver it towards the end of the summer or early autumn.

**RESOLVED: The Committee received the Audit Wales Progress Report, Audit Wales Annual Report, and the Annual Audit plan for 2024.**

**18/24 ANNUAL BOARD AND COMMITTEE EFFECTIVENESS REVIEWS 2023/24**

Prior to the update the Chair expressed his thanks to Trish Mills and her team's comprehensive and thorough report, acknowledging that it is more wide-ranging than reports seen elsewhere and serves as recognition for their efforts and the quality of their work.

**Audit Committee 2023 annual effectiveness review**

Trish Mills explained that the Audit Committee conducted its 2023/24 annual effectiveness review using the National Audit Office tool for survey questions. Members assessed their effectiveness based on this tool, the Committee's work throughout the year, and discussions held during the current meeting. Proposed changes to the terms of reference resulting from this review will be presented to the Board at its May meeting.

Seventeen questionnaires were distributed, with five responses received, resulting in a return rate of 29%, which was consistent with the previous year. However, not all questions were answered in some responses, possibly due to the questionnaire being tailored for central government departments, making certain questions less relevant. The detailed outcome analysis has not been uploaded to this Committee's papers but was sent separately via email, allowing members/attendees to examine and filter the responses more closely.

The results showcased the Committee's outstanding performance across multiple domains, notably in financial reporting, where only minimal areas for improvement were identified. Notably, there were improvements observed in the timeliness of submitted papers, potentially linked to the introduction of a document delineating paper deadlines, which was widely disseminated among all directorates. Furthermore, a new practice was introduced in 2023: a regular report from the Chair of the People and Culture Committee concerning the Trust's "speaking up safely" program. This initiative was a response to deficiencies in whistleblowing practices highlighted in the previous year's survey results.

The Audit Committee's terms of reference were reviewed to ensure all matters within the remit of the Committee were clear and were articulated with the oversight and scrutiny role of the Committee in mind. The following changes are proposed:

1. Change of name from Audit Committee to Audit, Risk and Assurance Committee (ARAC). The National Audit Office recognises this as best practice nomenclature, and it describes more appropriately the wider remit of the Committee and the focus in 2024/25 and beyond on the strategic Board Assurance Framework and the programme of integrated governance and assurance.

2. The addition of the Deputy Board Secretary/Head of Risk to the prescribed attendees.

3. Addition of a Chair's Action provision. It is likely that this would be utilised primarily for policy approval where waiting a quarter for a scheduled meeting would cause undue delay.

4. Addition of the commitment of the Committee to continuous improvement and the duty of quality.

The Audit Committee's annual report, as detailed in draft accompanying the update, underscores the breadth of responsibilities handled by this Committee throughout the year. Paragraph 16 of the annual report effectively highlights the extensive workload and the cyclical nature of business that the Committee manages, reflecting its significant remit.

Comments:

The Committee discussed ways of increasing the response rate for surveys which had been a concern, and exploring collective efforts from NEDs or senior staff could be a positive step forward in addressing this. A revised and streamlined approach to surveys for the 2024/25 reviews was agreed upon.

Clarity was sought on the wording with regards to controls in the Corporate Risk Register. Trish Mills explained that the introduction of the new Board Assurance Framework will provide a different perspective on internal controls, allowing for a more nuanced evaluation of whether controls and actions are excessive or within the Trust's appetite and tolerance levels. This shift in approach will likely enhance the effectiveness and efficiency of risk management processes moving forward.

The Committee were very supportive around induction for new members who may benefit from a more structured onboarding process to become more effective in their roles.

**Committee Effectiveness Reviews – Other Committees**

Trish Mills explained that the other six Board Committees and the one advisory group reviewed their effectiveness in Quarter 4 2023/24 following the methodology used in 2022/23 and based on the same question set along the themes of Committee focus, engagement, team working, and effectiveness.

All Committees have been quite productive over the year, handling a substantial workload. While the volume of papers and the length of agendas continue to be areas of concern, Members were reassured that their remits were suitable, and efforts are being made by the Executive to minimise volume and avoid duplication. The Audit Committee is asked to assess this distribution of delegated work and determine if it is fair and feasible.

Changes to terms of reference for the Committees include:

1. Academic Partnerships Committee: Change of purpose statement and a reduction in the non-executive director membership of the Committee from four to three (including the Committee Chair. There is a potential change of name of this Committee foreshadowed in 2024.

2. Charity Committee: Purpose of the Committee amended to provide clarity on its connection to the Corporate Trustee, and the need to make decisions with public benefit in mind. The level of approvals for the use of charitable funds has been reduced in line with changes on delegations for the Bids Panel. There has been a reduction in the non-executive director membership of the Committee from four to three (including the Committee Chair).

3. Finance and Performance Committee: The information governance and information security remit has been transferred from QUEST. Directorate specific plans aligned to the long term strategy 'Delivering Excellence' will be received by this Committee rather than reviewed for alignment. Clarity that the Audit Committee will receive assurance on the implementation of the Quality and Performance Management Framework and that this Committee will receive assurance on its effectiveness and the value of outcomes the framework produces.

4. Remuneration Committee: Addition of any interim appointments to the roles that are within the remit of the Committee.

Each Committee except the Remuneration Committee has set its priorities for 2024/25 and they were set in the update. These priorities will be monitored quarterly by way of an assurance report by the Director of Corporate Governance/Board Secretary to ensure they are on track. It should be stressed that this is not *additional to* the work of the Committee but provides a focus on areas of work that may be new or novel in the terms of reference or requiring of some specific oversight during the year.

A big thank you is due to the corporate governance team for their support provided to these committees. They manage an extensive cradle-to-grave process for each meeting, ensuring everything runs smoothly. Additionally, the chairs and leads of these committees deserve recognition for their dedication, considering the numerous meetings they attend. Efforts are made to streamline processes and reduce paperwork, although it may not always seem that way when faced with large bundles of documents.

Trish Mills added that a standardised questionnaire was introduced in 2022 to maintain a baseline for responses, which is a good practice. It is unfortunate that response rates are not as high as desired, especially during the winter months. Perhaps there are ways to encourage earlier responses or adapt the questionnaire to improve engagement throughout the year.

Comments:

Members endorsed the comprehensive work done by the corporate governance team and the committees and thanked all involved. Despite the challenges with response rates, they were assured that the results are reliable and dependable.

The Committee were in agreement about simplifying the questionnaire for other committees to potentially improve response rates. Whether it's condensing it to four or five questions, it was probably best left to the discretion of each Committee.

The Committee discussed whether the balance between governance, management, and time spent is appropriate given the current circumstances, especially with some Board Members not in place. Members suggested it might be worth reflecting on whether the current approach strikes the right balance and whether adjustments are needed to ensure effectiveness without overburdening individuals or the Trust. The Trust has reached a level of maturity where it might be appropriate to streamline reporting processes while still ensuring that the necessary governance and assurance measures are in place.

Members highlighted the importance of transparency and public accountability. By acknowledging the extensive work and scrutiny that happens at the Committee level, it helps demonstrate to the public that thorough deliberation and assessment have occurred before matters are brought to the Board. This transparency ensures that the public understands the depth of consideration that goes into decision-making processes. Additionally, the importance of discussing risks in detail was noted, especially during public Board meetings, to demonstrate transparency and accountability.

The Committee recognised the importance of aligning discussions with the appropriate forums and focusing on the key priorities outlined in the terms of reference. This ensures that discussions are productive and relevant, taking place in the right context and at the right time.

Members expressed their confidence in Trish Mills and her team's approach to governance, risk management, and assurance. They appreciated their diligence in ensuring that the processes remain proportionate, reasonable, and not overwhelming. This balance is essential to avoid excessive bureaucracy and ensure that the Trust's efforts are focused on meaningful outcomes rather than just fulfilling requirements. Overall, Members felt reassured and confident in their ability to maintain this delicate balance effectively.

The Committee noted there had been a significant cultural shift towards a more evolved governance culture within the Trust. This evolution is evident in the meticulous attention to detail and grassroots approach to governance practices. From aligning key projects with appropriate committees to documenting approval processes and management responses for audits, there is a clear emphasis on governance in day-to-day operations. This shift reflects a deeper understanding and integration of governance principles across all levels of

the Trust, particularly among senior teams, where governance considerations are consistently prioritised.

Trish Mills added that having a structured cycle of business for each Committee ensures alignment with their respective terms of reference. This approach provides assurance that the committees are focusing on the right priorities at the appropriate times. While adjustments may be necessary as circumstances evolve, the proactive nature of this approach prevents the Trust from passively navigating its governance responsibilities. She further recognised the ongoing journey towards a more strategic focus, with insights from the effectiveness reviews helping to guide this transition.

In terms of papers and reports Trish Mills added there was a recognition of the need to improve the presentation and writing of reports, perhaps leveraging tools like AI to enhance executive summaries and overall clarity.

Trish Mills explained that a plan would be in place to refine the effectiveness methodology for the next year, including using different questionnaires tailored to each committee's needs. The Audit Committee will review and advise if any further assurances are necessary before presenting the package to the Board for approval.

**RESOLVED: The Committee:**

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

**(2) Agreed the Committee's priorities for 2024/25.**

**(3) Approved the Audit Committee's annual report.**

**(4) Advised if changes are required to the effectiveness methodology for the 2024/25 reviews.**

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

- **Academic Partnership Committee**
- **Charity Committee**
- **Finance and Performance Committee**
- **People and Culture Committee**
- **Quality, Patient Experience and Safety Committee**
- **Remuneration Committee**
- **Welsh Ambulance Services Partnership Forum**

**and endorsed these and the annual reports for onward approval by the Trust Board**

**(6) Advised if any further assurances are sought on the effectiveness of the Trust's governance arrangements for its committees, including whether the spread of work as illustrated is appropriate and manageable.**

## 19/24 SELF-ASSESSMENT AGAINST THE CORPORATE GOVERNANCE CODE FOR CENTRAL GOVERNMENT DEPARTMENTS 2017 – 2024 REVIEW

Trish Mills advised the Committee that the Board is required to confirm adherence with the corporate governance code for central government departments 2017 in the annual governance statement. The Committee reviewed the self-assessment against the code and were assured that the Trust complies with all elements.

**RESOLVED: The Committee Reviewed the 2023/24 self-assessment against the Corporate Governance Code for Central Government Departments 2017, ahead of confirming compliance with the Code in the 2023/24 Accountability Report.**

## 20/24 SCHEME OF RESERVATION AND DELEGATION OF POWERS - CONTRACT AWARDS BY BOARD

Trish Mills advised the Committee that the Trust's Standing Orders (SOs) must be kept under review to ensure they remain current and that their practical application in the Trust is clear and communicated. The update report sets out amendments to the SOs from Welsh Government and clarifications made to the Scheme of Reservation and Delegations of Powers (SoRD) for endorsement by the Audit Committee.

**Interim Amendments to Standing Orders**

1. On 1 April 2024 the Joint Commissioning Committee (JCC) was established as a joint committee of the seven Health Boards. Standing Orders and a Scheme of Reservation and Delegation has now been adopted for the JCC.

2. Interim amendments have been made to the Model SOs to reflect the new arrangements for the JCC and to remove reference to the Welsh Health Services Commissioning Committee (WHSCC) and the Emergency Ambulance Services Committee (EASC) which ceased to exist on 31 March 2024.

3. On 1 April 2024 the Trust was awarded University Trust Status, and its name was changed to the Welsh Ambulance Services University NHS Trust. The SOs have been amended to reflect this.

4. The marked up changes to the SOs are at Annex 1 to the report and have been made in line with the Welsh Health Circular numbered 2024/019.

5. The Standing Orders at 7.2.5 provides for our Annual General Meeting (AGM) to be held by 31 July each year. Welsh Government have advised in the Manual for Accounts that for the 2023/24 annual report and accounts the AGM may be held before 30 September 2024. This ensures alignment with the external audit scheme. The Audit Committee is asked for formally endorse this for the Board's approval.

**Amendments to the Scheme of Reservation and Delegation of Powers**

Trish Mills advised that the Trust periodically reviewed the SoRD as it was essential to clarify its practical implementation and address any anomalies or inefficiencies. The recent Vehicle Replacement Programme Internal Audit, which provided reasonable assurance, identified a non-compliance issue concerning contract approvals by the Board. This occurred despite the Board having approved the overall programme and the annual business cases detailing the procurement process. The SoRD has been amended to allow for the logistical issues that flow from an award of contract to be delegated by the Board to the Chief Executive Officer.

Trish Mills added that there have been some other updates to the SoRD, particularly regarding alignment with SFI's on single tender waivers and adjusting limits to reflect changes in roles, such as a change to Director for the Board Secretary role. The amendments have been marked up for endorsement by the Committee and for subsequent approval by the Board.

**Governance Practice Note 005**

The draft Governance Practice Note 005 is attached to the report. This is for internal use to further support Directors in the development of business cases and the pathways to approval.

**RESOLVED: The Audit Committee:**

**(1) Endorsed the interim amendments to the Standing Orders and recommended their approval to the Board, including the deadline to hold the 2023/24 AGM by the 30 September 2024.**

**(2) Endorsed the amendments to the Scheme of Reservation and Delegation of Powers and recommended their approval to the Board.**

**(3) Approved Governance Practice Note 005.**

## 21/24 COMMITTEE CYCLE OF BUSINESS 2024-25 AND MONITORING REPORT

Trish Mills explained that the purpose of this paper is to provide the Committee with the updated cycle of business as the final step in the 2023/24 effectiveness review process. The cycle of business for the audit committee in 2024/25 has been simplified compared to other committees. The terms of reference are structured differently, with some areas color-coded for specific meetings or times of the year. Green items indicate topics covered meetings, while beige items serve as prompts during agenda setting. Additional notes may be added for context during agenda setting.

There has been a change in the monitoring report process for the Audit Committee compared to last year. These reports will now be provided at each Committee meeting, indicated in blue on the cycle of business document. This allows for tracking of items that have been presented as scheduled or moved to different meetings.

**RESOLVED: The Committee:**

**(1) Reviewed and approved the 2024/25 cycle of business; and**

**(2) Noted the cycle of business monitoring document.**

## 22/24 REGISTER OF INTERESTS & REGISTER OF GIFTS, HOSPITALITY AND SPONSORSHIP

Trish Mills explained that in response to a limited assurance audit on standards of business conduct during the 2022/23 period, a new comprehensive policy was developed. This report now presents the Register of Interests and the Register of Gifts and Hospitality, which have been incorporated into committee discussions and reflects efforts to address issues raised during the limited assurance internal audit. Furthermore, the Register of Gifts, Hospitality & Sponsorship for the 2023/24 financial year are presented for review and receipt by the Audit Committee. Both registers have been presented as at the 31 March 2024.

The audit also recommended expanding the publicly available list to include what they referred to as high-risk staff. This practice is considered best because these individuals are decision-makers. While the Electronic Staff Record (ESR) enables people to register their interests, the policy states that everyone in the Trust must register any interest, even if it is a nil declaration, and ESR has the capability to facilitate this. The Trust is taking a proactive approach to managing this development and ensuring that all staff members are aware of the new process. Using a Microsoft form will streamline the data collection process and provide clarity on which staff members have submitted their declarations. Adjustments and refinements along the way are expected.

In terms of the Declarations of Gifts, Hospitality and Sponsorship, since the approval of the Standards of Business Conduct Policy in July 2023 there have been a series of organisational-wide communications to aid understanding of the policy requirements, specifically in relation to gifts. These communications will be delivered on an ongoing basis throughout the year, particularly in the lead up to festive periods.

Comments:

Members were and gained further assurance through discussion that the appropriate levels of scrutiny and governance processes were in place in terms of the procedure regarding the declaration of gifts and hospitality.

Carl Window advised the Committee that significant progress was being made in addressing secondary employment concerns with emphasis on training and awareness, clear policies and procedures, regular audits and monitoring, manager accountability and the encouragement of reporting by staff. All these initiatives were designed to reduce fraud.

Damon Turner added it was important to maintain the option for patients to express their gratitude and support for staff members, even if the Trust has discontinued the practice of holding social funds locally.

**RESOLVED: The Audit Committee:**

**(1) Confirmed receipt of the Board and Executive Leadership Team Register of Interests as at 31 March 2024;**

**(2) Confirmed receipt of the Gifts, Hospitality, Sponsorship Register as at 31 March 2024.**

**23/24 REFLECTIONS & SUMMARY OF DECISIONS AND ACTIONS**

Members reflected on the meeting raising several points and noted that any key messages to the Board will be annotated in the AAA report.

**RESOLVED: The above was noted.**

**Meeting concluded at: 11:56**

**Date of Next Meeting: 7 June 2024**

# AUDIT COMMITTEE
# HIGHLIGHT REPORT TO BOARD

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

The papers for this meeting can be found by following this link to the Committee page on the Trust website.

| | |
|---|---|
| **Trust Board Meeting Date** | 30 May 2024 |
| **Committee Meeting Date** | 30 April 2024 |
| **Chair** | Peter Curran |

## KEY ESCALATION AND DISCUSSION POINTS

### ALERT

(Alert the Board to areas of attention)

1. The Committee reviewed interim **changes to the model Standing Orders** to reflect the Trust's change of name following approval of its university trust status, and the introduction of the Joint Commissioning Committee. The **Scheme of Reservation and Delegation (SoRD) was also revised** to provide more clarity on the approval of awards of contracts by the Board. This was following the escalation from the Committee's last meeting on the non-compliance with Standing Orders raised in the Vehicle Replacement Programme Internal Audit. The Committee also **approved Governance Practice Note No. 005** to provide further clarity to Directors on this issue. Changes to the Standing Orders and the SoRD are before the Board for approval at this meeting.

2. This meeting was primarily a **governance focused meeting** and therefore did not receive the usual standing items.

### ADVISE

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

3. A **pre-meet** was held with Audit Wales, Internal Audit and the Committee Chair ahead of the meeting.

4. Members **reflected** that the reports were succinct and recognised the collective effort of all members of the teams that supported the chairs in their review of the effectiveness of their committees. The hybrid nature of the meeting was not as effective for those in the room given the configuration of the IT, however an action was agreed to review instructions for their use in all meeting rooms. The meeting was well chaired.

**ASSURE**

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

5. The **2023/24 annual effectiveness review** was conducted for the Audit Committee. The National Audit Office tool was used for the survey questions and Members reviewed their effectiveness based on this, the work of the Committee during the year and discussions at today's meeting. Changes to the terms of reference will be proposed to the Board at its May meeting.

6. The Committee reviewed the 2023/24 annual reports for the Academic Partnerships Committee, Charity Committee, Finance and Performance Committee, People and Culture Committee, Quality Patient Experience and Safety Committee, Remuneration Committee, and Welsh Ambulance Partnership Team (WASPT). This is in line with the Committee's duty to advise and assure the Board on whether effective arrangements are in place to support them in their decision taking. Members were assured that effective arrangements are in place across all Committees and WASPT and represented the maturity of our corporate governance arrangements. A revised and streamlined approach to surveys for the 2024/25 reviews was agreed and all **annual reports and changes to terms of reference were endorsed for approval by the Board and the Committee**. The Board has before it at its 30 May meeting a separate paper with the results of these reviews.

7. The Board is required to confirm adherence with **corporate governance code for central government departments 2017** in the annual governance statement. The Committee reviewed the self-assessment against the code and were assured that the Trust complies with all elements.

8. Progress against the **2023/24 Internal Audit Plan** was received. There are five remaining audits for the 2023/24 audit plan which will be completed in time for the June meeting. The following **Internal Audits** reviews were completed during the quarter and presented to the Committee:

    - Seatbelt Action Plan – reasonable assurance. The purpose of this audit was to review the deployment of the seatbelt action plan, to ensure the safety of crews and patients on board Trust vehicles, and to assess compliance. The Quality, Patient Experience and Safety Committee will review this in more detail in May as will the People and Culture Committee given that this spans patient safety and health and safety.

    - ICT Contract Management – reasonable assurance. The purpose of this audit was to assess whether the Trust has appropriate contract management arrangements in place, ensuring achievement of value for money. The Finance and Performance Committee reviewed this audit at its March meeting.

9. The **2023 Audit Wales Annual Report for WAST** was received and is at Annex 1 for the Board's review. The report summarised the findings from the 2023 audit work which includes the audit of the 2022/23 accounts, 2023 structured assessment, national workforce review and the Trust's workforce planning arrangements. These reports have been reviewed by this Committee and the Board.

    The audit fee proposed for this work in 2023 was £188,424 and latest estimated by Audit Wales confirm the fee is in keeping with this. The **audit fee for the 2024/25** year was noted at £200,483. This is in line with the Fee Scheme as approved by the Senedd Finance Committee and represents a 6.4% increase.

The **2024 Audit Plan** was also received and is at Annex 2 for Board endorsement. Work includes the audit of the 2023/24 accounts, completing the national deep dive into financial efficiencies and a follow up of the Review of Quality Governance Arrangements which will begin in May 2024. A deep dive review will also start in Spring 2024 on investment in digital systems to support service resilience and transformation.

The **Review of Unscheduled Care** Part Two (accessing urgent and emergency care) has commenced and WAST will be formally engaged in this part of the overall review. The review encompasses Part One (flow out of hospital) which has been completed and is currently in clearance with the Regional Partnership Boards, and Part Three (national arrangements and leadership structures) which will begin over the coming months.

10. The Committee received the **register of members interests** as of 30 March 2024 and noted the next stage is for the interests of a cohort of decision makers in the Trust (in excess of 200 pax) to be centrally held and published during 2024. The **register of gifts, hospitality and sponsorship** was also received and is published on the Trust website.

11. The **Committee's cycle of business** was approved.

## RISK MANAGEMENT

This was a governance focused meeting therefore risk report was not cycled.

| COMMITTEE AGENDA FOR MEETING | | |
|---|---|---|
| Internal audit update and related audits | Audit Wales progress report, annual report and annual audit plan | Audit Committee effectiveness review and annual board and committee effectiveness reviews 2023/24 |
| Self-assessment against the Corporate Governance Code 2017 | Changes to Model Standing Orders and Scheme of Reservation and Delegation | Committee cycle of business 2024/25 |
| Register of members interests and register of gifts, hospitality and sponsorship | | |

| COMMITTEE ATTENDANCE | | | | | | |
|---|---|---|---|---|---|---|
| **Name** | **30 April 2024** | **7 June 2024** | **10 July 2024** | **12 Sep 2024** | **21 Nov 2024** | **6 Mar 2024** |
| Peter Curran | | | | | | |
| Kevin Davies | | | | | | |
| Joga Singh | | | | | | |
| Ceri Jackson | | | | | | |
| Chris Turley | | | | | | |
| Angie Lewis | | | | | | |
| Liam Williams | | | | | | |
| Judith Bryce | | | | | | |
| Trish Mills | | | | | | |
| Julie Boalch | | | | | | |
| Osian Lloyd | | | | | | |

| COMMITTEE ATTENDANCE | | | | | | |
|---|---|---|---|---|---|---|
| **Name** | **30 April 2024** | **7 June 2024** | **10 July 2024** | **12 Sep 2024** | **21 Nov 2024** | **6 Mar 2024** |
| Carl Window | | | | | | |
| Audit Wales | Fflur Jones[1] | | | | | |
| Damon Turner | | | | | | |
| Christian Fox | | | | | | |

| | |
|---|---|
| | Attended |
| | Deputy attended |
| | Apologies received |
| | No longer member |

[1] Darren Griffiths and Amy Lord also attended

# Head of Internal Audit Opinion & Annual Report 2023/2024

May 2024

Welsh Ambulance Services University NHS Trust

Private and confidential

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

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

**Contents**



| | |
|---|---|
| **Report status:** | Draft |
| **Draft report issued:** | 17 May 2024 |
| **Final report issued:** | XXX 2024 |
| **Author:** | Osian Lloyd, Head of Internal Audit |
| **Executive Clearance:** | Trish Mills, Board Secretary |
| **Audit Committee:** | 7th June 2024 |

# 1. EXECUTIVE SUMMARY

## 1.1 Purpose of this Report

Welsh Ambulance Services University NHS Trust's (Trust) Board is accountable for maintaining a sound system of internal control that supports the achievement of the organisation's objectives and is also responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system. A key element in that flow of assurance is the overall assurance opinion from the Head of Internal Audit.

This report sets out the Head of Internal Audit Opinion together with the summarised results of the internal audit work performed during the year. The report also includes a summary of audit performance and an assessment of conformance with the Public Sector Internal Audit Standards.

## 1.2 Head of Internal Audit Opinion 2023-24

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 2023/24 is that:

| | | |
|---|---|---|
| **Reasonable assurance** |  | The Board can take **Reasonable Assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved. |

## 1.3 Delivery of the Audit Plan

Our internal audit plan has needed to be agile and responsive to ensure that the Trust's key developing risks are covered. As a result of this approach, and with the support of officers and non-executive directors across the Trust, the plan has been delivered substantially in accordance with the agreed schedule and changes required during the year, as approved by the Audit Committee (the 'Committee'). In addition, regular audit progress reports have been submitted to the Committee. Although changes have been made to the plan during the year, we can confirm that we have undertaken sufficient audit work during the year to be able to give

an overall opinion in line with the requirements of the Public Sector Internal Audit Standards.

The Internal Audit Plan for the 2023/24 year was initially presented to the Committee in March 2023. Changes to the plan have been made during the course of the year and these changes have been reported to the Audit Committee as part of our regular progress reporting.

There are, as in previous years, audits undertaken at NWSSP, DHCW and EASC that support the overall opinion for NHS Wales health bodies (see section 3).

Our latest External Quality Assessment (EQA), conducted by the Chartered Institute of Public Finance and Accountancy (CIPFA) (in 2023), and our own annual Quality Assurance and Improvement Programme (QAIP) have both confirmed that our internal audit work 'fully conforms' to the requirements of the Public Sector Internal Audit Standards (PSIAS) for 2023/24. We are able to state that our service 'fully conforms to the IIA's professional standards and to PSIAS.'

## 1.4 Summary of Audit Assignments

This report summarises the outcomes from our work undertaken in the year. In some cases, audit work from previous years may also be included and where this is the case, details are given. This report also references assurances received through the internal audit of control systems operated by other NHS Wales organisations (again, see section 3).

The audit coverage in the plan agreed with management has been deliberately focused on key strategic and operational risk areas; the outcome of these audit reviews may therefore highlight control weaknesses that impact on the overall assurance opinion.

Overall, we can provide the following assurances to the Board that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively in the areas in the table below.

Where we have given Limited Assurance, management are aware of the specific issues identified and have agreed action plans to improve control in these areas. These planned control improvements should be referenced in the Annual Governance Statement where it is appropriate to do so.

In addition, we also undertook an advisory and non-opinion review 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 2023/24

| Substantial Assurance | Reasonable Assurance |
|---|---|
| • N/A | • Risk management and assurance (draft)<br>• Strategy development<br>• Serious Adverse Incidents Joint Investigation Framework<br>• Electronic Patient Clinical Record: Clinical compliance<br>• Senior Paramedic role<br>• Clinical audit<br>• Volunteers governance (draft)<br>• Seatbelt action plan<br>• Records management<br>• Technical resilience<br>• ICT contract management<br>• Retention of staff<br>• Disciplinary case management – Compassionate leadership (draft)<br>• Follow up review<br>• Vehicle replacement programme |
| **Limited Assurance** | **Advisory/Non-Opinion** |
| • Decarbonisation<br>• Estate condition | • 111 Service Commissioning Arrangements |
| **Unsatisfactory 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 Quality 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 University 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 Quality 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 2023/24 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** |  Yellow | 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 2023/24).

### 2.4.2 Basis for Forming the Opinion

The audit work undertaken during 2023/24, 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 Quality Standards including, if appropriate, the evidence available by which the Board has arrived at its declaration in respect of the self-assessment for the Leadership Standard.
- Other assurance reviews which impact on the Head of Internal Audit opinion including audit work performed at other organisations (see Section 3).
- Other knowledge and information that the Head of Internal Audit has obtained during the year including cumulative information and knowledge over time; observation of Board and other key committee meetings; meetings with Executive Directors, senior managers and Non-Executive Directors; the results of *ad hoc* work and support provided; liaison with other assurance providers and inspectors; research; and cumulative audit knowledge of the organisation that the Head of Internal Audit considers relevant to the Opinion for this year.

As stated above, these detailed results have been aggregated to build a picture of assurance across the Trust.

In reaching this opinion we have identified that the majority of reviews during the year concluded positively with robust control arrangements operating in some areas.

From the opinions issued during the year, 15 were allocated Reasonable Assurance and two were allocated Limited Assurance. No reports were allocated a 'substantial assurance' or a 'no assurance' opinion. In addition, one advisory or non-opinion report was issued.

At the time of producing the draft Annual Report, three reviews are at draft report stage. It is anticipated that the majority of the work will be sufficiently progressed so that the rating can be established before production of the final Annual Report.

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**

Both reviews in this area received **reasonable** assurance.

The audit of **Risk management and assurance (draft)** reflected positively on the effectiveness of the risk management and assurance arrangements in place within directorates.

Our **Follow up review** recognised the systems in place to monitor progress with the implementation of actions in response to internal audit reports (see section 2.4.3).

A review of the draft **Annual Governance Statement** highlighted that it was generally consistent with our knowledge of the Trust through the audit work performed in the Internal Audit plan and a review of other organisational documents. *– Still to be confirmed by review of the draft AGS submitted to the June AC.*

**Strategic Planning, Performance Management & Reporting**

We have undertaken three reviews in this area.

Our review of **Decarbonisation** received **limited** assurance. We recognise the significant work the Trust has been undertaking to address the requirements of the Decarbonisation Strategic Delivery Plan. However, the overall rating is in line with that determined across much of NHS Wales and reflects the complexity and range of risks associated with this area which, along with the financial shortfalls, impacts on the Trust's ability to deliver on the wider decarbonisation agenda.

Our **advisory** review of the **NHS Wales 111 Service commissioning arrangements** noted that they are still evolving, and the improvements identified will assist in strengthening the current framework for delivery but will also provide focus when inputting into the design of arrangements effective from April 2024 under the NHS Wales Joint Commissioning Committee.

A **reasonable** assurance rating was provided for **Strategy development,** which is a positive reflection on the arrangements in place. Medium priority recommendations were raised in relation to the Engagement Framework Delivery Plan, and opportunities to improve how the Trust measures and reports progress.

The **Delivery of major change programmes** audit was deferred following completion of the project and consideration by the Trust to deescalate the related principal risk from the Corporate Risk Register. Our 2020/21 review of Transformation Programmes: Change Management was awarded reasonable assurance.

Our review of the **Integrated Quality and Performance Management Framework** was deferred to 2024/25 at the request of management to allow time for processes to embed.

**Financial Governance and Management**

We have not undertaken reviews in this area.

This recognises the positive outcomes from audits undertaken in recent years, including Financial Planning and Budgetary Control and Savings and Efficiencies both receiving reasonable assurance. The Trust has continued its good financial track record and is currently on course to meet its objectives and duties for 2023-24. Our approach also aligns with the deep dive review Audit Wales are undertaking into financial efficiencies, given the financial challenges facing the NHS at present.

Aspects of financial governance and management have featured as part of delivery of the internal audit plan, including the Volunteers governance and ICT contract management audits.

The audits of the payment systems provided by NWSSP, which we undertake each year to provide assurance to the Health Board all concluded with positive assurance. The audit of payroll services was awarded Substantial assurance, with the reviews of primary care services (GMS) and accounts payable both receiving Reasonable Assurance. Procurement [WiP]

**Quality & Safety**

All three reviews undertaken in this area received **reasonable** assurance.

The outcome of the **Serious Adverse Incidents Joint Investigation Framework** report recognises the Trust's compliance with the framework for serious patient safety incidents, noting that as the Trust will lead on very few investigations. The matters requiring management attention include areas of non-compliance with the NHS Wales National Policy, noting a review of the internal policy should be undertaken.

Whilst we have issued reasonable assurance on **electronic Patient Clinical Record (ePCR) clinical compliance,** the assessment is based on where we would reasonably expect the Trust to be one year post implementation, recognising that a new system needs time to embed and mature. Work is ongoing to upgrade the software to facilitate better data quality and reporting to improve clinical indicator performance and care bundle compliance.

The review of **Clinical audit** reflects positively on the process and how it is used by Committees of the Trust to support assurance. Two medium priority recommendations were raised in relation to strengthening the reference to clinical audit within the Trust's Clinical Strategy, and the alignment between the clinical audit plan and the Trust's risks registers and priorities.

**Information Governance & Security**

All three reviews undertaken in this area received **reasonable** assurance.

Our review **Records management** recognised that the majority of records in use, particularly patient records, are in digital form. However, three high priority recommendations were raised in relation to reviewing the resource available to the Records Management Team, the main storage of physical records is with an external provider for which no formal agreement exists, and the need to ensure all records are disposed of according to schedules.

The review of **Technical resilience** found that ICT Services are provided from a resilient architecture, and improvements continue to be made. However, four medium priority findings were raised to strengthen the position.

The **ICT Contract Management** noted the progress made to strengthen arrangements following the recent appointment of the Contract Manager. Three medium priority findings were raised around ensuring the register includes all ICT related contracts and suppliers, and to evidence the processes to monitor contract performance and to review and assess effectiveness prior to the end of term before re-tender.

**Operational Service and Functional Management**

**Reasonable** assurance was provided for the three reviews undertaken in this area.

Our review of the **Senior Paramedic Role** review gave a positive assessment on the roll out of the role. Four medium priority matters were raised including to ensure the achievement of all areas of responsibility, to address the disparity in the allocation of staff to supervise and support, to review training provision and compliance, and limited reporting evaluating the impact and effectiveness of the role.

The audit of the **Volunteers Governance (draft)** considered the adequacy and effectiveness of the Trust's governance and operational management of volunteer activities. The review covered a broad range of areas including recruitment, retention, supervision and support, and fundraising and financial guidance. We raised nine medium priority matters to strengthen the processes in place.

The **Seatbelt action plan** review recognises the proactive approach undertaken by the Trust to respond to the incident. Findings raised related to strengthening quality assurance arrangements and reporting of their outcomes, and the absence of monitoring of the recommendations arising from subsequent the Health & Safety investigation and assurance reporting to Board.

**Workforce Management**

Both reviews in this area received **reasonable** assurance.

Our review of **Staff retention** noted that the Trust had identified that there were shortfalls in the retention process and are introducing new initiatives across the organisation, including the moving on interview process, to strengthen arrangements.

The outcome of the **Disciplinary case management (draft)** report reflects positively on the arrangements in place to comply with process requirements. Progress has been made against the compassionate practices action plan, but there are delays in the completion of some actions and timescales require revision. One high priority finding was raised in relation to case management documentation.

**Capital & Estates Management**

We have undertaken two reviews in this area.

The **Estates Condition** report derived **limited** assurance. While there was much evidence of good practice, the absence of a funded plan to eradicate high and significant risk backlog items resulted in a limitation to the assurance which could be provided at the time of the review. This assurance opinion is in line with that determined across much of NHS Wales, given the common challenges faced by each organisation.

**Reasonable** assurance was determined following our review of the **Vehicle replacement programme**. The opinion reflecting a mature process with a good understanding of the key factors determining vehicle refresh frequency (e.g. expiry of warranties). Recommendations were therefore made in the context of the robustness of the overall approach. These included one issue relating to compliance with Standing Orders (Standing Orders were subsequently amended) and several additional recommendations aimed at enhancing the management of the replacement programme.

## 2.4.3 Approach to Follow Up of Recommendations

As part of our audit work, we consider the progress made in implementing the actions agreed from our previous reports for which we were able to give only Limited Assurance. In addition, where appropriate, we also consider progress made on high priority findings in reports where we were still able to give Reasonable Assurance. We also undertake some testing on the accuracy and effectiveness of the audit recommendation tracker.

In addition, Audit Committees monitor the progress in implementing recommendations (this is wider than just Internal Audit recommendations) through their own recommendation tracker processes. We attend all audit committee meetings and observe the quality and rigour around these processes.

It is the role of Audit Committees to consider and agree the adequacy of management responses and the dates for implementation, and any subsequent request for revised dates, proposed by Management.

We have considered the impact of both our follow-up work and where there have been delays to the implementation of recommendations, on both our ability to give an overall opinion (in compliance with the PSIAS) and the level of overall assurance that we can give.

The Trust's recommendation tracking process continued during 2023/24. The Corporate Governance team has continued to review all outstanding recommendations with management and the outcomes have been reported to the Audit Committee. The Trust also continues to refer relevant extracts of the audit tracker to each Board Committee to support oversight and scrutiny of recommendations relating to their remit. The Trust is also developing a more automated tracker system, with support from Digital Health Care Wales.

We have undertaken work towards the end of the year to validate the stated position for a sample of recommendations within the tracker. We were able to confirm the recorded position for the majority of the sampled recommendations and therefore provide the Audit Committee with additional assurance around the accuracy of the tracker.

### 2.4.4 Limitations to the Audit Opinion

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems.

As mentioned above the scope of the audit opinion is restricted to those areas which were the subject of audit review through the performance of the risk-based Internal Audit plan. In accordance with auditing standards, and with the agreement of senior management and the Board, Internal Audit work is deliberately prioritised according to risk and materiality. Accordingly, the Internal Audit work and reported outcomes will bias towards known weaknesses as a driver to improve governance risk management and control. This context is important in understanding the overall opinion and balancing that across the various assurances which feature in the Annual Governance Statement.

Caution should be exercised when making comparisons with prior years. Audit coverage will vary from year to year based upon risk assessment and cyclical coverage on key control systems.

### 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 2023/24 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 2023/24.

## 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. In addition, at least once every five years, we are required to have an External Quality Assessment. This was undertaken by the Chartered Institute of Public Finance and Accountancy (CIPFA) in February and March 2023. CIPFA concluded that NWSSP's Audit & Assurance Services conforms with all 64 fundamental principles. It is therefore appropriate for NWSSP Audit & Assurance Services to say in reports and other literature that it conforms to the IIA's professional standards and to PSIAS.

The NWSSP Audit and Assurance Services can assure the Audit Committee that it has conducted its audit at Trust in conformance with the Public Sector Internal Audit Standards for 2023/24.

Our conformance statement for 2023/24 is based upon:

- the results of our internal Quality Assurance and Improvement Programme (QAIP) for 2023/24 which will be reported formally in the Summer of 2024; and
- the results of the EQA undertaken by CIPFA in 2023.

We have set out, in **Appendix A**, the key requirements of the Public Sector Internal Audit Standards and our assessment of conformance against these requirements. The full results and actions from our QAIP will be included in the 2023/24 QAIP report. There are no significant matters arising that need to be reported in this document.

We also note that there have been no impairments to the independence of the Head of Internal Audit or to any member of NWSSP's Audit & Assurance Service who undertook work on the Trust's audit programme for 2023/24.

### 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 Quality Standards;
- results of internal compliance functions including Local Counter-Fraud, Post Payment Verification, and risk management;
- reported compliance via the Welsh Risk Pool regarding claims standards and other specialty specific standards reviewed during the period; and
- reviews completed by external regulation and inspection bodies including Audit Wales and Healthcare Inspectorate Wales.

## 3. OTHER WORK RELEVANT TO THE TRUST

As our internal audit work covers all NHS Wales organisations there are a number of audits that we undertake each year which, while undertaken formally as part of a particular health organisation's audit programme, will cover activities relating to other Health bodies. These are set about

below, with relevant comments and opinions attached, and relate to work at:

- NHS Wales Shared Services Partnership;
- Digital Health & Care Wales; and
- Emergency Ambulance Services Committee.

## NHS Wales Shared Services Partnership (NWSSP)

As part of the internal audit programme at NHS Wales Shared Services Partnership (NWSSP), a hosted body of Velindre University NHS Trust, a number of audits were undertaken which are relevant to the Trust. These audits of the financial systems operated by NWSSP, processing transactions on behalf of the Trust, derived the following opinion ratings:

| Audit | Opinion | Outline Scope |
|---|---|---|
| Accounts Payable | Reasonable | To evaluate and determine the adequacy of the systems and controls in place over the management of the NWSSP Accounts Payable service. |
| Payroll | Substantial | To evaluate the design and operation of the systems and controls in place within Payroll Services. |
| Procurement | (WIP) | Review the adequacy of the systems and controls in place for procurement of contracts above OJEU thresholds. |

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 |
|---|---|---|
| Benefits Realisation | Reasonable | To determine if the principles of an appropriate benefits realisation framework have been implemented to support decision making. |
| Programme Management | Reasonable | To provide an opinion of the project management being operated over the Digital Services for Patients and Public (DSPP) programme. |
| Business Continuity (Ransomware) | Reasonable | To assess the adequacy and effectiveness of business continuity arrangements, including in the event of a cyber-attack (including ransomware). |
| Legacy Software Modernisation | Reasonable | To review the management of risks associated with older technology. |

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 University Health Board internal audit plan. These audits are listed below and derived the following opinion ratings:

| Audit | Opinion | Outline Scope |
|---|---|---|
| EASC – Adult critical care transfer service | Substantial | Our review focused on the governance arrangements, financial monitoring, meeting outcomes and performance monitoring, and the process to meeting longer term needs. |

While these audits do not form part of the annual plan for the Trust, they are listed here for completeness as they do impact on the organisation's activities. The Head of Internal Audit has considered if any issues raised in the audits could impact on the content of our annual report and concluded that there are no matters of this nature.

Full details of the NWSSP audits are included in the NWSSP Head of Internal Audit Opinion and Annual Report and are summarised in the Velindre NHS Trust Head of Internal Audit Opinion and Annual Report. DHCW audits are summarised in the DHCW Head of Internal Audit Opinion and Annual Report, and the EASC audits are summarised in the Cwm Taf Morgannwg University Health Board Head of Internal Audit Opinion and Annual Report.

# 4. DELIVERY OF THE INTERNAL AUDIT PLAN

## 4.1 Performance against the Audit Plan

The Internal Audit Plan has been delivered substantially in accordance with the schedule agreed with the Audit Committee, subject to changes agreed as the year progressed. Regular audit progress reports have been submitted to the Audit Committee during the year. Audits that remain to be reported but are reflected within this Annual Report will be reported alongside audits from the 2024/25 operational audit plan.

The audit plan approved by the Committee in March 2023 contained 20 planned reviews. Changes have been made to the plan with two audits deferred/cancelled. All these changes have been reported to and approved by the Audit Committee. As a result of these agreed changes, we have delivered 18 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 2023/24 | G | March 2023 | By 30 June | Not agreed | Draft plan | Final plan |
| Total assignments reported against adjusted plan for 2023/24 | G | 100% (18/18) | 100% | v>20% | 10%<v<20% | v<10% |
| Report turnaround: time from fieldwork completion to draft reporting [10 working days] | G | 78% (14/18) | 80% | v>20% | 10%<v<20% | v<10% |
| Report turnaround: time taken for management response to draft report [15 working days] * | G | 73% (11/15) | 80% | v>20% | 10%<v<20% | v<10% |
| Report turnaround: time from management response to issue of final report [10 working days] | G | 93% (14/15) | 80% | v>20% | 10%<v<20% | v<10% |

* We have agreed a particular focus with the Trust on providing clarity on timelines for 2024/25, with a view to improving the 15 working day turnaround.

## 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 18 audit reviews were reported during the year. Figure 2 below presents the assurance ratings and the number of audits derived for each.

**Figure 2 Summary of audit ratings**

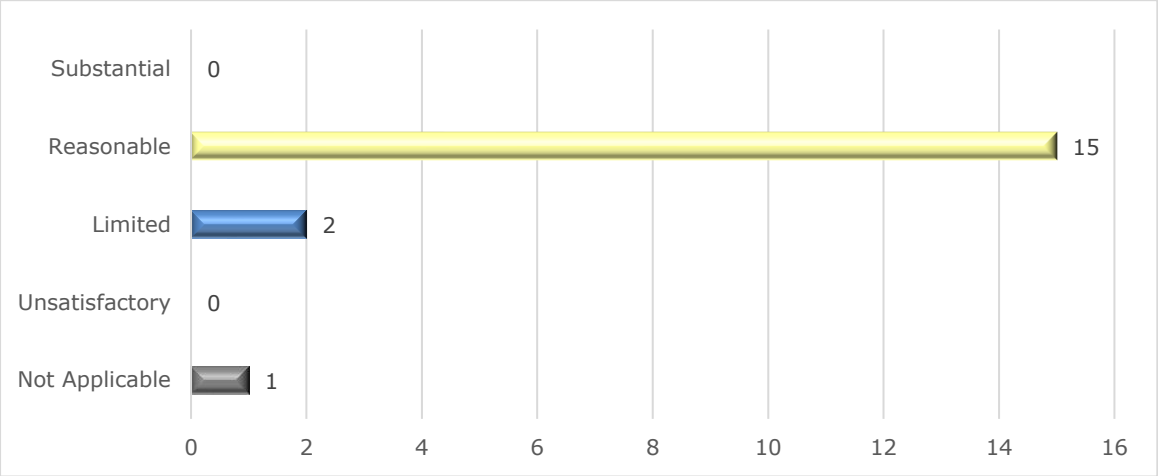


Figure 2 above does not include the audit ratings for the reviews undertaken at NWSSP, DHCW or EASC.

The assurance ratings and definitions used for reporting audit assignments are included in **Appendix B**.

In addition to the above, there were two audits which did not proceed following preliminary planning and agreement with management. These audits are documented in section 5.7.

The following sections provide a summary of the scope and objective for each assignment undertaken within the year along with the assurance rating.

## 5.2 Substantial Assurance (Green)

No reviews were assigned a 'substantial assurance' opinion.

## 5.3 Reasonable Assurance (Yellow)

In the following review areas, the Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. Some matters require management attention in either control design or operational compliance and these will have low to moderate impact on residual risk exposure until resolved.

| Review Title | Objective |
|---|---|
| Risk management and assurance (draft) | The audit sought to assess the effectiveness of the risk management and assurance arrangements in place within the Directorates. |
| Strategy development | The purpose of this audit was to assess the arrangements in place to support the development of the Trust's strategic ambitions. |
| Serious Adverse Incidents Joint Investigation Framework | The audit was undertaken to provide assurance of the Trust's compliance with the joint investigation framework for serious patient safety incidents. |
| Electronic Patient Clinical Record: Clinical compliance | The audit reviewed the operational deployment of the electronic Patient Clinical Record being developed and assess compliance. |
| Senior Paramedic role | The overall objective of this audit was to assess the extent Senior Paramedics are achieving their key role objectives. To include a comparison across Wales. |
| Clinical audit | The purpose of this audit was to review the process for clinical audit including how it is used by Committees of the Trust to support assurance. |
| Volunteers governance (draft) | The audit provided assurance on the adequacy and effectiveness of the Trust's governance and operational management of volunteer activities. |
| Seatbelt action plan | The objective of this audit was to review the deployment of the seatbelt action plan, to ensure the safety of crews and patients on board Trust vehicles, and to assess compliance. |
| Records management | The purpose of this audit was to evaluate the arrangements and processes in place to enable the effective management of records. |
| Technical resilience | The audit was undertaken to provide assurance on the Trust's digital operations to assess whether they have appropriate resilience to minimise the risk of disruption. |

| Review Title | Objective |
|---|---|
| ICT contract management | This audit reviewed the appropriateness of contract management arrangements, to ensure the achievement of value for money. |
| Retention of staff | This review sought to evaluate and determine the adequacy of the systems and controls in place within the Trust in relation to staff retention. |
| Disciplinary case management – Compassionate leadership (draft) | The objective of this audit was to assess the adequacy of the arrangements in place for the management of the disciplinary process. Including focus on the demonstration of compassionate leadership principles, in addition to compliance with the Trust's defined disciplinary processes. |
| Follow up review | The purpose of this audit was to provide assurance on the status of implemented recommendations on the audit tracker and review the systems and arrangements the Trust has in place to monitor progress with the implementation of actions. |
| Vehicle replacement programme | The audit was undertaken to evaluate the processes and procedures put in place by the Trust to support the management and control of the ongoing procurement of replacement vehicles. |

## 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 |
|---|---|
| Decarbonisation | The objective of this audit was to consider progress against the NHS Wales |

| Review Title | Objective |
|---|---|
| | Decarbonisation Strategic Delivery Plan and the Trust's Decarbonisation Action Plan. |
| Estate condition | The audit sought to evaluate the arrangements put in place by the Trust to identify and manage key risks associated with the existing estate and the implementation of resulting strategies to manage/mitigate the risk. |

## 5.5 Unsatisfactory Assurance (Red)

No reviews were assigned a 'unsatisfactory 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 |
|---|---|
| 111 Service Commissioning Arrangements | The objective of this review was to assess the effectiveness of the new commissioning arrangements and structures for the NHS 111 Wales service, to ensure there is a sustainable and improved patient quality experience provision with appropriate resourcing and finance mechanisms. |

## 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 |
|---|---|
| Delivery of major change programmes | Deferred following completion of the project and consideration by the Trust to deescalate the related principal risk from the Corporate Risk Register. |
| Integrated Quality and Performance Management Framework | Deferred at the request of management to 2024/25 to allow time for processes to embed. |

## 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 2023/24 plan.

Osian Lloyd
Pennaeth Archwilio Mewnol / Head of Internal Audit
Gwasanaethau Archwilio a Sicrwydd/ Audit and Assurance Services
Partneriaeth Cydwasanaethau GIG Cymru/ NHS Wales Shared Services Partnership

May 2024

# Appendix A – Conformance with Internal Audit Standards

| | |
|---|---|
| **ATTRIBUTE STANDARDS** | |
| **1000 Purpose, authority and responsibility** | Internal Audit arrangements are derived ultimately from the NHS organisation's Standing orders and Financial Instructions. These arrangements are embodied in the Internal Audit Charter adopted by the Audit Committee on an annual basis. |
| **1100 Independence and objectivity** | Appropriate structures and reporting arrangements are in place. Internal Audit does not have any management responsibilities. Internal audit staff are required to declare any conflicts of interests. The Head of Internal Audit has direct access to the Chief Executive and Audit Committee chair. There have been no impairments to our independence during 2023/24. |
| **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. An EQA was undertaken in 2023. |
| **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.<br>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.<br>**Low impact** on residual risk exposure. |
|  | **Reasonable assurance** | Some matters require management attention in control design or compliance.<br>**Low to moderate impact** on residual risk exposure until resolved. |
|  | **Limited assurance** | More significant matters require management attention.<br>**Moderate impact** on residual risk exposure until resolved. |
|  | **Unsatisfactory assurance** | Action is required to address the whole control framework in this area.<br>**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.<br>These reviews are still relevant to the evidence base upon which the overall opinion is formed. |

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

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# Follow Up Review
# Final Internal Audit Report

May 2024

## Welsh Ambulance Services University NHS Trust

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

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

# Contents



| | |
|---|---|
| Review reference: | WAST-2324-20 |
| Report status: | Final |
| Fieldwork commencement: | 5 March 2024 |
| Fieldwork completion: | 11 April 2024 |
| Debrief meeting: | 30 April 2024 |
| Draft report issued: | 26 April 2024 |
| Management response received: | 17 May 2024 and 20 May 2024 |
| Final report issued: | 31 May 2024 |
| Auditors: | Osian Lloyd, Head of Internal Audit; Felicity Quance, Deputy Head of Internal Audit; Johanna Butt, Principal Auditor |
| Executive sign-off: | Trish Mills, Board Secretary |
| Distribution: | Alex Payne, Corporate Governance Manager; Duncan Robertson, Assistant Director of Clinical Development; Louise Colson, Head of Infection Prevention and Control; Aled Williams, Assistant Director of Digital – ICT; Judith Bryce, Assistant Director of Operations, National Operations & Support; Carl Window, Local Counter Fraud Manager. |
| Committee: | Audit Committee |

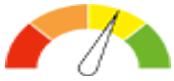
Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

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

# Executive Summary

## Follow-up Report Classification [1]

Reasonable



**Follow up:** All high priority recommendations implemented and progress on the medium and low priority recommendations

[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.

## Recommendation Summary

| | High | Medium | Low | Total |
|---|---|---|---|---|
| Closed | 7 | 2 | - | **9** |
| Partially closed | 1 | - | - | **1** |
| Outstanding | - | - | - | **-** |
| | **8** | **2** | **-** | **10** |

**Purpose / Background**

To provide assurance on the status of implemented recommendations on the audit tracker and review the systems and arrangements the Trust has in place to monitor progress with the implementation of actions.

**Overview of findings**

We have issued reasonable assurance on this area.

The Trust has effective arrangements in place to track progress in relation to audit findings; and there is scrutiny by the Corporate Governance team and the Assistant Director Leadership Team (ADLT) prior to the closure of actions on the tracker.

Our testing confirmed that nine of the ten recommendations tested at this review were appropriately classified as complete on the tracker.

However, we note that one of the recommendations was closed on the tracker when the management actions had not been fully implemented. We acknowledge from our review of audit evidence that these were close to completion at the time of reporting.

The tracker has been further developed to include reasons why recommendations are overdue, whether progress has been achieved and if there is a new proposed completion date. The Trust is also developing a more automated tracker system, with support from Digital Health Care Wales.

We advise that the Trust considers the inclusion of recommendations from other assurance providers, e.g., Counter Fraud, on the new digital solution. This repeats a recommendation we raised in the prior year, which was not accepted by the Trust due to capacity within the Corporate Governance Team.

## Key Matters Arising

| | | Control Design or Operation | Recommendation Priority |
|---|---|---|---|
| 1 | Inclusion of recommendations from other assurance providers on the tracker | Design | Medium |

# 1. Introduction

1.1 We undertook a follow-up review of the three limited assurance internal audit reports issued during 2022/23, to provide assurance that the Welsh Ambulance Services University NHS Trust (the Trust) has implemented the related recommendations appropriately and in a timely manner. We also considered high priority recommendations from reasonable assurance reports, and reviewed the systems and arrangements the Trust has in place to monitor progress with the implementation of actions.

1.2 The potential risks considered for this review were:

- failure to implement agreed audit recommendations in a timely manner;
- increased financial, clinical, statutory, and reputational risk for the Trust; and
- inaccurate reporting of the Tracker within the Trust.

1.3 The scope of this follow-up review does not provide assurance against the full scope and objectives of the original audits or that the matters arising to which they relate have been fully closed. The follow-up review opinion provides assurance against the level of implementation of the recommendations reviewed only.

# 2. Detailed Audit Findings

2.1 This section of the report captures a summary of our previous findings from our testing sample, along with progress made to implement the associated recommendations. All matters arising and the related recommendations and management actions are detailed in **Appendix A**.

2.2 Our review incorporates a sample of recommendations (high and medium priority that have been recorded as closed on the Trust's Audit Recommendations Tracker (the tracker)) raised in the following Limited Assurance reports:

- Pain Management – to review the application of pain relief methods and their effect on patient outcomes in terms of pain relief and patient satisfaction; and
- Standards of Business Conduct: Declarations - to review compliance with the Standards of Business Conduct, including arrangements in place to manage declarations of interest, gifts and hospitality.

2.3 It was noted that all recommendations relating to the third limited assurance report: Trade Union Release Time (which sought to provide assurance on the deployment of the refreshed Trade Union facilities agreement and included a review of progress made to implement recommendations raised in the 2018/19 report) remained open, therefore testing was not undertaken. The four recommendations raised at this report are detailed as nine management actions on the tracker (see table 1 at para 2.5). Two are reported as closed. For the

remaining seven, as at the date of fieldwork, six were overdue and one not yet due.

2.4 We also included a sample of high priority recommendations that have been recorded as closed on the tracker from reasonable assurance reports issued during 2022/23, being:

- Infection Prevention and Control - to assess adherence to organisational policies and the Standards for Health Services in Wales and consider progress to implement recommendations raised in the 2019/20 'limited' assurance Cleaning Standards report;
- Data Analysis - to establish and assess data analysis within the Trust and the foundations for it becoming a data-led organisation;
- Major Incidents - to assess the Trust's approach to prepare for major incidents, including counter terrorism incidents, and how it ensures it learns from such events; and
- Hazardous Area Response Team - to review how the Trust ensures the team is appropriately trained and equipped to respond to high-risk and complex emergency situations.

2.5 As per paras 2.2 - 2.4, we selected a sample of closed recommendations from the tracker. These are detailed in table 1 below:

**Table 1**

| As per original Internal Audit Report | | | | As per Tracker Note 1 | |
|---|---|---|---|---|---|
| **Report title** | **Assurance Rating** | **Matters arising raised** | **Number of recommendations** | **Number of management actions in tracker** | **Total Reported Closed** |
| Standards of Business Conduct | Limited | 7 | 10 | 10 | 8 |
| Pain Management | Limited | 3 | 4 | 6 | 4 |
| Trade Union Release Time | Limited | 4 | 4 | 9 | 2 |
| Infection Prevention and Control | Reasonable | 7 | 12 | 16 | 11 |
| Data Analysis | Reasonable | 6 | 12 | 13 | 5 |
| Major Incidents | Reasonable | 5 | 9 | 8 Note 2 | 8 |
| Hazardous Area Response Team | Reasonable | 10 | 12 | 12 | 8 |

**Note 1** For some recommendations raised, we note that there is more than one management action associated with their implementation and these are split out on the tracker. This accounts for the difference in the recommendations in this table.

**Note 2** For Major Incidents, we note that two recommendations (1.1 and 1.2) have been merged into one, though this is not clear from the tracker.

## Corporate approach to tracking recommendations

2.6 As previously reported, the Trust has effective arrangements to monitor progress in relation to the implementation of recommendations. 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, including those from Healthcare Inspectorate Wales (HIW).

2.7 The Team have produced the 'Audit Process and Reporting Handbook', which was issued in October 2023. Section 4 of the handbook refers to '*The Audit Tracker'* and details the cycle of review and responsibilities for associated actions.

2.8 The handbook details that Directorates are asked to monitor / review and update the tracker on a monthly basis, so that there is continuous review and monitoring of progress against the actions. The tracker is received by the Assistant Directors Leadership Team (ADLT) - either at a formal meeting or by email circulation. This is to facilitate a 'check and challenge' following Directorate updates, and to escalate where they have not been provided.

2.9 As stated in the handbook, the Board Secretary will also undertake a formal quarterly review of the tracker and will examine the evidence provided to support closure of an action, before reporting updates on a quarterly basis to Committees.

2.10 Audit Wales' Structured Assessment 2023 (issued November 2023) reported that the Trust was strengthening its systems for tracking responses to audit recommendations. It stated that "*the Trust is seeking to improve how it monitors implementation of internal and external audit recommendations. The Trust is working with Digital Health Care Wales to develop an automated tracker system for March 2024. This should reduce the manual work required to keep the tracker up to date. In the meantime, the Trust has developed an interim tracker which provides clear information on actions which it closed during the previous quarter and revised dates for actions, where required. The Trust has also developed an audit guide to explain the role of audit, the mechanism for developing management responses to audit recommendations, and responsibilities for maintaining the audit tracker. These actions have also increased understanding of the purpose of audit work as well as the oversight role of each committee for their respective trackers. Focused work has enabled the Trust to close and substantially reduce the number of outstanding recommendations on its audit tracker*."

2.11 In our 2022/23 follow up report we recommended that enhancements to the tracker should be considered to include reasons why recommendations are overdue, whether progress has been achieved and if there is a new proposed completion date. Review of the current tracker confirms that it has been enhanced to address this. It is intended that new tracker solution will be ready to implement / use early in the 2024/25 financial year. However, the Trust recognises further work is required to consider the transition from the current to new tracker – which is a significant task.

2.12 Furthermore, as reported to the September and November 2023 Audit Committee, the Trust is looking to enhance the reporting of the tracker to improve oversight and scrutiny, particularly where actions have gone past their due dates; with focus on those that are rated as high priority and relate to limited assurance reports.

2.13 We also recommended that the Trust should consider the inclusion of recommendations from other assurance providers within the tracker e.g., Counter Fraud. This recommendation was not accepted by the Trust due to capacity. However, we would advise that any new digital solution / automated tracker should include these. **See Matter Arising 1**.

### Standards of business conduct: Declarations

2.14 Eight out of ten recommendations were marked as complete on the tracker, this included four high priority and four medium priority recommendations. We selected three closed recommendations from this report. For the two recommendations that remained open, these had not met their original due date, but a revised date was agreed, which was not yet due.

#### Recommendation 2.1: Staff awareness of declaration of interest (DOI) requirements (Design) - Medium priority

2.15 Our previous audit reported that a review of other NHS Wales organisations identified that information / requirements regarding gifts, hospitality and declarations of interest are communicated through the induction process or staff handbooks. Within the Trust, aside from new Board members, there was no guidance for new employees within the Trust.

2.16 It was recommended that policies and procedures, including the requirements of the Gifts and Hospitality policy, should be appropriately communicated to all new employees upon appointment, to ensure they are familiar with the requirements.

2.17 Through discussion and review, we have confirmed that, on induction, each operational staff cohort is set up with a new 'OneNote' portfolio, which is the Trust's version of the staff handbook. This contains a useful links section, including one to the Siren SharePoint homepage which is where the policies are saved. On induction, all inductees are informed of how to access all relevant WAST policies and procedures, which includes the Standards of Business Conduct Policy.

2.18 We also acknowledge from review of audit evidence provided under Recommendation 7.1 below, that the requirements in respect of Gifts, Hospitality and Declaration of Interests have been widely communicated on Siren. As such, all staff should be aware of the requirement. In addition to this, all staff are required to complete an annual declaration form.

2.19 For Corporate / non-operational staff a 'New Starter checklist' form has been developed for use by managers for induction. The form is available on the People and Culture pages on Siren. Review of the form confirms that it includes the following narrative "*arrange for starter to read the Standards of Business Conduct Declaration (Gifts and Hospitality), Trust Email, Internet, IT Security, Social Media policies*".

2.20 This recommendation is considered **fully implemented** and is therefore **closed**.

### Recommendation 5.1: DOI register (Design) - High priority

2.21 Our previous audit reported that other NHS Wales Bodies centrally held registers were not exclusive to Board members but expanded to include 'high-risk' employees and decision makers and also referenced disclosure for secondary employment where applicable. The Trust only listed the interests for Board members.

2.22 It was recommended that the Trust should look to implement a centrally maintained register which includes the DOIs of all 'high risk' staff and decision makers.

2.23 We reviewed the most recent version of the Trust's register of interests and note it still only captures the interests of Board members. It does not include 'high risk' staff or other 'decision makers' within the Trust. The Trust initially responded that they would be targeted for the completion of declarations of interest and the register would be held centrally by the Board Secretary.

2.24 In July 2023, the Board Secretary presented a paper to Audit Committee on 'Standards of Business Conduct Policy and Internal Audit Update'. This paper recommended that the Audit Committee is asked to note the update on the standards of business conduct internal audit, endorse the policy for approval by the Trust Board and note the next steps for the Corporate Governance Team. The next steps detailed that "*the process of collecting and adding interests and receiving declarations of gifts, hospitality etc. is ongoing throughout the year and cyclical for the more formal collection of declarations in March. There are however maturity elements to this area of work which will form part of the Corporate Governance Team's Local Directorate Plan"* this included *"(d) Contact the cohort of decision makers in Q3 to obtain their declarations of interest and add to the centrally held register*".

2.25 In March 2024, the Trust gave a presentation to both ADLT and Executive Leadership Team (ELT) that DOIs of all 'high risk' staff and decision makers are to be included on the register. The decision makers, in addition to Board Members and Executive Management Team, being ADLT; Board and Committee attendees and staff on Band 8 and above, as detailed in the policy.

2.26 At the time of our audit, a Microsoft Forms Declaration of Interests Form had been developed for completion. A Corporate Governance Directorate Official Notice has also been drafted, detailing the Annual Declaration of Interests updates, including the new process for decision-makers; and will be published post issue of the form.

2.27 This recommendation is considered **partially implemented**. However, whilst the 'complete' register of interests is not yet available, the Trust has demonstrated the extent of work undertaken, to date, towards producing the register for high-risk staff. We have therefore concluded that the recommendation remains **open** as the 'complete' register of interests is not yet available.

### Recommendation 7.1: Completion of gifts & hospitality forms (Operation) - High priority

2.28 Our previous audit reported that eight of the 15 gift and hospitality forms for 2021/22 and 2022/23 reviewed were not completed in a timely manner.

2.29 It was recommended that management should remind all staff of the requirements of the Gifts and Hospitality Policy, and that completed forms should be submitted to Corporate Governance in a timely manner for review.

2.30 In June 2023, the Trust developed a 'Standards of Business Conduct Communication Plan' - a rolling programme with the aim of communicating the requirements of the Standards of Business Conduct policy and we have evidenced such being published via Siren.

2.31 To confirm timeliness of declaration, we reviewed the register of 'Gifts, Hospitality and Sponsorships' for 2023/24 and the following observations were made in relation to the eight declarations included:

a. Three were declared ahead of the event to which they were related;

b. Three were declared at the same time that the gift/hospitality was received;

c. One declaration was received a month after it was gifted; and

d. One declaration was made 6 months after the donation (from a member of staff) was received.

2.32 The timeliness of submission of declarations is an improvement from our previous review, with a total of 75% (previously 46.7%) being made before, or as soon as the gift/hospitality/donation was received. We also note that all were declared within the year to which they related, which was not previously the case.

2.33 This recommendation is considered **fully implemented** and is therefore **closed**.

## Pain management

2.34 Four recommendations were raised in the original report. There are six management actions associated with these recommendations on the tracker. Four of these management actions (three high priority and one medium priority) are recorded as closed. We selected two closed recommendations from this report. For the two open management actions, one was not yet due, and one was overdue but in the process of agreeing a revised completion date.

### Recommendation 1.1: Patient Group Directions (Operation) - High priority

2.35 Our previous audit stated that the Trust reported on the compliance levels of three EMS Patient Group Directions (PGDs) on a regular basis; and it was noted that these were not administered as an analgesia. Based on Appendix 3 and 4 of the Medicines Management Policy, it was identified that the Trust have a further 19 PGDs in place relating to Advanced Paramedic Practitioners (APP), 3 PGDs relating to enhanced analgesia and 4 PGDs in place for Occupational Health staff. Whilst review of compliance for these was undertaken by the Head of Medicines Management, there was no formal reporting of compliance levels with APP PGDs.

At the date of reporting, compliance rates varied between 32% and 81% across the Trust, with 13 not achieving the 75% target.

2.36 It was recommended that whilst not all PGD's are in relation to analgesia, the current data maintained for compliance for all, should be formally reported to an appropriate forum and action taken to address areas of non-compliance.

2.37 We reviewed the monthly Medicines Management Assurance Report (MMAR), for the period July 2023 to February 2024, and confirmed that the these include the compliance for 'Paramedic', 'Advanced Practice' and 'Enhanced Analgesia' PGDs. The report details the compliance against each PGD by region and also pan-Wales. The most recent report stated that the average compliance in each region, for the current 18 APP PGDs, was between 80-97%. The pan-Wales average is currently 88%. APPs on bank contracts have also been added into the compliance percentages as it is important to see all those that are represented on the Medicines Management database.

2.38 Review of agendas for the Ambulance Practice Steering Group (APSG) and highlights to Clinical & Quality Governance Group (CQGG) confirms that the APSG receives monthly updates on the MMAR. The triple A (Advise/Assure/Alert) for APSG is reported to the CQGG, and is the route for escalation.

Conclusion:

2.39 This recommendation is considered **fully implemented** and is therefore **closed**.

Recommendation 3.1: Patient Group Directions (Operation) - Medium priority

2.40 Our previous audit reported that from review of the electronic Patient Clinical Record (ePCR) records provided we were unable to identify the Trust member administering the analgesia. Management advised that any Trust member can complete the form, even if their grade is below that required to administer the analgesia, with the assumption it would have been the most senior member of staff responsible for administering the analgesia. However, in the event of any patient recourse, this does not provide the required assurances as to the qualifications / experience of the actual member of staff providing the pain relief.

2.41 It was recommended that the functionality of the ePCR system should be reviewed for the inclusion of a field to track the details of the member of staff who administered the analgesia to the patient.

2.42 A change request form 'WAST_CR0037' *Improvement to Drug / Intervention Capturing* was completed and signed/dated by the Head of Capital Development on 7 July 2023, with the detail being *when a clinician is administrating a drug or providing an intervention, could ePCR have the option to select the clinician's name against the drug/intervention by means of a drop-down of names allocated to that incident*.

2.43 A change authorisation note has also been completed that details the total cost for this change request (£2.6k exc. VAT). The original management response noted that delivering any change to the ePCR would have a cost associated with it,

meaning that it may not be able to be delivered in practice until the funds have been identified.

2.44 The recommendation was closed on the tracker in October 2023 with the detail that *the change request had been written up but would not be progressed at that stage due to a lack of funding*. However, at the date of audit fieldwork, the timeframe for implementation had been agreed between Terrafix and the Trust, with the test system scheduled to be updated with all the developed change controls in place by mid-April 2024.

Conclusion:

2.45 Noting that appropriate funding has been secured and the deployment of the change request is imminent, this finding is considered **fully implemented** and it is therefore acceptable that the recommendation remains **closed**.

## Infection prevention and control (IPC)

2.46 12 recommendations were raised in the original report. There are 16 associated management actions associated on the tracker. 11 of these management actions are recorded as closed. This included two high priority and nine medium priority management actions. We selected one closed recommendation from this report. The implementation dates for the five remaining management actions have been extended, and at the time of our fieldwork four of these were not yet due and one was overdue.

### Recommendation 6.1: Trust IPC Assurance Mechanisms (Design) - High priority

2.47 Our audit reported that The Trust IPC audit programme requirements are outlined within the IPC policy and included within the IPC work plan. Following suspension due to pandemic pressures audits had yet to be restarted. The Trust had some mitigating measures around Make Ready Depot (MRD) vehicle cleaning and premise cleaning; however, the previous development of Adenosine Triphosphate (ATP) swab testing, which provided a method for assessing cleaning standard compliance, had not been implemented fully, resulting in an absence of assurance reporting.

2.48 It was recommended that whilst continuing to progress the updating of IPC audit tools, the Trust should develop a prioritised schedule of audits which can be delivered by the IPC team for the remainder of 2022/23. This should be alongside finalising and communicating expected criteria and standards.

2.49 A paper on the IPC Vehicle and Premises audit was presented to the IPC Strategic Group in June 2023, setting out the plans for both vehicle and premises audits to be performed with a proposed commencement date of November 2023. It detailed that "*there are currently no clear guidelines on audit sample size and audit methodology, support for this has been given from the Clinical Effectiveness team and online resources*".

2.50 As part of the planning process, the IPC team worked with the Clinical Effectiveness team to identify a suitable representative sample size, noting the Trust has in excess of 750 vehicles and almost 100 sites therefore the ability to audit all is not

practical. A sample size of 10% (for both vehicles and sites) was approved by the IPC Strategic Group.

2.51 Microsoft Forms audit tools have been developed to standardise the audit process and facilitate collating the results, including:

a. IPC Premises audit tool;

b. IPC Vehicle Cleanliness and Equipment audit tool; and

c. Premises ATP Swabbing audit tool.

2.52 We have reviewed the spreadsheet collating all audits undertaken. This confirmed that a total of 76 vehicles and 16 premises (the expected sample size) have been audited across all localities. At the time of our review, a report of the audits was being drafted.

Conclusion:

2.53 This recommendation is considered **fully implemented** and is therefore **closed.**

## Data analysis

2.54 12 recommendations were raised in the original report, with 13 associated management actions associated on the tracker. Five of these management actions are recorded as closed. This included three high priority management actions. We selected two closed recommendations from this report. Eight management actions remained open, with one not yet due. The remaining seven had missed their original due date - revised due dates had been agreed but were not yet due.

Recommendations 4.1 and 4.2: CCC System Administrator Continuity (Design) - High priority

2.55 Our previous audit reported that Computer Aided Despatch (CAD) reports were maintained by the Clinical Contact Centres (CCC) system administrator. There was no catalogue of these reports, nor entity relationship diagrams or meta data for CAD. It was noted that there were no instructions, procedures or user guides in place for the reporting role to ensure continuity when the Administrator was away. Anecdotally, as no data was available to confirm this, the CCC system administrator estimated that producing and supporting CAD reporting represented 25% of their time. We considered this a potential single point of failure. The CAD system administrator role in maintaining data quality, by clearing calls generating 'cause for concern', was not carried out when they were not available.

2.56 It was recommended that (4.1) the reporting and administration tasks completed by the CCC system administrator should be recorded and used to produce user guides and procedure documents; and (4.2) recognising that the CAD system is essential to the Trust's EMT operations, the Trust should establish appropriate cover for the CCC system administrator role to ensure continuity when they are not available, e.g. away on leave.

2.57 We have confirmed that the Trust has produced guidance documents of the processes to be followed for reporting and administration tasks 'C3-CAD ICT Notes' which include screen shots of the system detailing the different processes.

2.58 In January 2024, an additional EMS Coordination Systems Administrator was appointed to the CCC and it is anticipated that this role should reduce the reliance on ICT to back fill as the absence will be managed locally between the two administrators.

Conclusion:

2.59 These recommendations are considered **fully implemented** and are therefore **closed**.

## Major incidents

2.60 Nine recommendations were raised in the original report. There are eight management actions associated with these recommendations on the tracker. Two recommendations (1.1 and 1.2 in the original report) have been merged as one management action on the tracker. All management actions are recorded as closed. This included two high priority management actions, one of which was selected in our testing sample.

Recommendation 2.2: Testing and exercising frequency and outcomes (Operation) - High priority

2.61 Our previous audit reported that the Trust did not maintain a budget for live exercises, resulting in a reliance on exercises undertaken on a multi-agency basis. Whilst this provided best practice circumstances, it limited the ability to set overall scope and objectives of the exercise. Information provided by the Incident Response Plan (IRP) team confirmed that the IRP had been tested in live and tabletop multi agency exercises. However, this had been limited to the Southeast territory and involved a small number of WAST Commanders. We also reported that whilst there had been testing (or upcoming scheduled test) of a number of other WAST incident plans (airport, 7 tunnel, casualty dispersion), records showed these would be for a single occasion only. We noted that undertaking exercising would have been difficult given the operational demands of the COVID-19 pandemic, and co-ordinating representation from key partners would have been challenging. Whilst the team had produced a checklist to support IRP testing, due to the above, there was limited evidence of its use, and currently no comparison of outcomes across exercises undertaken. Recognising this gap in arrangements, the Emergency Preparedness, Resilience and Response (EPRR) Team were developing a draft template to capture this at time of fieldwork closing.

2.62 It was recommended that the EPRR Team should continue to develop a system to capture all exercising undertaken and establish quality measures which could be applied to all incident plans. The system should also capture attendance, exercise type, plan tested and any outcomes/themes from the exercise. If specific recommendations are raised these should be captured within the Organisational Learning Spreadsheet.

2.63 The EPRR team has developed a spreadsheet which captures the details of exercises that the team delivers – the 'EPRR Exercises spreadsheet'. Review of the spreadsheet confirms that it captures details of the exercise undertaken, the partners that participated; and the plans that have been tested through their

delivery. The spreadsheet is reported to the Senior Operations Team (SOT) on a quarterly basis. In addition, updates to SOT have included Exercise and Command Competency Reports, the EPRR Exercise Report and Specialist Operations Quality Dashboards for 2023-2024.

2.64 A debrief report is prepared following each exercise. This collates comments from the participants and focusses on areas for improvement, perceptions of what went well, and provision of their recommendations. The agreed actions are added to the Trust's Organisational Lessons Identified tracker with owners and timeframes for delivery identified to assist the Trust in improving the planning and management of similar incidents or events.

2.65 Progress against these actions is monitored by the SOT and escalated to the Senior Leadership Team (SLT) for assurance purposes via the Alert/Advise/Assure (AAA) reporting. Review of the Trust's Organisational Learning spreadsheet confirms that recommendations included in the debrief report are captured.

Conclusion:

2.66 This finding is considered **fully implemented** and is therefore **closed.**

## Hazardous Area Response Team (HART)

2.67 12 recommendations were raised in the original report. Eight of these recommendations are recorded as closed. This included one high priority recommendation. We selected one closed recommendation from this report. Four recommendations were open and had not met their original due date, revised due dates had been agreed but were not yet due.

### Recommendation 7.1: Training competencies and reporting (Design) - High priority

2.68 Our previous audit reported that due to the unprecedented pressures brought by the pandemic, compliance with the National Ambulance Resilience Unit (NARU) training frequency requirements had not been achieved, specifically for 'Marauding Terrorist Attack', 'Water Operations', 'Support to Security Operations', and 'Fitness Assessments' (bi-annual requirement not met). Training was also not undertaken for 'HAZMAT Personal Protective Equipment' due to a changeover in the generation of PPE which was not available until 2022, and 'Polaris and Winch' where the vehicle was unavailable. We also identified opportunities to improve the recording and reporting of training competencies.

2.69 It was recommended that action is taken to trial recording operative training on NARU's PROCLUS system, and the Trust should review opportunities to incorporate data from the system to support training performance and compliance monitoring and reporting.

2.70 The previous compliance issues were as a result of training not taking place due to the pressures of the pandemic. The Unit is now operating as business as usual (BAU), as such training is ongoing throughout the year. The unit is split into seven different 'watches' and there is a spreadsheet in place that details when each 'watch' will undertake training. Training is over a seven-week cycle, so the percentage compliance will increase as the topic is completed. By the end of the

training cycle, 100% compliance will not be achievable due to sickness or secondments. Staff returning from secondments are placed on a period of training to catch up before returning to live operations.

2.71 The PROCLUS HART training report provides the compliance position for the unit as a whole, however, the 'live' system allows the user to drill down into the granular detail to identify individuals who have not completed the training. Review of the PROCLUS report as at 25/04/24 confirms that 10/13 of the training modules have a compliance of over 75%, with valid reasons provided for the three modules where training was below 75%.

2.72 We were informed that training compliance data recorded on the PROCLUS system is monitored weekly by both the Training Manager and the Locality Manger; and is discussed verbally in monthly 1:1 sessions with the Service Manager. It is also noted that the PROCLUS report also details compliance against each sub-competency, which we were previously unable to verify. We would suggest that the training compliance rates are formally reported to an appropriate forum, but acknowledge that there have not been compliance issues, to date, that require escalation.

Conclusion:

2.73 This finding is considered **fully implemented** and is therefore **closed.**

# Appendix A: Management Action Plan

| **Matter Arising 1: Inclusion of recommendations from other assurance providers and inspection bodies on the tracker (Design)** | | | **Impact** |
|---|---|---|---|
| We previously recommended that the Trust should consider the inclusion of recommendations from other assurance providers within the tracker e.g., Counter Fraud. This recommendation was not accepted by the Trust due to the capacity of the Corporate Governance Team at the time.<br><br>The Trust is developing a more automated tracker system for March 2024, with support from Digital Health Care Wales. This should reduce the manual work required to keep the tracker up to date. This may free up capacity within the Corporate Governance Team to include recommendations from assurance providers and inspection bodies. | | | Potential risk of:<br>• Failure to implement agreed audit recommendations from all assurance providers; and<br>• Increased financial, clinical, statutory and reputational risk for the health board. |
| **Recommendations** | | | **Priority** |
| 1.1 | The Trust should consider the inclusion of recommendations from other assurance providers within the enhanced tracker system. | | **Medium** |
| **Agreed Management Action** | | **Target Date** | **Responsible Officer** |
| 1.1 | This recommendation is accepted.<br><br>A separate tracker will be developed to capture counter fraud recommendations. Progress will be reported to the closed session of the Audit Risk and Assurance Committee. | 31 August 2024 | Director of Corporate Governance / Board Secretary & Local Counter Fraud 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** | **Follow Up**: All recommendations implemented and operating as expected. |
|  | **Reasonable assurance** | **Follow Up**: All high priority recommendations implemented and progress on the medium and low priority recommendations. |
|  | **Limited assurance** | **Follow Up**: No high priority recommendations implemented but progress on most of the medium and low priority recommendations |
|  | **Unsatisfactory assurance** | **Follow Up**: No action taken to implement recommendations. |
|  | **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.<br>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.<br>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.<br>Some risk to achievement of a system objective. | Within one month* |
| Low | Potential to enhance system design to improve efficiency or effectiveness of controls.<br>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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# Clinical Audit

# Final Internal Audit Report

May 2024

## Welsh Ambulance Services University NHS Trust

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

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

EXTERNAL • QUALITY • ASSESSMENT

# Contents



| | |
|---|---|
| Review reference: | WAST-2324-010 |
| Report status: | Final |
| Fieldwork commencement: | 11 March 2024 |
| Fieldwork completion: | 22 April 2024 |
| Debrief meeting: | 24 April 2024 |
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| Final report issued: | 30 May 2024 |
| Auditors: | Osian Lloyd, Head of Internal Audit; Felicity Quance, Deputy Head of Internal Audit; Rhian-Lynne Lewis, Principal Auditor |
| Executive sign-off: | Andy Swinburn, Director of Paramedicine |
| Distribution: | Duncan Robertson, Assistant Director of Clinical Development; Kevin Webb, Head of Clinical Intelligence and Assurance. |
| Committee: | Audit Committee |

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

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

# Executive Summary

**Purpose**

To review the process for clinical audit including how it is used by Committees of the Trust to support assurance.

**Overview**

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

The matters requiring management attention include:

- The Clinical Strategy lacks sufficient reference to clinical audit and its role within the Trust; and
- The Clinical Audit Plan could be strengthened to demonstrate alignment between individual audits and the Trust risk register and priorities.

Other recommendations are included within the detail of the report.

## Report Opinion

| | | Trend |
|---|---|---|
| Reasonable  | Some matters require management attention in control design or compliance.<br>**Low to moderate impact** on residual risk exposure until resolved. | 2017/18  |

## Assurance summary[1]

| Objectives | | Assurance |
|---|---|---|
| 1 | Clinical Audit Strategy | Reasonable |
| 2 | Clinical Audit planning | Reasonable |
| 3 | Clinical Audit outcome reporting | Reasonable |
| 4 | Benefit realisation and lessons learned | Substantial |

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

## Key Matters Arising

| | | Objective | Control Design or Operation | Recommendation Priority |
|---|---|---|---|---|
| 1 | Insufficient coverage of clinical audit within clinical strategy | 1 | Design | Medium |
| 2 | Alignment of clinical audits with Trust risks and priorities | 2, 3 | Design | Medium |

# 1. Introduction

1.1 Clinical audit is designed to improve the quality of patient care and outcomes across a range of interventions, processes, and conditions. Its purpose is to undertake a systematic evaluation of clinical practice against standards and to support and encourage improvement in the quality of treatment and care. Additionally, it provides information for patients and the public on the quality of specific healthcare services being provided locally and nationally.

1.2 This review considered the clinical audit activity that took place in the year 2023/24 and the clinical audit planning for 2024/25. We have not re-performed any of the clinical audits to assess their completeness or accuracy.

1.3 The risks considered during the review were:

- Lack of robust clinical audit planning leading to the inability to identify areas where practice needs to be improved.
- Poor clinical audit governance and failure to act on results of clinical audits preventing improvement in the quality of treatment and care.
- Inability to identify and mitigate some areas of clinical risk.

# 2. Detailed Audit Findings

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

| | Recommendation Priority | | | Total |
|---|---|---|---|---|
| | High | Medium | Low | |
| Control Design | - | 3 | - | 3 |
| Operating Effectiveness | - | - | 2 | 2 |
| Total | - | 3 | 2 | 5 |

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

**Objective 1: There is an approved clinical audit strategy and clinical risk register in place.**

2.3 The national clinical audit commissioner, the Healthcare Quality Improvement Partnership (HQIP), specifies the organisational documents that are necessary for the effective management of clinical audit by a healthcare provider. These include:

- A policy for the use and conduct of clinical audit: to set out the principles, roles, responsibilities and practices a healthcare provider will follow in auditing clinical practice, and improving the quality of services to meet the needs of patients, healthcare commissioners, healthcare regulators, and others; and

- A strategy for the development of clinical audit: to describe how a healthcare provider will implement the policy, and increase the impact of audit on clinical services.

2.4 Previous audit reports in this area (2017/18: Limited Assurance, issued February 2018; and 2018/19: Follow Up, Reasonable Assurance, issued May 2019) reported on the development of a Clinical Audit Strategy with the latter stating that *whilst it had been identified that a Clinical Audit Strategy had been developed in draft, it had been determined by the wider Clinical Directorate that the Clinical Audit Strategy needed to form part of the wider Clinical Strategy, incorporating audit, research and improvement.*

2.5 The Trust's draft Clinical Strategy 2020-2025 was presented to the Quality, Patient Experience and Safety (QuEST) Committee in February 2020 where it was determined that minor amendments were required to the Strategy and, subject to these changes, it could be taken to Trust Board for final approval. This was approved at the July 2020 meeting.

2.6 Review of the strategy document notes there is minimal reference to clinical audit and the Clinical Intelligence and Assurance Team (CIAT) who are responsible for the conduct of such. **See MA1**. The CIAT maintains a 'how to' guide for the undertaking of clinical audit which sets out a step-by-step process for audit completion, and such could be considered for further enhancement to address the omissions within the strategy.

2.7 Risks linked to the clinical audit function are included within the Clinical Directorate Risk Register. This is maintained by the Clinical Directorate Business Manager within Datix Cymru. Up to 3 risks are reviewed each month to 'deep dive' into them and assess them appropriately. Those selected for review are determined based on the longest outstanding risks or those with highest priority, to ensure discussion and monitoring of the risks is active.

2.8 There is only one current risk on the clinical directorate risk register assigned to the clinical audit sub-directorate, with a risk score of 20: Risk *#535 Deterioration in Clinical Indicator Performance following transition from Digital Pen to electronic Patient Clinical Record (ePCR).* We were provided with the detailed risk record from Datix which sets out 16 mitigating actions, which include a mixture of clinical audits, improvement methodologies, ePCR prompts and ePCR layout re-design. 11 have been completed to date, with the remaining five being included in the 2024/25 clinical audit plan (see audit objective 2)

Conclusion:

2.9 The Trust's Clinical Strategy has limited reference to Clinical Audit. A 'how to' guide is available on the intranet to support staff in carrying out clinical audits. The clinical directorate risk register includes only one current clinical audit risk, which was linked to five audits included in the plan. A **reasonable** assurance rating is determined for this objective.

**Objective 2: An appropriate local clinical audit plan is developed through an appropriate forum, is based on the Trust's clinical agenda, organisational risks and concerns that have been identified; and has been approved by the relevant Committee.**

2.10 Topics for inclusion within the Clinical Audit Plan (CAP) are maintained and discussed by the CIAT in consultation with senior clinical and non-clinical management within the Trust. The decision for clinical audit topics chosen for inclusion are influenced by the following:

- Opportunities to improve clinical effectiveness and evidence-based practice (e.g. efficacy of treatment, new initiatives, pilot projects).
- Clinical risk management/patient safety (e.g., choosing topics in response to concerns highlighted by patient safety incidents.
- Local and Trust wide priorities.
- Guidance documents (e.g. NICE and AACE / JRCALC).
- Policy documents relating to health and healthcare.
- Other benchmarking activities as appropriate.

2.11 Further, from review of the 2023/24 and 2024/25 CAP's, we noted an absence of a reference/link to Trust, Directorate or local risks and priorities, resulting in the lack of justification/reasoning to support the inclusion of individual audits. See **MA2**.

2.12 The CIAT maintains a working document (Clinical Audit Delivery Plan) which includes a tab that pulls together all potential clinical audit topics. Audit topics and ideas are received through a number of methods, including via discussion with clinical staff, attendance at wider Trust meetings, discussion within the CIAT, contact with sub-directorates and also potential audit requests received by the CIAT for consideration. Other work undertaken by the CIAT includes deep-dive data reviews into potential audit topics to establish whether a full clinical audit is required.

2.13 We were advised that the CIAT meet fortnightly to discuss ongoing progress against in year audits and actions included in the Clinical Audit Delivery Plan, and also potential ideas/topics for consideration for inclusion in the CAP. These meetings are informal and so the Team does not maintain minutes. Instead, the Clinical Audit Delivery Plan is updated, and a decision log captures decisions made and/or changes within the Teams arrangements and also an action log to document meeting outputs. We note there was minimal reference within these documents to the clinical audit plan and decisions made as to which audits will be included in the plan and its development. See **MA2.**

2.14 As stated in the Terms of Reference (refer to audit objective 3), *'The CIAG will be responsible for developing and monitoring the annual Clinical Audit Plan'*. The 2023/24 CAP was approved by the CIAG in January 2023/24 where there was evidence of discussion around plan content. It was subsequently approved by QuEST at its May 2023 meeting.

2.15 We note that arrangements for the 2024/25 CAP, include the approval by QuEST at its February 2024 meeting and that, due to the timetable of meetings, retrospective approval of the 2024/25 plan was sought at CIAG the day after the QuEST meeting. (see para 2.11).

Conclusion:

2.16 The clinical audit plan is produced by the CIAT in consultation with senior management, however the link between the audits included and Trust risks and priorities is not always clear. The plan is approved via CIAG and QuEST. A **reasonable** assurance rating is determined for this objective.

**Objective 3: Results of clinical audits undertaken (including action / improvement plans), and progress against the agreed clinical audit plan, are reported to the appropriate clinical forums and committees.**

2.17 The process for audit completion includes the preparation of a clinical audit proposal form which sets out the proposer and sponsors of the audit, the background establishing audit rationale, the aims and objectives and the standard of care to be measured. There is also a section for inclusion of a risk reference and a Local Delivery Plan (LDP) priority, however we note that of the three clinical audits reviewed (see para. 2.21), these sections were not consistently completed (see **MA2**).

2.18 Audits are either undertaken by a member of the CIAT or they support relevant clinicians to complete the audit work. Once the audit is complete, the CIAT collates all relevant information and prepares an audit report which is subsequently presented to the CIAG for review and approval. Reports are also taken to the Clinical Quality Governance Group (CQGG) for noting.

2.19 We reviewed three clinical audits finalised in year in order to document the process followed and ensure that it was in line with expectation. These audits were:

- Administration of Methoxyflurane (Penthrox®) – audit the safe and effective care to patients administrated Methoxyflurane (Penthrox®) and that pain scores are captured in line with Protocol.
- Morphine Administration (Recording accuracy) – to assess the accuracy of clinical (ePCR) and statutory (CD02) record-keeping.
- Levetiracetam (Keppra) Potential Use in Convulsions – to establish the potential for use of levetiracetam (Keppra) in cases of multiple anticonvulsant administration.

2.20 Proposal forms were provided for each review, and we confirmed the issuing of final clinical audit reports, following to their presentation for approval at CIAG.

2.21 The reporting framework for clinical audit includes CIAG, CQGG, Executive Leadership Team (ELT), Clinical Directorate Business Meeting (CDBM) and QuEST.

2.22 The CIAT (as detailed further in ***audit objective 2***) undertake all aspects of clinical audits, from CAP development through to clinical audit final reports. The Team prepares monthly updates which are presented to the CIAG.

2.23 The CIAG was established to provide oversight of the development of clinical indicators and the ongoing reporting against them, to monitor the safety effectiveness and efficiency of clinical care provided by the Trust, and the development and monitoring of the CAP and Action Tracker. The group's membership includes Clinical Directorate Leads, Clinical Intelligence Leads, ePCR Team Representative, Health Informatics Lead and Trade Union Representatives.

2.24 Minutes have not been maintained for CIAG during 2023/24. Rather, an Alert, Advise, Assure (AAA) report is prepared and presented to CQGG on a monthly basis. This summarises the Trust's current position on matters discussed at CIAG, including the clinical indicator dashboard, brief summary of the clinical audit action tracker position, and an update against the progress of the clinical audit delivery plan.

2.25 The CIAG meets monthly and is chaired by the Assistant Director of Clinical Development. We reviewed a sample of meetings (September, October, and December 2023; and February 2024) and confirmed all were quorate and were generally well attended. However, we note there was one member that has consistently not attended and that the names of some members are not included. **See MA3**.

2.26 The 2023/24 clinical audit plan included 11 audits when approved with one latterly split in two. An additional four audits were added during the year. Of these 16, 11 have been completed with audit reports published on Siren post their approval at CIAG and the remaining 5 have been impacted by delays to ePCR system upgrades.

2.27 We selected a sample of three completed audits (refer to Table 1 in ***audit objective 4***) and reviewed the CIAG AAA reports which showed evidence of scrutiny and discussion around report outcomes, recommendations, any required amendments and also who the reports should be shared with including: Health Board Clinical Leads and the Ambulance Practice Steering Group.

2.28 Following their approval at CIAG, clinical audit reports are presented for noting at CQGG on a quarterly basis. We were able to confirm the presentation of clinical audit #011 which was presented in February 2024 following its finalisation in December 2023, while audit references 006 and 010 were confirmed to be included in the agenda for the May CQGG meeting. A review of three meetings (December 2023 to February 2024) confirmed quoracy and appropriate membership attendance in line with the agreed terms of reference. The minutes show evidence of discussion and scrutiny around the clinical audit reports presented providing an additional level of assurance over report approval.

2.29 Following its monthly meeting, CQGG prepares an AAA report to the ELT which includes a brief summary of the individual clinical audit reports that have been presented and discussed.

2.30 QuEST receives a quarterly update against the status of the CAP and the clinical audit action tracker. The latest report (presented February 2024) provided an update stating that four further clinical audits had been finalised and a further 16 actions had been completed that were aligned to eight clinical audits.

2.31 The CDBM occurs monthly and pulls together the wider remit of the Clinical Directorate including Finance, Corporate Governance, Risk and Health and Safety. An update against the progress for the CAP and action tracker is also presented. An action log is maintained for this meeting, rather than minutes; and review of a recent log (January 2024) confirmed that there have been no actions assigned to the Head of Clinical Intelligence and Assurance nor the CIAT during 2023/24.

Conclusion:

2.32 There is a clear reporting framework in place for both the approval and monitoring of the CAP. Proposal forms are completed prior to the commencement of each clinical audit however these are not consistently completed in relation to risk and LDP priorities, therefore a **reasonable** assurance rating is determined for this objective.

**Objective 4: Actions are monitored to ensure implementation and benefits realisation, and results of all clinical audits undertaken are triangulated with learning from other quality governance mechanisms and inform future planning.**

2.33 The clinical audit action tracker captures actions identified following the completion of an audit and includes the priority rating, accountable officer, due date for completion, and Red, Amber, Green or Blue (RAG-B) ratings to indicate the status of the actions and whether they are on track. As detailed in audit objective 3, this is reported and scrutinised at appropriate forums.

2.34 During audit fieldwork, the January 2024 action tracker was reviewed which confirmed the inclusion of all relevant findings and recommendations from the completed clinical audit reports. Narrative comments are included against each of the actions which include the date of entry to evidence ongoing progress.

2.35 During 2023/24, there were 46 actions reported following the completion of the clinical audits. Of these, 39 were completed in year, 5 are on track and 2 are off track with recovery action being taken.

2.36 Discussion with the Head of Clinical Intelligence & Assurance advised that following the completion of a clinical audit, learning is captured within the following:

- Final Reports – Following the approval of the clinical audit final reports at CIAG, the reports are published on the CIAT Siren page and are accessible to all staff. Reports include sections on good practice and areas for improvement.
- Clinical Notices – where applicable, clinical notices are produced and shared on Siren, and are also added to the JRCALC[1] app for ease of access for operational staff while out in the field.
- Infographics – The CIAT produce infographics for each completed clinical audit, which communicate audit findings and other data through a combination of text, images and design, providing an easy read summary of the clinical audit

[1] Joint Royal Colleges Ambulance Liaison Committee

outcomes. These are shared on Siren and are also included within the final reports.

2.37 The infographics produced for each clinical audit provide a high-level narrative as to why the clinical audits have been completed, and the results within the clinical audit reports provide a summary of outcomes to establish whether or not the expected benefits have been realised. The table below sets out these criteria for the three clinical audits tested as part of this review:

*Table 1*

| Audit Reference and Name | Why We Did It | High Level Outcomes | Benefit Realised |
|---|---|---|---|
| CIAT23_006 - Administration of Methoxyflurane (Penthrox) | To audit the safe and effective care of patients in accordance with the WAST Methoxyflurane Protocol. | Pain scores prior to and following administration of Penthrox® were not always obtained/documented. 16.1% patients had no pain score recorded prior to and after the first dose of Penthrox® administered.<br>The administration of Penthrox® was not always documented in the drugs section. 6.5% (30/460) administrations were documented in the narrative section only. | Yes - improvements are required to ensure that appropriate documentation of pain scores within ePCR to support the use of Penthrox® |
| CIAT23_010 - Morphine Administration (Recording accuracy) | To assure that the details relating to the morphine administered to the patient and the quantity of morphine disposed of were a match on both the ePCR and on the vehicle based controlled drugs register (CD02). | A high level of compliance between ePCR and CD02 records, however it is important to note that as morphine is a schedule 2 controlled drug, the accuracy of records is an essential requirement in all cases.<br>It was not always possible to locate the CD02 book and In 7.1% of cases (2/28), the amount of morphine administered was not recorded in the drugs section of the ePCR. | Yes – a high level of compliance (92.9%) was identified matching the dose recorded on the ePCR with that recorded in the CD02 book. |
| CIAT23_011 - Levetiracetam (Keppra) Potential Use in Convulsions | To consider if levetiracetam could potentially be used instead of a third dose of benzodiazepine | It was considered that there was a potential for levetiracetam administration in the following scenarios:<br>• Convulsions not stopped prior to hospital handover<br>• Maximum dose exceeded, whether or not convulsions have stopped | Yes - the Trust have identified areas of potential use of Levetiracetam which could be of benefit to the Trust |

## Conclusion:

2.38 The clinical audit action tracker captures recommendations from clinical audits and this is reported and monitored at appropriate forums. Learning from clinical audits is captured within clinical audit reports, clinical notices and infographics and are accessible to all staff. Benefits of clinical audits is also captured across the above documents. We have therefore determined a **substantial** assurance rating for this objective.

# Appendix A: Management Action Plan

| Matter Arising 1: Insufficient coverage of clinical audit within clinical strategy (Design) | | | Impact |
|---|---|---|---|
| The Trust has a Clinical Strategy in place for the period 2020-2025. Our review of the Strategy and the Clinical Audit Plan has shown that there is an absence of detail in relation to clinical audit as outlined as being necessary by HQIP for the effective management of clinical audit.<br><br>We note that the Trust has an easily accessible 'how to' guide available which outlines the requirements for the completion of a clinical audit, and such could be considered for further enhancement to address the omissions within the strategy. | | | Potential risk of:<br><br>• Ineffective documentation to support the management of clinical audit. |
| **Recommendations** | | | **Priority** |
| 1.1 | The Trust should ensure appropriate detail in relation to clinical audit is included and documented it within its organisational documents. | | **Medium** |
| **Agreed Management Action** | | **Target Date** | **Responsible Officer** |
| 1.1 | There are workshops scheduled (4th, 9th and 10th July 2024) to plan the next iteration of the Trust clinical strategy. The Clinical Directorate will ensure that clinical audit is given the space it needs to articulate the need for, and link to the guidelines on how to undertake an audit in the final approved document. Where update presentations are given up to, and including, board level meetings, the Clinical Directorate will ensure clinical audit is included. The clinical strategy will articulate clearly how clinical audit meets HQIP standards and will link to the clinical audit plan (for example, to the Clinical Audit section on the Trust intranet). | 31st March 2025 | Assistant Director for Clinical Development. |

| **Matter Arising 2: Link of clinical audit plan to risk register or Trust priorities (Design)** | | | **Impact** |
|---|---|---|---|
| The clinical audit plan is developed in consultation with the CIAT and senior clinical and non-clinical management and is approved by the CIAG and QuEST.<br><br>The decision for clinical audit topics chosen for inclusion are influenced by a number of factors including Trust risks and priorities. However, our review of the Clinical Audit Plan noted an absence of a reference/link to Trust, Directorate or local risks and priorities, resulting in the lack of justification/reasoning for the inclusion of individual audits.<br><br>We also note that the process for the development of the plan and discussion around audits included in the plan, has not been clearly documented. | | | Potential risk of:<br><br>• Limited evidence of justification to support the inclusion of audits.<br>• Absence of evidence of plan development process. |
| **Recommendations** | | | **Priority** |
| 2.1 | The Trust should link all clinical audits to either the clinical directorate risk register or Trust/Directorate priorities to support the justification for undertaking them. Where a link cannot be made, additional narrative should be included to justify the inclusion of the clinical audit within the audit plan. | | **Medium** |
| 2.2 | The development of the clinical audit plan should be formally documented to provide assurance on the appropriateness of inclusion of individual audits. | | |
| **Agreed Management Action** | | **Target Date** | **Responsible Officer** |
| 2.1 | Work will be undertaken to ensure relevant risks are linked to clinical audit activity; specifically, a mandatory field will be added to the proposal form to link to either a clinical risk or organisational clinical priority. This form will be submitted to CIAG for approval. The Trusts/Directorate priorities are not always clearly identifiable, but we will look to include in the 2024/25 CAP a justification linked to the IMTP/LDP. | 30th September 2024 | Head of Clinical Intelligence and Assurance |

| | | | |
|---|---|---|---|
| 2.2 | The CIAT decision log and proposal form to include more detail outlining the priority of the audit activity and the justification for inclusion in the workplan, which will also be reflected in the completed audit reports. A review of the clinical audit documentation is scheduled. This will be reported for approval to the CIAG. | 30th September 2024 | Head of Clinical Intelligence and Assurance |

| Matter Arising 3: CIAG Membership (Operation) | Impact |
|---|---|
| Our review of member attendance at the CIAG confirmed the quoracy of the meetings and that they are generally well attended. However we observed that one member had consistently not attended.<br><br>The Terms of Reference of the CIAG state *'If a member of the group misses three consecutive meetings without sending an informed deputy or offering apologies, the chair will contact the member to confirm if they still intend to attend or whether they will offer an alternative.'* We have confirmed that his has not been completed.<br><br>We also note that other members weren't included in the attendance record on the AAA reports taken to CQGG and so we were unable to confirm their attendance/non-attendance. | Potential risk of:<br><br>• Inappropriate membership at CIAG.<br>• Member attendance is not effectively captured. |

| Recommendations | | Priority |
|---|---|---|
| 3.1 | A review of the CIAG Members within the Terms of Reference should be undertaken to ensure Membership is appropriate. | **Low** |
| 3.2 | The members listing included within the AAA reports to CQGG should be updated to provide an accurate record of attendance at CIAG. | |

| Agreed Management Action | | Target Date | Responsible Officer |
|---|---|---|---|
| 3.1 | The TOR is scheduled for review by CIAG and membership will be reviewed at this time. In addition, the stated action regarding missing meetings and follow-up will be similarly reviewed. | 31st July 2024 | Assistant Director of Clinical Development |
| 3.2 | This has already been amended (May CIAG). | Actioned since fieldwork | N/A |

# 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.<br>**Low impact** on residual risk exposure. |
|  | **Reasonable assurance** | Some matters require management attention in control design or compliance.<br>**Low to moderate impact** on residual risk exposure until resolved. |
|  | **Limited assurance** | More significant matters require management attention.<br>**Moderate impact** on residual risk exposure until resolved. |
|  | **Unsatisfactory assurance** | Action is required to address the whole control framework in this area.<br>**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.<br>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.<br>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.<br>Some risk to achievement of a system objective. | Within one month* |
| Low | Potential to enhance system design to improve efficiency or effectiveness of controls.<br>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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Archwilio Cymru
Audit Wales

# Audit, Risk and Assurance Committee Update – Welsh Ambulance Service University NHS Trust

Date issued: May 2024

Document reference: 4195A2024

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

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

Audit Wales is the non-statutory collective name for the Auditor General for Wales and the Wales Audit Office, which are separate legal entities each with their own legal functions as described above. Audit Wales is not a legal entity and itself does not have any functions.



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

# Contents

**Audit, Risk and Assurance Committee update:**

# About this document

1 This document provides the Audit Committee with an update on our current and planned accounts and performance audit work at the Welsh Ambulance Service University NHS Trust. We presented our most recent Audit Plan to the committee on 30 April 2024.

2 We also provide additional information on:

- Other relevant examinations and studies published by the Audit General.
- Relevant corporate documents published by Audit Wales (e.g. fee schemes, annual plans, annual reports), as well as details of any consultations underway.

3 Details of future and past Good Practice Exchange (GPX) events are available on our website.

# Accounts audit update

4 Exhibit 1 summarises the status of our current and planned accounts audit work.

Exhibit 1 – Accounts audit work

| Area of work | Executive Lead | Current status | Planned date for consideration |
|---|---|---|---|
| **Audit of the Trust's 2023 -24 Financial Statements** | Executive Director of Finance and Corporate Resources | The Auditor General wrote to NHS bodies on 5 February 2024 to confirm an audit certification deadline for 2023-24 accounts of 15 July 2024. We are working with management to confirm specific arrangements for this audit in order to meet this deadline.<br>We received the 2023-24 draft accounts and annual report in accordance with the submission timetable. The audit is currently ongoing. | July 2024 |

# Performance audit update

5 Exhibit 2 summarises the status of our current and planned performance audit work.

Exhibit 2 – Performance audit work

| Area of work | Executive Lead | Focus of the work | Current status | Planned date for consideration |
|---|---|---|---|---|
| **Review of Unscheduled Care** | Executive Director of Operations | This work examines different aspects of the urgent and emergency care system in three parts:<br>• Part One: Flow out of hospital (not applicable to the Trust).<br>• Part Two: accessing urgent and emergency care.<br>• Part Three: national arrangements and leadership structures. | Part Two: Fieldwork underway | September 2024 |

| Area of work | Executive Lead | Focus of the work | Current status | Planned date for consideration |
|---|---|---|---|---|
| **Follow up Review of Quality Governance Arrangements** | Executive Director of Quality and Nursing | This review is examining the Trust's progress in responding to the audit recommendations arising from our 2022 Review of Quality Governance Arrangements, which was reported to the committee in September 2022. | Fieldwork underway | September 2024 |
| **Structured Assessment – deep dive into financial efficiencies** | Executive Director of Finance and Corporate Resources | Given the significantly challenging financial position across NHS Wales, this review is examining the approaches NHS bodies are taking in respect of achieving cost improvements, efficiencies, and financial sustainability. | Reporting | September 2024 |
| **Structured Assessment - core** | Director of Corporate Governance / Board Secretary | This work will review the following core areas:<br>• Board and committee effectiveness, cohesion, and transparency.<br>• Corporate systems of assurance.<br>• Corporate planning arrangements.<br>• Corporate financial planning arrangements. | Planning | November 2024 |

| Area of work | Executive Lead | Focus of the work | Current status | Planned date for consideration |
|---|---|---|---|---|
| | | This work will also seek to provide an update on the Trust's progress in addressing audit recommendations made in previous structured assessment reports. | | |
| **Structured Assessment - deep dive review of investment in digital systems to support service resilience and transformation** | Director of Digital Services | This audit will examine digital arrangements, with a particular focus on how NHS bodies are investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency. | Scoping | To be confirmed |

# Audit Committee Update

## Other relevant publications

6 Exhibit 3 provides information on other relevant examinations and studies published by the Auditor General in the last six months. The links to the reports on our website are provided. The reports highlighted in **bold** have been published since the last committee update.

Exhibit 3 – Relevant examinations and studies published by the Auditor General

| Title | Publication Date |
|---|---|
| **Community Pharmacy Data Matching Pilot** | **May 2024** |
| From firefighting to future-proofing – the challenge for Welsh public services | February 2024 |
| Board effectiveness follow-up – Betsi Cadwaladr University Health Board | February 2024 |

## Additional information

7 Audit Wales has not published any corporate documents since the last committee update.

8 There are no relevant Audit Wales consultations currently underway.


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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.

| | |
|---|---|
| **AGENDA ITEM No** | **7** |
| **OPEN or CLOSED** | **Open** |
| **No of ANNEXES ATTACHED** | **4** |

# RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

| | |
|---|---|
| **MEETING** | Audit Committee |
| **DATE** | 7th June 2024 |
| **EXECUTIVE** | Trish Mills, Director of Corporate Governance/Board Secretary |
| **AUTHOR** | Julie Boalch, Head of Risk, Deputy Board Secretary |
| **CONTACT** | Julie.Boalch@wales.nhs.uk |

## EXECUTIVE SUMMARY

1. The purpose of the report is to provide assurance in respect of the management of the Trust's principal risks and an update on the risk management transformation programme.

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

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

4. The principal risks are updated as at 08 May 2024 and each of the risks have been reviewed during this reporting period in line with the agreed schedule detailed at Annex 3. Focus has been given to the risk ratings, controls, assurances, gaps, and mitigating actions.

5. The focus for the forthcoming round of reviews will predominantly be in relation to the mitigating actions identified and taken to support risks to achieve their target score.

6. Updates are highlighted in blue on the BAF which show changes to actions, controls, and assurances.

7. The Trust's highest rated risks: **Risk 223** (*the Trust's inability to reach patients in the community causing patient harm and death*) and **Risk 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*), remain at the highest score of 25. These scores reflect individual cases of

avoidable harm, highlighting ongoing challenges in the unscheduled care system due to the levels of handover delays.

8. **Risk 424** *Resource availability (revenue, capital and staff capacity) to deliver the organisation's Integrated Medium-Term Plan (IMTP)* has reduced in score to 12 (3x4), linked closely with financial duties outlined in **Risk 139**. A vehicle/fleet risk may be developed to consider requirements against the Strategic Outline Plan and funding requirements.

9. **Risk 458** *A confirmed commitment from EASC and/or Welsh Government is required in relation to funding for recurrent costs of commissioning to deliver the IMTP and/or any additional services* has achieved its target score of 8 (2x4) and will be removed from registers.

10. Two risks have achieved their target score and have been de-escalated to the Directorate Risk Registers (DRR) for monitoring. These are **Risk 543** *Major disruptive incident resulting in a loss of critical IT systems* from 15 (3x5) to 10 (2x5) and **Risk 283** *Failure to implement the EMS Operational Transformation Programmes* from 12 (3x4) to 8 (2x4).

11. Two new risks have been assessed and approved for inclusion on the CRR and BAF; these are **Risks 542** *Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan* at a score of 16 (4x4) and **Risk 623** *Failure to comply with Data Protection Legislation* at a score of 15 (3x5).

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

13. Detailed reviews, discussion and challenge continue to take place with the Executive Leadership Team (ELT) and Assistant Director Leadership Team (ADLT) on each of the risks monthly in support of achieving this activity and movement on the CRR and BAF.

14. BDO were commissioned to support the team to progress the Risk Transformation Programme, as set out in the 2024/25 IMTP, advising on best practice areas such as the development of a strategic BAF, risk appetite statements as well as exploring options for digitising the BAF. Additionally, the programme will consider the repositioning of Risks 223 and 224. The draft report issued by BDO is being checked for factual accuracy and a handling plan is being established which will be presented in detail to Committee at its September 2024 meeting.

**RECOMMENDATION:**

15. Members are asked to consider and discuss the contents of the report and:
    1) Note the reduction in two risk scores:
       Risk 163 from 20 (5x4) to 16 (4x4) and

Risk 424 from 16 (4x4) to 12 (3x4)

2) Note the de-escalation of two risks to the Directorate Risk Registers:
   Risk 543 achieving target of 10 (2x5) and
   Risk 283 achieving target of 8 (2x4)
3) Note the inclusion of two new risks:
   Risk 542 at a score of 16 (4x4) and
   Risk 623 at a score of 15 (3x5)
4) Note the closure of Risk 458 from all registers.
5) Receive assurance on the review and attention to the principal risks, their review at ELT and at relevant Committees.
6) Note the ratings and mitigating actions for each principal risk.
7) Note the update on the Risk Management Transformation Programme.

| **KEY ISSUES/IMPLICATIONS** |
|---|
| The key issues and implications are set out in the Executive Summary above. |
| **REPORT APPROVAL ROUTE** |
| Each of the Principal Risks have been or are due to be considered by the following Committees, as relevant to their remit, during the forthcoming reporting period:<br><br>ADLT (29 April 2024)<br>ELT (08 May 2024)<br>Quality, Safety & Patient Experience (07 May 2024)<br>People & Culture Committee (09 May 2024)<br>Finance & Performance Committee (14 May 2024) |

| **REPORT ANNEXES** |
|---|
| SBAR report.<br>Annex 1 - Summary table describing the Trust's Principal Risks.<br>Annex 2 – Scoring Matrix<br>Annex 3 – Frequency of Risk review<br>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

2. The purpose of the report is to provide assurance in respect of the management of the Trust's principal risks and against the Risk Management Transformation Programme.

## BACKGROUND

3. Risks are allocated to appropriate Directors to drive the reviews and actions to mitigate the Trust's principal risks. In addition to directorate reviews there are formal risk review discussions with the Assistant Directors Leadership Team (ADLT) and the Executive Leadership Team (ELT) in relation to risk escalation, changes in ratings, and any new risks for inclusion on the CRR.

4. This report highlights the focus that is maintained on management of these risks, not only because of risk discussions in the various forums but also because of broader attention to planned mitigations across the system.

## ASSESSMENT

5. The summary of the Trust's principal risks is set out in Annex 1 with the full risk detail including controls, assurances, gaps, and mitigating actions contained within the Board Assurance Framework (BAF) in Annex 4.

6. The ELT has approved the principal risk activity described in this paper and considered the full review of each risk undertaken throughout March and April 2024 by Risk Owners and the Assistant Directors Leadership Team (ADLT).

<u>Principal Risks</u>

7. Each of the risks have been reviewed during this reporting period in line with the agreed schedule detailed at Annex 3 with continual and dynamic focus on the highest rated risks scoring 15-25. Attention has been given to the risk ratings of each principal risk and the mitigating actions identified and taken to ensure that risks achieve their target score. This is in addition to the standard and regular review of all controls, assurances, and any gaps.

8. The Trust's highest rated Risks 223 *the Trust's inability to reach patients in the community causing patient harm and death* and Risk 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*, remain static at the highest score of 25. The score is not based on the volume of cases of

catastrophic harm, it is based on any one individual that experiences avoidable harm. The quality dimension of each of these risks will always be a challenging one to reduce whilst patients and the Trust are experiencing delays in the way in which they currently are.

9. Despite a slight decrease in the number of handover lost hours in April 2024 the sustained and extreme pressure continues across the Welsh NHS urgent and emergency care system which is negatively impacting on patient flow and leading to avoidable patient harm and death.

10. As reported to the May 2024 Trust Board, the Trust continues to focus on the actions to mitigate these two risks that are within its control, and these are highlighted in the avoidable harm action plan which is presented at each Board meeting. Further mitigations and transformative actions are described in the Integrated Medium Term Plan (IMTP) to address these risks.

11. There are a range of efficiencies described in the report that the Trust has undertaken in mitigation of these two risks. Two key ones being the number of calls being closed safely and efficiently by clinicians through the Consult and Close initiative in the contact centres as well as a significant improvement in sickness and attendance levels.

12. Most of the Trust's actions in the action plan have been completed and a several efficiencies and improvements implemented that have stabilised performance; however, the Trust is unable to mitigate the scale of handover lost hours due to the environment which it is operating in or make improvements in performance because of the continued challenges in the urgent and emergency care system.

13. The Executive Director of Quality and Nursing and Executive Director of Paramedicine are working with the National Data Resource in relation to levels of harm that are occurring in the system by understanding current pathways.

14. The Quality, Patient Experience and Safety Committee (QUEST) reviewed both risks at its meeting in May 2024 with the Agenda items reflecting the controls and mitigations discussed at this meeting. These risks continue to be escalated to the Board via the meeting's Alert, Assure and Advise (AAA) report.

15. Additionally, both risks were presented to the Finance & Performance Committee (FPC) and the People & Culture Committee (PCC) meetings in May 2024 to continue to ensure that all perspectives and elements of the risks are considered and reviewed.

16. Work is underway to consider how the Trust might articulate and manage these two risks differently given that their score has remained catastrophic over a significant period. Options have been considered, with external support, as part

of the Risk Management Transformation Programme and internal discussions are ongoing on a potential new internal approach.

17. Risk 160 *High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service*, whilst there has been a significant reduction in absence levels, the score remains static during this quarter; however, this will remain under review given the significant work undertaken to strengthen the controls, assurances, and mitigating actions.

18. Risk 163 *Maintaining Effective & Strong Trade Union Partnerships* – The score has been reduced to 16 (4x4) in this review period because of a tailored bespoke development programme for managers and Trade Union Partners at all levels has been launched to address issues. The programme of engagement and relationship building will continue throughout 2024/25. Work is underway to deliver the action plan in partnership.

19. Risk 201 *A loss of stakeholder confidence that damages the Trust's reputation*, remains static at a score of 20 given that many of the mitigations are outside the Trust's control. The PCC undertook a deep dive of this risk at its meeting in May 2024. The reputation audit was discussed at the Welsh Ambulance Services Partnership Team in May 2024 and will be the subject of a Board development discussion in June 2024.

20. Risk 594 *The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death* remains at a score of 20 (4x5) reflecting the continued challenges across the unscheduled care system. Further work to determine resources following the Manchester Arena Inquiry remains underway.

21. A detailed discussion took place at the May Board in relation to Risk 424 *Resource availability (revenue, capital, and staff capacity) to deliver the organisation's Integrated Medium-Term Plan (IMTP)* which has reduced in score to 12 (3x4) and which is closely linked with Risk 139 *Failure to Deliver our Statutory Financial Duties*. This highlighted the reasonable revenue position for 2024/25 and that a separate risk could be considered in relation to capital funding. Accepting this, a vehicle/fleet risk may be developed on the future outlook for the fleet replacement Strategic Outline Plan (SOP) and the business case for 2025/26 accepting this is the 3rd consecutive year that full the full funding requirement has not been forthcoming.

22. Risk 458 *A confirmed commitment from EASC and/or Welsh Government* has been closed having achieved its target score of 8 (2x4) from 16 (4x4) and will be removed from all registers.

23. All original actions are now complete in relation to Risk 260 *A significant and sustained cyber-attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems*; however, a review of the recent Cyber Resilience Unit (CRU) assessment is to be undertaken to identify any further actions. On this basis the score remains the same given continued activity by cyber actors due to wider world events. There is a general heightened alert for government and public sector bodies although no specific threat has been identified against NHS bodies.

24. Two risks have achieved their target score and have been de-escalated to the Directorate Risk Registers (DRR) for monitoring. These are Risk 543 *Major disruptive incident resulting in a loss of critical IT systems* from 15 (3x5) to 10 (2x5) and Risk 283 *Failure to implement the EMS Operational Transformation Programmes* from 12 (3x4) to 8 (2x4).

25. Risk 558 *Deterioration of staff health and wellbeing in as a consequence of both internal and external system pressures* currently remains unchanged during this quarter.

26. Risk 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* remains unchanged and is not due for review again until July 2024.

27. Two new risks have been assessed and approved for inclusion on the CRR and BAF; these are Risks 542 *Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan* at a score of 16 (4x4) and Risk 623 *Failure to comply with Data Protection Legislation* at a score of 15 (3x5).

<u>Risk Management Transformation Programme</u>

28. The Risk Management Transformation Programme has entered its third and final year.

29. Work has progressed with BDO who were commissioned to support us with enhancing our existing risk management culture, delivering on the risk management programme objectives as set out in the 2024/25 IMTP and to help us build on three main areas that:
    1) Provide best practice guidance design and build a strategic BAF that reflects the Trust's future strategic ambition and provide clarity on the strategic risks that would prevent us from achieving our organisational objectives.
    2) Provide expert advice on developing a series of risk appetite statements to support the Trust in articulating the amount of risk it is willing to take in pursuit of its objectives, ensuring decisions remain within defined risk tolerance levels and that they are aligned to our strategy.

3) Support us with repositioning Risks 223 and 224 and reframing them in such a way that best describes the mitigations that are within the Trust's control and actions that can be taken to mitigate the impact on our people and the avoidable harm experienced by our patients.

30. A comprehensive, draft report has been issued by the BDO which provides clear guidance and advice on each of these areas. The team are finalising the report which will be shared with Committee in advance of the September 2024 meeting along with a work plan outlining the timings of the next steps required to deliver on the objectives of this programme.

31. This programme is reported through the Strategic Transformation Board and to Audit Committee for oversight.

**RECOMMENDED**

32. Members are asked to consider and discuss the contents of the report and:
1) Note the reduction in two risk scores:
   Risk 163 from 20 (5x4) to 16 (4x4) and
   Risk 424 from 16 (4x4) to 12 (3x4)
2) Note the de-escalation of two risks to the Directorate Risk Registers:
   Risk 543 achieving target of 10 (2x5) and
   Risk 283 achieving target of 8 (2x4)
3) Note the inclusion of two new risks:
   Risk 542 at a score of 16 (4x4) and
   Risk 623 at a score of 15 (3x5)
4) Note the closure of Risk 458 from all registers.
5) Receive assurance on the review and attention to the principal risks, their review at ELT and at relevant Committees.
6) Note the ratings and mitigating actions for each principal risk.
7) Note the update on the Risk Management Transformation Programme.

**Annex 1 –** Corporate Risk Register Summary

| CORPORATE RISK REGISTER | | | | |
|---|---|---|---|---|
| **RISK ID** | **NEW RISK TITLE** | **NEW SUMMARY DESCRIPTION** | **EXECUTIVE OWNER** | **RISK SCORE** |
| 223<br><br>QuEST | The Trust's inability to reach patients in the community causing patient harm and death. | **IF** significant internal and external system pressures continue<br><br>**THEN** there is a risk of an inability and/or a delay in ambulances reaching patients in the community<br><br>**RESULTING IN** patient harm and death | Executive Director of Operations | **25 (5x5)** → |
| 224<br><br>QuEST | Significant handover delays outside A&E departments impacts on access to definitive care being delayed and affects the trust's ability to provide a safe and effective service. | **IF** patients are significantly delayed in ambulances outside A&E departments<br><br>**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<br><br>**RESULTING IN** patients potentially coming to harm and a poor patient experience | Executive Director of Quality & Nursing | **25 (5x5)** → |
| 160<br><br>PCC | High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service. | **IF** there are high levels of absence<br><br>**THEN** there is a risk that there is a reduced resource capacity<br><br>**RESULTING IN** an inability to deliver services which adversely impacts on quality, safety and patient/staff experience | Director of People & Culture | **20 (5x4)** → |
| 201<br><br>PCC | A loss of stakeholder confidence that damages the Trust's reputation. | **IF** there is an inability of the Trust to deliver its core services because of system or organisational pressures<br><br>**THEN** there will be a loss of stakeholder confidence in the Trust<br><br>**RESULTING IN** a lack of stakeholder support for the Trust's long term | Director of Partnerships & Engagement | **20 (4x5)** → |

| CORPORATE RISK REGISTER | | | | |
|---|---|---|---|---|
| **RISK ID** | **NEW RISK TITLE** | **NEW SUMMARY DESCRIPTION** | **EXECUTIVE OWNER** | **RISK SCORE** |
| | | strategic vision, a failure to deliver its strategic ambition, damage to reputation and increased external scrutiny | | |
| 594<br><br>FPC | The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death. | **IF** a major incident or mass casualty incident is declared<br><br>**THEN** there is a risk that the Trust cannot provide its pre-determined attendance as set out in the Incident Response Plan and provide an effective, timely or safe response to patients<br><br>**RESULTING IN** catastrophic harm (death) and a breach of the Trust's legal obligation as a Category 1 responder under the Civil Contingency Act 2004. | Executive Director of Operations | **20 (4x5)** → |
| 163<br><br>PCC | Maintaining Effective & Strong Trade Union Partnerships | **IF** the response to tensions and challenges in the relationships with Trade Union partners is not effectively and swiftly addressed and trust and (early) engagement is not maintained<br><br>**THEN** there is a risk that Trade Union partnership relationships increase in fragility and the ability to effectively deliver change is compromised<br><br>**RESULTING IN** a negative impact on colleague experience and/or services to patients. | Director of People & Culture | **16 (4x4)** ↓ **20 (5x4)** |
| **NEW**<br>542<br><br>FPC | Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan | **IF** there is a lack of resources and available technology and infrastructure<br><br>**THEN** there will be a failure to deliver the commitments outlined in | Executive Director of Finance & Corporate Resources | **16 (4x4)** |

| CORPORATE RISK REGISTER | | | | |
|---|---|---|---|---|
| **RISK ID** | **NEW RISK TITLE** | **NEW SUMMARY DESCRIPTION** | **EXECUTIVE OWNER** | **RISK SCORE** |
| | | the action plan and within the Welsh Government timelines<br><br>**RESULTING IN** negative environmental and social impacts causing and reputational damage | | |
| 458<br><br>FPC<br><br>**CLOSED** | A confirmed commitment from EASC and/or Welsh Government is required in relation to funding for recurrent costs of commissioning. | **IF** sufficient recurrent funding is not forthcoming there is a risk that the Trust will be committed to additional expenditure through delivery of the IMTP and in year developments which are only recognised by commissioners on a cost recovery basis<br><br>**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.<br><br>**RESULTING IN** patients not receiving services, the Trust not achieving financial balance and a potential failure to meet statutory obligations causing reputational damage. | Executive Director of Finance & Corporate Resources | **16 (4x4)** → |
| 260<br><br>FPC | A significant and sustained cyber-attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems. | **IF** there is a large-scale cyber-attack on WAST, NHS Wales and interdependent networks which shuts down the IT network and there are insufficient information security arrangements in place | Director of Digital Services | **15 (3x5)** → |

| CORPORATE RISK REGISTER | | | | |
|---|---|---|---|---|
| **RISK ID** | **NEW RISK TITLE** | **NEW SUMMARY DESCRIPTION** | **EXECUTIVE OWNER** | **RISK SCORE** |
| | | **THEN** there is a risk of a significant information security incident<br><br>**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 | | |
| 558<br><br>PCC | Deterioration of staff health and wellbeing in as a consequence of both internal and external system pressures | **IF** significant internal and external system pressures continue<br><br>**THEN** there is a risk of a significant deterioration in staff health and wellbeing within WAST<br><br>**RESULTING IN** increased sickness levels, staff burnout, poor staff and patient experience and patient harm | Director of People & Culture | **15 (3x5)** → |
| **NEW**<br>623<br><br>FPC | Failure to comply with Data Protection Legislation | **IF** the Trust fails to comply with and demonstrate it is meeting the accountability requirements under the Data Protection Act, the UK General Data Protection Regulation (GDPR) and the Common Law Duty of Confidentiality<br><br>**THEN** the Trust will breach its legal obligations and potentially cause the personal or sensitive data to be compromised, lost, or inappropriately used<br><br>**RESULTING IN** unauthorised data breaches/loss, financial or compensatory penalties, an increased regulatory scrutiny or enforcement as well as stakeholder mistrust and reputational damage. | Director of Digital Services | **15 (3x5)** |

| CORPORATE RISK REGISTER | | | | |
|---|---|---|---|---|
| **RISK ID** | **NEW RISK TITLE** | **NEW SUMMARY DESCRIPTION** | **EXECUTIVE OWNER** | **RISK SCORE** |
| 100<br><br>FPC | Failure to persuade EASC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience. | **IF** WAST fails to persuade EASC/Health Boards about WAST ambitions<br><br>**THEN** there is a risk of a delay or failure to receive funding and support<br><br>**RESULTING IN** a catastrophic impact on services to patients and staff and key outcomes within the IMTP not being delivered | Executive Director of Strategy Planning & Performance | **12 (3x4)** → |
| 424<br><br>FPC | Resource availability (revenue, capital, and staff capacity) to deliver the organisation's Integrated Medium-Term Plan (IMTP) | **IF** resources are not forthcoming within the funding envelope available to WAST (link to risk 139)<br><br>**THEN** there is a risk that there is insufficient capacity to deliver the IMTP<br><br>**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. | Executive Director of Strategy Planning and Performance | **12 (3x4)** ↓ **16 (4x4)** |
| 543<br><br>FPC<br><br>**De-escalate to the DRR** | Major disruptive incident resulting in a loss of critical IT systems | **IF** there is an unexpected or uncontrolled event e.g. flood, fire, security incident, power failure, network failure in WAST, NHS Wales or interdependent systems<br><br>**THEN** there is a risk of a loss of critical IT systems<br><br>**RESULTING IN** a partial or total interruption in WAST's effective ability to deliver essential services. | Director of Digital Services | **15 (3x5)** ↓ **10 (2x5)** |

| CORPORATE RISK REGISTER | | | | |
|---|---|---|---|---|
| **RISK ID** | **NEW RISK TITLE** | **NEW SUMMARY DESCRIPTION** | **EXECUTIVE OWNER** | **RISK SCORE** |
| 139<br><br>FPC | Failure to Deliver our Statutory Financial Duties in accordance with legislation. | **IF** the Trust does:<br>• not achieve financial breakeven and/or<br>• does not meet the planning framework requirements and/or<br>• does not work within the EFL and/or<br>• fails to meet the 95% PSPP target and/or<br>• does not receive an agreement with commissioners on funding (linked to 458)<br><br>**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)<br><br>**RESULTING IN** potential interventions by the regulators, qualified accounts and impact on delivery of services and reputational damage | Executive Director of Finance & Corporate Resources | **8 (2x4)** → |
| 283<br><br>FPC<br><br>**De-escalate to the DRR** | Failure to implement the EMS Operational Transformation Programme | **IF** there are issues and delays in the planning and organisation of the EMS Demand & Capacity Review Implementation Programme<br><br>**THEN** there is a risk that WAST will fail to implement the EMS Operational Transformation Programme to the agreed performance parameters<br><br>**RESULTING IN** potential patient harm, deterioration in staff wellbeing and reputational damage | Executive Director of Strategy Planning & Performance | **8 (2x4)** ↓<br><br>**12 (3x4)** |

## **Annex 2 -** Risk Scoring Matrix

| Consequence: | 1 Negligible | 2 Minor | 3 Moderate | 4 Major | 5 Catastrophic |
|---|---|---|---|---|---|
| Safety & Well-being - Patients/ Staff/Public | Minimal injury requiring no/minimal intervention or treatment.<br>No time off work.<br>Physical injury to self/others that requires no treatment or first aid.<br>Minimum psychological impact requiring no support.<br>Low vulnerability to abuse or exploitation - needs no intervention.<br>Category 1 pressure ulcer. | Minor injury or illness, requiring minor intervention.<br>Requires time off work for >3 days<br>Increased hospital stay 1-3 days.<br>Slight physical injury to self/others that may require first aid.<br>Emotional distress requiring minimal intervention.<br>Increased vulnerability to abuse or exploitation, low level intervention.<br>Category 2 pressure ulcer. | oderate injury/professional intervention.<br>Requires time off work 4-14 days.<br>Increased hospital stay 4-15 days.<br>RIDDOR/Agency reportable incident.<br>Impacts on a small number of patients.<br>Physical injury to self/others requiring medical treatment.<br>Psychological distress requiring formal intervention by MH professionals.<br>Vulnerability to abuse or exploitation requiring increased intervention.<br>Category 3 pressure ulcer. | Major injury leading to long-term disability.<br>Requires time off work >14 days.<br>Increased hospital stay >15 days.<br>RIDDOR Reportable.<br>Regulation 4 Specified Injuries to Workers.<br>Patient mismanagement, long-term effects.<br>Significant physical harm to self or others.<br>Significant psychological distress needing specialist intervention.<br>Vulnerability to abuse or exploitation requiring high levels of intervention.<br>Category 4 pressure ulcer. | Incident leading to death.<br>RIDDOR Reportable.<br>Multiple permanent injuries or irreversible health effects.<br>An event which impacts on a large number of patients. |
| Quality/ Complaints/ Assurance/ Patient Outcomes | Peripheral element of treatment or service suboptimal.<br>Informal complaint/inquiry. | Overall treatment/service suboptimal.<br>Formal complaint (Stage 1).<br>Local resolution.<br>Single failure of internal standards.<br>Minor implications for patient safety.<br>Reduced performance. | Treatment/service has significantly reduced effectiveness.<br>Formal complaint (Stage 2). Escalation.<br>Local resolution (poss. independent review).<br>Repeated failure of internal standards.<br>Major patient safety implications. | Non-compliance with national standards with significant risk to patients.<br>Multiple complaints/independent review.<br>Low achievement of performance/delivery requirements.<br>Critical report. | Totally unacceptable level or quality of treatment/service.<br>Gross failure of patient safety.<br>Inquest/ombudsman/inquiry.<br>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.<br>Unsafe staffing level (>1 day)/competence.<br>Low staff morale.<br>Poor staff attendance for mandatory/key professional training. | Uncertain delivery of key objective/ service due to lack/loss of staff.<br>Unsafe staffing level (>5 days)/competence.<br>Very low staff morale.<br>Significant numbers of staff not attending mandatory/key professional training. | Non-delivery of key objective/service due to loss of several key staff.<br>Ongoing unsafe staffing levels or competence/skill mix.<br>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.<br>Reduced performance levels if unresolved. | Single breach in statutory duty.<br>Challenging external recommendations/improvement notice. | Enforcement action. Multiple breaches in statutory duty. Improvement notices.<br>Low achievement of performance/ delivery requirements. Critical report. | Multiple breaches in statutory duty.<br>Zero performance rating. Prosecution.<br>Severely critical report. Total system change needed. |
| Adverse Publicity or Reputation | Rumours.<br>Low level negative social media.<br>Potential for public concern. | ocal media coverage - short-term reduction in public confidence/trust.<br>hort-term negative social media.<br>ublic expectations not met. | Local media coverage - long-term reduction in public confidence & trust.<br>Prolonged negative social media. Reported in local media. | National media coverage <3 days, service well below reasonable public expectation.<br>Prolonged negative social media, reported in national media, long-term reduction in public confidence & trust.<br>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.<br>Total loss of public confidence/trust.<br>Escalation of scrutiny status by WG. |
| Business Objectives or Projects | Insignificant cost increase/ schedule slippage. | <5 per cent over project budget.<br>Schedule slippage. | 5–10 per cent over project budget.<br>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.<br>Schedule slippage.<br>Key objectives not met. |
| Financial Stability & Impact of Litigation | Small loss.<br>Risk of claim remote. | Loss of 0.1–0.25% of budget<br>Claim less than £10,000. | Loss of 0.25–0.5% of budget.<br>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.<br>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.<br>Minor disruption. | Loss/interruption of >8 hours.<br>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.<br>Total shutdown of operations. |
| Environment/Estate/ Infrastructure | Minimal or no impact on environment/service/property. | Minor impact on environment/ service/property. | Moderate impact on environment/ service/property. | Major impact on environment/ service/property. | Catastrophic impact on environment/service/property. |
| Health Inequalities/ Equity | Minimal or no impact on attempts to reduce health inequalities/improve health equity. | Minor impact on attempts to reduce health inequalities or lack of clarity on the impact on health equity. | Lack of sufficient information to demonstrate reducing equity gap, no positive impact on health improvement or health equity. | Validated data suggests no improvement in the health of the most disadvantaged, whilst supporting the least disadvantaged, no impact on health improvement and/or equity. | Validated data demonstrates a disproportionate widening of health inequalities, or negative impact on health improvement and/or equity. |

| Risk Scoring Matrix (Likelihood x Consequence = Risk Score) | | Consequence: | | | | |
|---|---|---|---|---|---|---|
| Likelihood: | Frequency: | 1 Negligible | 2 Minor | 3 Moderate | 4 Major | 5 Catastrophic |
| 1 Highly Unlikely: Will probably never happen/recur | Not for years | 1 | 2 | 3 | 4 | 5 |
| 2 Unlikely: Do not expect it to happen/recur but it is possible | At least annually | 2 | 4 | 6 | 8 | 10 |
| 3 Likely: It might happen/recur occasionally | At least monthly | 3 | 6 | 9 | 12 | 15 |
| 4 Highly Likely: Will probably happen/recur, but not a persisting issue | At least weekly | 4 | 8 | 12 | 16 | 20 |
| 5 Almost Certain: Will undoubtedly happen/recur, maybe frequently | At least daily | 5 | 10 | 15 | 20 | 25 |

**Annex 3 -** Frequency of Risk Review

| Risk Score | Review Frequency | Risk Rating |
|---|---|---|
| 15 – 25<br>Red | Review monthly | High |
| 8 – 12<br>Amber | Review quarterly | Medium |
| 1 – 6<br>Green | Review every 6 months | Low |

**Annex 4** – Board Assurance Framework

| Risk ID 223 | The Trust's inability to reach patients in the community causing patient harm and death | Date of Review: | 15/04/2024 | TREND | 25 (5x5) |
|---|---|---|---|---|---|
| | | Date of Next Review: | 15/05/2024 | ➡ | |

| 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:

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

**Risk Commentary Q4 2023/24**

The risk score remains constant at 25 (almost certain & catastrophic). Internal and external assurances remain weak as there remains a daily risk of actual patient harm and death because of the Trust not being able to reach patients in the community. The Trust continues to receive Prevention of Future Death Reports (Regulation 28) from Coroners across NHS Wales. **Handover lost hours in February and March 2024 were 23,896 (Feb) and 23,404 (March).**
Only Cardiff & Vale University Health Board has demonstrated material improvement and is a positive outlier. The impacts on patients waiting for extended periods of time both in the community and then outside emergency departments is well documented (AACE Delayed Hospital Handovers: Impact assessment of patient harm, 2021) and includes pressure damage, acute kidney injury, deconditioning, poorer outcomes, and extended recovery times. Delays across the system continue to be the focus of patient safety incidents, complaints, Coronial enquires and redress / claims. The effectiveness of our controls in many areas are dependent on external partners acknowledging and having ownership of the risk across the urgent and emergency care system. Key to moving the position is to continue to work in collaboration influencing system partners, being present and engaging in key conversations, whilst continually seeking opportunities internally to swiftly identify and mitigate the risks within our control and share those with relevant system partners that we cannot control. Of note, recent data analysis highlights the increased levels of red activity which has doubled since the pre covid period, plus an average increased on scene time of circa 10 minutes. Both measures are reflective of an increasingly challenged system with WAST crews fully exploring admission avoidance alternatives.

Improvement actions led by Welsh Government and system partners include: -

a) Audit Wales's investigation of Urgent and Emergency Care System. Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time? (E)
b) Consideration of additional WAST schemes to support risk mitigation through winter (I)
c) NHS Wales reduces emergency department handover lost hours by 25% (E)
d) NHS Wales eradicates all emergency department handover delays in excess of 4 hours (E)
e) Alterative capacity equivalent to 1000 beds (E)
f) Implement nationwide approach to emergency department 'Fit 2 Sit' (E)
g) Implementation of Same Day Emergency Care services in each Health Board (E)
h) National Six Goals programme for Urgent and Emergency Car (E)

| CONTROLS | ASSURANCES |
|---|---|
| | **Internal Management (1st Line of Assurance)** |
| 1. Regional Escalation Protocol | 1. Daily conference calls to agree RE levels in conjunction with Health Boards |
| 2. Immediate release protocol | 2. The Immediate Release Protocol is a Nationally agreed NHS Wales protocol. Refusals by Health Boards are Datixed by WAST and compliance report shared weekly with the Health Board Chief Operating Officers (COOs) |
| 3. Resource Escalation Action Plan (REAP) | 3. Weekly review by Senior Operations team with assessment of action compliance. The Senior Leadership Team convenes every Tuesday as the Weekly Performance Meeting to review performance and demand data, and review/assign REAP Levels as appropriate. Dynamic escalation via Strategic Command structure. REAP has undergone an annual review with v4.1 released in November 2023. |
| 4. 24/7 Operational Delivery Unit (ODU) | 4. Shift reports from ODU & ODU Dashboard received by Exec, SOT and On-Call Team at start/end. Provides operational oversight with dynamic CSP review and system escalation as required. |
| 5. Strategic, Tactical and Operational 24 hour/ 7 day per week system to manage escalation plans | 5. Same as 5 - Shift reports from ODU & ODU Dashboard received by Exec, SOT and On-Call Team at start/end. Provides operational oversight with dynamic CSP review and system escalation as required. On Call cover is reviewed weekly at SLT Performance Meetings. |
| 6. Limited Alternative Care Pathways in place | 6. Limited Assurance - Health Informatics reports, APP dashboard monitors, reports on app use by Consultant Connect, APP development and expansion, and bids for additional prescribing APPs. |
| 7. Consult and Close (previously Hear and Treat) | 7. The Trust ambition is to attain 17% Consult and Close rate, with an improvement plan in place to achieve this. The Trust has however already achieved the inclusion of Mental Health Practitioners in CSD, a key contributor to the achievement of Consult and Close rates. Reported through integrated quality meeting. Whilst Consult and Close is in place, the action to increase compliance is detailed in action 10. |
| 8. Advanced Paramedic Practitioner (APP) deployment model / APP Navigation | 8. WAST has attempted to secure additionality within its APP numbers, as the evidence illustrates a dramatic impact upon ED avoidance with more people being managed within the community. At this stage, no additional funds have been secured. However, it remains the case the prospective APPs are completing their education and could be deployed into the operational setting to mitigate the risk. ELT has therefore agreed to grow the APP numbers further this year, redirecting existing operational spend to bolster APP growth. |

| Risk ID 223 | The Trust's inability to reach patients in the community causing patient harm and death | Date of Review: | 15/04/2024 | TREND | 25 (5x5) |
|---|---|---|---|---|---|
| | | Date of Next Review: | 15/05/2024 | ➡ | |

| 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 |

| | |
|---|---|
| 9. Clinical Safety Plan | 9. Clinical agreement – agreeing escalation to higher levels, ODU dashboard, AACE paper through National Director of Operations group. In December 2023, Version 2.21 of the Clinical Safety Plan was released. The subsequent reduction in the demand is the assurance which is dynamically monitored via ODU. |
| 10. Recruitment and deployment of CFRs | 10. Approaching 500 active CFRs at end of Q4 with a training trajectory to recruit a minimum of 250 more in the coming 12 months. Response data indicates that our CFRs are reaching more patients, especially those with life threatening conditions in 8 minutes compared to this time last year. Numbers of CFR's, percentage of contribution to performance a governance framework is in place. Monitoring through AD 1:1's and volunteer highlight report (IMTP). |
| 11. ETA scripting | 11. The ETA Dashboard is a tactic that was signed off by ELT. The dashboard supports scripting analysed by comparing with real time data. ETA performance is reviewed weekly at SLT weekly performance meeting. The effect of the ETA scripting results in cancellations of ambulances which is monitored through algorithmic review process. |
| 12. Clinical Contact Centre (CCC) emergency rule | 12. Emergency Rule is incorporated into CSP 999 levels. |
| 13. National Risk Huddle | 13. This is a tactic contained in REAP ratified through SPT and EPT. Daily risk huddles are recorded, and documented actions are shared with stakeholders and progress monitored via the ODU. |
| 14. Summer/Winter initiatives | 14. Monitoring through SLT and STB. Senior Planning Team (SPT) is now stood up for the duration of Winter 2023/24. |
| 15. CHARU implementation | 15. Recruitment of 153 WTE has continued; To lift further, a trial of a rotational model is due to be trialled in Aneurin Bevan Health Board area. |
| 16. Clinical Model and clinical review of code sets | 16. Reported through CPAS and DCR Review reporting through CQGG |
| 17. Remote clinical support enabling discharge at scene | 17. Strategic Transformation Board – IMTP deliverable; Providing support to the Community Welfare Responders (CWR) initiative and supporting CFRs to discharge at scene with current non conveyance rates for CFRs in excess of 40% |
| 18. Trust Board paper (28/07/22) detailing actions being taken to mitigate the risks (see actions section for details of specific work streams being progressed to mitigate this risk) | 18. Formally documented action plan – actions captured are contained within and monitored via the Mitigating avoidable harm paper from PIP. |
| 19. Information sharing | 19. Information Sharing: Patient Safety Reports, Chief Operating Officer (COO) Data Pack, Immediate Release Declined (IRD) Reports. |
| 20. Completed EMS Roster Review | 20. Helps to ensure that we have the maximum available capacity to respond to dispatch to 999 calls received in a timely manner. Monitor production against the rosters weekly at performance meeting and that provides a level of UHP as a percentage. |
| 21. Delivered a reduction in the number of multiple vehicle attendances dispatched to red calls | 21. This will increase vehicle availability generally across the Trust and is monitored through SLT weekly performance meeting**.** |
| 22. Transfer of Care | 22. WAST has clearly articulated to the Health Board COOs the risk associated with delayed handovers. Consequently, work has commenced to withdraw WAST staff from portering duties on hospital premises, cease the practice of ED swaps and cease the use of WAST equipment in EDs across Wales. Please refer to the following documents:<br>i) Letter to COO Handover Delays 30.03.2023<br>ii) Letter to COO Handover Delays<br>iii) WAST – Transfer of Care Brief |
| 23. Virtual Ward – Connect Support Cymru | 23. Multi phased approach commenced in Dec 2022 with St John Ambulance Cymru virtual ward responder, a digital and telehealth platform, and a Community Welfare Responder model to enhance community resilience.<br>• Phase 1 delivered through St John Ambulance Cymru with a further extension in place.<br>• Funding also obtained through external grant funding to pilot a volunteer phase. which went live mid-October with twelve teams piloting the approach and has now completed.<br>• Work has now commenced to recruit CWR volunteers with engagement taking place with organisations across Wales.<br>• **St John Ambulance Cymru virtual ward now extended to the end of April 2024.** |
| 24. ARA – Acute Release Area - GUH | 24. Live until 31st March 2024 |
| 25. 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 / | 25. 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. |

| Risk ID 223 | The Trust's inability to reach patients in the community causing patient harm and death | Date of Review: | 15/04/2024 | TREND | 25 (5x5) |
|---|---|---|---|---|---|
| | | Date of Next Review: | 15/05/2024 | ➡ | |

| 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 |

NHS Wales Executive Delivery Unit under the Joint Investigation Framework which was formalised in the National Patient Safety Policy in May 2023. Sharing of potential case of serious avoidable harm/death with Health Boards for investigation when response delay associated with system congestion is the primary cause. CNO and CMO plus peer group and COOs regularly updated on patient safety incidents. 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.

26. WAST membership of the working group (Executive Director of Quality & Nursing) to reform the Framework for the Investigation of Patient Safety Serious Incidents (SIs) national investigation framework with system partners. Chaired by the Deputy Chief Ambulance Commissioner and commenced in August 2022.

27. Workshop with system partners in place with executive directors of nursing attendance and to date is working well with good engagement from health board colleagues. Following the last meeting on 25.01.2023 it was agreed that sub-groups would be formed to meet more frequently to gather themes / evaluation / develop more consistency which would include aligning the outputs / outcomes with the 'Six Goals for Urgent and Emergency Care' work.

| GAPS IN CONTROLS | GAPS IN ASSURANCE |
|---|---|
| 1. Acknowledgement and acceptance of risk by Health Boards and balancing the risks across the whole system | 1. Improvement in handover delays across Cardiff and Vale and more latterly across AB have led to improved handovers at Eds. This has now been sustained for some months across C&V in a phased programme of improvement with no delays in excess of 2 hours. Programme of improvement underway in AB, commencing at 4hour tolerance with a plan to reduce over time. In other Health Boards, there remains little or no controls, with variation in both handovers and risk levels across Health Boards. An extraordinary incident declared by WAST on 22 October 2023 as direct result of system risk associated with handover delays at Morrison hospital has increased focus on handover delays with external partners and across the media. Some plans are in train (detailed in actions) following a meeting with Swansea Bay COO to include mobile imaging, pathways to bypass ED and a pod solution ahead of winter. |
| 2. Blockages in system e.g., internal capacity within Health Boards which affect patient flow | |
| 3. Local delivery units mirroring WAST ODU | |
| 4. Handover delays link to risk 224 | |
| 5. There is an ambition that no handover should exceed 4 hours and for lost hours to handover to be reduced by 25% but given the track record over last 12 months there is a low confidence in attaining this. | The majority of Health Boards have failed to deliver on this ambition; With the exception of Cardiff and Vale University Health Board, the remaining 5 Health Boards with acute Trusts that were required to deliver on this target, have failed to do so. |
| 6. Handover Improvement Plans agreed between WAST and Health Boards | 12. **Performance targets for Handover with Health Boards have been introduced by the commissioner**. |
| 18. Access to Same Day Emergency Care (SDEC) for paramedic referrals | 18. This forms part of the handover improvement plans in place with Health Boards; however, assurance is limited given that the uptake is low (less than 1% of total demand). There is an inconsistency in approach from Health Boards on eligibility and availability; The national Once for Wales acceptance criteria has not been uniformly deployed by Health Bards across Wales. |
| *Please note that the gaps listed are not WAST's and are therefore outside of the control of WAST* | |

| Actions to reduce risk score or address gaps in controls and assurances | Action Owner | By When/Milestone | Progress Notes: |
|---|---|---|---|
| 1. Exploring Rural model options (Paused during Pandemic Response) – subject to funding through IMTP. Now refreshed to wider rural model opportunities to include recruitment of CFRs. Additional funding has been sourced to increase posts within the volunteer function. | Assistant Director of Operations EMS / Assistant Director of Operations – National Operations & Support | Superseded | Rural model superseded by Action 9 below (Recruitment and deployment of CFRs) |
| 2. Leading Change Together (forum to progress workforce related work streams jointly with TUPs) | ADLT Sub-Group | 30.09.22 - Superseded | |
| 3. Recruit and train more Advanced Paramedic Practitioners – Value Based Healthcare Fund bid for up to 50 WTE (I) [Source: Action Plan presented to Trust Board 28/07/22] | Director of Paramedicine / Director of People & Culture | **Extended to June 2024** | WAST has attempted to secure additionality within its APP numbers, as the evidence illustrates a dramatic impact upon ED avoidance with more people being managed within the community. At this stage, no additional funds have been secured. However, it remains the case the prospective |

| Risk ID 223 | The Trust's inability to reach patients in the community causing patient harm and death | Date of Review: | 15/04/2024 | TREND | 25 (5x5) |
|---|---|---|---|---|---|
| | | Date of Next Review: | 15/05/2024 | ➡ | |

| 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 |

| | | | |
|---|---|---|---|
| | | | APPs are completing their education and could be deployed into the operational setting to mitigate the risk. ELT has therefore agreed to grow the APP numbers further this year, redirecting existing operational spend to bolster APP growth.<br>**May24 - Initial bid unsuccessful however an action within the new IMTP to grow our APP workforce by up to 40 per year for the next 3 years. Updates will progress through the IMTP within quarters. Milestone changed from March 2024 to June 2024.** |
| 4. Transition Plan (I) [Source: Action Plan presented to Trust Board 28/07/22] | | Superseded | |
| 5. Overnight Falls Service extension (I)<br>[Source: Action Plan presented to Trust Board 28/07/22] | Assistant Director of Quality & Governance / Head of Quality Improvement | Ended March 2023 | The temporary extension of the SJAC contract for overnight provision was evaluated, demonstrating on available evidence a positive performance impact over the period of operation (Jan-April 2023). The evaluation report was presented to EMT on 5 April 2023. The contract extension (as a temporary arrangement) ceased on 5 April 2023. Falls service enhanced day and night provision remains in place and utilisation of resources is reviewed at weekly performance meetings by Operations SLT. |
| 6. New 2023 EMS Demand and Capacity (roster) review | Assistant Director of Planning & Performance | **August 2024** | ORH modelling underway. Initial findings January 2024, full report to Trust Board and EASC in March.<br>**May24 - The review is scheduled to be presented to Trust Board end of July 2024. Milestone changed from March 2024 to August 2024.** |
| 7. Swansea Bay Winter actions | Assistant Director of Operations, EMS | **Completed** | Some plans are in train following a meeting with Swansea Bay COO to include mobile imaging, pathways to bypass ED and a pod solution ahead of winter.<br>Palliative Care Paramedics commenced on 15/01/2024.<br>22/02/2024 - POD solution now in operation which is facilitating shift breaks. Palliative care paramedics have been deployed for a pilot in care homes and nursing homes.<br>**May24 - Significant reduction in overruns realised. In addition, during the last 2 months, 0 missed meal breaks recorded in Swansea Bay area. Completed** |
| 8. Mental Health response pilot | Assistant Director of Operations, EMS | **Completed** | Pilot to commence in Aneurin Bevan Health Board area Nov 2023.<br>22/02/2024 - Mental Health pilot launched in Aneurin Bevan January 2024 with a view to run until end of March 2024.<br>**May24 - Mental Health Response pilot finished in March 2024 – Complete. NB: there is an appetite to further the MH response pilot within the IMTP.** |
| 9. Connected Support Cymru – is initially designed to utilise NHS and voluntary-sector resources and responders to enable patients to be supported in their own home whilst waiting for an urgent healthcare need to be managed. The service will employ digital health technologies to connect patients, communities and clinicals to achieve better health outcomes. The initiative will improve patient experience and safety, while supporting the healthcare system in directing patients to the right pathway at an appropriate time for their care need. It is expected this will help reduce unnecessary demand upon Emergency Departments. | Assistant Director of Quality Governance | **April 2024** | Multi phased approach commenced in Dec 2022 with St John Ambulance Cymru virtual ward responder, a digital and telehealth platform, and a Community Welfare Responder model to enhance community resilience.<br>• Phase 1 delivered through St John Ambulance Cymru with a further extension in place **and further extended until April 2024**<br>• Funding also obtained through external grant funding to pilot a volunteer phase. which went live mid-October with twelve teams piloting the approach and has now completed. |

| Risk ID 223 | The Trust's inability to reach patients in the community causing patient harm and death | Date of Review: | 15/04/2024 | TREND | 25 (5x5) |
|---|---|---|---|---|---|
| | | Date of Next Review: | 15/05/2024 | ➡ | |

| 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 |

| | | | |
|---|---|---|---|
| | | | Work has now commenced to recruit CWR volunteers with engagement taking place with organisations across Wales. |
| 10. Maximise the opportunity from Consult and Close:<br>- **Successful resolution without ambulance (double EMS)**<br>- **Successful resolution without conveying to ED** | | **March 2025** | Trust ambition is **to improve** Consult and Close rate, with an improvement plan in place to achieve this. The Trust has however already achieved the inclusion of Mental Health Practitioners in CSD, a key contributor to the achievement of Consult and Close rates. Consult and Close compliance remains around 14%. Action plan activities therefore continue with a review of triage processes which may lead to shorter triage durations, along with increase in staffing, which together will enable more triages to take place, **thus increasing the number of successful resolutions without a double EMS ambulance and numbers conveyed to an ED.** |
| 11. Development of new model of care | Head of Strategy Development | 2024/25 | Development of the model remains ongoing |
| 12. Development of the pathway which connects mental health users connecting via the 999 system to 111 Press 2 services | Assistant Director of Operations, Integrated Care | **Completed** | Development of the model remains ongoing.<br>**May24 – Pathway went live on 30th April 2024. Completed** |
| 13. Palliative Care Paramedic Unit | Assistant Director of Operations | **Extended to May 2024** | Reducing demand via APPs – 15th January Start.<br>**15/04/2024 - 3 Month Health Board funded trial ended. Whilst utilisation was low, the results demonstrated a circa 75% ED avoidance therefore local decision made to extend for a further 2 months, however, opening the trial up to wider community and crew referrals.** |
| 14. Audit Wales investigation of Urgent and Emergency Care System: Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time? | CEO | Q1 2024-2025 | • Conducted in three phases Audit Wales will independently investigate and report on patient flow out of hospital: access to unscheduled care services and national arrangements (structure, governance, and support)<br>• WAST will proactively support this work and offer best practice examples from other jurisdictions that can support benchmarking and improvement activities.<br>• Expected outcomes in 2023/24. |
| 15. Winter Ambulance Handover Improvement Plan Meetings | Executive Director of Operations | **Completed** | • Weekly meetings set up with Welsh Government, NHS Executive, CASC and the Health Board COOs. All parties (including WAST) to provide updates on actions being taken to alleviate and improve handover delays. WAST to update on C&C, CWR, red dispatch and local updates from EMS HOS on initiatives. |
| **16. Royal Glamorgan Early Diagnostic** | **Executive Director of Operations** | **May 2024** | • **Initial data from Qlik shows that there has been no reduction in N2H times however data received from Health Board show indication of patient benefit to reach earlier diagnostic. Local meetings this month to discuss findings and explore opportunities.** |

| 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: | 14/04/2024 | TREND | 25 (5x5) |
|---|---|---|---|---|---|
| | | Date of Next Review: | 14/05/2024 | ➡ | |

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

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

IMTP Deliverable Numbers:

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

**Risk Commentary Q4 2023/24**

- The risk score remains constant at 25 for quarter 4 2023/24 (almost certain & catastrophic). Internal and external assurances remain weak as there remains a daily risk of actual patient harm due to handover of care delays. **There were 2,091 +4-hour patient handovers in February 2024, compared to 1,586 in February 2023. The target was originally to have 0 by September 2022. The EASC expectation was that these would be eradicated by end of 2023/24. Handover lost hours in February 2024 were 23,896 compared to 19,110 in February 2023. Early data from March 2024 shows**
- **some days where over 1,000 hours were lost. Cardiff & Vale UHB has demonstrated material improvement and is a positive outlier when compared to other health boards.** The impacts on patients waiting for extended periods of time both in the community and then outside emergency departments is well documented (AACE Delayed Hospital Handovers: Impact assessment of patient harm, 2021) and includes pressure damage, acute kidney injury, deconditioning, poorer outcomes, and extended recovery times. Delays across the system continue to be the main focus of patient safety incidents, complaints, coronial enquiries and redress / claims. The Trust continues to receive Prevention of Future Death Reports (Regulation 28) from Coroners across NHS Wales. The Trust has received 10 reports since April 2023, including 3 reports in quarter 4 2023/4. 6 of these reports directly relate to system pressures with the coroners raising concerns about delays in responding to patients in the community and handover of care delays at emergency departments. **The Trust received the first Prevention of Future Deaths Report in February 2024 relating to pressure damage, which is a joint Report with Swansea Bay University Health Board. On 22.02.2024 a Prevention of Future Deaths Report was sent solely to the Minister for Health and Social Services, Welsh Government in respect of delays responding to a patient in community which also references handover of care delays.** The effectiveness of our controls in many areas are dependent on external partners acknowledging and having ownership of the risk across the urgent and emergency care system. Key to moving the position is to continue to work in collaboration influencing system partners, being present and engaging in key conversations, whilst continually seeking opportunities internally to swiftly identify and mitigate the risks within our control and share those with relevant system partners that we cannot control. WAST CEO and Directors have ensured that system safety and avoidable harm remain a live topic of discussion in all relevant forums and continue to seize opportunities as they emerge that can contribute to mitigating avoidable harm. **Given the long-standing nature of the system pressures and long handover times, we have commenced work to better define mitigations to safety risks and quality of care deriving from extended periods in an ambulance; these include the application of Mental Capacity Act and Deprivation of Liberty Safeguards and, Fundamentals of Care including pressure area care, mobilisation and nutrition. One specific area of focus is the development of a prototype mattress for our ambulance trolleys.**

Improvement actions led by Welsh Government and system partners include:

a) Right care, right place, first time Six Goals for Urgent and Emergency Care - A policy handbook 2021–2026. Goal 4 'Improving ambulance patient handover, ensuring no one arriving by ambulance at an Emergency Department waits more than 60 minutes from arrival to handover to a clinician – (Welsh Government) ***by the end of April 2025***
b) National Six Goals programme for Urgent and Emergency Care: Led by the NHS Wales Deputy Chief Executive this programme seeks to modernise access to and the provision of Urgent and Emergency Care across Wales. WAST is represented on the Clinical Reference Group by the Director of Paramedicine and on the overarching programme board by the Executive Director of Strategy, Planning & Performance.
c) The Trust also has a presence on all the individual goal boards. The Trust has been asked to provide a presentation on its offer to the system at the next Six Goals Programme Board (24 January 2024).
d) NHS Wales eradicates all emergency department handover delays more than 4 hours (LHB CEOs) ***revised to March 2023/24.***
e) Alternative capacity equivalent to 1,000 beds project (LHB CEOs) – 678 additional beds delivered, a significant achievement, but short of the target of 1,000.
f) Investigation of Urgent and Emergency Care System: Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time? (Audit Wales)
g) Implement nationwide approach to emergency department 'Fit 2 Sit' (Welsh Government: Chief Medical Officer and Chief Nursing Officer) - paused.
**Health boards have previously been required to develop handover reduction action plans, which are monitored at their Integrated Quality, Planning & Delivery (IQPD) meetings by Welsh Government. Handover is also discussed at the Integrated Commissioning Action Plan (ICAP) meetings (currently paused as commissioning arrangements transition into the new Joint Commissioning Committee) which are held monthly between the CASC, the Trust and each Health Board.**

| CONTROLS | ASSURANCES |
|---|---|
| | **Internal Management (1st Line of Assurance)** |
| 1. WAST Serious Clinical Incident Forum (SCIF) is in place to discuss patient safety incidents, learning and improvement actions to prevent future harm, working in collaboration with Health Boards / NHS Wales Executive Delivery Unit under the Joint Investigation Framework which was formalised in the National Patient Safety Policy in May 2023. Sharing of potential case of serious avoidable harm/death with Health Boards for investigation when response delay associated with system congestion is the primary cause. CNO and CMO plus peer group and COOs regularly updated on patient safety incidents. | 1. Patient safety reporting and escalation through the Serious Clinical Incident Panel (SCIF), Patient Safety Highlight Reports, Health Board specific reports in place with escalation through WAST governance framework. |

| 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: | 14/04/2024 | TREND | 25 (5x5) |
|---|---|---|---|---|---|
| | | Date of Next Review: | 14/05/2024 | ➡ | |

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

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

| | |
|---|---|
| 2. WAST membership of the working group (Executive Director of Quality & Nursing) to reform the Framework for the Investigation of Patient Safety Serious Incidents (SIs) national investigation framework with system partners. Chaired by the Deputy Chief Ambulance Commissioner and commenced in August 2022. | 2. Workshop with system partners in place with executive directors of nursing attendance and to date is working well with good engagement from health board colleagues. Following the last meeting on 25.01.2023 it was agreed that sub-groups would be formed to meet more frequently to gather themes / evaluation / develop more consistency which would include aligning the outputs / outcomes with the 'Six Goals for Urgent and Emergency Care' work. **An event reviewing the effectiveness of the joint Investigation Framework is currently being scoped nationally.** |
| 3. WAST and system compliance with National Standards - 15-minute handover (NHS Wales Hospital Handover Guidance v2 (May 2016) | 3. Monthly Integrated Quality and Performance Report, Health Informatics reports, APP dashboard on app use by Consultant Connect and shared at local and corporate meetings regarding patient safety and handover of care position across NHS Wales and NHS England. |
| 4. WAST Clinical Notice in place - Escalating a clinical concern with a deteriorating patient outside the Emergency Department (11.02.2021). National Early Warning Score (NEWS) trigger of 5 or above for escalation to hospital clinicians. NEWS data available via EPCR (electronic patient care record). | 4. NEWS data now available via ePCR and escalation system in place via local managers and the Operational Delivery Unit. |
| 5. Workstreams put in place to meet requirements of *Right care, right place, first time Six Goals for Urgent and Emergency Care A policy handbook 2021–2026.* Goal 4 incorporates the reduction of handover of care delays through collective system partnership.<br>WAST membership at system workshops supported by Commissioners looking at handover of care delays which includes the implementation of the Fit2Sit programme and handover of care checklist pan NHS Wales. Learning from NWAS shared that indicates up to 20% of ambulance arrivals may be suitable for Fit 2 Sit Additionally, the Emergency Ambulance Services Committee (EASC) have stated that no delay should exceed 4 hours. | 5. Monthly Integrated Quality and Performance Report |
| 6. Hospital Ambulance Liaison Officer (HALO) (Some Health Boards). | 6. |
| 7. Regional Escalation Protocol and Resource Escalation Action Plan (REAP). Proactive and forward-looking weekly review of predicted capacity and forecast demand. Deployment of predetermined actions dependant on assessed level of pressure. Consideration of any bespoke response/actions plans in the light of what is expected in the coming week. WAST has updated the REAP in advance of winter, including revised triggers (higher) for handover lost hours. | 7. The Senior Leadership Team convenes every Tuesday as the Weekly Performance Meeting to review performance and demand data, and review/assign REAP Levels as appropriate. Dynamic escalation is via the Strategic Command structure. REAP has undergone an annual review with v4.1 released in November 2023. |
| 8. Staff from WAST, Health Boards and third sector organisations assisting to meet patient's Fundamentals of Care as best they can in the circumstances. | 8. Confirmed through Healthcare Inspectorate Wales (HIW) workshops and Health & Care Standards self-assessment process and Putting Things Right Quarterly Reports to Clinical Quality Governance Group and QuEST |
| 9. 24/7 operational oversight by ODU with dynamic Clinical Safety Plan review and system escalation as required. Realtime management and escalation of risks and harm with system partners. Triggering and escalation levels within CSP to best manage patient safety in the context of prevailing demand and available response capacity. Monitoring, escalation and reporting of extreme response or handover delays. | 9. Shift reports from ODU & ODU Dashboard received by Executive Management Team (EMT), Senior Operations Team (SOT) and On-Call Team at start/end. Realtime management and escalation of risks and harm with system partners. Triggering and escalation levels within CSP to best manage patient safety in the context of prevailing demand and available response capacity. Monitoring, escalation and reporting of extreme response or handover delays. In December 2023, Version 2.21 of the Clinical Safety Plan was released. The reduction in the demand is the assurance which is dynamically monitored via ODU. |
| 10. Gold/Strategic, Silver/Tactical and Bronze/Operational 24 hour/ 7 day per week system to manage escalation plans. | 10. Shift reports from ODU & ODU Dashboard received by EMT, SOT and On-Call Team at start/end. On Call cover is reviewed weekly at SLT Performance Meetings. |
| 11. Escalation forums to discuss reducing and mitigating system pressures. | 11. Daily risk huddles are recorded, and documented actions are shared with stakeholders and progress monitored via the ODU. |
| 12. WAST Education and training programmes include deteriorating patient (NEWs), tissue viability and pressure damage prevention, dementia awareness, mental health. | 12. Monthly Integrated Quality and Performance Report (October 2023 overall 76% - Safeguarding and dementia awareness remains over 91%. |
| 13. Clinical audit programme in place. | 13. Clinical audit programme in place (dynamic document) with oversight from the Clinical Quality Governance Group and QuEST. |

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|---|---|---|---|---|---|
| | | Date of Next Review: | 14/05/2024 | ➡ | |

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

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

| | |
|---|---|
| 14. Workshop set up by the Deputy Chief Ambulance Commissioner to respond to the findings in the Health Care Inspectorate Wales (HIW) Report *Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover* (undertaken 2021). WAST has senior representation at this meeting. – assurance is that HIW approve and sign off WAST elements and Health Board elements of recommendations. | 14. Workshop set up by the Deputy Chief Ambulance Commissioner to respond to the findings in the Health Care Inspectorate Wales (HIW) Report Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover (undertaken 2021). WAST has senior representation at this meeting. A collective response from WAST and Health Boards is being overseen by EASC. |
| 15. Escalation of patient safety concerns by Trust Board: featured in provider reports to the Emergency Ambulance Committee (EASC); been the subject of Accountable Officer correspondence to the NHS Wales Chief Executive; numerous escalations to professional peer groups initiated by WAST Directors; and coverage at Joint Executive Meetings with Welsh Government.<br>Evidence submission to Senedd Health and Social Care Committee. Written evidence submitted during Q4 21/22 to the committee to assist their inquiry into Hospital Discharge and its impact on patient flow through hospitals.<br>Report published in June 2022 containing 25 recommendations with recommendation six specifically WAST related stating "The Welsh Government should explain how the targets outlined in the Minister for Health and Social Service's statement of 19 May 2022 on urgent and emergency care and the Six Goals Programme to eradicate ambulance patient handover delays of more than four hours and reduce the average ambulance time lost per arrival by 25 per cent (from the October 2021 level) have been set. It should also confirm the target dates for the achievement of these targets." | 15. Monthly Integrated Quality and Performance Report, CEO Reports to Trust Board including 'Actions to Mitigate Avoidable Patient Harm Report' (last presented to Trust Board November 2023) and Board sub-committee oversight and escalation through 'Alert, Advise and Assure' reports. |
| 16. Implementation of Duty of Quality, Duty of Candour, and new Quality Standards requirements in April 2023. | 16. Welsh Government Road Map in place (soft launch) with milestones for organisations – baseline assessment and monthly updates (RAG ratings) in place with Trust Board oversight. The current internal assessment overall as of **February** 2024 is 'Implementing and operationalising'. The Trust has representation on the All Wales Duty of Candour Implementation Group and is actively engaged in developing resources. From April 2024 the Trust will publish an annual quality report and compliance with Duty of Candour. Operational oversight occurs at the Quality Management Group and Executive oversight is via the Clinical Quality Governance Group. |
| 17. Clinical Support Desk First in place | 17. |
| 18. Summer/Winter initiatives | 18. Monitoring through SLT and STB. Senior Planning Team (SPT) is now stood up for the duration of Winter 2023/24. |
| | **External Sources of Assurance Management (1st Line of Assurance)** |
| | 1. Monitoring and oversight of the Ambulance Quality Indicators (AQIs) including handover of care timeliness and Commissioning Framework by the Chief Ambulance Services Commissioner (CASC), the Emergency Ambulance Services Committee (EASC) including the Integrated Commissioning Action Plans (ICAPS) and Joint Executive Team (JET) meetings with Welsh Government (I&E). |
| | 2. Healthcare Inspectorate Wales (HIW) 'Review of Patient Safety, Privacy, Dignity and Experience whilst waiting in Ambulances during Delayed Handover' Report and system wide improvement plan with working group in place with WAST senior representation. Oversight by HIW and EASC |
| | 3. Duty of Quality and Duty of Candour readiness returns assessment by Welsh Government. |
| | **4. Internal Audit Report (April 2024) Serious Incidents: Joint Investigation Framework (WAST internal processes) provided 'Reasonable Assurance' with low to moderate impact on residual risk exposure until resolved. Improvement actions are monitored via the Audit Tracker.** |
| **GAPS IN CONTROLS** | **GAPS IN ASSURANCE** |
| 1. Lack of capacity in the Putting Things Right Team to deliver across the functions due to competing priorities resulting from sustained system pressures – recruitment in line with Organisational Change Process is progressing **with full establishment expected by July 2024.** | 1. |

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

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

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|---|---|
| 2. | 2. Implementation of the revised Joint Investigation process with good engagement seen by system partners. Several overdue patient safety investigations remain presenting a risk to patient safety across the system. The Trust has **56** overdue nationally reportable incident **(NRI)** investigations, **with 63 NRIs open in total**. Shared system learning from the Joint Investigation Framework is currently limited with no new learning identified to date. |
| 3. Lack of implementation and holding to account regarding the NHS Wales of the Handover Guidance v2 and recognition of the patient safety risks pan NHS Wales. | 3. 15-minute handover target is not being achieved pan-Wales consistently and has led to a substantial growth in emergency ambulance handover lost hours. In October 2023, 23,232 hours were lost with 1,888 +4 hour delayed patient handovers. |
| 4. Variation in responsiveness at Emergency Departments to the escalating concerns regarding patients' NEWS. | 4. Strengthening of patient safety reports and audit processes as e PCR system embeds. |
| 5. Variation pan Wales / England as position not implemented across all emergency departments. | 5. New Quality Management System in development which will include monitoring of the new Quality Standards & Enablers and underpinning governance structure. |
| 6. 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. | 6. HIW approve and sign off WAST elements of recommendations. |
| | **External Gaps in Assurance**<br>1. Lack of escalation and response to AQIs by the wider urgent care system and regulators |

| Actions to reduce risk score or address gaps in controls and assurances | Action Owner | By When/Milestone | Progress Notes: |
|---|---|---|---|
| 1. Handover checklist implementation – Nationally WAST Quality Improvement (QI) Project | WAST QI Team (QSPE) | TBC – Paused | • Timeframes awaited via Emergency Department Quality & Delivery Framework (EDQDF). |
| 2. Implement patient safety dashboards (live and look back data) triangulating quality metrics / KPIs and performance data sourcing health informatics resource. | Assistant Director of Quality & Nursing | **Q3 2024/25** | • Incremental improvements to quality and safety data and information to enable triangulation / collective intelligence at Trust and system level.<br>• Access to ePCR data (NEWS) now available **and access for the Patient safety Team is being explored**. Work on-going with Health Informatics regarding patient safety and health board dashboards **capacity in Health Informatics impacting and dates revised.**<br>• **Local dashboards have been developed but requiring manual data extraction** |
| 3. Continued Health Board interactions – my next patient (boarding), patient safety team dialogue – proactive conversations with Health Board Directors of Quality & Nursing. | Executive Director of Quality & Nursing | Monthly and as required. | • Monthly meetings continue to be held and networking through EDoNS. |
| 4. Recruit and train more Advanced Paramedic Practitioners. | Director of Paramedicine | Q4 2024/25 | • **Whilst no additional funding has been secured, ELT has agreed to offer places to all APPs completing their education, funded from a reduction in technician posts (1/2s) i.e. internal movement.**<br>• **The net uplift to the APP establishment (after filling vacancies) is 15.7 FTEs. The Trust expects to see the APP establishment increase to over 100 FTEs in 2024/25. The current staff in post to establishment is 86.5 FTEs / 88.7 FTEs.**<br>• **The Trust is currently undertaken the next strategic EMS demand & capacity review, which includes a future service model and expansion of APPs. The review should be available in Jan-23 (being reported to ELT 31 January 2024, with final report to March EASC).**<br>• **The Trust engaged with HEIW and commissioners in Dec-23 as part of developing the future education requirements for EMS and is aiming to have a draft strategic workforce plan, subject to final approval, by 31 Mar-2024. An internal workshop on APPs workforce planning is arranged for 29 January 2024 (complete).**<br>• **An APP Utilisation task & finish group now being established.** |

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|---|---|---|---|---|---|
| | | Date of Next Review: | 14/05/2024 | ➡ | |

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

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

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|---|---|---|---|
| | | | • **The 2024/25 budget (and IMTP) includes a further uplift in the APP establishment**. |
| 5. Overnight falls service extension and future modelling | Executive Director of Quality & Nursing | 31.09.2024 | • **Night Car Scheme extension agreed to 31 September 2024 (2 regional resources)**<br>**• Utilisation rates continue to be monitored:**<br>**• Nighttime utilisation: -**<br>- **Q2 65%**<br>- **Q3 64%**<br>- **Q4 to date 64%**<br>**• Daytime utilisation: -**<br>- **Q2 57%**<br>- **Q3 56%**<br>- **Q4 to date 58%**<br>**• Combined day and night Q2-Q3 58%**<br>• **Combined day and night Q4 to date 59%**<br>• **The EMS Demand & Capacity Review has completed its modelling of falls level 1 and level 2 resources. This will now need to be considered further by the Trust, commissioners, and health boards.**<br>• **There is an immediate focus on the contract beyond September.**<br>**2024.** |
| 6. Duty of Quality, Duty of Candour and new Quality Standards implementation from April 2023 with development of a Quality Monitoring System supporting monitoring and oversight systems in place and embedded. Quality Report development underway – mandatory requirement to publish 2024/25 (no fixed date for publication nationally). | Executive Director of Quality & Nursing | Q4 2024/25 | • Monthly updates to progress against actions following the baseline assessment and readiness returns continued.<br>• RL Datix Dashboards and KPIs under development nationally by National Quality & Safety Group.<br>• Key policies updated and approved further updates following release of revised Putting Things Right Regulations **which is delayed now expected release by Welsh Government in Autumn 2024 therefore timescale amended.**<br>• Participation in the All Wales Duty of Candour implementation group by Patient Safety Team – monthly. |
| 7. Connected Support Cymru is initially designed to utilise NHS and voluntary-sector resources and responders to enable patients to be supported in their own home whilst waiting for an urgent healthcare need to be managed. The service will employ digital health technologies to connect patients, communities and clinicals to achieve better health outcomes. The initiative will improve patient experience and safety, while supporting the healthcare system in directing patients to the right pathway at an appropriate time for their care need. It is expected this will help reduce unnecessary demand upon Emergency Departments. | Executive Director of Quality & Nursing | Q1 2024/25 | • Awaiting feedback on business case **from Welsh Government**<br>• Executive Director Strategy, Planning & Performance presenting to Six Goals Programme in January on Trust's offer to the system, which will include CSC.<br>• Preliminary end date for the community welfare responders (CWR) pilot identified as 8 February 2023.<br>• This eyes on support to CSD clinicians, by volunteers, is producing positive results, with early data continuing to suggest a 35% consult & close rate for the cohort of patients responded to.<br>• PDSA cycles being undertaken on Luscii (remote diagnostic technology). |
| 8. Organisational change process (OCP) of Putting Things Right Team (PTR) to enable increased capacity across all functions to manage increasing complexity and demands. | Executive Director of Quality & Nursing | **Q2 2024/25** | • OCP commenced 25.09.2023 and the consultation period has concluded with the final new structure confirmed. Next steps are to recruit to vacant positions which has commenced. It is anticipated that all positions will be filled by May 2024 (taking notice periods into account). Recruitment is progressing well with multiple applications for each post and some internal promotion opportunities.<br>• **Final posts due to be recruited to and in place by July 2024**. |
| 9. Connect with All Wales Tissue Viability Network to explore strengthening the current investigations into harm from pressure damage across the whole patient pathway. | Assistant Director Quality & Nursing | Q4 2023/24 | • Positive meeting held in August 2023 with the Chair of the TVN network. Next steps are for the Patient Safety Team to attend a TVN leads meeting to discuss opportunities for collaborative |

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|---|---|---|

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

| | | | |
|---|---|---|---|
| | | | working and data / information sharing. Date to be confirmed and there has been good engagement from Health Board Tissue Viability Nurses.<br>• Meeting held with Tissue Viability Nurses from each Health Board on 17.01.2024 and colleagues encouraged to contact WAST for data / information for Pressure Damage Panels to detect harm caused in the prehospital environment. The Patient Safety Team are also engaging with Welsh Wound Innovation Centre (WWIC).<br>• **Links to actions progressing in Action 16 and further engagement with the All Wales Tissue Viability Network – close.** |
| 10. Audit Wales investigation of Urgent and Emergency Care System: Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time? | CEO | Q2 2024/25 | • **Conducted in three phases Audit Wales will independently investigate and report on patient flow out of hospital: access to unscheduled care services and national arrangements (structure, governance, and support).**<br>• **WAST will proactively support this work and offer best practice examples from other jurisdictions that can support benchmarking and improvement activities. Expected outcomes in 2023/24.**<br>• **The audit is proceeding. Trust awaiting the outcome. AD Commissioning & Performance has requested an update from Audit Wales.**<br>• **Audit Wales have confirmed this has been reprofiled into 2024/25.** |
| 11. Internal Audit to undertake a review of Serious Adverse Incidents & Joint Investigation Framework | Executive Director of Quality & Nursing | **Closed** | • Internal audit completed.<br>• **Completed – Reasonable Assurance reported in April 2024. Improvement actions included on the Audit Tracker.**<br>• **Close. Moved to external assurance.** |
| 12. Winter Ambulance Handover Improvement Plan Meetings | Executive Director of Operations | **Removed** | • Weekly meetings set up with Welsh Government, NHS Executive, CASC and the Health Board COOs. All parties (including WAST) to provide updates on actions being taken to alleviate and improve handover delays. WAST to update on C&C, CWR, red dispatch and local updates from EMS HOS on initiatives.<br>• May24 – Removed as no longer included on the Board action plan (recently reviewed) and the period has now passed. |
| 13. Integrated Commissioning Action Plans (ICAPs) | Executive Director of Strategy, Planning and Performance | **Paused** | • The ICAP meetings focus on ambulance response performance, handover delay performance and the development of actions to reduce handover delays and improve ambulance response times.<br>• NCCU have sought confirmation from health boards regarding the impact of financial savings plans on the delivery of actions aligned to the ICAP's.<br>• Health boards have not identified any direct impact, but there may be a potential impact on health board's abilities to flex some services due periods of increased demand.<br>• NCCU secured financial support from the Six Goals Program for additional ED discharge transport.<br>• Key initiatives being discussed across ICAPs:<br>○ MDT Navigation Hubs.<br>○ Falls & frailty pathways.<br>○ System Escalation Processes<br>○ SDEC<br>○ System Flow (Continuous Flow Model & Effective Discharge)<br>• WAST's 'Menu of options' are being updated and reviewed to include evidence to support initiatives and prioritisation in each health board. |

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|---|---|---|---|---|---|
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|---|---|---|

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

| | | | |
|---|---|---|---|
| | | | • The 2024/25 ICAP structure is being reviewed by the NCCU to consider the planned changes with regards to the new Joint Commissioning Committee (JCC). |
| 14. Patient handover actions. | Executive Team | Under review | • Some English ambulance services operate a system whereby handovers are mandated or forced after a certain period of time e.g. WMAS and LAS. This will be reviewed by the Executive team. |
| **15. Work in progress to better define mitigations to safety risks and quality of care deriving from extended periods in an ambulance; these include the application of Mental Capacity Act and Deprivation of Liberty Safeguards and Fundamentals of Care including pressure area care, mobilisation and nutrition. One specific area of focus is the development of a prototype mattress for ambulance trolleys.** | **Executive Director of Quality & Nursing** | **Q3 2024/25** | • **Fundamentals of Care meeting, chaired by the Executive Director of Quality & Nursing held on 08.03.2024.** |

| 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: | 16/04/2024 | TREND | 20 (5x4) |
|---|---|---|---|---|---|
| | | Date of Next Review: | 16/05/2024 | ➡ | |

| IF | THEN | RESULTING IN |
|---|---|---|
| there are high levels of absence e.g., sickness and alternative duties. | there is a risk that there is reduced resource capacity | an inability to deliver services which adversely impacts on quality, safety, and patient/staff experience |

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

IMTP Deliverable Numbers:

| EXECUTIVE OWNER | Director of People & Culture | ASSURANCE COMMITTEE | People and Culture Committee |
|---|---|---|---|

**Risk Commentary**

Sickness absence remains one of the key challenges for the organisation. Whilst there has been a significant reduction in absence levels over the past 18 months, rates remain higher than desired and therefore a continued focus on supporting good attendance at work is needed by both managers and the People and Culture team. Increased pressures on our people like handover delay, missed breaks and cost of living impact on health and wellbeing. The outcome of this is to maintain the risk at a score of 20 and review the level at the end of Q1 2024/25.

| CONTROLS | ASSURANCES |
|---|---|
| | **Internal Management (1st Line of Assurance)** |
| 1. Managing Attendance at Work Policy/Procedures in place **and followed** | 1. **(a) Audits undertaken by People Services Team**<br>**(b) Outputs reviewed** |
| 2. Respect and Resolution Policy- recognising issues at work may contribute to sick absence | 2. **R&Rs addressed in timely way to reduce risks of sickness absence.**<br>**Compassionate Practices approach engaged.**<br>**Referral of colleagues to appropriate levels of support** |
| 3. Updated Freedom to Speak Up Policy replacing the Raising Concerns Policy- recognising issues at work may contribute to sick absence | 3. Policy reviews to ensure policies and procedures are fit for purpose in line with agreed time frames Completed - 28/11/23 Freedom to speak Up Safely process introduced from the start of October 2023 including three Trust guardians. |
| 4. Health and Wellbeing Strategy – key document that outlines commitment to wellbeing and supportive culture | 4. Regular reference to strategy to ensure themes are addressed and linked to wider people and culture plan 28/11/2023 Health and Wellbeing Strategy coming to an end in 2024 to be replaced with a new plan with a focus on employee experience in line with the All-Wales Framework and the People and Culture Plan 2023-2026 |
| 5. Operational Workforce Recruitment Plans - provide evidence of sufficient resources and identify any gaps or potential areas of increased workload pressure | 5. |
| 6. Roster Review & Implementation- to support demand and capacity which can have an impact on absence levels | 6. Roster Review for EMS completed. Review in 111 underway |
| 7. Return to Work interviews are undertaken - SharePoint Sway document ensuring accurate reporting of reason for absence and identifying any additional support required | 7. Process regularly reviewed and managers provided with relevant training and coaching on process and importance of carrying out return to work interviews promptly |
| 8. Training on all aspects of Managing Attendance – ensures focus is high and understanding of why this is important is maintained | 8. Regular bitesize training provided for managers, adapted to reflect feedback and to ensure all aspects of managing attendance is understood |
| 9. Directors receive monthly email with setting out ESR sickness data - ensures ownership and awareness. | 9. Monthly reporting provided with opportunity for discussion with relevant people services lead and Director |
| 10. Operational managers receive daily sickness absence data via GRS- ensures ownership and awareness | 10. Provided daily, with opportunity for discussion with relevant people services lead and operational managers |
| 11. People Services & Occupational Health & Wellbeing support/Employee Assistance Programme- providing professional support | 11. Monthly reporting on services provided, volume of referrals and timeframes for accessing support. |
| 12. WAST Keep Talking (mental health portal) additional measures to offer support | 12. Quarterly reporting on numbers accessing and regular promotion of service. **Reported in MIQPR** |
| 13. Suicide first aiders- additional layer of support | 13. Quarterly reporting of numbers of trained suicide first aiders and numbers who have access. Mental Health Team deliver this |
| 14. TRiM- additional layer of support | 14. Quarterly reporting on access to TRiM and promotion of service Included in MIQPR |
| 15. Peer Support network- additional level of support | 15. Promotion of network and support provided |
| 16. Coaching and mentoring framework- additional level of support | 16. Promotion of network and support provided 28/11/2023 on pause to focus on Leadership Framework with a focus on culture and its impact on the experience of work and workplace wellbeing |
| 17. Staff surveys- assess levels of engagement and wellbeing | 17. New HIVE survey tool will provide data on overall engagement and wellbeing 28/11/2023 the NHS Wales Staff Survey has also just closed and will provide information in the new year to inform us further. |
| 18. Stress risk assessments- identify measures that can be taken to address issues | 18. Reference to the assessments during attendance management line manager training and to the TUS 28/11/2023 OH to lead on a refresh of stress risk assessments use |

| 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: | 16/04/2024 | TREND | 20 (5x4) |
|---|---|---|---|---|---|
| | | Date of Next Review: | 16/05/2024 | ➡ | |

| IF | THEN | RESULTING IN |
|---|---|---|
| there are high levels of absence e.g., sickness and alternative duties. | there is a risk that there is reduced resource capacity | an inability to deliver services which adversely impacts on quality, safety, and patient/staff experience |

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

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|---|---|
| 19. Sickness statistics are reported to SLT, SOT, People & Culture Committee, Trust Board and the CASC | 19. Sickness forms part of Workforce Scorecard to People & Culture Committee and is also supported by PCC deep dives into sickness. Reporting is also shared with CASC and EASC. Discussions on sickness are reported in minutes and AAA to Board |
| 20. External agencies support e.g., St John Ambulance, Fire and Rescue- if needed at times of increased demand pressure | 20. |
| 21. Monthly reviews of colleagues on Alternative duties | 21. Action plans arising from meetings with colleagues implemented through monthly diarised meetings |
| 22. Manager guidance on managing Alternative duties | 22. Evidence of managers guidance in place and referenced in attendance management training |
| 23. Monthly report on absence to ELT and report to every meeting of People & Culture Committee via the Workforce Report and provision of deep dives when requested. | 23. |
| 24. Sickness audits for localities- provides additional level of detail | 24. Audits carried out and actions taken forward |
| 25. Additional support for areas with higher-than-average absence – emphasis is on understanding reasons and developing action plans | 25. Dedicated meetings taking place and support from people services for areas with absence with local plans in place to address specific issues |
| 26. Review of top 100 cases -carried out monthly | 26. Provides a focus on cases with a clear focus on support and making sure there are plans attached to each case. |
| 27. Deep dives on specific issues and reasons for absence | 27. Enables wider consideration of additional measures that may be adopted and identifies themes and keeps focus on absence management e.g. – mental health and causes 28/11/23 Recognition of the impact of employee experience and workplace conditions and link to absence. **Reported to ELT for information** |
| 28. Implementation of the Managing Attendance Project 2022-23 completed and ongoing activities maintained | 28. **BAU evaluating for delivery** |
| 29. Implementation of Behaviours Refresh Plan completed | 29. **BAU evaluated for delivery** |
| 30. 2023 10-point action plans shared with EMT for assurance and RAG rated to track progress quarter | 30. Offers assurance to ELMT on the activities and measures in place. Figures on absence are being reported monthly to ELT which is reflected in the minutes and AAA reports |
| 31. Work in Confidence system implemented and Freedom to Speak Up Month in October 2023 focused attention on this | 31. External Management (2nd Line of Assurance) |
| 32. Actions from Audit of Nov 22 **completed** | 32. **Audit actions completed** |
| 33. Strengthen Freedom to Speak Up Arrangements policy and advice and roll out of platform for raising concerns (in relation to Freedom to Speak Up Arrangements) (Having additional mechanisms in place for individuals to speak up potentially reducing work related stress and anxiety which is a key reason for absence) | 33. Monitor FTSU concerns and they are dealt with in agreed timeframes and assessed whether absence related to mental health and anxiety reduces. |
| 34. **Health and Wellbeing Steering Group in place** | 34. Monitored through numbers of FTSU concerns raised and continual promotion via Comms and Roadshow Events. |
| 35. **Actions identified from the Managing Attendance Audit implemented** | 35. Agendas, minutes etc. |
| 36. **PADR review undertaken and now including wellness questions** | 36. Underway and now BAU – we need to say what this means by way of assurance |
| 37. **Scrutinising on a monthly basis all long-term sickness absence case to ensure there is a tailored, individual action plan which identifies interventions that will support a return to work as soon as reasonably possible**. | 37. PADRs undertaken and questions asked |
| 38. **Accountability meetings on attendance management between People Services and senior ops managers to ensure this issue is given sufficient focus on priorities.** | **Independent Assurance (3rd Line of Assurance)** |
| 39. **Senior Ops Managers have accountabilities sessions on attendance management with their Heads of Service.** | 1b. Internal Audits scheduled through Shared Services Partnership. Last audit on attendance was November 2022 and the last actions from this due at the end of December 2023. (last audit November) |
| 40. **Ensure that the specific issues associated with muscular skeletal conditions is discussed regularly at the H&S Committee and relevant additional interventions are identified** | 2. Audit Wales – Taking Care of the Carers report in October 2021 |
| **GAPS IN CONTROLS** | **GAPS IN ASSURANCE** |
| **(a) Consistency and Application in Managing Attendance at Work Policy** | There are other factors that impact on sickness which can't be controlled |
| **9 and 10 It is not known what is undertaken with respect to the data covered in assurances 9 and 10 once it is received** | 9, 10 and 19 Absence data is not updated in a timely manner into ESR by managers |

| 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: | 16/04/2024 | TREND | 20 (5x4) |
|---|---|---|---|---|---|
| | | Date of Next Review: | 16/05/2024 | ➡ | |

| IF | THEN | RESULTING IN |
|---|---|---|
| there are high levels of absence e.g., sickness and alternative duties. | there is a risk that there is reduced resource capacity | an inability to deliver services which adversely impacts on quality, safety, and patient/staff experience |

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

| 1 – 22 Education and communication with managers about resources available and how to implement it e.g., stress risk assessments | 1. | | |
|---|---|---|---|
| **Actions to reduce risk score or address gaps in controls and assurances** | **Action Owner** | **By When/Milestone** | **Progress Notes:** |
| 1. Scrutinising on a monthly basis all long-term sickness absence case to ensure there is a tailored, individual action plan which identifies interventions that will support a return to work as soon as reasonably possible. | Deputy Director of People & Culture | | Discussion on levels of long term sick absence is undertaken in a variety of forums including EASC, ELT and PCC |
| 2. Develop guidance and training for line managers to equip them with the confidence and skills to have meaningful and sensitive conversations related to attendance. | Deputy Director of People & Culture | | Measured through ongoing participation in development sessions and feedback from TU regarding management handling of absence cases. |
| 3. Accountability meetings on attendance management between People Services and senior ops managers to ensure this issue is given sufficient focus on priorities. | Deputy Director of People & Culture | | Assurance – meetings taking place and active discussions on operational areas experiencing high levels of absence |
| 4. Senior Ops Managers have accountabilities sessions on attendance management with their Heads of Service. | ADOs Operations | | Assurance – meetings taking place and active discussions on operational areas experiencing high levels of absence |
| 5. Case studies developed on examples of areas of business where attendance management has improved significantly to share learning across WAST | Deputy Director of People & Culture | | Case studies published and discussed at leadership meetings and evidence of good practice adopted |
| 6. Review of top 100 cases by the wider People & Culture Team on a monthly basis (Wellbeing, OCC Health, People Services) | Deputy Director of People & Culture | 31/05/24 | Understanding within the wider People & Culture Directorate of cases and action plans clearly identified |
| 7. Connect to other Ambulance sector organisations to identify additional interventions they have implemented to address attendance management, share learning and consider whether to adopt in WAST | Deputy Director, People and Culture | | Discuss at P&C Business Meeting and share at ELT/PCC with recommendations. |
| 8. Ensure that the specific issues associated with muscular skeletal conditions is discussed regularly at the H&S Committee and relevant additional interventions are identified | AD Q&N | 30/06/24 | It is on the agenda and outcomes are available for discussion at H&SC |
| 9. Targeted culture change reviews are undertaken in areas of the business where levels of absence are high and other metrics such as turnover indicates concerns. Alongside this these areas are also experiencing significant change. | Director of People & Culture | Ongoing | Culture review action plans are produced and taken forward. Sick absence in these areas is evaluated and monitored to assess whether reductions are achieved. |
| 10. Implementation of new approach to regularly checking in with staff. Piloting a simple conversation framework for Managers to use with their staff on a monthly basis which provides a focus on wellbeing, goals and personal development. | AD for Culture, Inclusion & Wellbeing | Ongoing | Evaluation of pilot after 6 months to assess if there has been a reduction in sick absence in specific areas where this approach has been adopted. |
| 11. Development of the 2024/25 Managing Attendance Plan (see below for individual actions. | Deputy Director, People and Culture | To commence 30/05/24 | Key plan actions noted below |
| 12. Delivery of actions to support managers handling attendance issues with skills, capability and confidence | Deputy Director, People and Culture | 31.03.2025 | |
| 13. Coaching for managers on cases on one and locality basis. | Deputy Director, People and Culture | 31.03.2025 | |
| 14. Increase manager support on data interpretation and analysis | Deputy Director, People and Culture | 31.03.2025 | |
| 15. Increase manager understanding of options for colleagues who are not able to sustain their attendance e.g. flexible hours, reduced hours etc | Deputy Director, People and Culture | 31.03.2025 | |
| 16. Culture work on creating the sense of team and peer responsibility / ownership | AD for f Culture Inclusion and Wellbeing | 31.03.2025 | |
| 17. Analyse link between hot spots and the culture in these areas to address cultural issues | AD for Culture, Inclusion & Wellbeing | 31.03.2025 | |
| 18. Improve preventative measures and pro-active work | Deputy Director of People and Culture | 31.03.2025 | |

| 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: | 16/04/2024 | TREND | 20 (5x4) |
|---|---|---|---|---|---|
| | | Date of Next Review: | 16/05/2024 | ➡ | |

| 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 |

| | | | |
|---|---|---|---|
| **19. Identify opportunities to improve roles – flexibility, control, confidence** | Deputy Director of People and Culture / ADs, Operations | 31.03.2025 | |
| **20. Opportunities to adapt the work environment – overruns, shift patterns, rest and recuperation** | Deputy Director of People and Culture / ADs, Operations | 31.03.2025 | |
| **21. Review workloads** | Deputy Director of People and Culture / ADs, Operations | 31.03.2025 | |
| **22. Review patterns of absence** | Deputy Director of People and Culture | 31.03.2025 | |
| **23. Development of a mental health referral pathway** | AD for Culture, Inclusion and Wellbeing | 31.03.2025 | |
| **24. Develop the team around the person model / individual support network** | Deputy Director of People and Culture | 31.03.2025 | |
| **25. Increase lifestyle advice and guidance** | AD for Culture, Inclusion and Wellbeing | 31.03.2025 | |
| **26. Undertake proactive testing to identify undiagnosed conditions** | AD for Culture, Inclusion and Wellbeing | 31.03.2025 | |
| **27. Review reporting on OH** | AD for Culture, Inclusion and Wellbeing | 31.03.2025 | |
| **28. Review opportunities on men's mental health e.g. support groups** | AD for Culture, Inclusion and Wellbeing | 31.03.2025 | |

| Risk ID 201 | A loss of stakeholder confidence that damages the Trust reputation | Date of Review: | 11/04/2024 | TREND | 20 (4x5) |
|---|---|---|---|---|---|
| | | Date of Next Review: | 11/05/2024 | ➡ | |

| IF | THEN | RESULTING IN |
|---|---|---|
| there is an inability of the Trust to deliver its core services because of system or organisational pressures | there will be a loss of stakeholder confidence in the Trust | a lack of stakeholder support for the Trust's long term strategic vision, a failure to deliver its strategic ambition, 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:

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

**Risk Commentary Q3 2024/25**

The risk score remains constant at 20 (highly likely and catastrophic). The organisation's reputational risk is one which is long-standing and entrenched. After initial improvements in risk rating some years ago, the impact of the pandemic, long standing performance and morale issues, coupled with the levels of patient harm and poor patient experience which are being documented all result in limited opportunity to de-escalate the risk. Significant efforts are being made to address all of these factors. However, to date, the issues which contribute to reputation continue to be problematic and, therefore, militate against de-escalation of the risk for the foreseeable future. As part of the mitigation, extensive stakeholder engagement briefing, including with Welsh Government and civil service colleagues, together with politicians, commissioners and partners, media relations work, patient experience and internal communication and engagement continue, in order to build trust and credibility. The day-to-day experience of staff and patients, coupled with the need to further build relationships, mean the risk remains heightened. The lead Director and wider Executive Team discuss matters of reputation on a regular basis and the Trust's approach to stakeholder engagement is regularly reviewed in this context, including as it relates to support for the Trust's longer-term strategy and ambition.

| CONTROLS | ASSURANCES |
|---|---|
| | **Internal Management (1st Line of Assurance)** |
| 1. CEO and DSP meeting with HB CEOs throughout Q4 to informally discuss strategic ambition | 1. Feedback reported via ELT, TSAG etc/ |
| 2. Revision of engagement framework delivery plan (approved by Board Jan 2023) to reflect feedback from stakeholders and revised timelines for strategy engagement | 2. Will report via strategy programme architecture plus discussion at Board development/PCC etc. Included in 2024/25 IMTP |
| 3. Challenging of media reports to ensure accuracy | 3. Programme of daily media engagement documented on digital system |
| 4. Media liaison to ensure relationships developed with key media stakeholders | 4. Programme of daily media engagement documented on digital system |
| 5. Routine stakeholder and staff engagement, including the recent round of Executive roadshows and WAST Live. | 5. Agendas, minutes, and documents of engagement events. Informal feedback via ELT and reported via Trust Board (CEO update) |
| 6. Engagement governance and reporting structures are in place | 6. Relevant information which impacts on reputation is reported and scrutinised via all internal committees e.g., ELT, FPC, PCC, QuEST & Audit Committee – minuted meetings and action logs. |
| 7. Annual deep dives on reputation in place | 7. Reported to Committees, documented in minutes, action logs and papers |
| 8. Engagement of the Board on matters of reputation in development sessions. If required, escalation procedure for issues to the Board where circumstances dictate, following discussion at ELT | 8. Minuted meetings, action logs and Board papers |
| 9. Regular engagement with senior stakeholders e.g., Ministers, senior Welsh Government officials, commissioners, elected politicians and NHS Wales organisational system leaders | 9. Informal feedback reported via ELT and occasionally in formal correspondence (nature of discussion often precludes formal recording) |
| 10. Monitoring external factors that may affect the Trust | 10. ELT verbally updated on a regular basis with written notes if appropriate |
| 11. Board oversight, scrutiny and challenge of performance, concerns, quality | 11. What is the assurance that this control is effective |
| 12. Internal Quality and Performance monitoring in the Trust and raising system issues | 12. What is the assurance that this control is effective - reports at ELT, Finance and Performance Committee, Quality, Safety and Patient Experience Committee, People and Culture Committee, Audit Committee |
| **GAPS IN CONTROLS** | **GAPS IN ASSURANCE** |
| 1. The delivery plan is currently under review and is subject to further agreement | 1. |
| 2. Managing the narrative of the media | 2. |
| 3. Strategic collaboration – further work needed to formalise opportunities | 3. |

| Actions to reduce risk score or address gaps in controls and assurances | Action Owner | By When/Milestone | Progress Notes: |
|---|---|---|---|
| 1. Reputation audit year two planned | Director of Partnerships & Engagement | **April 2024** | **Audit launched on 09 April 2024, and will run until 01 May 2024.** |
| 2. **Agree Stakeholder Influencing** Plan | Director of Partnerships & Engagement | Q1 24/25 | **Currently in development.** |
| **3. Roll out of Stakeholder Influencing Plan** | **Director of Partnerships & Engagement** | **Q2 24/25 onwards** | |
| 4. Reputation Audit deep dive on findings to be presented at Board Development | Director of Partnerships & Engagement | Q1 2024/25 | **Findings will also be presented at the 09 May People and Culture Committee meeting.** |

| RISK ID 594 | The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death | Date of Review: | 15/04/2024 | TREND | 20 (4x5) |
|---|---|---|---|---|---|
| | | Date of Next Review: | 15/05/2024 | ➡ | |

| **IF** a major incident or mass casualty incident is declared | **THEN** there is a risk that the Trust cannot provide its pre-determined attendance as set out in the Incident Response Plan and provide an effective, timely or safe response to patients due to vehicles not being released from hospital sites | **RESULTING IN** catastrophic harm (death) and a breach of the Trust's legal obligation as a Category 1 responder under the Civil Contingency Act 2004 |
|---|---|---|

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

IMTP Deliverable Numbers: TBC

| EXECUTIVE OWNER | Director of Operations | ASSURANCE COMMITTEE | Finance & Performance Committee |
|---|---|---|---|

**Risk Commentary Q4**

The challenges across the unscheduled care system**. Handover lost hours in February and March 2024 were 23,896 (Feb) and 23,404 (March).** There is a direct correlation with ambulance availability and high levels of resources unavailable due to protracted waits at hospital E.Ds. Several incidents declared have failed to provide sufficient on the ground assurance that vehicles would be released. Health Boards have declined to incorporate testing of vehicle release into a recent mass casualty exercise. Further, a recent workshop undertaken by the EPRR team as part of the Manchester Arena Inquiry assurance process which has tested our ability to fulfil the PDA in North and South Wales, both in and out of hours, has confirmed that we would only meet the PDA in one of these four mass casualty scenarios.

| CONTROLS | ASSURANCES |
|---|---|
| | **Internal**<br>**Management (1st Line of Assurance)** |
| 1. Immediate release protocol | 1. The Immediate Release Protocol is a Nationally agreed NHS Wales protocol. Refusals by Health Boards are Datixed by WAST and compliance report provided weekly to the DG for Health & Social Services. |
| 2. Resource Escalation Action Plan (REAP) | 2. The Senior Leadership Team convenes every Tuesday as the Weekly Performance Meeting to review performance and demand data, and review/assign REAP Levels as appropriate. Dynamic escalation via Strategic Command structure. REAP has undergone an annual review with v4.1 released in November 2023. |
| 3. Regional Escalation Protocol | 3. Daily conference calls to agree RES levels in conjunction with Health Boards |
| 4. Incident Response Plan | 4. The Incident Response Plan has been ratified via EMT |
| 5. Mutual Aid arrangement with NARU | 5. AACE National Policy on mutual aid in place |
| 6. Clinical Safety Plan | 6. CSP adopted by EMT and operational; reviewed annually by SLT in December 2023, Version 2.21 of the Clinical Safety Plan was released. The reduction in the demand is the assurance which is dynamically monitored via ODU. |
| 7. Operational Delivery Unit 24/7 cover | 7. Shift reports from ODU & ODU Dashboard received by Exec, SOT, and On-Call Team at start/end of shift and cover review at weekly performance meeting |
| 8. In hours and Out of hours command cover | 8. Civil Contingency requirement as set out in the Command Policy and Incident Response Plan. Cover review at weekly performance meetings |
| 9. Notification and Escalation Procedure | 9. Published procedure in operation, reviewed 3 yearly by SLT |
| 10. Continued escalation of risk to partners and stakeholders | 10. Referenced by the Executive Director of Operations in correspondence sent to health board Chief Operating Officers dated 30 March 2023. It was further emphasised at the face-to-face COO Peer Group meeting on 14 April 2023. |
| | **External Independent Assurance**<br>N/A |
| 11. CEO letter to Health Boards dated 3 Jan 2023, and DOO letter to Chief Operating Officers dated 30 March 2023 to seek assurance on plans. | 11. Acknowledgement and acceptance of risk by HBs and balancing the risk across the whole system. Improvement in handovers in C&VHB and ABUHB. This has been sustained form some months across C&V in a phased programme of improvement with no delays more than 2 hours. Programme of improvement underway in ABUHB commencing at 4-hour tolerance with a plan to reduce over time. In other HBs there remains little or no controls with variation in both handovers and risk levels across HBs. |
| 12. Health boards are asked to provide assurance of existing and tested plans to immediately reduce emergency ambulances on incident declaration. | 12. All Health Boards responded with assurance of plans except BCU. |
| 13. Multi Agency Exercise to be arranged. | 13. This exercise has taken place although Health Boards declined to incorporate vehicle release plans |
| 14. Meeting with Welsh Government to outline this risk; WG agreed to write to HBs seeking assurance from EPRR leads in HBs on the ability to clear EDs and release vehicles. WG agreed to incorporate testing into the forthcoming mass casualty exercise, and a timeframe for vehicle release was proposed by WAST with | 14. WG have confirmed that they have written to HB EPRR leads.<br>Health Board COOs approved the proposals for vehicle release as outlined. |

| RISK ID 594 | The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death | Date of Review: | 15/04/2024 | TREND | 20 (4x5) |
|---|---|---|---|---|---|
| | | Date of Next Review: | 15/05/2024 | ➡ | |

| | | | | | |
|---|---|---|---|---|---|
| **IF** a major incident or mass casualty incident is declared | **THEN** there is a risk that the Trust cannot provide its pre-determined attendance as set out in the Incident Response Plan and provide an effective, timely or safe response to patients due to vehicles not being released from hospital sites | **RESULTING IN** catastrophic harm (death) and a breach of the Trust's legal obligation as a Category 1 responder under the Civil Contingency Act 2004 | | **Likelihood** | **Consequence** | **Score** |
| | | | **Inherent** | **4** | **5** | **20** |
| | | | **Current** | **4** | **5** | **20** |
| | | | **Target** | **2** | **5** | **10** |

30% of vehicles released within 10 minutes of an incident declaration, 50% within 20 minutes and 100% within 40 minutes.

| GAPS IN CONTROLS | GAPS IN ASSURANCE |
|---|---|
| Despite the controls listed, the single most limiting factor in providing a pre-determined response in line with the Incident Response Plan is the lost capacity due to hospital handover delays. In this area, WAST has no control. – link to CRR 223 on CRR. | The Trust is not assured that Hospital sites have plans in place that are trained and tested to release ambulances effectively and immediately in the event of an incident declaration. |
| | Following two incidents (Pembroke Dock Ferry fire on 11th February 2023 and the Swansea gas explosion on 13 March 2023), The Trust is not assured by the effectiveness of assurances given by Health Boards (responses provided following correspondence from WAST CEO – formal returns received from LHBs except BCU). Despite these two incidents being lower-level incident declarations where the pre-determined attendance was met, the experience does not add confidence to the ability to release all resources from hospitals which would support assurance. Further testing of the pre-determined attendance levels has been undertaken as part of the Manchester Arena Inquiry recommendations; This tested the Trust's ability to fulfil the PDA in North Wales and South Wales in the event of a mass casualty scenario both in hours and out of hours. This simulation concluded that in three of these four scenarios, the Trust would be unable to fulfil the PDA. A further declared major incident at Treforest Industrial Estate in December 2023 following an explosion, failed to release resources from Morriston Hospital, Wales's dedicated burns unit (formal debrief still to be conducted). |

| Actions to reduce risk score or address gaps in controls and assurances | Action Owner | By When/Milestone | Progress Notes: |
|---|---|---|---|
| 1. Review of Manchester Arena Inquiry | Assistant Director of Operations | **July 2024** | This programme of work is underway, and a workshop has confirmed that the PDA would be unable to be met in three out of four simulated mass casualty scenarios. The financial case associated with MAI is planned to be familiarised with ELT and EASC during Jan and Feb 2024, with the final outline case to ELT in March 2024. **A revised timeline for the governance process for the final MAI reports has been agreed, commencing in May 2024 and finalising at Trust Board the end of July 2024.** |
| 2. Further correspondence to Welsh Government to seek assurance of testing plans following recent mass casualty exercise where Health Boards declined to incorporate vehicle release plans | Assistant Director of Operations | **July 2024** | Correspondence with Welsh Government remains ongoing.<br>22/02/2024 - Risk 594 has also been referenced in the context of MAI presentation to Welsh Government (6th Feb 2024). Further follow up will be provided as MAI progresses. **Welsh Government has been and will continue to be kept up to date on the developing case, as have the JCC.** |
| **3. Request from COO network to share Action cards related to risk** | **Executive Director of Operations** | **Q1** | **March 24 – This risk was discussed at both EASC management and in the COO meeting.** |

| Risk ID 163 | Maintaining Effective & Strong Trade Union Partnerships | Date of Review: | 16/04/2024 | TREND | 16 (4x4) |
|---|---|---|---|---|---|
| | | Date of Next Review: | 16/05/2024 | ➡ | |

| | | | | 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 | 4 | 16 |
| | | | **Target** | 4 | 3 | 12 |

IMTP Deliverable Numbers:

| **EXECUTIVE OWNER** | Director of People & Culture | **ASSURANCE COMMITTEE** | People & Culture Committee |
|---|---|---|---|

**Risk Commentary**

**Proposal to reduce the score because of a tailored bespoke development programme for managers and Trade Union Partners at all levels has been launched to address issues. The programme of engagement and relationship building will continue throughout 2024/25. Also, specific workforce issues related to potential respect and resolution processes have been addressed.**

Work is **well** underway to seek to improve partnership working **through the delivery of the action plan.** The engagement structures below WASPT are in place and running. The Deputy Director of P&C **and Head of Culture and OD have delivered workshop sessions** for TU **partners** and managers across the organisation **in senior and local roles**. **Personal** relationships with TUPs are **generally** good. However, there is a further prospective risk as discussions on pay commence for 2024/25 which are out of the gift of WAST but may result in further tension and industrial action if an offer made is not accepted by the trade unions. This is in the context of the current financial pressures for Welsh Government who are seeking to make significant savings. At a local level there are challenging issues to be managed such as EMT 2-3, demand and capacity reviews and changes to the workforce profile. When there are discussions on one area then there appears to be difficulty disengaging different issues.

| **CONTROLS** | **ASSURANCES** |
|---|---|
| | **Internal Management (1st Line of Assurance)** |
| 1. Agreed (Refreshed) TU Facilities Agreement developed in partnership | 1. Agreed document which states governance arrangements and the criteria for time off for TU activity etc. |
| 2. Go Together Go Far (GTGF) statement and CEO/TU Partners statement | 2. Both parties refer to the documents and are signed up/committed to it |
| 3. IPA Workshops | 3. Meetings completed with participation from TUs and senior managers. Attendance lists are available |
| 4. Trade Union representation at Trust Board, Committees | 4. Committee or Board ask TU representative for feedback or whether they have been consulted. Big issues items progress as planned because of TU partner buy in |
| 5. Monthly Informal Lead TU representatives and Chief Executive meetings | 5. Diarised meetings |
| 6. Staff representative management in Task & Finish Groups | 6. Good attendance and commitment are observed at the meetings. TU partners listed as members in terms of reference |
| 7. WASPT re-established post stand down of cell structure post pandemic. | 7. Diarised meetings with a formal agenda. Any business needed to be discussed is included in the agenda. Good attendance and commitment observed at meetings. |
| **8.** Local Co-Op Forums, and informal monthly meetings between TUs and Senior Operations Team **in place and operating** | 8. Consistency of invitation and good attendance/commitment observed at meetings. Trade Union representations on SOT meetings |
| 9. Quarterly Report on TU activity to People and Culture Committee | 9. Report at every P& C committee meeting regarding activities TUPs involved with which is noted. Whenever Partnerships are discussed, the value of these is formally minuted in the Board and Committee minutes |
| 10. Structures below WASPT in place from June 2023 | 10. Triple A reports through to WASPT and to PCC. **Any escalations are appropriately noted**. |
| 11. Project plan in place to support the improvement in relationships based on the ACAS report from 2022. | 11.Development of mentoring and training opportunities for TUPs to support their roles. |
| **12. AAA report of formal Partnership Forum (WASPT) reported to PCC or Board in future (return to BAU).** | 12.Training for local managers and TUPs in development and **diarised delivery for February / March 2024**. |
| **13. AAA from SLT Partnership Forum and Corporate Partnership Forum reported to WASPT** | 13.**Change in senior TU personnel on a temporary basis meaning new senior TU representative needs to be brought up to speed with work on improving partnership working.** |
| **GAPS IN CONTROLS** | **GAPS IN ASSURANCE** |
| 1. Need to move back to business-as-usual footing | None identified |
| 2. Facility to manage situations where there is a failure to agree, to avoid grievance and disputes from occurring | |

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

| Risk ID 163 | Maintaining Effective & Strong Trade Union Partnerships | Date of Review: | 16/04/2024 | TREND | 16 (4x4) |
|---|---|---|---|---|---|
| | | Date of Next Review: | 16/05/2024 | ➡ | |

| IF the response to tensions and challenges in the relationships with TU partners is not effectively and swiftly addressed and trust and (early) engagement is not maintained | THEN there is a risk that TU partnership relationships increase in fragility and the ability to effectively deliver change is compromised | RESULTING IN a negative impact on colleague experience and/or services to patients |
|---|---|---|

| | Likelihood | Consequence | Score |
|---|---|---|---|
| Inherent | 5 | 3 | 15 |
| Current | 4 | 4 | 16 |
| Target | 4 | 3 | 12 |

| | | | |
|---|---|---|---|
| 1. Proposed externally facilitated mediation session(s) building on the IPA workshops and specifically to address the thorny issue of what happens when we fail to agree. | Deputy Director of People & Culture | Completed 12/01/23 | Rearranged date 24.08.22 due to COVID in ACAS facilitators. First ACAS sessions delivered in June. Joint ACAS session with TUPs and Senior Team delivered on 24.08.22. Awaiting report from ACAS advised they are finalising by 23.09 and will forward week of 26th Sept. Draft plan in development to capture actions from the meeting. Actions from the ACAS recommendations will be added on receipt. Report received in October. Action plan developed and shared with TUs. Implementation underway |
| 2. Refresh of engagement programme post Industrial Action and establish work | Deputy Director of People & Culture | 30/08/23 Underway and work ongoing. Plan delivery to be completed in 2024. However, this will be subject to the national picture. | Plan agreed and being monitored via WASPT. Draft training development underway in partnership with TUPs **– list of training needs shared from TUPs.** Principles on engagement being developed (in part from the training) and as a result the partnership statement will be updated. |
| **3. Continue the rollout of partnership training across WAST** | Deputy Director of People & Culture | Ongoing | |
| **4. Develop the next round of initiatives based on the output from recent sessions** | Deputy Director of People & Culture | 30.06.24 | |
| **5. Learning and Development opportunities for TU partners e.g. shadowing, digital skills, coaching and mentoring** | Deputy Director of People & Culture | 30.06.24 | |
| **6. Develop consultation guidance for managers** | Deputy Director of People & Culture | 30.06.24 | |
| **7. Consider how we celebrate success and capture the positive learning** | Deputy Director of People & Culture | 30.09.24 | |
| **8. Implement a rhythm of meetings to curate and focus on relationships** | Deputy Director of People & Culture | 30.06.24 | |

| Risk ID 542 | Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan | Date of Review: | 04/05/2022 | TREND | 16 (4x4) |
|---|---|---|---|---|---|
| | | Date of Next Review: | 04/05/2024 | | |

| **IF** there is a lack of resources and available technology and infrastructure | **THEN** there will be a failure to deliver the commitments outlined in the action plan and within the Welsh Government timelines | **RESULTING IN** negative environmental and social impacts causing and reputational damage | | Likelihood | Consequence | Score |
|---|---|---|---|---|---|---|
| | | | Inherent | | | |
| | | | Current | 3 | 4 | 12 |
| | | | Target | 2 | 4 | 8 |

IMTP Deliverable Numbers: TBC

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

**Risk Commentary**

| **CONTROLS** | **ASSURANCES** |
|---|---|
| | **Internal Management (1st Line of Assurance)** |
| 1. Oversight of implementation and delivery of Decarbonisation project and monitoring of action plan at Decarbonisation Programme Board and Capital Management Board | 1. Regular meetings of the Decarbonisation Programme Board quarterly. Requirements of the Decarbonisation project have been presented to the Trust Board & Finance and Performance Committee. Challenges of the project have also been highlighted. Report goes regularly to FPC and then onto Trust Board |
| 2. Capital and Estates directorate lead support – Director of Finance (DOF) | 2. Regular briefings to DOF |
| 3. Partnership working via Communications/Stakeholder liaison group with NHS Wales, Welsh Government and other bodies to gain support and knowledge- with the anticipation of working in collaboration. | 3. Sharing of knowledge via partnership working through various forums is documented in minutes of meetings held. Requirements also form part of the action plan |
| 4. Approach changed for heating/lighting/energy systems to become more energy efficient- replacing old inefficient plant with more sustainable technology such as natural gas boilers for air source heat pumps | 4. (i) Estate Survey undertaken every 5 years. This is a 6-facet survey to understand where the back log is and the requirements for energy systems.<br>(ii) Approved Estates SOP<br>(iii) Estate Retrofit Guide and framework used to prepare schemes |
| 5. Changing procurement practices for fleet, Estates, equipment, supplies, and ICT to reduce emissions | 5. Fleet SOP shows move to ULEV vehicles. BJC 2024/25 details intention for move to EV for smaller and support vehicles |
| 6. Board Development sessions with respect to Decarbonisation to raise awareness of decarbonisation requirements, additional sessions will be required. | 6. Board Development session occurred on 8th November 2021 – presentation slides are available. |
| 7. Finance & Performance Committee has oversight of decarbonisation project, decarbonisation to become a standard agenda item. | 7. (i) Routine updates at every other FPC meeting (3 times a year)<br>(ii) Annual report (which includes a Sustainability section) is approved by the Finance & Performance Committee |
| 8. KPIs with respect to energy transmissions are communicated to Estates team annually by sustainability manager | 8. KPIs to Estates team includes energy use at all WAST managed buildings |
| 9. ISO14001 accreditation in place | 9. ISO14001 – Annual audits are undertaken against the accreditation. Environmental Coordinators act as champions in the organisation. |
| 10. Environment Strategy in place | 10. Environment strategy has been approved by the Trust Board. This covers the next 5 years |
| 11. Programme Board Risk Register | 11. Programme Risk Register reviewed at every Decarbonisation Programme Board meeting |
| 12. Reporting to WG via DCR reporting, qualitative, and quantitative reports and emissions reporting | 12. Submissions to WG – quarterly DCR reporting. Annual qualitative and quantitative reporting |
| 13. Membership of National Programme Board (WG), Transport Task and Finish Group and BELP Project Board | 13. Minutes and papers of meeting |
| | **External - Independent Assurance:**<br>• Sustainability section in Annual Report audited by Internal Audit. Annual audits by BSI on accreditation |
| **GAPS IN CONTROLS** | **GAPS IN ASSURANCE** |
| 1. Establishment of further workstreams to address a Programme Plan to support strategy requirements | |
| 2. Ability to deliver on EV infrastructure plan including electrical capacity issues for the purposes of electronic charging points for vehicles | |
| 3. Procurement of an electronic fleet of vehicles – this is not currently possible for anything other than a car/van (limited) | |
| 4. NED support ended April 2022 | |

| Risk ID 542 | Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan | Date of Review: | 04/05/2022 | TREND | 16 (4x4) |
|---|---|---|---|---|---|
| | | Date of Next Review: | 04/05/2024 | | |

| **IF** there is a lack of resources and available technology and infrastructure | **THEN** there will be a failure to deliver the commitments outlined in the action plan and within the Welsh Government timelines | **RESULTING IN** negative environmental and social impacts causing and reputational damage | | Likelihood | Consequence | Score |
|---|---|---|---|---|---|---|
| | | | Inherent | | | |
| | | | Current | 3 | 4 | 12 |
| | | | Target | 2 | 4 | 8 |

5. Resources to be able to deliver extent of DAP – work ongoing to establish actions required and potential cost impacts. Note detailed schemes are challenging to work up without appropriate resource which in turn allow for realistic financial estimates to be made about cost.

| Actions to reduce risk score or address gaps in controls and assurances | Action Owner | By When/Milestone | Progress Notes: |
|---|---|---|---|
| 1. Establishment of further workstreams to address a Programme Plan to support strategy requirements: Consider further workstreams required in support of delivering DAP actions, including grouping of similar actions | Capital Development and Estates Team | 31.06.24 | |
| 2. Ability to deliver on EV infrastructure plan including electrical capacity issues for the purposes of electronic charging points for vehicles: develop an investment strategy/prioritised list of sites where further EV charging is required. Will need further investment. | Decarbonisation Programme Board | March 2025 (in line with the IA recommendation action) | |
| 3. Procurement of an electronic fleet of vehicles – this is not currently possible for anything other than a car/van (limited): development of specifications for vehicles considering achievable and safe ULEV options where possible. NOTE: will be dependent on confirmation of 2024/25 BJC funding | Fleet Team | March 2025 | |
| 4. NED support ended April 2022: A new NED will need to be nominated to champion this risk/project at Trust Board level | Director of Corporate Governance / Board Secretary | 31.06.24 | |
| 5. Resources to be able to deliver extent of DAP – work ongoing to establish actions required and potential cost impacts. Note detailed schemes are challenging to work up without appropriate resource which in turn allow for realistic financial estimates to be made about cost: Development of an investment requirements schedule (also aligned to IA recommendations). Contribute resources to support the Decarbonisation Strategy action plan | Director of Finance & Corporate Resources | 31.03.25 | |

| CLOSED 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:** | **16/02/2024** | **TREND** | **16 (4x4)** |
|---|---|---|---|---|---|
| | | **Date of Next Review:** | **15/03/2024** | ➡ | |

| **IF** sufficient recurrent funding is not forthcoming there is a risk that the Trust will be committed to additional expenditure through delivery of the IMTP and in year developments which are only recognised by commissioners on a cost recovery basis. | **THEN** there is a risk that the Trust may not be able to deliver services and there will be a lack of funding certainty when making recurrent cost commitments. Any potential 'exit strategies' from developed services could be challenging and harmful to patients. | **RESULTING IN** patients not receiving services, the Trust not achieving financial balance and a potential failure to meet statutory obligations causing reputational damage | | **Likelihood** | **Consequence** | **Score** |
|---|---|---|---|---|---|---|
| | | | **Inherent** | **3** | **4** | **12** |
| | | | **Current** | **4** | **4** | **16** |
| | | | **Target** | **2** | **4** | **8** |

IMTP Deliverable Numbers:

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

**Risk Commentary**

Linked to risk 139, though funding has been sourced internally for the EMS staff, and non-recurrently from EASC, the score remains the same as clarity from Commissioners has still not been provided on any recurrent funding ask on this topic which could have a negative recurrent impact on the Trusts financial position. Other key item to note is funding for 111, WAST continues dialogue with commissioners of the service and any financial risk is mitigated by operating on a spend and cost recovery basis with commissioners.

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

| **Actions to reduce risk score or address gaps in controls and assurances** | **Action Owner** | **By When/Milestone** | **Progress Notes:** |
|---|---|---|---|
| 1. A formal approach to service change to be developed providing secure recurrent funding with commissioners. | Executive Leadership Team | 31.3.24 | Update: 23/24 Recurrent funding remains an issue for the 100 WTE £6m funding from commissioners. In addition, discussions continue with commissioners to ensure WAST continue to obtain funds in relation to 111 on a spend and recover basis. |
| 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 | 31.3.24 | Update: Work to identify the PROMS & PREMS evaluation criteria for Emergency based services via the Value-Based Healthcare working group continues. |

| 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: | 16/04/2024 | TREND | 15 (3x5) |
|---|---|---|---|---|---|
| | | Date of Next Review: | 16/05/2024 | ➡ | |

| 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:

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

**Risk Commentary**

The latest National Cyber Security Centre (NCSC) assessment indicates that the threat of Cyber-attacks remains unchanged with activities of state actors and criminal gangs still high. Whilst the Trust and wider NHS Wales organisations have in place several layers of technology to protect the Trust and its information systems, there is still a risk that users will be fooled by phishing emails which are becoming ever more sophisticated. To raise user awareness of cyber threats the Trust ICT department run regular phishing exercises as well as short security training packages, reporting the results and uptake through IGSG and into FPC. Risk has been fully reviewed in the cycle and the score remains static.

| CONTROLS | ASSURANCES |
|---|---|
| | **Internal Management (1st Line of Assurance)** |
| 1. Appropriate policy and procedures in place for Information/Cyber Security | 1. Information Security Policy reviewed every 3 years (currently due for renewal). Incident Policy and Procedure put in place in February 2022 – renewed annually. |
| 2. Trust Business Continuity Procedure and Incident Response Plan | 2. Debrief from significant business continuity incidents captured within organisational learning spreadsheet. Governance with respect to this goes through SOTs. Full review of Incident Response plan every 3 years - currently undergoing a partial review. BCPs and BIAs should be reviewed annually by their owners. Annual schedule of testing |
| 3. IT Disaster Recovery Plan | 3. Organisation-wide tabletop exercise undertaken in March 2022 with all BC leads and Digital teams. |
| 4. Relevant expertise in Trust with respect to information security | 4. Staff undertake relevant training courses e.g., CISSP to increase knowledge and expertise |
| 5. Data Protection Officer in post | 5. In job description of Head of ICT |
| 6. Cyber and information security training and awareness | 6. Training statistics are available on ESR and from Phish threat module |
| 7. Mandatory Information Governance training which includes GDPR | 7. Training statistics reported on by Information Governance department |
| 8. ICT tests and monitoring on networks & servers | 8. Any issues would be identified and flagged and actioned |
| 9. Information Governance framework | 9. WAST self-assesses its Information Governance Framework against the Welsh Information Governance toolkit. |
| 10. Internal and NHS Wales governance reporting structures in place | 10. Internal WAST Information Governance Steering Group & All Wales Information Governance Management Advisory Group (IGMAG) meets quarterly, National Ambulance Information Governance Group (NIAG) meets every 2 weeks, Operational Security and Service Management Board (OSSMB) (national) – daily/weekly meetings and minuted meetings every 2 months. Minutes and actions logs available for meetings. |
| 11. Checks undertaken on inactive user accounts | 11. Software in place to run check on inactive accounts as and when |
| 12. Business Continuity exercises | 12. Annual schedule of testing |
| 13. Operational ICT controls e.g., penetration testing, firewalls, patching | 13. Monthly scans on infrastructure. Penetration testing has occurred for different systems. 2 physical firewalls on networks to monitor traffic. Monthly patching occurs or as and when. 04/08/23 – Exploring procurement of additional penetration tests with the aim of annual testing of all critical systems. |
| 14. Security alerts | 14. Daily alerts are received. Anti-virus alerts received as and when threat discovered |
| 15. Cyber/Info Security KPI are reported to senior management and committees | 15. Monthly KPI reports now being generated routinely and fed into the Digital Leadership Group, ELT, IGSG and FPC |
| 16. Regular cyber awareness campaigns are conducted | 16. Cyber training is provided to staff and regular phishing campaigns are conducted. These are reported as part of the KPI reports |
| 17 IT recovery Plan does include a cyber response | 17. Cyber response incorporated into IT Disaster Recovery Plan |

| 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: | 16/04/2024 | TREND | 15 (3x5) |
|---|---|---|---|---|---|
| | | Date of Next Review: | 16/05/2024 | | |

| 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 |

| | |
|---|---|
| 18.Information Security Policy refreshed and approved | |
| 19. Suite of business continuity exercises that departments can undertake to test their plans are available via EPRR. | 19. |
| 20. The cyber risk is reviewed and monitored | 20. The ongoing cyber threat to the organisation is continually monitored using daily comms feeds and automated alerts from various external sources via ICT security team and reported to AD of Digital and DPO. The corporate cyber risk assessment will be reviewed monthly at the Digital Leadership Group informed by the threat and intelligence monitoring and national strategic trends. |
| | **External Independent Assurance**<br>NHS Wales Cyber Response Unit independent view of Network and Information Systems (NIS) Directive compliance within last 4 – 5 months (covering controls 1 -,3 – 11, 13 – 14 |
| **GAPS IN CONTROLS** | **GAPS IN ASSURANCE** |
| 1. Lack of understanding and compliance with policy and procedures by all staff members | 1. |
| 2. No organisational information security management system in place | 2. SIRO in place and ISMS evolving in line with refresh of Trust information Security Policy |
| 3. | 3. |
| 4. Departments do not communicate in a timely manner with Digital Services around putting in new processes, new projects, and procurement and this has a cyber security, information governance and resource impact | |

| Actions to reduce risk score or address gaps in controls and assurances | Action Owner | By When/Milestone | Progress Notes: |
|---|---|---|---|
| 1. Development of a Cyber Improvement Plan | Senior ICT Security Specialist | Next checkpoint date 25.06.2024 | Implementation of Cyber Improvement Plan actions ongoing and reported into IGSG |

| Risk ID 558 | Deterioration of staff health and wellbeing in the face of continued system pressures as a consequence of workplace experiences | Date of Review: | 16/04/2024 | TREND | 15 (3x5) |
|---|---|---|---|---|---|
| | | Date of Next Review: | 16/05/2024 | ➡ | |

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

IMTP Deliverable Numbers: TBC

| EXECUTIVE OWNER | Director of People & Culture | ASSURANCE COMMITTEE | People & Culture Committee |
|---|---|---|---|

**Risk Commentary**

This risk should be considered alongside Risk 160 as the resulting increased sickness levels mentioned above will be addressed by the same controls and assurances. However, the ongoing system pressures including long handover delays, overruns, missed breaks and the perpetuating impact of increased sickness levels continues to mean this risk remains static. WAST continues to work in partnership with the system to pilot viable options for addressing the external factors. Although there has been some success in some areas, we are yet to see these being scaled to an extent that the employee experience has been impacted. Since 2020 we have not seen the previous pattern of easing over the summer months and with the current public health risk of measles and continuing risks of covid this risk remains static. The People and Culture Plan 2023-2026 is a good summary of the controls and actions addressing this risk. The old Health and Wellbeing Strategy and its replacement build on this. Nationally the Health and Wellbeing Framework due for publication in Summer 2024 also addresses the system wide employee experience challenges. The ongoing system challenges remain with long handover delays which are likely to worsen again as we head into winter pressures. Work on reducing shift overruns continues with various pilots being run to test viable options which could be implemented. Front line operations had little respite over the summer months.

| CONTROLS | ASSURANCES |
|---|---|
| | **Internal Management (1st Line of Assurance)** |
| 13. Health and wellbeing strategy 2020-2024 in place and shared across the Trust. The new Health and Wellbeing Plan 2025-2028 has now been drafted and is out for consultation. The aim of the new plan is to expand on consideration of employee experience to recognise that individual wellbeing interventions are not sufficient in mitigating system wide pressures. | 14. New Health and Wellbeing Plan 2025-2028 aligned closely to People and Culture Plan and delivery monitored via the Health and Wellbeing Steering Group, reporting into the People and Culture Business Meetings. New All Wales Framework also in development with an emphasis on workplace experience due for publication in June 2024. |
| 14. Occupational Health & Wellbeing team with range of support options for individual mental health interventions, MSK support, reasonable accommodations and recommendations, supported by mental and physical health expert clinicians. | 15. Current waiting times now within SLA of 6 days, self-referrals and self-appointment booking. External providers meet quarterly and provide monthly engagement figures. Reporting into OHW operational team meeting and MIQPR. |
| 15. Wellbeing support and training for line managers a peer support network and TRiM intervention for trauma information. | 16. Rolling programme of workshops, attendance at team events when requested, evaluation and numbers trained reported at OHW operational meetings. Diarised meetings, webinars and workshops in place through a rolling programme. Have these happened and what was the benefit? How do we measure it. |
| 16. | 17. Tools are available on WAST intranet. |
| 17. TRiM | 18. TRiM Coordinator has regular dialogue with TRiM managers and practitioners. Project plan and training schedule in place. |
| 18. Acting on results of staff surveys relating to staff experience, data triangulated with pulse surveys and other cultural metrics as detailed in the People and Culture Plan. | 19. Each Directorate has developed their own action plan to address staff surveys. NHS staff survey high level results released 19/02/204 with directorate specific data released in April 2024. |
| 19. HSE stress risk assessments | 20. Undertaken by managers and advice is provided on how to use them by Occupational Health and Health and Safety teams. |
| 20. KPIs are reported fortnightly to regarding Occupational Health and Wellbeing activity | 21. Received at OHW operational team meeting and reported in MIQPR. |
| 21. Wellbeing drop-in sessions for CCC and 111 staff | 22. These sessions are now part of business as usual across services and a user experience form is being designed to collate more formal quantitative feedback for OHW operational team meetings. Data to date has been qualitative and the quantitative has been measured by engagement with the service. |
| 22. Fast track physiotherapy to address MSK issues. | 23. Regular review meetings with physiotherapy provider and monthly monitoring information received at People and Culture Business meetings and MIQPR |
| 23. Occupational Health team inclusion in sickness and absence meetings | 24. Have the meetings been of benefit and how do we measure it |
| 24. Stress risk assessments | 25. These are part of the IOSH Managing Safely Training. |
| | **External - Independent Assurance -** Audit Wales – Taking Care of the Carers report in October 2021 – all actions complete |
| **GAPS IN CONTROLS** | **GAPS IN ASSURANCE** |
| | 4. Reporting on wellbeing training take up this is now being reported into OHW Operational Team Meetings. |
| 11. Need to increase the education and communication with managers about stress risk assessments. Presentation developed and shared with people services. Delivery dates being agreed in conjunction with Health and Safet. With the arrival of the new OH Manager these discussions have restarted, and | Lack of awareness about staff wellbeing services, this continues to be a challenge due to small team, non-wired colleagues and competing communication messages. |

| Risk ID 558 | Deterioration of staff health and wellbeing in the face of continued system pressures as a consequence of workplace experiences | Date of Review: | 16/04/2024 | TREND | 15 (3x5) |
|---|---|---|---|---|---|
| | | Date of Next Review: | 16/05/2024 | | |

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

| | |
|---|---|
| colleagues are directed to the stress risk assessment information and education sessions will be started in Q1 & Q2. | |
| | Effects of elevated reap status affecting the ability of staff to engage with staff health and wellbeing services. Important to recognise the consistent reports of the impact of culture on wellbeing. Attendance at all events by operational staff consistently low due to service pressures. |

| Actions to reduce risk score or address gaps in controls and assurances | Action Owner | By When/Milestone | Progress Notes: |
|---|---|---|---|
| 1. People and Culture Plan 2023-2026 relevant Actions | Assistant Director for Inclusion, culture and wellbeing | Annual Plan | First year due to be reviewed at next People and Culture Committee May 2024 |
| 2. Health and Wellbeing Plan 2025-2029 | Assistant Director for Inclusion, culture and wellbeing | To be agreed at board autumn 2024. | New plan out for consultation until June 2024<br>**16/4/2024 Ongoing** |

| Risk ID 623 | Failure to comply with Data Protection Legislation | Date of Review: | 14/03/2024 | TREND | 15 (3x5) |
|---|---|---|---|---|---|
| | | Date of Next Review: | 14/04/2024 | NEW | |

| | | | | Likelihood | Consequence | Score |
|---|---|---|---|---|---|---|
| **IF** the Trust fails to comply with and demonstrate it is meeting the accountability requirements under the Data Protection Act, the UK General Data Protection Regulation (GDPR) and the Common Law Duty of Confidentiality | **THEN** the Trust will breach its legal obligations and potentially cause the personal or sensitive data to be compromised, lost, or inappropriately used. | **RESULTING IN** unauthorised data breaches/loss, financial or compensatory penalties, an increased regulatory scrutiny or enforcement as well as stakeholder mistrust and reputational damage | **Inherent** | 4 | 5 | 20 |
| | | | **Current** | 3 | 5 | 15 |
| | | | **Target** | 2 | 5 | 10 |

IMTP Deliverable Numbers:

| EXECUTIVE OWNER | Director of Digital Services | ASSURANCE COMMITTEE | Finance & Performance Committee |
|---|---|---|---|

**Risk Commentary**

**The consequences of this risk depend on the worst-case scenario which crosses of a number Domains on the Risk Scoring Matrix e.g. Loss of, or access to mass clinical data, the reputational damage this would cause, subsequent high-level involvement of ICO, Regulatory Body and Government involvement the subsequent fall out, fines and reduction in the level of clinical care. The likelihood would be small NB Just like pandemics. However, there are lower consequences of failure of statutory compliance which would warrant a higher level of likelihood even daily but in this case like near misses they indicate the need for change/improvement to demonstrate managing the risks. Therefore, the consequences will always be 5 but improvements are needed to lower the risk, and should we demonstrate meeting Statutory Requirements even if a serious incident/event/failure arises evidence provided would reduce / mitigate against the consequences.**

| CONTROLS | ASSURANCES |
|---|---|
| | **Internal Management (1st Line of Assurance)** |
| 1. **Data Protection Expertise: 1 FTE Data Protection and Compliance Manager (DPCM); 1 FTE Information Governance Officer, 1 FTE Cyber Security Officer** | 1. **Two Data Protection and Compliance Managers have been employed on a consultancy basis to provide cover and support backlog clearance (E).** |
| 2. **Temporary Data Protection Officer position held by Head of ICT** | 2. **Temporary Data Protection Officer** |
| 3. **Data Protection and Information Governance Policies and Procedures (Incl. DPIAs and Cloud Assessments)** | 3. **Monthly Information Governance Steering Group which includes progress**<br>**DPC, DSA and DPIA reviews (I)**<br>**IG Training**<br>**IG Toolkit (System for providing a level of assurance of compliance (I)**<br>**Incident Reporting**<br>**Accountability to ELT**<br>**Development of reporting (dashboard) which supports IGSG, ELT and QUEST Board Committee for scrutiny.** |
| 4. **Contracts and agreements: Data processing, Data Sharing and Employment & Consultancy** | |
| 5. **Register of information assets and data flows (outdated)** | |
| 6. **Staff training on updated training module (Apr 2023)** | |
| 7. **Incident Reporting and management (DATIX)** | |
| 8. **NIIAS?** | |
| 9. **Digital Notices / comms?** | |
| 10. **Proactive engagement outbound (not inbound to team)** | |
| **GAPS IN CONTROLS** | **GAPS IN ASSURANCE** |
| **1. WAST has been carrying a DPCM vacancy since January 2023. There has been 1 unsuccessful attempt to fill the position which has led to capacity constraints. In Qtr. 4 2023/24 the Job Description will be reviewed and readvertised before the end of the financial year.** | 1. **See 21. Further Actions (1)** |

| Risk ID 623 | Failure to comply with Data Protection Legislation | Date of Review: | 14/03/2024 | TREND | 15 (3x5) |
|---|---|---|---|---|---|
| | | Date of Next Review: | 14/04/2024 | NEW | |

| IF | THEN | RESULTING IN |
|---|---|---|
| IF the Trust fails to comply with and demonstrate it is meeting the accountability requirements under the Data Protection Act, the UK General Data Protection Regulation (GDPR) and the Common Law Duty of Confidentiality | THEN the Trust will breach its legal obligations and potentially cause the personal or sensitive data to be compromised, lost, or inappropriately used. | RESULTING IN unauthorised data breaches/loss, financial or compensatory penalties, an increased regulatory scrutiny or enforcement as well as stakeholder mistrust and reputational damage |

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

| | |
|---|---|
| **2. Unfilled and unfunded position which is required to meet Article 39 UK GDPR 2018. *The DPO must also be independent, an expert in data protection, adequately resourced, and report to the highest management level* [DPA 2018].** | 2. **This is a stop gap.** |
| **3. Resource capacity constraints to update, implement or monitor the controls; and lack of engagement by management and staff which either bypass the requirements or stalled engagement.** | 3. **Even with increased capacity without engagement by managers and staff to meet their compliance requirements there will continue to be information reported to IGSG which will demonstrate low levels of assurance i.e. Reports on DPIA log, DSA log, Training Levels, IG Toolkit, and Implementation Plan** |
| **4. Personal identifiable information (PII) is being processed or shared with no data processing contracts (DPC) or data sharing agreements (DSA) when legally required; or incomplete DPC or DSA due to stalled engagement.** | 4. **Lack of Data Protection pre procurement controls which form part of Data Protection by Design and Default means that Departments could purchase IT systems, hire document scanning companies, external data consultants and analytical firms and bypass WAST's controls for appropriate due diligence or legislative required controls in managing these risks.** |
| **5. New data, or new data processes which have either bypassed the controls or there are no information asset owner and therefore doesn't get on to the asset register or the dataflow is not mapped and creates a weakness in assurance (See 3)** | 5. **Data Protection and Compliance Risks not fully realised.** |
| **6. Currently not meeting levels of IG staff training.** | |
| **7. Lack of Data Protection pre procurement controls which form part of Data Protection by Design and Default means that Departments could purchase IT systems.** | |

| Actions to reduce risk score or address gaps in controls and assurances | Action Owner | By When/Milestone | Progress Notes: |
|---|---|---|---|
| 1. **Recruitment of Data Protection and Compliance Manager(s) – funding agreed** | **Leanne Smith** | **Q2 2024/25** | **Interviewing 01 May 2024 – in post Q2** |
| 2. **Seeking funding to recruit/upskill/resource DPO who will encourage engagement** | **Jonny Sammut** | **Q3 2024/25** | **Recruitment and in post Q3** |
| 3. **Ensure compliance with the appropriate IG level training across all Directorate and Departments**<br>a. **Demonstrate a regular series of comms on IG and DP**<br>b. **Regular monitoring of training compliance through IGSG**<br>c. **Targeted training compliance reporting to line manager on individuals to ensure that 85% target is reached.**<br>d. **BAU on Siren training notices and specific guidance or advice** | **Leanne Smith** | **Q2 2024/25** | **Lock screen issued 04/24 in relation to WhatsApp and training. This will be refreshed in 06/24. Siren notice drafted for ELT 05/24** |
| 4. **Report on physical security to IGSG – working with fleet and estates team** | **Leanne Smith and Aled Williams** | **Q2 2024/25** | **Reporting to IGSG and FPC** |
| 5. **Implementation of Data Protection by Design and Default which includes pre procurement of IT systems, hiring of document scanning companies, external data consultants and analytical firms and bypass WAST's controls for appropriate due diligence or legislative required controls in managing these risks.** | **TBA** | **TBA** | **IG colleagues are part of the Impact Assessments TFG<br>Series of SMART actions will be developed to address this overarching action** |

| 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: | 16/04/2024 | TREND | 12 (3x4) |
|---|---|---|---|---|---|
| | | Date of Next Review: | 16/07/2024 | | |

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

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

IMTP Deliverable Numbers:

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

**Risk Commentary**

The ambition is appropriate levels of patient safety and good working conditions for our staff. Clearly neither of these are currently being achieved in the emergency ambulance care pathway as evidenced by the long waits, shift overruns and volume of concerns and reportable incidents. The Trust is currently commissioned on the assumption of 6,000 hours of handover lost hours, with current levels at 26,000 (Jan-24). EASC has an ambition to achieve 12,000 handover lost hours by the beginning of quarter four 2023/24, which has not been achieved, but even if it was achieved, it would still be double what the EMS rosters are predicated on. The Trust is not fully funded on these rosters either. The Trust is not fully funded for the CHARU roster lines, with an identified shortfall of -89.5 FTEs. The Trust has made the decision to transfer staff from emergency ambulance roster lines to CHARU roster lines, which is almost complete, but this is an internal movement of staff, not an increase in establishment. Similarly, the Trust has made the decision (delivered) to recruit another intake of APPs, an additional 16 FTEs, but this is also being funded through internal movements, with a planned temporary relief gap to fund these internal movements.

The 2023 EMS Demand & Capacity Review is live with an estimated completion date of **July** 2023 **Trust Board (draft results received by end of 23/24 and in time for IMTP).** This strategic review will enable the Trust to articulate the type and level of resource that optimises response and conveyance to deliver appropriate levels of patient safety and good working conditions for our staff i.e., the ambition. If handover levels remain unchanged **and a traditional conveyance model is used to meet demand,** the review is indicating **an unacceptably high-level modelled staff requirement. The Review estimates a more reasonable figure of +300 FTEs, if handover can be reduced to 7,000 hours (handovers within one hour) supported by full triangle inversion.**
The Trust has some limited room for manoeuvre in its 2024/25 budget to put more resource into "shift left"/" invert the triangle", but if further funding is not forthcoming, post the 2023 EMS Demand & Capacity Review, the risk may need to be revised upwards.

NEPTS is also commissioned via EASC (it is commissioned at NEPTS, not Ambulance Care), with agreement that in Q1 2024/25 there should be a joint collaborative workshop between the Trust, the Joint Commissioning Committee (JCC), which is the new organisation commissioning EMS and NEPTS, and health boards.

From May 2023 111Wales has also become a commissioned service, with the 111 Board commissioning the front end of the 111Wales service from the Trust.

From the 01 April 2024 111Wales will be commissioned by the JCC as well, bringing all three patient pathways operated by the Trust under a single commissioning umbrella. This is viewed as a positive development by the Trust, supporting the development of an organisational ambition.

| CONTROLS | ASSURANCES |
|---|---|
| | **Internal & External Management (1st Line of Assurance)** |
| 1. EASC/WAST Forward Plan for EMS and NEPTS in place and monitored at EASC meetings | 1. Minutes of meetings and a standard agenda item |
| 2. EASC and its 2 sub-committees established as a forum to discuss WAST's strategy | 2. Minutes of meetings and a standard agenda item |
| 3. Weekly catch up between CASC/CEO | 3. Meetings are diarised every week |
| 4. Collaboration between EASC and WAST on specific projects e.g. Amber Review, EMS Operational Transformation Programme, Ambulance Care Programme | 4. Representatives are co-opted onto meetings and frequency is between 3–6 weeks. Set agendas with NCCU reps co-opted. |
| 5. Monthly CASC Quality and Delivery Meeting established | 5. Formal meeting with agendas, minutes, and action logs available. |
| 6. Patient Safety information e.g. Appendix B incidents, weekly/monthly patient safety reports produced | 6. These reports supplied to Director of Quality and Nursing in Health Boards and other senior stakeholder's fortnightly |
| 7. Programme structure has been established for 'inverting the triangles' including EASC | 7. This is now an established programme of work with the Trust making an offer to the system via the Six Goals Programme in January 2024. |
| 8. Commissioning intentions. | 8. In year progress reported each quarter to the relevant commissioning meeting and 24/25 commissioning intentions approved for 111Wales and expected to be approved by Mar-24 EASC. |
| 9. Governance arrangements for 111 commissioning: 111 Board, 111 Commissioning Board + 111 DAG etc. | 9. Minutes of meetings and a standard agenda item |

| 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: | 16/04/2024 | TREND | 12 (3x4) |
|---|---|---|---|---|---|
| | | Date of Next Review: | 16/07/2024 | | |

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

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

**External Management (1st Line of Assurance)**
1. Plans go to every bi-monthly meeting
2. Meet bi-monthly and agendas, minutes and action logs available

| GAPS IN CONTROLS | GAPS IN ASSURANCE |
|---|---|
| 1. EASC meetings focus largely on EMS and cursory note of NEPTS | 1. NEPTS is covered in the WAST Provider Report to EASC **(assumption that provider reports will continue in the JCC)** |
| 2. Governance coordination between NCCU **(now JCC)** and WAST to be improved. | 2. Identified need for a governance meeting between NCCU and WAST to manage the overall commissioner/provider interface. Actioned, but has lapsed due to capacity and resourcing in NCCU team. The Trust is currently meeting every two weeks connected to the development the IMTP. This will be further reviewed as the JCC goes live in April-24 **(period of transition likely to extend through Q1).** |
| 3. WAST's ability to influence hospital handover delays (this is outside of the Trust's control and a Health Board responsibility) | 3. Ministerial direction on handover reduction with significant pressure being applied to health boards through the NHS Leadership Board and NHS Executive accountability arrangements. |
| 4. Funding does not flow in a manner to balance demand with capacity (outside of WAST's control) | 4. Strategic demand and capacity review being undertaken with output due to be reported to EASC in Mar-24, with initial findings already shared. On advice from the CASC, formally reporting the findings of the review has been re-programmed into Q1 2024/25, for the new JCC. **JCC dates to be determined.** |

| Actions to reduce risk score or address gaps in controls and assurances | Action Owner | By When/Milestone | Progress Notes: |
|---|---|---|---|
| 1. Agree and influence EASC/Health Boards that sufficient funding to be provided to WAST | CEO WAST | 02/08/23 Checkpoint Date **(this is almost a permanent action by the CEO, so not sure it has a by when date?)** | 30.09.22 Additional £3m provided for +100 FTEs into Response by 23/01/23. 12/01/23 Recurrent funding for the +100 not secure. 02.05.23 Recurrent funding still not secure. **16.04.24 Recurrent funding for +100 FTEs now secured.** 28.07.23 Funding secure for 23/24, but not recurring. 18.01.24 Offer being made to the system in January 2024 via the Six Goals Programme. The reception of the Trust's offer was mixed. A key area of focus in the 2024/25 IMTP will be data linking that enables the Trust to better prove the value of investing in the Trust; **(16/04/24) and the development of system metrics dashboard that enables the Trust to track its impact on the wider system** |
| 2. Agree and influence EASC/Health Board of the need for significant reduction in hospital handover hours | CEO WAST | 02/08/23 Checkpoint Date **(this is almost a permanent action by the CEO, so not sure it has a by when date?)** | 30.09.22 4-hour handover backstop agreed and -25% reduction in handover from October 2021 baseline. 12/01/23 There has been a significant worsening picture. 02.05.23 Continued worsening picture with almost 29,000 lost in March 2023. 28.07.23 There has been some reduction, but levels remain extreme. 18.01.24 NHS Leadership Board is increasing accountability and focus of health board handover reduction actions. The emerging 2023 EMS Demand & Capacity Review models the level of resource required with no handover reduction and the level of resource required if there is a handover reduction to 12,000 hours. **26/04/24 This modelling has been further supplemented by modelling the Ministerial target of no handovers of more than one hour.** |
| 3. Increased understanding of NEPTS by EASC | Executive Director of Strategy Planning and Performance | 02/08/23 **30/06/24** | 30.09.22 "Focus on" session in May 2022 EASC and NCCU represented on Ambulance Care Programme Board. 12/01/23 F&P Deep Dive made available to NCCU. 02.05.23 Continued attendance by NCCU at Ambulance Care Transformation Programme. 28.07.23 EASC want WAST to develop a LTS for NEPTS, which will increase the focus on it. 18.01.24 Ambulance Care strategy sessions held as part of the inverting the triangle programme and IMTP development held, which will now be taken forward into a collaborative workshop with commissioners in Q1 2024/25. **16/04/24 Workshop arranged for April 2024.** |
| 4. Governance meeting between NCCU and WAST to manage the commissioner provider interface | Assistant Director Commissioning & Performance | 02/08/23 Checkpoint Date | 30.09.22 Meeting in place and meeting regularly. 12/01/23 Meetings continue. 02.05.23 These have lapsed due to pressures and sickness absence in the NCCU. HB to reboot, subject to ability of NCCU to undertake. 28.07.23 Availability remains a challenge, but there is regular informal dialogue between WAST and NCCU. 18.01.24 This specific meeting remains lapsed, but the Trust is currently meeting every two weeks with the NCCU on the |

| 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: | 16/04/2024 | TREND | 12 (3x4) |
|---|---|---|---|---|---|---|---|
| | | | | Date of Next Review: | 16/07/2024 | | |

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

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

| | | | |
|---|---|---|---|
| | | | development of the IMTP. As the Trust moves into the new JCC from 01 April 2024 there will be a further opportunity to address this control.<br>**16/04/24 The new commissioning arrangements are in transition and still quite fluid at the moment.** |
| 5. Develop and roll out the Stakeholder Influencing Plan | Director of Partnerships & Engagement<br>AD Planning & Transformation | Q2 24/25 onwards | 15/03/24 This action is captured in Risk 201 on the CRR. The reputation audit being repeated in Q1 will inform the development and roll out of this plan in Q2.<br>**16/04/24 One for Estelle.** |

| Risk ID 424 | Resource availability (revenue, capital, and staff capacity) to deliver the organisation's Integrated Medium-Term Plan (IMTP) | Date of Review: | 18/03/2023 | TREND | 12 (3x4) |
|---|---|---|---|---|---|
| | | Date of Next Review: | 18/06/2024 | ➡ | |

| **IF** resources are not forthcoming within the funding envelope available to WAST (link to risk 139) | **THEN** there is a risk that there is insufficient capacity to deliver the IMTP | **RESULTING IN** delay or non-delivery of IMTP deliverables which will adversely impact on the Trust's ability to deliver its strategic objectives and improvement in patient safety and staff wellbeing | | Likelihood | Consequence | Score |
|---|---|---|---|---|---|---|
| | | | Inherent | 4 | 4 | 16 |
| | | | Current | 3 | 4 | 12 |
| | | | Target | 1 | 4 | 4 |

IMTP Deliverable Numbers: All

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

**Risk Commentary**

It is recommended that the risk score be reduced to 12 based on a reduction of likelihood score. There is funding allocated within the IMTP financial plan for support to deliver key areas of work that has been agreed with commissioners. The vacancies and gaps within the central Transformation team have been reduced so there are better levels of support for delivery of key workstreams and delivery of mitigations listed in this BAF.

IMTP priorities have been set and are going to Trust Board on 28th March 2024 covering the next three years, taking into account the external context in which the Trust is working. These priorities are considered realistic within the funding envelope, and this has been through rigorous prioritisation processes (revenue and capital).

In addition, the Project Path Framework has now been developed to replace the existing PPM, which will enable awareness, training, and a network of project resources across the Trust to develop consistency in delivery. This is due to be signed off at Integrated Strategic Planning Group (ISPG) on 22nd March 2024 (STB delegated authority to sign off at ISPG on 26th February 2024.

This risk will remain under review as we consider any put further controls in place but also taking account of the new commissioning landscape, financial context and our strategic developments.

| CONTROLS | ASSURANCES |
|---|---|
| | **Internal Management (1st Line of Assurance)** |
| 1. Prioritisation of IMTP deliverables | 1. Prioritisation session held with ADLT/ELT on 14th February 2024 |
| 2. Financial policy and procedures | 2. |
| 3. Governance and reporting structures e.g., Strategic Transformation Board (STB) | 3. IMTP sets out delivery structures and meeting minutes are available for ISPG, TSAG and STB |
| 4. Assurance meetings with Welsh Government and Commissioners | 4. Agendas, minutes, and slide decks available |
| 5. Transformation Support Office (TSO) which supports the major delivery programmes | 5. Paper on TSO to Strategic Transformation Board |
| 6. Project Path Framework (PPF) - Project and Programme Management Framework to be replaced with Project Path Framework, with toolkits, training, and networks in place to support consistency of project delivery across the Trust | 6. PowerPoint pack detailing Project Path Framework |
| 7. Regular engagement with key stakeholders | 7. Stakeholder Engagement Framework |
| 8. Financial Sustainability Programme – savings and income work streams | 8. FSP programme highlight reports |
| 9. Head of Transformation | 9. Head of Transformation in Post |
| | **Independent Assurance (3rd Line of Assurance)**<br>2. Subject to Internal Audit |

| GAPS IN CONTROLS | GAPS IN ASSURANCE |
|---|---|
| 1. Project and programme management (PPM) framework to be reviewed | 1. PPM needs to be reviewed and approved through STB |
| 2. Lack of a commercial contractual relationship with Commissioners (link to risk 458) | 2. Benefits have not been fully linked at programme level through to benefits realisation plan. |

| Actions to reduce risk score or address gaps in controls and assurances | Action Owner | By When/Milestone | Progress Notes: |
|---|---|---|---|
| 1. Review the PPF | Head of Transformation | Extended from 31.03.23 – To 31.06.23 and then to 30.09.23 in line with milestone for delivery<br>Extend to 31.12.23 in line with timescales for sign off.<br>Extend to 31.01.24 in line with timescales for sign off.<br>Extend to end of Feb in line with next STB. | Currently (January 2023) working through delivery structures for 2023-26 which will inform the PPM review – changed checkpoint date to 31.06.23.<br>Workshop held in Q1 and Q2 to develop new Project Path Framework. Milestone for delivery in Q3.<br>Planning Framework approved by STB on 04.07.2023 which sets out the Project Path framework at a high level.<br>Project Path Framework presented at ISPG on 27.10.23 and is scheduled for approval at STB on 27.11.23. |

| Risk ID 424 | Resource availability (revenue, capital, and staff capacity) to deliver the organisation's Integrated Medium-Term Plan (IMTP) | Date of Review: | 18/03/2023 | TREND | 12 (3x4) |
|---|---|---|---|---|---|
| | | Date of Next Review: | 18/06/2024 | ➡ | |

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

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

| | | | |
|---|---|---|---|
| | | Extend to end March to allow for ISPG sign off (delegated from STB) | STB reviewed the Project Path Framework and generally good feedback but some alterations to be made and brought back to STB in January 2024 for approval.<br>Further finalisation required; approval deferred to STB meeting 26.02.24.<br>STB delegated authority to ISPG to finalise and sign off the PPF at the end of March. |
| 2. Develop Benefits Realisation plans in line with Quality and Performance Management framework | Assistant Director of Planning/Assistant Director, Commissioning & Performance | Extended from 30.09.22 – to 31.03.23. Further extend to 31.06.23 and then to 30.09.23 in line with milestone for delivery<br>Extend to 31.12.23 as priorities have taken precedence but there is work ongoing in this space.<br>Extend to 29.02.24 as other priorities have taken precedence but there is work ongoing in this space.<br>As above extend to end of Feb.<br>Extend to 30.06.24 as further resources become available / return to enable this work to be done. | Reviewed action and extended checkpoint date further as approach being developed for next iteration of IMTP. Work ongoing.<br>Workshop held in Q1 and Q2 to develop new Project Path Framework. Milestone for delivery in Q3 as part of Project Path Framework.<br>Work continues with the Commissioning and Performance Team to align performance metrics with programme/IMTP deliverables.<br>An evaluation methodology is being trialled with Swansea University to look at benefits realisation of small, agile projects and PDSA cycles.<br>Work continues this but will be rolled out as part of the PPF.<br>The PPF has a clear template for benefits realisation plans, and benefits maps will be developed in Q1 to enable programmes and directorates to develop their benefits realisation plans. |
| 3. A formal approach to service change to be developed providing secure recurrent funding with commissioners (link to risk 458) | Director of Finance | 31.12.22 – checkpoint date 31.06.23 and then to 30.09.23 Extend to 31.12.23.<br>As above extend to end of Feb.<br>Extend to end March to allow for ISPG sign off PPF (delegated from STB) | Extend checkpoint date to 31.03.2023 on basis of new financial allocations for 2023 to be worked through with Commissioner.<br>A business case panel process has been developed and trialled as part of the development of the project path framework and is factored into the IMTP planning cycle, to give finance colleagues a timelier view of potential developments into the next 3-year cycle.<br>Extended in line with the roll out of PPF as the business case process is within that framework, however it has been utilised to review the recent CSC Business Case and was found to be helpful and supportive – albeit the model for developing business cases needs to be reviewed further to make the actual output more streamlined.<br>At ADLT/ELT prioritisation (14.02.24) it was agreed that for areas that have been allocated funding a clear 'spend plan' in lieu of a business case would be needed to draw down funding so that it is clear what the benefits of funding would be. |

| Risk ID 139 | Failure to deliver our Statutory Financial Duties in accordance with Legislation | Date of Review: | 09/04/2024 | TREND | 8 (2x4) |
|---|---|---|---|---|---|
| | | Date of Next Review: | 09/07/2024 | ➡ | |

| | Likelihood | Consequence | Score |
|---|---|---|---|
| Inherent | 3 | 4 | 12 |
| Current | 2 | 4 | 8 |
| Target | 2 | 4 | 8 |

**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

IMTP Deliverable Numbers:

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

Risk Commentary Q4 2023/24

The risk has now been further reviewed in conjunction with the level of financial risk detailed in the Trust's financial monitoring returns submitted to WG. The score has improved in year as a result, in part due to WAST being able to resource the remaining cost of the EMS staff increase itself in year, whilst further confirmation and assurance has been received from WG on any pay award funding due. In addition, a recent letter from WG confirmed that the Trust does not need to contribute anything further to the wider NHS Wales deficit reduction plan or will see any further reduction in its income to do so, providing further confidence that for this financial the risk has reduced. It must be noted that even though the risk has reduced for this year, in the current challenging financial climate for all public sector organisations the risk will remain elevated especially as focus turns towards financial planning for the new financial year e.g., recurrent funding will still need to be agreed with Commissioners for the new financial year for the 100 WTE EMS staff.

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

| Risk ID 139 | Failure to deliver our Statutory Financial Duties in accordance with Legislation | Date of Review: | 09/04/2024 | TREND | 8 (2x4) |
|---|---|---|---|---|---|
| | | Date of Next Review: | 09/07/2024 | ⟹ | |

| | | | | | |
|---|---|---|---|---|---|
| **IF** the Trust does:<br>• not achieve financial breakeven and/or<br>• does not meet the planning framework requirements and/or<br>• does not work within the EFL and/or<br>• fails to meet the 95% PSPP target and/or<br>• 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 | | **Likelihood** | **Consequence** | **Score** |
| | | | **Inherent** | **3** | **4** | **12** |
| | | | **Current** | **2** | **4** | **8** |
| | | | **Target** | **2** | **4** | **8** |

| **GAPS IN CONTROLS** | **GAPS IN ASSURANCE** |
|---|---|
| • Lack of formalised service contracts between Commissioner and WAST as a commissioned body | **10.** None identified. |

| **Actions to reduce risk score or address gaps in controls and assurances** | **Action Owner** | **By When/Milestone** | **Progress Notes:** |
|---|---|---|---|
| 1. Continuing negotiations with Commissioners | Director of Finance and Corporate Resources/ Director of Strategy Planning and Performance | 31/03/24<br>**31/03/25** | In line with the recent WAST financial position and monthly monitoring letter sent to WG, WAST can resource the cost of the EMS staff itself. In addition, discussions continue with commissioners to ensure WAST continue to obtain funds in relation to 111 on a spend and recover basis. |
| 2. Embed a transformative savings plan and ensure organisational buy in | ADLT and Savings subgroup | 31/03/24<br>**31/03/25** | **The Financial Sustainability Program (FSP) continues to be a key vehicle for the Trust to fully identify its savings program. Over delivery was achieved for the 23/24 financial year and the point of strong delivery is further highlighted with the programs ability to fully identify the 24/25 £6.4m savings plan before the start of the financial year.** |
| 3. Embed value-based healthcare working through the organisation | Executive Leadership Team and Value Based Healthcare Group | 31/03/24<br>**31/03/25** | Work to identify the PROMS & PREMS evaluation criteria for Emergency based services via the Value-Based Healthcare working group continues. |
| 4. Foundational economy, Decommissioning, and procurement to mitigate social and economic wellbeing of Wales | Estates, Capital and Fleet Groups, NHS Wales Shared Services Partnership | 31/03/24<br>**31/03/25** | The organisation utilises the NWSSP Shared Services Procurement framework to ensure contracts tendered provide best value for money while ensuring criteria within the tender docs ask bidders to highlight their ability to serve the aims of FE, Decommissioning, Decarbonisation and social as well as the economic wellbeing of Wales. **Ad hoc reports are received from Shared Services on WAST's progress in switching more expenditure to Welsh suppliers to keep the Welsh pound in Wales.** |

| Risk ID 283 | TO BE DE-ESCALATED TO DIRECTORATE RISK REGISTER<br>Failure to implement the EMS Operational Transformation Programme | Date of Review:<br>Date of Next Review: | 29/02/2024<br>28/05/2024 | TREND ➡ | 8 (2x4) |
|---|---|---|---|---|---|

| IF | THEN | RESULTING IN |
|---|---|---|
| there are issues and delays in the planning and organisation of the EMS Demand & Capacity Review Implementation Programme | there is a risk that WAST will fail to implement the EMS Operational Transformation Programme to the agreed performance parameters | potential patient harm, deterioration in staff wellbeing and reputational damage |

| | Likelihood | Consequence | Score |
|---|---|---|---|
| Inherent | 4 | 4 | 16 |
| Current | 2 | 4 | 8 |
| Target | 2 | 4 | 8 |

IMTP Deliverable Numbers:

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

**Risk Commentary**

The EMS Operational Transformation Programme is the Trust's strategic delivery response to the 2019 EMS Demand & Capacity Review. The programme has now largely been delivered e.g., closure of relief gap (recruitment of +300 staff), increase consult & close above the 10.2% benchmark, re-roster EMS, ensure that there was sufficient fleet and estate to support these changes and roll out the new CHARU resource. The main area outstanding is the reconfiguration of EMSC, which was initially delayed by the pandemic and then further delayed by the need to update the data used to ensure the recommended actions were still correct. This update has just been completed, so the focus is now on finishing the EMSC project within this programme. The full role out of the CHARU resource also remains an open action. The programme was subject to internal audit in 2022 and narrowly missed substantial assurance (quoracy to be reflected in PID and PID updated, both of which have been addressed).

Whilst the programme has largely delivered on its agreed outputs, it has not delivered the required levels of patient safety and staff working conditions for two main reasons: extreme handover (+20,000 lost hours v the 6,000 that the programme was predicated on) and abstractions (34% v the 30% benchmark). Handover remains extreme, but abstractions are reducing.

Subject to agreement with Strategic Transformation Board (STB), the Senior Responsible Owner for the programme, is expecting to close (and evaluate) the programme in March 2024. STB will then determine what programme arrangements are required in 2024/25 for the new actions arising out of the 2023 EMS Demand & Capacity Review.

| CONTROLS | ASSURANCES |
|---|---|
| | **Internal**<br>**Management (1st Line of Assurance)** |
| 1. Implementation Programme Board in place – meetings held every 3 weeks with the DASC and TU reps on the membership. Now every 6 weeks as the programme largely delivered. | 1. Minutes and papers of Implementation Programme Board. |
| 2. Executive sponsor and Senior Responsible Owner (SRO) for programme in place. | 2. Project Initiation Document (PID) detailing structure and minutes of Implementation Programme Board. PID is up to date. |
| 3. Programme Manager and Programme support office in place (for delivery of the programme). | 3. Same as 2 above. |
| 4. Programme risk register. | 4. Highlight reports showing key risks reported to STB every 6 weeks. |
| 5. Assurance meetings held with Strategic Transformation Board (STB) every 6 weeks and with CEO every 3 weeks. | 5. Highlight reports presented to STB every 6 weeks. |
| 6. Programme budget in place. | 6. Programme budget monitoring report is provided to the Implementation Programme Board – every 6 weeks. |
| 7. Programme documentation and reporting is in place to Programme Board every 6 weeks and STB receives highlight report. | 7. PID and Programme Plan Summary kept up to date**.** PID is presented to the STB if there is a significant change in the programme deliverables. Programme Plan Summary reported to the Implementation Programme Board every 3 weeks. |
| 8. Regular engagement with the Commissioner and Trade Unions and representation | 8. Commissioner and TU participation at the Implementation Programme Board. |
| 9. Management of external stakeholder and political concerns | 9. Communications and Engagement Plan sets out WAST's arrangements for engagement with stakeholders. |
| 10. Secured specialist consultancy to support decision making | 10. Reports and contractual compliance. |
| 11. Timetabled completion of programme closure and evaluation report. | 11. Agreed templates for these reports. |
| | **External**<br>**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. |

| Risk ID 283 | TO BE DE-ESCALATED TO DIRECTORATE RISK REGISTER<br>Failure to implement the EMS Operational Transformation Programme | Date of Review: | 29/02/2024 | TREND | 8 (2x4) |
|---|---|---|---|---|---|
| | | Date of Next Review: | 28/05/2024 | ➡ | |

| **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** | **2** | **4** | **8** |
| | | | **Target** | **2** | **4** | **8** |

| | |
|---|---|
| | c. EASC receives an update every 2 months on the programme as part of the WAST Provider Report. |
| **GAPS IN CONTROLS** | **GAPS IN ASSURANCE** |
| 1. Current controls on workforce buy in are not sufficient due to changes in working practices | 1. Project Initiation Document (PID) needs to be updated to reflect 22/23 budget position. The PID has been updated for 2023/24 and reflects the budget, commissioning intentions and IMTP. |
| 2. System pressures – patient handover delays at hospitals (link to risks 223 & 224) | 2. No prompts from STB for programme PID or risk register updates. The SRO continues to provide the HLR, but the PID needs to be signed off by the Executive Sponsors. This can be done outside of STB. This will be overtaken by the programme closure and evaluation report. |

| **Actions to reduce risk score or address gaps in controls and assurances** | **Action Owner** | **By When/Milestone** | **Progress Notes:** |
|---|---|---|---|
| 1. Increase in engagement on the specifics of change through facilitation mechanisms | Assistant Director – Commissioning & Performance | 02.08.23 Checkpoint Date Engaged **has now largely concluded. Evaluation to next STB.** | 30.09.22 Significant engagement through roster review project. 12/01/23 Largely complete. 02.05.23 There remains some minor engagement as the project concludes. 18.01.24 The main o/s action here is engaging with the TU partners on the evaluation of the roster review. A draft evaluation has been written up and will be shared with TU partners this quarter (currently awaiting new roster keys from ORH to enable comparison with roster keys implemented – the 2023 EMS Demand & Capacity Review clearly identifies that the keys current keys are insufficient to meet demand). |
| 2. More capacity requested (transition plan) | Assistant Director of Planning & Transformation | 02.08.23 **Closed and transferred to triangle inversion programme.** | 30.09.22 Transition plan not funded, but +100 FTE agreed. 12/01/23 Recurrent funding not secure. 02.05.23 this has not been forthcoming, and handover lost hours are offsetting all of the gains that the Trust has made. 03.08.23 More capacity unlikely within current financial pressures, but Trust has recently started the next iteration of the strategic EMS Demand & Capacity Review. 18.01.24 Trust currently making an offer to the system via the Six Goals Programme. This offer received a mixed reception. A key area of focus for the Trust is data linking that enables the Trust to more clearly demonstrate the value of investing in inverting the triangle. **This will be taken forward through the triangle inversion programme. No further action for this programme.** |
| 3. Engage with key stakeholders to reduce handover delays | CASC | 02.08.23 **Closed and transferred to triangle inversion programme.** | 30.09.22 Reduction commitments agreed, but trend is still upwards. 12/01/23 Extreme and upward trend. 02.05.23 handover hours remain extreme. 28.07.23 Increasing focus through ICAP meetings, with C&V showing notable progress and early signs of progress in some other health boards. 18.01.24 Significant increase in health board accountability and focus via the NHS Leadership Board. The 2023 EMS Demand & Capacity Review models **three** scenarios: handover at 25,000 hours and the required level of ambulance resource to cope with this; handover at 12,000 with the much lower level of ambulance resource growth to cope with this level of handover**; and handover at 7,000 hours (maximum weight one hour). The review will be taken forward through the triangle inversion programme. Closed** |
| 4. Reduce abstractions in particular sickness absence | Deputy Director of Workforce & OD | 02.08.23 **Closed. BAU to monitor abstractions and sickness absence.** | 30.09.22 Sickness absence reducing, but abstractions high linked to sickness, but also training abstraction linked to the +100. 12/01/23 Abstractions have reduced, but still very high. Sickness is reducing and on trend to achieving the 10% Mar-23 target. High abstractions linked to internal movements caused by internal recruitment. 02.05.23 the Trust achieved 7.99% in Feb-23, but levels are higher in Operations. Continued focus into 2023/24 to reach 6% by 31/03/23. 28.07.23 Abstractions, which includes sickness now less than 35% with benchmark to 30%. 18.01.24 Abstractions were 31% in November 2023. They did increase in December but went below 30% in January 2024 for the first time since pre-pandemic. |

| Risk ID 283 | TO BE DE-ESCALATED TO DIRECTORATE RISK REGISTER<br>Failure to implement the EMS Operational Transformation Programme | | Date of Review:<br>Date of Next Review: | 29/02/2024<br>28/05/2024 | TREND ➡ | 8 (2x4) |
|---|---|---|---|---|---|---|

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

| | | | |
|---|---|---|---|
| 5. Engage with Assistant Director of Planning and Transformation on process for PID updates | Assistant Director – Commissioning & Performance | 02.08.23<br>**Closed. PID being used as part of closure and evaluation report.** | 30.09.22 HoT recruited and now started. Initial contact made with HoT. PID is up to date. 12/01/23 PID has been further updated but requires sign off by the SRO and STB. 02.05.23 PID has been updated but needs to be signed off by Executive Sponsors. 28.07.23 PID updated and programme aligned to new arrangements required by HoT. 18.01.24 PID up to date. |

| | |
|---|---|
| **AGENDA ITEM No** | **8** |
| **OPEN or CLOSED** | **OPEN** |
| **No of ANNEXES** | **2** (4 tabs) |

# AUDIT TRACKER 2.0 – MARCH 2024 (Q4)

| | |
|---|---|
| **MEETING** | Audit, Risk and Assurance Committee |
| **DATE** | 07 June 2024 |
| **EXECUTIVE** | Trish Mills, Director of Corporate Governance/Board Secretary |
| **AUTHOR** | Trish Mills, Director of Corporate Governance/Board Secretary<br>Alex Payne, Corporate Governance Manager |
| **CONTACT** | trish.mills@wales.nhs.uk |

## EXECUTIVE SUMMARY

1. This paper provides the Committee with the current position with respect to management actions for audits within the purview of the Committee, in addition to the wider progress in Quarter.

2. There has been excellent engagement with Directorates on the revised Tracker 2.0, for Quarter four, with the result that of the total of 162 internal audit actions on the Tracker, 64 have been closed in quarter. This is a closure figure of 40% of all internal audit actions, and 57% of the total actions due in Quarter.

3. The current version of the tracker is now open for Directorate review for actions due in April, May, and June. These updates will then be reported to the Committee at its meeting in August 2024.

**RECOMMENDATION**

4. The Committee is requested to:
   (a) Receive assurance that the management actions for the audits within the purview of this Committee (at **Annex 1**), and overall (at **Annex 2**), are being effectively and appropriately managed and closed off in quarter;

   (b) Receive and review any Internal Audits and Audit Wales reviews within their remit where relevant. For this meeting these are the following internal audits: -
      - Follow Up Audit.

| KEY ISSUES/IMPLICATIONS |
|---|
| As set out above. |

| REPORT APPROVAL ROUTE |
|---|
| Tracker presented to ADLT via email in April 2024. |

| REPORT APPENDICIES |
|---|
| Annex 1 – Tracker 2.0 January – March 2024 for Committee Reporting - Audit<br>Annex 2 – Tracker 2.0 January – March 2024 for Committee Reporting – Full Tracker |

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

## SITUATION

5. This paper provides the Committee with the current position with respect to management actions for audits within the purview of the Committee, in addition to the wider progress in Quarter.

## BACKGROUND

6. In September 2023 the Audit Committee approved the Audit Process and Reporting Handbook. The Handbook has been further revised in November 2023 since this date to include Audit Wales content and it was agreed that going forward non-material changes would be approved by the Executive Leadership Team

7. The team continues to work on the development of the SharePoint solution for Tracker 3.0 with colleagues in Digital Health and Care Wales Centre of Excellence. It is intended that this solution will be ready to implement / use early in the 2024/25 financial year, however further work is required to consider the process of moving from Tracker 2.0 to Tracker 3.0 before the transition can be made.

## ASSESSMENT

Audit Committee Audit Actions

8. The Handbook notes that it is the responsibility of a Board Committee to:
   - Receive audits in their remit;
   - Monitor management actions to address recommendations.

9. The audit recommendations within the purview of the Audit Committee relate to Risk Management and Standards of Business Conduct and are listed at **Annex 1.** One internal audit action from the Risk Management and Assurance internal audit was closed in quarter.

10. The Follow Up Audit presented includes a review of a sample of actions from the Standards of Business Conduct audit completed in 2022/23 and indicates (in paragraph 2.26) that one recommendation is considered only *partially implemented*, as the complete Register of Trust 'decision-makers' is not yet available. Internal Audit have acknowledged the extent of the work undertaken to date. The related action on the Tracker (reference 549) will be re-opened. The item was closed as the Audit Committee noted the deferral of this item to April 2024 and the fact that another action related to the development of the decisions makers register was left open. Notwithstanding this we accept the position of Internal Audit.

11. The Tracker includes the management actions generated from the 2023 Structured Assessment, three of which have been closed in quarter. Of the three remaining actions one date has moved in quarter to May 2024 (external audit tab, action reference 149).

Full Tracker Review

12. The Tracker has been updated in Quarter four following its complete revision in Quarter two. Members will receive a copy of the Tracker by email and are invited to filter the excel sheet to their particular Committee to view the relevant audit actions. A copy of the Tracker is also reproduced at **Annex 1** filtered to the actions assigned to this Committee for oversight.

13. As well as monitoring management actions for audits in their purview, the Audit Committee has the responsibility to scrutinise the progress of audits overall, escalating to the Board any issues or concerns. Members will receive a copy of the Tracker by email and a copy of the full Tracker is also reproduced at **Annex 2.**

14. The Quality, Patient Experience and Safety Committee, Finance and Performance Committee, and the People and Culture Committee have reviewed the management actions for audits within their purview in the last few weeks. Their AAA reports to Board will note this and there have been no escalations to Board.

15. Discussions have also taken place on historical actions and those where management actions may need to be amended in view of the current operating context. There has been excellent progress in the closure of actions in this reporting period, however.

16. The result of this excellent engagement with Directorates is that of the total of 162 internal audit actions on the Tracker, 64 have been closed in quarter. This is a closure figure of 40% of all internal audit actions, and 57% of the total actions due in Quarter.

17. The current version of the tracker is now open for Directorate review for actions due in April, May, and June. These updates will then be reported to the Committee at its meeting in May 2024. The team will work with Directorate contacts to ensure a smooth transition between Tracker 2.0 and 3.0.

18. There continues to be good engagement with the Directorate points of contact to support the management of the actions in the Tracker. The Corporate Governance Team will work closely with the points of contact as the SharePoint Tracker 3.0 develops.

Impact of Closed Management Actions

19. The Handbook also notes that it is the responsibility of a Board Committee to scrutinise impact of actions in response to audit recommendations in terms of, for example, quality improvement, the provision of more efficient and effective patient care, improved governance, better use of resources etc.

Audit Committee Reporting

20. As noted in November, the development of Tracker 3.0 with Digital Health and Care Wales is ongoing with the reporting / functionality which the Audit Committee approved in September 2023. The transition to Tracker 3.0 will continue over the coming months, with reporting to Committees adjusting in mid-late 2024.

**RECOMMENDATION**

21. The Committee is requested to:

(c) Receive assurance that the management actions for the audits within the purview of this Committee (at **Annex 1**), and overall (at **Annex 2**), are being effectively and appropriately managed and closed off in quarter;

(d) Receive and review any Internal Audits and Audit Wales reviews within their remit where relevant. For this meeting these are the following internal audits: -

- Follow Up Audit.

**Points of Contact, Directors and Owners of Audit Actions - Do Not Amend Any Column With a Red Header**
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**ALL FINAL INTERNAL AUDIT REPORTS CAN BE FOUND ON THE CORPORATE GOVERNANCE SIREN PAGE**

| Trust Ref. No. | Year/ Audit Plan | Committee assigned to | Report Title | Assurance Rating | Responsible Officer | Director | Priority Level | Rec. No.in Audit | Recommendation | Respons e. No.in Audit | Management Response | Agreed Deadline in Report | Status - met or not met agreed deadline in report | 1st revised date | 2nd revised date | 3rd revised date | Closure Status | Where a management action has not met the agreed or revised date, Director must inlcude here:<br>1. Date (of your update)<br>2. Proposed revised date<br>3. Reasons why action is overdue and<br>4. Progress made if not yet complete.<br>**Please add most recent update first** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 545 | 22/23 | AC | Standards of Business Conduct: Declarations | Limited | Trish Mills | Trish Mills | Medium | | 4.1 Management should determine and implement a solution to ensure the completeness and accuracy of declarations of interest, including nil returns. | | Initially 'decision makers' will be targeted for completing of declarations of interest and the register of those decision makers will be held centrally by the Board Secretary. | Jun-23 | Not Met | Apr 24 | | | Open | Last updated: 11/07/23<br>Declarations for the decision makers listed in the policy will commence from March 2024 so as not to duplicate efforts given declarations were sought from ADLT in March 2023 as part of the annual review. |
| 547 | 22/23 | AC | Standards of Business Conduct: Declarations | Limited | Trish Mills | Trish Mills | Medium | | 4.2 Consideration should also be given to introducing a tracking system and reporting the results, including declarations requested but outstanding, to an appropriate forum e.g., Audit Committee. | | The 'decision makers' will be a finite known cohort and initially their declarations will be captured via Microsoft Forms to allow for tracking and escalation | Jun-23 | Not Met | Apr 24 | | | Open | Last updated: 11/07/23<br>There will be a known cohort to enable the tracking any outstanding declarations. The PADR form now has a prompt for the line manager to ensure staff have completed their declarations. |
| 596 | 22/23 | AC | Risk Management & Assurance | Reasonable | Julie Boalch | Trish Mills | Medium | 1.1 | Following the development of the risk appetite matrix, the Trust should develop and finalise its risk appetite statements | 1.1 | Accepted. Formal risk appetite statements will be developed in conjunction with the transformational BAF in 23/24; however, the risk consequence matrix is in place and includes risk appetite across a range of categories. The Trust sets out its risk appetite for patient harm in its annual report. This action forms part of the risk management transformation programme monitored at the Strategic Transformation Programme Board. Additionally, a Board Development Session is planned for February 2024. | Jun-24 | Not Yet Due | | | | Open | External consultant support has been procured who will provide us with a clear risk appetite methodology and coaching aimed at enabling us to deliver a Risk Appetite. The outputs will be Risk Appetite guidance used to complete risk Appetite statements as well as examples of how Risk Appetites enable and support the delivery of the Trust's objectives. |
| 598 | 22/23 | AC | Risk Management & Assurance | Reasonable | Julie Boalch | Trish Mills | Medium | 3.1 | Management should continue the rollout of risk management training across the Trust and seek to obtain feedback from attendees, including to capture views on the impact the training has had on their understanding of risk management principles and practice and to identify areas of further training need and improvement. | 3.1 | Accepted. Risk Management training will continue; however, the level 1 and 2 training packages will not be fully established until late 2024. Bespoke and directorate training will continue to be delivered as requested and a feedback form will be put in place at the next session. Continuous 1:1 support is delivered to Risk Officers to manage their risks. | Sep-24 | Not Yet Due | | | | Open | The risk management training for level one and two has been inlcuded as a deliverable in the IMTP risk transformation programme and will flow from the publication of the Risk Management Policy following approval at the March 2024 Audit Committee. |
| 600 | 22/23 | AC | Risk Management & Assurance | Reasonable | Julie Boalch | Trish Mills | Medium | 4.1 | The Trust should continue its work to strengthen the BAF, including to;<br>a) ensure alignment to the broader long-term strategy.<br>b) provide further assurances on the effectiveness and impact of controls and mitigating actions in reducing the strategic risks. | 4.1 | a) Accepted. This is one element of the Risk Management Transformation Programme included in the IMTP and monitored at the Strategic Transformation Board.<br>b) Accepted. A review of mitigating actions and the impact these have had on current scores forms part of the quarter 2 reports for Trust Board and Committees. This is good practice risk management and is part of each risk review discussion. The impact and effectiveness of controls and mitigating actions will continue to be strengthened and drawn out in the risk reports over the coming year. | Mar-24 | Not Met | | | | Closed in Quarter | 11042024: Discussion held with Internal Audit (on 09 April) and agreed closure based on the position indicated here. Propose closing this action on the basis that we were unable to advance all of the risk management transformation programme as expected due to Covid-19 Inquiry pressures and part of this programme has rolled forward into the 24-27 IMTP. Closure proposed.<br><br>(a) External consultant support has been procured to provide advice and guidance on the development of our strategic BAF. The consultant report has been received and an action plan is being developed by the Trust.<br><br>(b) The current BAF includes full details of the principal risks is reviewed as part of the agreed cycle. The BAF guidance document was produced in April 2024 to support the Board in interpret and challenging the data within the BAF.<br><br>Internal Audit were content to close the recommendation on this basis given the progression of work acknowledging the need to bolster the resources in the Corporate Governance Directorate to support the delivery of enterprise risk and the risk transformation programmes. |

## Points of Contact, Directors and Owners of Audit Actions - Do Not Amend Any Column With a Red Header

## When proposing a revised 1st, 2nd or 3rd date, include the rationale for the movement and any progress on the action to date

| Trust Ref No | Audit Wales or HIW Report | Year | Committee Assigned to | Report Title | Responsible Officer | Director | Priority Level | Rec No in Audit | Recommendation | Response no. in Audit | Management Response | Agreed Deadline in Report | Status | 1st revised date | 2nd revised date | 3rd revised date | Where a management action has not met the agreed or revised date, Director must inlcude here:<br>1. Date (of your update)<br>2. Proposed revised date<br>3. Reasons why action is overdue and<br>4. Progress made if not yet complete.<br>**Please add most recent update first** | Closure Status |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 144 | Audit Wales | 22/23 | Audit | Structured Assessment 2023 | Trish Mills | Trish Mills | Medium | 1(a) | **Transparency of Board and committee business**<br>Opportunities exist to further enhance the transparency of Board and Committee business. The Trust should:<br>a) provide a written Chair's Report to each Board meeting. (Medium Priority) | 1 (a) | Agreed. A written Chair's Report will be provided to each Board meeting effective the January 2024 Board meeting | Ongoing | Met | | | | 12042024: Met as the Chair's Report is now written, effective January 2024. | Closed in Quarter |
| 145 | Audit Wales | 22/23 | Audit | Structured Assessment 2023 | Trish Mills | Trish Mills | Medium | 1(b) | **Transparency of Board and committee business**<br>Opportunities exist to further enhance the transparency of Board and Committee business. The Trust should:<br>b) review and publish unconfirmed minutes of committee and Board meetings within 14 days of the meeting. | 1(b) | Agreed that minutes should be drafted and approved by the Chair and Executive Lead within 14 days. However, these are not final until approved by the Board/Committee. To facilitate transparent and timely communication, it is proposed that the AAA report from the Committee Chair to the Board is published within 14 days of the meeting. These AAA reports provide a summary of the meeting and gives the attendance and agenda items also. | Ongoing | Met | | | | 120424: This recommendation has been implemented and will continue as it is now business as usual. | Closed in Quarter |
| 146 | Audit Wales | 22/23 | Audit | Structured Assessment 2023 | Trish Mills | Trish Mills | High | 2 | **Public access to key strategies and plans**<br>Publish key plans on the Trust website, including the most recent IMTP and the People and Culture Plan. | 2 | Agreed, both now on website. | Complete | Met | | | | 12042024: This recommendation is now complete; cited documents now available on the Trust's Publications page. | Closed in Quarter |
| 147 | Audit Wales | 22/23 | Audit | Structured Assessment 2023 | Rachel Marsh | Alex Crawford | High | 3 | **Clarity of IMTP objectives/actions**<br>We found that the Trust's IMTP does not include SMART actions, many do not include a specific measurable outcome and it is also unclear in the IMTP which year each action is due for delivery. However, delivery milestones are set out elsewhere. The Trust should ensure all actions set out in future IMTPs are SMART by specifying measurable outcomes and delivery milestones. | 3 | The IMTP is a three year plan. Assurance on delivery of the plan in year is to the Finance and Performance Committee and the Board via the Strategic Transformation Board. These in year actions will be SMART and wherever possible specify measurable outcomes and delivery milestones. | May-24 | | | | | | Open |
| 148 | Audit Wales | 22/23 | Audit | Structured Assessment 2023 | Rachel Marsh | Alex Crawford | High | 4 | **Oversight of IMTP delivery**<br>Whilst there have been recent improvements to the reporting of IMTP progress to Committee and Board, there is scope to provide better clarity on whether the actions delivered have achieved the intended impact. The Trust should ensure all plan delivery progress reports include information about the impact achieved. | 4 | Agreed. Consideration will be given as to how this can best be achieved, and this will be taken forward into the 2024/25 reporting processes. | Jun-24 | | | | | | Open |
| 149 | Audit Wales | 22/23 | Audit | Structured Assessment 2023 | Chris Turley | Navin Kalia | High | 5 | **Oversight of Savings plans**<br>The Trust does not clearly specify in its finance plans and reports whether savings schemes are recurrent or non-recurrent. To strengthen oversight of savings, the Trust specify whether schemes are recurrent or non-recurrent in its financial plans and reports. | 5 | Agreed. Whist not always specifically called out in the main report, the Trust is required to provide a monthly financial return to WG that details recurrent schemes. The latest return is provided as an appendix to every financial report. Consideration will be given to more explicitly calling some of this out in the main body of the report.<br>Recognising the current and future climate for the public sector and the NHS specifically, the organisation has instigated a strategy of pursuing a Financial Sustainability Program to identify increases in recurrent savings schemes via two separate working group lenses of Achieving Efficiency and Income Generation in mitigation.<br>This should also allow for greater clarity of the split between recurring and non-recurring savings within future financial plans. It is inevitable however that an element of any in year delivery of financial balance will include an element of non-recurrency, whether that be spend or savings. | Mar-24 | Not Met | May-24 | | | 170424: Update from Navin: The new financial year savings report identifying recurrent and non-recurrent savings will be produced for May Trust Board and should suffice as evidence. Jason Collins will send this to the CGT once it has been produced at the end of May. Date extended in quarter 4 to May 2024. | Open |

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**When proposing a revised 1st, 2nd or 3rd date, include the rationale for the movement and any progress on the action to date**
**ALL FINAL INTERNAL AUDIT REPORTS CAN BE FOUND ON THE CORPORATE GOVERNANCE SIREN PAGE**

| Track Ref. No. | Year/ Audit Plan | Committee assigned to | Report Title | Assurance Rating | Responsible Officer | Director | Priority Level | Rec. No.in Audit | Recommendation | Response No.in Audit | Management Response | Agreed Deadline in Report | Status - met or not met agreed deadline in report | 1st revised date | 2nd revised date | 3rd revised date | Closure Status | Where a management action has not met the agreed or revised date, Director must inlcude here:<br>1. Date (of your update)<br>2. Proposed revised date<br>3. Reasons why action is overdue and<br>4. Progress made if not yet complete.<br>**Please add most recent update first** |
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| 420 | 21/22 | FPC | Service Management | Reasonable | Aled Williams | Jonny Sammut | Medium | | WAST should develop their Service Management framework and once complete, the Service Catalogue should be published and communicated to all appropriate stakeholders. | | Agreement has been reached to employ consultants to undertake a review of current position and to develop ITIL based procedures covering the whole service management disciplines. This work is expected to commence during September 2021. A deliverable of this work will be a refreshed service catalogue<br>which can then be published and communicated. | Mar-22 | Not Met | Dec22 | Sep-23 | Apr-24 | Open | Last Updated: 20/03/2024 - The implementation of the new service desk software has been delayed due to contract finalisation and work associated with CAS replacement.<br>Work is now underway with the new system in build and is expected to go-live in Jun-24 with the CMDB and service catalogue available shortly after. suggested revised date on Sep-24<br><br>Given a very similar recommendation on service catalogue in the 22/23 Resilience audit suggest this is closed or linked to recommendation 621 (the second one on row 242)<br><br>10/10/23 - There is limited capability to support Service Catalogue in Service point and an attempt was made to develop one in Excel see attached draft. Whilst this could be completed and shared with stakeholders it would not be particularly user friendly.<br>We are now close to procuring a replacement for Service Point where there will be a central service catalogue available to digital staff and the users within the system. Aim is to get new system operational by Mar-24. |
| 462 | 21/22 | QSPE | Role of Advanced Paramedic Practitioner | Reasonable | Kerry Robertshaw, Jonathan Chippendale | Andy Swinburn | Medium | | Formal structures should be established to ensure APPs are appropriately supported to deliver a high standard of practice. This could include a peer review network, where feedback and themes are reported to the Care Closer to Home Group. | | Development of proposed standardised clinical appraisal and supervision model to ensure APPs remain up-to-date and competent within their clinical practice. | Mar-22 | Not Met | Dec 22 | Mar-24 | | Closed in Quarter | Closed confirmed on this basis as this work has been completed.<br>Last updated: 04.04.2024<br>Recommended for closure: Happy to close as per TM's recommendation 120324<br>Last updated: 06.03.2024<br>CSP policy through formal process supported by ELT but requires implementation plan for the whole organisation. Work through ACPDG and task and finish group commissioned by ELT to provide options appraisal.<br>Last updated: 03.07.2023<br>APP leadership/clinical supervision rollout not supported at formal SOT in the current financial climate due to concerns around releasing APP leadership (8a) workforce from clinical duties to engage in leadership portfolio work streams.<br>Decision to be revised in Q3. AHP funding bid against installing APP leadership infrastructure within the workforce appears unlikely to be successful.<br>ePortfolio and curriculum development underpinned by clinical supervision framework, unable to progress until review in Q3 |
| 463 | 21/22 | QSPE | Role of Advanced Paramedic Practitioner | Reasonable | Kerry Robertshaw, Jonathan Chippendale | Andy Swinburn | Medium | | The Trust should, through an effective appraisal process, appropriately monitor APPs development in order to achieve all four pillars of advanced practice. | | The creation of a 'Principles of Advanced Practice' guidance document to be created which will detail the methodology, application and monitoring of how the four pillars of advanced practice are being addressed within APP practice. Following approval, reporting against this will take place on a 6-monthly basis. | Mar-22 | Not Met | Dec 22 | Mar-24 | | Closed in Quarter | Closed confirmed on this basis as this work has been completed.<br>Last updated: 04.04.2024<br>Recommended for closure: Happy to close as per TM's comments 120324, with skeleton document to be presented to OCG this month.<br>Last updated: 06.03.2024<br>Skeleton document for OCG April 24 detailing where the work for this will take place. This requires significant infrastructure and is dependant on the CSP (above) with elements led by APP's in specific roles.<br>Last updated: 03.07.2023<br>Principles of advanced practice document to be written over Q2 and steered through the Advanced practice Working group (new group created within LDP) and underpinned by the All Wales national advanced and enhanced advanced practice framework. |
| 470 | 21/22 | FPC | Asset Management - RAM System | Reasonable | Jill Gill | Chris Turley<br>Jonny Sammut | Medium | | The Trust should consider the requirement to use the proposed RFID system to validate assets not included in its current processes (e.g. stretchers, defibrillators, suction units, emergency lifting cushions and oxygen delivery systems) against the RAM Asset Management system and review and update its procedures as<br>appropriate. | | The Trust has considered the potential of linking RAM and an RFID system, however this would not be practical as RAM is updated on a quarterly basis and the RFID system is a live system with constant streaming updates. These two products would not align in a manner that would deliver a safe and valued output.<br>The proposed solution will be a quarterly download from the RFID system that will be reconciled into RAM and variances investigated. RFID is currently in development, however due to operational pressures the rollout is unlikely to be completed before December 2022. | Mar-23 | Not Met | Mar-24 | Sep-25 | | Open | Last updated 11.03.24<br>As a result of ongoing issues outlined above, together with the need to divert ICT resources to CAS replacements since November 2024, the RFID tagging system is not yet live. The ICT team are looking to re-engage with the supplier and clinical teams from May 2024 onwards with a view to this system being live by December 2024. Following this, work will commence with the finance team looking to reconcile the two systems.<br>Last updated 25.09.23<br>This work cannot be taken any further forward until the RFID system is fully implemented and quarterly reports become available to reconcile to RAM, this is as per the management response. The RFID system needs to be implemented at pace by the Trust, work is progressing with Fleet in the North and SE to tag items however currently a separate ICT resource is required in C&W to complete, following the previous update the ICT lead has now left the Trust, in addition ICT currently has circa 10 vacancies and is experiencing difficulties in recruiting to these posts, this is resulting in other schemes having to be prioritised over this scheme to ensure core systems function. The previous completion date of Mar 2023 shows as it is unclear due to the recruitment issues faced by ICT exactly when this action will be completed, Mar 2024 put as estimate by ICT dept. |
| 480 | 21/22 | QSPE | Information Management - Hear and Treat | Reasonable | Paula Jeffery | Liam Williams / Andy Swinburn | Medium | | 1.1 We recommend that greater use is made of referral data in the incident records to inform further developments of current and future referral pathways, including; production of reports showing more detailed analysis by stop code. | | 1.1.1 A new report is available with data back to January 2021 which shows the referral pathway presented to the patient once the consultation with CSD is complete. This will be able to be broken down by health board area given the nature of the patient's location information. The Ops team is also reviewing in more detail the calls into CSD and their outcome. A review of this is likely late Q4 2022. | Mar-22 | Not Met | Mar-24 | | | Closed in Quarter | 170424: (AP) Closure proposed.<br>Last updated: 04.04.2024<br>Last update showed that data is now available in a Power BI report which shows the volume of telephone triaged calls referred to other services and can be broken down by HB area. Next steps to review and analyse the reports though suspect there is limited capacity for auditing at the current point in time.<br>Could propose for closure as info was reported into MIQPR starting December 2023 and as and when forum becomes available/request comes in from Health Boards to view the data, this can be shared with them. Similarly, when capacity to complete audit becomes available within the CSD team, this can be implemented.<br><br>Last Updated: 06.03.2024: CSD ECNS outcome data reported monthly at the national SDEC meeting with a view to scoping opportunity in patients with suitable RLC outcomes for alternative disposition (in the first instance, SDEC)<br><br>Updated: 061023: Capacity building in the CSD team will enable this action to be progressed. Currently in IMTP actions for this area for delivery Q3-4 pending team expansion. Detailed analysis by stop code can be reported from a CSD perspective. Can be evidenced through Power BI dashboards and this information can be shared with the National SDEC Pathway Group on a monthly basis. All 7 HBs are cited from a community and hospital background at this group.<br>The information is not currently provided in a report as it is live data but a functionality request for referral data to be shown by Health Board on a Power BI dashboard will be raised with Health Informatics and should be achievable by end of Q4.<br>Update 19/10/22 Q4 2022 Update (Q3 2022-23) - Data is now available in a report in Powr BI which shows the volume of telephone triaged calls which were referred to other services and can be broken down by Health Board area. Next steps this quarter is to work with Clinical Services to review the reports and analyse. |

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| 480 | 21/22 | QSPE | Information Management - Hear and Treat | Reasonable | Paula Jeffery | Liam Williams / Andy Swinburn | Medium | | 1.2 Coordinated analysis, review and scrutiny of these internally to inform quality improvement. | | 1.1.2. The review can be shared to inform quality improvement. | Jun-22 | Not Met | Sep-24 | | | Closed in Quarter | 170424: (AP) Closure proposed.<br>Last Updated 04.04.2024<br>As above - Last update showed that data is now available in a Power BI report which shows the volume of telephone triaged calls referred to other services and can be broken down by HB area. Next steps to review and analyse the reports though suspect there is limited capacity for auditing at the current point in time.<br>Could propose for closure as info was reported into MIQPR starting December 2023 and as and when forum becomes available/request comes in from Health Boards to view the data, this can be shared with them. Similarly, when capacity to complete audit becomes available within the CSD team, this can be implemented.<br><br>Last Updated 061023: Further investigation to be undertaken on whether this data would benefit HB partners e.g. could report into SDEC meetings as it is currently unconfirmed whether there is a forum to enable this data to be shared. Management action relevent in 2018 before work undertaken to build on pathways. Info broken down for reporting currently not done by HB level in the usual process by CSD team (see 480 1.1 above). Team to look at possibility of incorporating this filter for reporting if it will be useful to the HBs or whether this is already reported on by Operations. Development of project work (480 1.2 above) may provide more information to accompany the data which HBs may find useful.<br>Updated: 19/10/22<br>See above, subsequent action. |
| 480 | 21/22 | QSPE | Information Management - Hear and Treat | Reasonable | Paula Jeffery | Liam Williams / Andy Swinburn | Medium | | 1.3 Reporting referral volumes at health board level to assist with their service provision planning | | 1.1.3. The detail in the new stop codes will allow for the reporting referral volumes through Consult and Close in CSD. | Jun-22 | Not Met | Nov 22 | Mar-24 | | Closed in Quarter | 170424: (AP) Closure proposed.<br>Last Updated 04.04.2024<br>As above - Last update showed that data is now available in a Power BI report which shows the volume of telephone triaged calls referred to other services and can be broken down by HB area. Next steps to review and analyse the reports though suspect there is limited capacity for auditing at the current point in time.<br>Could propose for closure as info was reported into MIQPR starting December 2023 and as and when forum becomes available/request comes in from Health Boards to view the data, this can be shared with them. Similarly, when capacity to complete audit becomes available within the CSD team, this can be implemented.<br><br>Last Updated 061023: Further investigation to be undertaken on whether this data would benefit HB partners e.g. could report into SDEC meetings as it is currently unconfirmed whether there is a forum to enable this data to be shared. Management action relevent in 2018 before work undertaken to build on pathways. Info broken down for reporting currently not done by HB level in the usual process by CSD team (see 480 1.1 above). Team to look at possibility of incorporating this filter for reporting if it will be useful to the HBs or whether this is already reported on by Operations. Development of project work (480 1.2 above) may provide more information to accompany the data which HBs may find useful.<br>Updated: 19/10/22<br>See above, subsequent action. |
| 501 | 21/22 | FPC | Waste Management | Limited | Richard Davies / Nicci Stephens | Chris Turley | High | | 1. The Waste Process document review should be concluded as scheduled, with consideration given to the Policy guidance set out in WHTM 07-01, and with enhanced detail regarding governance structure and training arrangements. The Trust should ensure the Waste Process document, following review and update, is approved at the relevant Board-level Committee as a formal policy, in accordance with WHTM 07-01 requirements. | | 1. Agreed as the key priority, recommendation and action for immediate further improvement from this review. From which the response and resolution for many of the other actions will naturally follow. To progress many of these, it has been jointly agreed at Exec level that a task and finish group (TFG) will be immediately created with representatives from the following departments:<br>• Estates and Facilities<br>• IPC<br>• Health and Safety<br>• Operations<br>• ICT<br>• Fleet<br>• Corporate Services<br>• Training<br>• Finance<br>• Medical directorate (for drug management issues)<br>• Clinical equipment and logistics<br>• TU rep<br>The TFG will develop a National Waste policy to cover both domestic waste and clinical waste. The policy will identify the management structure for both sections of waste (which will be different) and therefore a reporting structure, including through to Board Committees (likely to be by exception) and therefore Trust Board itself. It will also identify training needs and all compliance and audit obligations. | Sep-22 | Not Met | Sep-23 | Nov-23 | Mar-24 | Closed in Quarter | Proposed closure on the basis that this Policy will be taken to FPC for approval in May 2024.<br>Latest Update 08.03.2024 - Waste Policy being presented at March 27th Policy Group for approval . Ownership of clincial waste management issue resolved.<br>Update 201223. Discussions have now been held at Exec level, including with CEO on any required realignment of Exec level responsibilities, part of which links to changing Exec portfolios from 01/01/24. Following this, all remaining items to conclude the new waste management policy will be progressed at pace in January 2024, with a view for ensuring formal sign off before 31/03/24. Revised date in Q3 to March.<br>Updatd 180923: Waste management policy is drafted however discussions regarding Director level responsibility for clinical waste are being held. The SOPs that form part of the master list of waste in the policy have been implemented however it is the overarching policy that brings them together with roles, responsibilities and governance structures that is out for consultation. Given the clinical waste ownership discussions, it is proposed that this action be moved to November 2023 for the policy to be presented back to the Policy Group to enable those discussions to be held. The policy will thereafter be approved by the FPC.<br>Last updated 13/07/23<br>Waste Management Policy out to consulation and due to be approved by FPC in September 2023. |
| 505 | 21/22 | FPC | Waste Management | Limited | Nicci Stephens | Chris Turley | High | | 5.1 The Trust should review the arrangements in place for the transfer of clinical waste and seek to gain assurance that the current arrangements as detailed are in keeping with the requirements of WHTM-07-01. | | 5.1 – The WHTM 07-01 was amended from HTM 07-01 in 2013, this predates the separation of HCS from WAST. Under its current form WAST is not able to comply with this particular section of the document as WAST does not have a direct contract with the current clinical waste contractor. NWSSP FS, the documents authors, have been contacted regarding this point. The WHTM is due for review. However, those confirmed under the TFG as clinical waste lead will produce an annual hazardous waste transfer note for Denbigh Stores and Pontypool Ambulance Station for completion by HCS, therefore compliant with current hazardous waste legislation. | Jun-22 | Not Met | Sep-23 | Jan-24 | Mar-24 | Closed in Quarter | Last Update 19.03.24 (TM) Finance and Performance Committee agreed, given the passage of time, the way that risks identified are managed and mitigated in a differently, and the fact that the Trust has done everything in its control and influence to close the action it was agreed it should be closed on the tracker. Internal Audit who were in the meeting supported this approach. Minutes of that meeting will serve as evidence.<br>Target date moved in Quarter 3 to align to update in 501 i.e. these will come to FPC with the Waste Mangement Policy in March 2024.<br>Update 180923: WAST does not have a contract with HCS regarding clinical waste. A hazardous waste transfer note was sent to HCS but they have not signed it, stating it was not required. Natural Resources Wales have also confirmed that we have an exemption for transferring clinical waste to HCS and that the only agreements that need to be in place are between HCS and Stericycle (which they are). The only body to whom WAST could have a contract that satisfied WHTM 07-01 is NWSSP (the authors of that WHTM) and they have declined to do so. Propose that this item is closed when a paper is taken to the Finance and Performance Committee setting out the ways in which the risk regarding the absence of a contract for clinical waste for WAST is mitigated. It is proposed that the timing for this is when the Waste Management Policy is taken to FPC (January 2024) so that director responsibilities for clinical risk are clear.<br>Last Updated: 13/07/23<br>A paper to be prepared and shared at an appropriate forum detailing the current status and the proposals to manage the risk. |

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| 505(a) | 21/22 | FPC | Waste Management | Limited | Nicci Stephens | Chris Turley | High | | 6. WAST should contact the respective Health Boards on an annual basis to obtain a duty of care transfer note covering handover of clinical waste from Ambulances at Health Board sites, in keeping with the requirements as stipulated in WHTM 07-01. | | 6. The WHTM 07-01 was amended from HTM 07-01 in 2013. HTM 07-01 is the English management of waste in healthcare technical note. On amending the HTM to the WHTM this section should have been replaced. As a commissioned service to the health boards clinical waste sits with the patient and therefore the health board. NWSSP FS, the documents authors, have been contacted regarding this point. However, to further add to the assurance of this, it is also now requested that the TFG will propose the production of an annual hazardous waste transfer note for each Health board, therefore compliant with current hazardous waste legislation. This will be included in the national waste management policy. | Sep-22 | Not Met | Jan-24 | Mar-24 | | Closed in Quarter | Last Update 19.03.24 (TM) Finance and Performance Committee agreed, given the passage of time, the way that risks identified are managed and mitigated in a differently, and the fact that the Trust has done everything in its control and influence to close the action it was agreed it should be closed on the tracker. Internal Audit who were in the meeting supported this approach. Minutes of that meeting will serve as evidence.<br>Update 08.03.2024 - WTN's have been chased and none been returned , WAST has completed all it can with this action, if healthboards choose not to sign and return there is little more we can do . A national clincal waste group for WAST has been implemented, chaired by an Operations Service Manager , to manage , support and instruct staff in safe segregation and diposal methods of clinical waste, alongside legal compliance . Suggest this action is now closed as the recommendation is fullfilled.<br>Target date moved in Quarter 3 to align to update in 501 i.e. these will come to FPC with the Waste Mangement Policy in March 2024<br>Reopened September 23 followng 22/23 Follow Up Audit.<br>Update: Only two HBs have not returned the duty of care transfer. CVUHB are awaiting the appointment of their waste manager to sign the document. BCUHB did not sign it based on improvements being required on WAST segregation methods. WAST has held fortnightly meetings with local mangers in the HB region, as well as BCUHB management and conducted waste management audits in the area. WAST has identified issues and put in place mitigations and have written to BCUHB indicating as much and seeking their agreement to the duty of care transfer note. It is proposed that this action is closed when the paper which encompasses matter arising 5 and the Waste Management Policy are presented to the FPC in January 2024<br>Update 02/09/22. WTN have been written and sent. |
| 512 | 21/22 | FPC | Service Reconfiguration | Reasonable | Mark Harris / Deborah Kingsbury | Rachel Marsh | Medium | | 1.1 We recommend that the service specification is finalised and reissued for the period beginning June 2022, reflecting any amendments to the model that post-implementation service reviews have indicated. This is particularly significant because of the contribution this project may make to an upcoming all-Wales model to cover similar service reconfigurations. Future service change SLAs must be signed before the renew date. | | 1.1 The timescale is dependent on commissioners agreeing the longer term commissioning agreement. Meetings with commissioners (ABUHB and NCCU leading)<br>have commenced to take forward the recommendations of the GUH Evaluation and this should include the agreement on the next commissioning agreement. However this may need to be backdated. | Sep-22 | Not Met | Apr-24 | | | Open | 250424: Update from Alex C: Positive progress made with SLA negotiations, final comments and financial response sent to ABUHB. Awaiting response to enable the finalisation of documents and move to formal sign off stages through appropriate governance. Operational changes required to shift to the new level of service underway and delivering agreed against a plan discussed with AB.<br>4.12.23 Requirement is related to an operational issue around the service specification at The Grange - Planning is assisting with the work and it should be finalised before the review date of April 2024. Updated in quarter 3 to April 2024.<br>Update 101023: After initial exchange as noted on 030523 update, Pending receipt of something formally. Informal conversations indicate that based on activity review and remodelling work ABUHB will be looking to reduce peak capacity Currently 10 crews at 1400 hrs daily to 6 Crews. ABUHB will also be redefining the service purpose in the SLA refresh to take out what is believed to be mission creep example Step Across and Discharge activity. WAST will be undertaking its own modelling to corroborate Health Borad modelling and also to ensure there are no unintended consequences or at least the stakeholders are appraised of the risks if any. ABUHB has also indicated that they will be disinvesting from the Paramedic resource it commissioned under this contract and will be looking to increase the Transfer Practitioner resource (TP) instead. The single system project that is looking to move all ACA2 activity under the GUH inter site transfer service on to Cleric CAD system is being progressed with this assumption in agreement with ABUHB<br>03.05.23 Initial exchange on SLA undertaken, response from WAST considered by ABUHB who are preparing a report to their Execs, advised by NCCU that they will facilitate a further meeting to discuss, likely to be in June. Acknowledged that SLA will not be able to progress until requirements clear from ABUHB. 25.01.23<br>NCCU proposing a new SLA for April 23. Regular meetings led by the NCCU continue with supporting work to enable the new specification and SLA following the evaluation of the service. The remaining supporting actions are now being prioritised to enable. One key element is the work being undertaken by the health board to review its future clinical needs for transfers as part of the health boards model. Last updated: 02/11/22<br>Enabling pieces of work are scheduled to be completed for discussion with NCCU and AB in December, NCCU proposing a new SLA for April 23. Regular meetings led by the NCCU continue with supporting work to enable the new specification and SLA following the evaluation no the service. The remaining supporting actions are now being prioritised to enable. One key element is the work being undertaken by the health board to review its future clinical needs for transfers as part of the health boards model. |
| 502 | 22/23 | FPC | Immediate Release Directions | Reasonable | Caroline Miftari | Liam Williams | High | | 3.1 Datix incidents should be reviewed and closed in a timely manner and any lessons learned should be shared with the relevant parties. | | It remains challenging for the Trust to investigate and subsequently close Datix as refusal to comply with an Immediate Release Direction is a Health Board Decision and so any harm that subsequently occurs, requires the Health Board to lead on a joint investigation, with the same principle being expected by the Trust where harm has not explicitly been identified. A new Joint Investigation Process is being piloted under the leadership of the NHS Wales Delivery Unit, which commenced in November and that will run until March 2023. IRD requests that have been declined and where harm has been identified or is considered to have occurred, will form a part of this Pilot and a decision to recommend changes to the process will follow this pilot.Of note the Duty of Candour, that comes into place on 1 April 2023, further regulates the need for openness and transparency with families across the NHS. | Mar-23 | Not Met | Apr-23 | Dec-23 | Jan-24 | Closed in Quarter | Update 4.3.24: Revised procedure for Management of Immediate Release Declines reported via Datix Cymru was approved at the Clinical & Quality Governance Group (CQGG) on 29.2.24. Emergency Medical Services Coordination Standard Operating Procedure to be updated and communication of change to be published to demonstrate improvement. Additional procedure for management of incident management associated with Datix Cymru portal is due for approval on 20th March and will be subsequently published to support line managers in the timely and accurate investigation and closure process. Proposed for closure; accepted and upated to closure proposed 160424.<br><br>Update 26.1.24: Quality Management Group Forum now established with themes and trends of adverse incidents discussed as part of quality assurance agenda. Data to information is driving further deep dives and quality improvement initiatives. Ref 502 recommendations include thematic analysis of 6 months data to provide assurance of current monitoring activity.<br><br>Target date changed in quarter.<br>14.12.23 The SOP for the management of all incidents reported over Datix Cymru is currently in final draft on the new Directorate template, feedback from patient safety to be incorporated.<br>The Quality Management Group have received and considered a presentation on open incidents within the incident module on Datix Cymru. As part of the presentation, Immediate Release Declines reported via Datix was also reviewed. A draft SBAR for Immediate Release Decline has been discussed at QMG with a view to looking at an alternative process for the management of immediate release declines that are not considered, adverse incidents, near misses and/or hazzards as per the Adverse Incidident Policy 2023. Further discussions are planned in December 2023.<br>As the SBAR for an alternative process for reporting Immediate Release Declines has not yet been shared with or approved by SOT, we request a revised date of January 2024 for completion<br><br>121023: The SOP developed is a QSPE SOP which relates to the management of records through datix as opposed to the SOP in S04 which is the guidance from EMS Coordination in relation to live management of incidents. The review undertaken by the delivery unit in relation to the joint investigation process did not specifically pick up any additional learning regarding immediate release declines however there is now a 'standing agenda' item in the quarterly PTR report regarding serious incidents linked to declines so that we have a method to capture incidents and identify thematic activity. TBC at next review if this now closes this item.<br>Update: 26.09.23 - Standard Operating Procedure for Datix drafted to step out expectations for managers. Review currently ongoing for how datix is used with proposals to be drafted to more easily identify those IRD records where harm has occurred. Proposed revised date of 31.12.23 to allow datix team to provide analysis and proposols for change. |

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| 503 | 22/23 | FPC | Immediate Release Directions | Reasonable | Caroline Miftari | Liam Williams | High | | 3.2 Noting the capacity issues above, the Trust should review the requirement to investigate all Amber 1 declined directions and consider introducing a streamlined mechanism of reporting. The Trust's SOP should then be updated accordingly to reflect the outcome of this review. | | The Trust will agree a process to record all Amber 1 declined IRDs and report occurrence thematically based on UHB and clinical code sets. Where thematic analysis identifies additional areas of concern, these will be taken forward on a 'task and finish' basis by the Trust with the appropriate UHB and clinical representation. | Feb-23 | Not Met | Apr-23 | Dec-23 | Jan-24 | Closed in Quarter | Update 4.3.24: Revised process to report only those incidents where patient safety and/or working safety issues have been identified to reduce the number of Amber 1 incident declines that require investigation (EMS Coordination currently review 10% of all Amber 1 level declined requests to provide feedback to the relevant Health Board via the Director of Operations). A thematic analysis is being undertaken by the Quality Management Group covering the 6 months prior to end February 2024. Proposed for closure; accepted and upated to closure proposed 160424.<br><br>What will close the action: Thematic analysis is already underway through Quality Management Group. Terms of Reference identifies the purpose of the Quality Management Group in supporting the Quality Management System - this should close the action however approval of the recommendations for improvement ref 502 would meet the recommendation.<br>What will you provide as evidence for the closure: Revised process to address capacity challenges; evidence of thematic analysis from Quality Management Group<br>Is date reasonable: Acceptable to meet the action set out however Extension required for end of April 2024 to meet Trust Ref 502 if improved response aligned recommendation is preferable<br>Target date moved in quarter.<br>14.12.23 A draft SBAR for Immediate Release Decline has been discussed at Quality Management Group with a view to looking at an alternative process for the management of immediate release declines that are not considered, adverse incidents, near misses and/or hazzards as per the Adverse Incident Policy 2023. Further discussions planned in December 2023 therefore we request a revised date of January 2024 for completion<br><br>Update 121023: Given that the action is to include the process to record all Amber 1 declined IRDs and report thematically, with TFGs being estabisherd where areas of concern identified, we will close this when the SOP (the SOP is different to that in item 504) has been approved as that will close off the action. The action was not to embed processes. Propose extending to Dec 23 on that basis. All Amber 1 declined IRDs are now recorded through datix. There may be further tweaks to the process as we continue to develop our quality management system.<br>Update 26.09.23: Linked to Ref 502 review now ongoing for how datix is used which will include recommendations on how themeatic anaysis can be provided. Quality Management Group now commencing which will allow for review of thematic analysis to support quality improvement planning and subsequent T&F tasking. Proposed revised date of 31.03.24 to allow recommendations to be approved and QMG to embed processes, pre-requisite for Ref 502 to be completed before this action can be recommended for closure. Reason for delay is due to capacity within team. Senior Quality Governance lead now in place, OCP completed for department but 1 vacancy still remains.<br>Last update: 14.04.23<br>Delayed due to management capacity and impacts of industrial request for extensiont to end of April 23 - coaching |
| 506 | 22/23 | QSPE | Infection Prevention and Control | Reasonable | Louise Colson | Liam Williams | Medium | | 1.1 Once the overarching IPC policy is formally approved, the supporting policies/procedures/guidance documents should be reviewed and approved in a timely manner. | | 1.1-1.3 The recommendations are accepted. A project of work 'IPC 3P' will be undertaken to assess policies, procedures, and other 'powers' (including guidance documents, protocols, and activity-based risk assessments). The aim of the project is to 'map' current provision, monitoring arrangements, undertake a gap analysis, and embed a RACI framework to ensure organisational 'buy-in' and accountability. This work will lead to systematic review of departmental and relevant organisational documents. | Mar-23 | Not Met | Sep-23 | Dec-23 | | Closed in Quarter | 3.4.24: The 3Ps Framework was submitted to Senior Quality Team on 20 March 2024. Assistant Director for Quality Governance has provided a supporting email as evidence on closure of this action. Proposed for closure<br><br>6.3.24 Update: Decision by Chair's Action to approve the Infection, Prevention & Control Policy by the Quality, Patient Experience & Safety Committee was formally recorded as at Tuesday 30 January 2024. This decision was ratified at the Quality, Patient Experience & Safety Committee on 8 February 2024. IPC 3P Mapping Workshop took place on 16 February 2024 with work progressing on the development of the 3P Project Framework. To be presented to Senior Quality Team on 20 March 2024 and Senior Quality Leadership Team on 26 March 2024<br><br>What will close the action: Approval of IPC Policy and 3P Project Framework developed<br>What will you provide as evidence for the closure: Approved IPC Policy and 3P Project Framework<br>Is date reasonable: Given delays in getting everyone together for a 3P Workshop, an extension required to end March 2024<br>201223: IPC Policy will go for approval by Chair's Action in December. Propose closing this action once policy is approved. Linked actions 507 and 508 relate to the wider IPC 3P programme actions also.<br>21.11.23: Ongoing discussions with TU Partners on IPC Policy which will be discussed at Executive Leadership Team 22.11.23<br>Update 27.09.23: Both the IPC and Premise and Vehicle cleaning policies are in the policy group process still. Several meetings have been cancelled due to competing priorities involving the public enquiry. Two policies are awating final approval, the next meeting is now the 10th October. I anticiapte approval at this meeting with final approval at QUEST at the December meeting.<br>The 3P project initial outlay is complete and incorporated into annual plan of work and was presented at the IPC strategic meeting on the 26th September.<br>30.06.23 (as per previous)<br>The IPC policy has now been to the Policy group 24.04.23, a longer delay than anticipated but this was due to circumstances outside of the control of the IPC team. This will now be available for consultation. This will be a new policy which combines the AACE national policy. In the meantime work has been undertaken within the 'IPC 3P' to map out other forms of Standard Operating Procedures and Guidance and where they are aligned to.<br>The RACI framework is being used to aid with identifyng responsibilites, risks and monitoring responsibilities. This along with the audit tracker will be presented at the next IPC strategic meeting in Q2. |
| 507 | 22/23 | QSPE | Infection Prevention and Control | Reasonable | Louise Colson | Liam Williams | Medium | | 1.2 The Trust should clarify arrangements within the Premise and Vehicle Cleaning policy to ensure cleaning instructions, responsibilities and monitoring are comprehensive and align with other related documents. | | 1.1-1.3 The recommendations are accepted. A project of work 'IPC 3P' will be undertaken to assess policies, procedures, and other 'powers' (including guidance documents, protocols, and activity-based risk assessments). The aim of the project is to 'map' current provision, monitoring arrangements, undertake a gap analysis, and embed a RACI framework to ensure organisational 'buy-in' and accountability. This work will lead to systematic review of departmental and relevant organisational documents. | Mar-23 | Not Met | Sep-23 | Feb-24 | Aug-24 | Open | 3.4.24: The Polciy Group have deferred the submission of the Premises and Vehicle Cleaning Policy to 23 April 2024 Policy Group. The Policy will then be submitted to the Quality, Patient Experience & Safety Committee in August 2024. Date updated to August 2024 in quarter four, as Poliy approval through governance route delayed.<br><br>20.2.24: Review Meeting held on 9.2.24 with Julie Boalch; Head of Infection, Prevention Control; and members of the Estates Team to fully discuss and review the Premises and Vehicle Cleaning Policy. A Teams folder has been set up for the Estates Team to review the Policy and track all changes. Updated Policy to be presented to Policy Group on 27 March 2024.<br><br>What will close the action: Approved Premises and Vehicle Cleaning Policy<br>What will you provide as evidence for the closure: Approved Premises and Vehicle Cleaning Policy<br>Is date reasonable: Given the delay in the engagement with this Policy being reviewed, submission to the February Policy Group was missed and Policy will now be presented to 23 April 2024 Policy Group therefore an extension required due to onward reporting and approval by the Quality, Patient Experience & Safety Committee on 7 May 2024.<br><br>21.12.23: Estates have confirmed that the section regarding the Buildings Group and Buildings Manager are to remain in the Premises and Vehicle Cleaning Policy therefore this can now progress to Policy Group<br><br>Update 121023: this action will be closed once the IPC and the Premises and Vehicles Polices are approved at Committee . These Policies have been deferred to February Committee due to cancellation of Policy Group Meetings.Update 27.09.23 The Premise and Vehicle cleaning policy is awating approval vai the Policy Group pathway. There is a delay in its progress due to cancelled meetings. The nxt meeting is the 10th October and i anticiapate fianl approval at QUEST December 2023<br>The trust has a clear vehicle decontamination SOP. The vehilce audit tool has been redesigned, piloted and is good to go. |

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| 508 | 22/23 | QSPE | Infection Prevention and Control | Reasonable | Louise Colson | Liam Williams | Medium | | 1.3 The Trust should map IPC and related policies, responsibilities, ownership, monitoring and governance arrangements to support future review and development of policies and guidance | | 1.1-1.3 The recommendations are accepted. A project of work 'IPC 3P' will be undertaken to assess policies, procedures, and other 'powers' (including guidance documents, protocols, and activity-based risk assessments). The aim of the project is to 'map' current provision, monitoring arrangements, undertake a gap analysis, and embed a RACI framework to ensure organisational 'buy-in' and accountability. This work will lead to systematic review of departmental and relevant organisational documents. | Mar-23 | Not Met | Mar 24 | | | Closed in Quarter | 3.4.24: The 3Ps Framework was submitted to Senior Quality Team on 20 March 2024. Assistant Director for Quality Governance has provided a supporting email as evidence on closure of this action. Proposed for closure. Accepted by BoardSec.<br><br>Update 6.2.24: Linked to Trust Ref 506<br><br>What will close the action: 3P's Project Framework<br>What will you provide as evidence for the closure: 3P's Project Framework<br>Is date reasonable: Yes - but will be an ongoing Project (Directorate and Trust wide)<br><br>21.11.23: Meeting arranged with Julie Boalch for 3 January 2024 on taking the 3 Ps Project forward<br>Update 27.09.23: The 3 P project continues, the content of which is now incorporated into the IPC annual plan. This was discussed and shared with the IPC Strategic meeting and is now at a stage for cross directorate working. All IPC related policies within the trust have been identified as the parent document, along with associated guidance, standards, SOPs, audit tools, risk assessments and training. Included is the RACI for each area of responsibility.This document has now started to identify the gaps and the work is at the stage to be shared as there are cross directorate respons nsibilites. The progress has also been reported in the IPC Q1 highlight report<br>Update 30.06.23<br>IPC 3P project to be reported to CQGG in Q2 |
| 517 | 22/23 | QSPE | Infection Prevention and Control | Reasonable | Louise Colson | Liam Williams | Low | | The Trust should ensure online resources contain up to date links and guidance | | We accept the recommendation, future workplans will detail requirements. | Jan-23 | Not Met | Sep-23 | Apr-24 | | Open | Update 3.4.24: all on track for completion by end April 2024.<br>What will close the action: Upload onto LMS365<br>What will you provide as evidence for the closure: Link to new site<br>Is date reasonable: Yes - April 2024 achievable<br><br>Update 27.09.23: Proposed revised date 31.03.24. The prehospital Care ESR training resources has been updated. The ANTT Training package is in the process of being updated along with the All Wales ANTT policy. We have a plan with training school for ANTT training on the MIST training for 2024/25. This will commence April 2024. A discussion with the training school at the last IPC strategic meeting to transer some of the onclick training to the Learning Launchpad. The priority modules will be PPE, RED Level PPE training, Vehicle Cleaning and Waste management. The other modules via onlick can be incorporated into these modules as they are largely pandemic related training..<br><br>Updated 30.6.23 (as per previous 26.04.2023) |
| 519 | 22/23 | QSPE | Infection Prevention and Control | Reasonable | Louise Colson | Liam Williams | High | | 6.2 The Trust should consider longer term mechanisms for compliance which incorporate and map responsibilities of the wider IPC Strategic membership and include outline of compliance monitoring and reporting. | | We accept the recommendation to standardise documentation formats. This action will be addressed through the IPC 3P Project (management response 1.1) | Jun-23 | Not Met | Mar-24 | | | Closed in Quarter | 12042024: Action proposed for closure as IPC Strategic Group in existence and ToR and recent meeting record received as evidence, which includes evidence of approval. AP updated status to 'closure proposed' on this basis.<br><br>Update 27.09.23:The 3P project documentation was presented to the IPC strategic group in the September meeting, this will be reflected in the AAA report to CQGG and then in Q2 IPC Highlight report.<br><br>Update 30.6.23: 3P project outputs to be presented to IPC Strategic Group and CQGG in Q2. |
| 522 | 22/23 | FPC | Data Analysis | Reasonable | Jon Hopkins | Jonny Sammut | Medium | | 1.1 A report (template) catalogue should be created and maintained. It should list all reports available, their purpose, the data fields they contain, and the parameters that can control the actual report production e.g. period, location etc. This can be supported by the MI on report production; if it has not been produced for over 12 months is it still needed, should it be archived? | | A report catalogue is already in development. We will also set up a small selection of report templates to help speed up development, make self-serve easier for consumers, and streamline this report cataloguing effort. | Apr-23 | Not Met | Dec-23 | Feb-24 | Jun-24 | Open | Last updated 22/03/24: the report templates are now complete, but work remains to fully populate the catalogue. Request for date to be revised to June 2024. Date revised in Q4 to June24.<br>Updat 22/11/23: A specialist 'Reporting Analyst' secondment position was created and successfully recruited into to support this work. Progress has been made since this appointment in Oct-23, with a goal of finalising and publishing Jan-24.<br>Update 28/06/23: Capacity in the analytics team means although progress has been made against this action, it is not yet complete. The report catalogue now exists, but cycles of review for the reports contained within it have not yet commenced. |
| 523 | 22/23 | FPC | Data Analysis | Reasonable | Jon Hopkins | Jonny Sammut | Medium | | 1.2 The process of requesting a new or modified report should be formalised. It should include reference to the catalogue at 1.1 so that specialised analyst time is not wasted reproducing existing reports | | The recommendation is welcomed, and we will look to expand on the existing request process with a formalised (potentially guided self-serve) check of existing functionality, and an ability to decline requests if the content already exists in other places, or if not aligned with organisational priorities. | May-23 | Not Met | Dec-23 | Feb-24 | Apr-24 | Open | Last Updated: The Data & Analytics request process has been revisited and modernised - this is currently being aligned with the wider request process for the Health Informatics function as part of a rapid cycle of improvement currently taking place across the function, before being approved for implementation. Although work is almost complete, evidence will not be able to be provided until launch in April 2024. Date revised in Q4 to April24.<br>Target date moved in quarter.<br>Update 22/11/23: This work is on-track, and the proposed process is waiting review by the data and analytics leadership team. Changed date requested.<br>Update 28/06/23: The new report catalogue has been embedded within HI processes: when new requests for intelligence are received a check is made whether a report already exists which could allow the requestor to self-serve the information before the task is actioned. Due to capacity constraints within the team, the request mechanism is still to be amended to ensure alignement with WAST strategic priorities in 2023-24. |
| 524 | 22/23 | FPC | Data Analysis | Reasonable | Leanne Smith | Jonny Sammut | Medium | | 1.3 Data on report production and usage should be maintained, and feedback from the requestor obtained. This should be used to maintain and limit the reports available to a manageable number of reports with their usage and priority recorded. | | We do already obtain some feedback on service and products, but will look to formalise the collection of this and the embedding of findings within the development cycle process, as well as create management KPIs around these metrics to take through Digital governance routes. However, a dependency here is the management of the HI HelpDesk inbox, and work to converge this with the ICT ServiceDesk inbox. | Jun-23 | Not Met | Dec-23 | Feb-24 | Apr-24 | Open | Last updated 22/03/24: A review of all reports and dashboards made available by this team is almost complete, but is being finalised as part of a rapid cycle of improvement taking place across the Health Informatics function in March and April. Additionally, all 111 related reports are undergoing a review for utilisation as part of the 111 CAS replacement project. Request for extension to April 2024 when the internal review and 111 review will be complete, and a meta report for report utilisation will be implemented. Date revised in Q4 to April24.<br>Target date moved during quarter.<br>Update 22/11/23: This action is linked to the catalogue work of action 522. We have gathered intel on all available data products and are now grading reports. Expected to be able to complete early 2024 - propose date change to Feb-24.<br>Update 02/10/23: Report usage data is routinely collected and used on an ad-hoc basis, but we don't currently obtain much feedback from requester/users. We are beginning to implement a report review cycle for all reports. Linked to 522. |
| 525 | 22/23 | FPC | Data Analysis | Reasonable | Jon Hopkins | Jonny Sammut | Low | | 2.1 There should be a series of Entity Relationship Models available covering all of the tables in the data warehouse. | | We will develop an ERD library, including meta-data, starting with **EMS CAD.** We will plan out a roadmap for this exercise to expand into the other systems supporting EMS, Ambulance Care, 111 and Corporate teams around the organisation, to build up a full WAST ERD library and meta-data source. | Mar-23 | Not Met | Mar-24 | | | Closed in Quarter | Last Updated 22/03/24: An Entity Relationship Diagram for EMS CAD is now complete and available for use by the Data Engineering team. Propose Closure accepted.<br>191223: Update from LS: Role being interviewed for this week.The ability to meet the March date will therefore depend on the notice period and start date of the appointed candidate. Leave as Mar-24 for now and review if required in January.<br>Update 22/11/23: Recruitment is in progress to bring in a principal data engineer to bolster capacity in the team, but also support oversight on this project from March-24.<br>Update 28/06/23: The EMS CAD Data diagram is now complete. Deadline for full ERD library is unrealistic, suggest this is reviewed against other priorities. This work will ultimately be used within Digital and not wider Trust stakeholders.<br>There has been a Principal Data Engineer vacancy since Jun-23 and as part of the savings plan, there is no intention to backfil for this post in the short-term. |

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| 526 | 22/23 | FPC | Data Analysis | Reasonable | Jon Hopkins | Jonny Sammut | Low | | 2.2 All tables should have a completed meta-data table describing their contents | | We will develop an ERD library, including meta-data, starting with EMS CAD. We will plan out a **roadmap** for this exercise to expand into the other systems supporting EMS, Ambulance Care, 111 and Corporate teams around the organisation, to build up a full WAST ERD library and meta-data source. | Jul-23 | Not Met | Dec 23 | Mar-24 | | Closed in Quarter | Last Updated 22/03/24: An Entity Relationship Diagram for EMS CAD is now complete, as per action 525. This offers a example of what will be created for all other data tables in our warehouse. However, it should be noted that there are over 400 tables, and so this action was to create a ***roadmap*** for ERDs for the remaining core data sources. This roadmap has now been developed and will be tracked internally to Digital Directorate. Propose closure accepted.<br>Target date moved in quarter 3.<br>191223: Update from LS: Update from LS: Role being interviewed for this week. The ability to meet the March date will therefore depend on the notice period and start date of the appointed candidate. Move to Mar-24 for now and review if required in January.<br>Target date moved during quarter 2.<br>Last updated 22/11/23: Recruitment is in progress to bring in a principal data engineer to bolster capacity in the team, but also support oversight on this project from March-24.<br>Update 02/10/23: As per update of item 525. A sequence of design for the ERD library has been agreed within Digital, but timelines for completion are not yet available due vacancies in the team (recruitment is underway). The EMS CAD item is complete, with goal of achieving ePCR diagram by December 2023 (followed by CAS then NEPTS in Spring 2024). |
| 527 | 22/23 | FPC | Data Analysis | Reasonable | Aled Williams | Jonny Sammut | High | | 3.1 A programme to replace all of the Qlik reports with Power BI equivalents should be scoped and completed. Qlik should then be decommissioned and removed. | | **A risk-assessment** will be conducted to understand the exposure to WAST of Qlik Sense being out of vendor support. This platform is not internet facing (i.e. for internal users only, not on a publicly accessible web url), and not believed to present an information security risk, but pending ICT assessment, we will devise a mitigation plan, or an options appraisal for maturity - **due March 23**. In the meantime, there is already a programme of work to migrate reports and dashboards to **PowerBI.** However, this is a lengthy and high-capacity activity, and is not prioritised highly at this current time - due March 24. | Mar 24 | Not Met | Oct-24 | | | Open | 12042024: BoardSec reveiew - recommended extension to October based on the update given, and that once this programme is completed and evidence received can be closed. Target date moved in Q4 to October 2024.<br>Last updated 22/03/24: Risk assessment complete and on Datix, and monthly meeting in place between Cyber and Data Engineering experts to review the risk and track any vulnerabilities. This is managed through the 'national vulnerability management dashboard' reported through to Closed FPC. Additioanlly, a migration workstream for moving all dashboards from Qlik to PowerBI is in progress, with completion date of September 2024.<br>Update 02/10/23: Risk assessment completed and in Datix. A 12-month secondment has been created for a PowerBI specialist to start the work of migration from Qlik before decommissioning. March-24 is likely unrealistic, but a roadmap will be developed once the secondment begins (November-23).<br>Previous update 27/06/23: Qlik is considered a low IS risk. Work is already ongoing to move reports into powerBI but due to capacity constraints within the team will take most of 2023-24 to complete |
| 531 | 22/23 | FPC | Data Analysis | Reasonable | Leanne Smith | Jonny Sammut | Low | | 5.1 A defined quality (accuracy) level should be established for all data fields, so that particular focus can be made on those determined as being key, e.g., patient identifiers have to be 100% accurate. | | It should be noted that we have only 0.4 WTE capacity in this specialist function and so any activities around data quality management improvements will not be able to be completed quickly. However, we will commit to review our Data Quality Policy, adding in detail regarding the minimum level of acceptable accuracy and error rates for key fields where appropriate. | Aug-23 | Not Met | Dec 23 | Jun-24 | | Open | Target date moved during quarter 3 to June24.<br>Last updated 22/11/23: propose that the target date be moved out 12 months to enable review of the policy in 2024-25 and a data quality assurance plan to be created with appropriate resource secured to support the work. **The approval of the policy will close this action.**<br>Update 02/10/23: Data Quality Policy review not yet started - this is agreed to be part of the 2024-25 policy workplan. (Digital are reviewing 3 other higher priority policies in 2023-24.). Date for approval of the Data Quality Policy aimed at November 2024 QUEST. |
| 532 | 22/23 | FPC | Data Analysis | Reasonable | Leanne Smith | Jonny Sammut | Low | | 5.2 Acceptable error rate(s) should be agreed and processes put in place or improved, so that Trust data reaches the agreed accuracy levels. | | It should be noted that we have only 0.4 WTE capacity in this specialist function and so any activities around data quality management improvements will not be able to be completed quickly. However, we will commit to review our Data Quality Policy, adding in detail regarding the minimum level of acceptable accuracy and error rates for key fields where appropriate. | Aug-23 | Not Met | Dec 23 | Jun-24 | | Open | Target date moved during quarter 3 to June24.<br>Last Updated 22/11/23: propose that the target date be moved out 12 months to enable review of the policy in 2024-25 and a data quality assurance plan to be developed with appropriate resource secured to support the work. **The approval of the policy will close this action.**<br>Update 02/10/23: Data Quality Policy review not yet started - this is agreed to be part of the 2024-25 policy workplan. (Digital are reviewing 3 other higher priority policies in 2023-24.) Date for approval of the Data Quality Policy aimed at November 2024 QUEST |
| 545 | 22/23 | AC | Standards of Business Conduct: Declarations | Limited | Trish Mills | Trish Mills | Medium | | 4.1 Management should determine and implement a solution to ensure the completeness and accuracy of declarations of interest, including nil returns. | | Initially 'decision makers' will be targeted for completing of declarations of interest and the register of those decision makers will be held centrally by the Board Secretary. | Jun-23 | Not Met | Apr 24 | | | Open | Last updated: 11/07/23<br>Declarations for the decision makers listed in the policy will commence from March 2024 so as not to duplicate efforts given declarations were sought from ADLT in March 2023 as part of the annual review. |
| 547 | 22/23 | AC | Standards of Business Conduct: Declarations | Limited | Trish Mills | Trish Mills | Medium | | 4.2 Consideration should also be given to introducing a tracking system and reporting the results, including declarations requested but outstanding, to an appropriate forum e.g., Audit Committee. | | The 'decision makers' will be a finite known cohort and initially their declarations will be captured via Microsoft Forms to allow for tracking and escalation | Jun-23 | Not Met | Apr 24 | | | Open | Last updated: 11/07/23<br>There will be a known cohort to enable the tracking any outstanding declarations. The PADR form now has a prompt for the line manager to ensure staff have completed their declarations. |
| 558 | 22/23 | FPC | IMTP Delivery | Reasonable | Heather Holden | Rachel Marsh | Medium | | 1.1 The PDDs of the sample programmes should be enhanced to include a Quality Management element to assure the quality of the programme and its deliverables. | | This recommendation is accepted. We will define the quality standards to be implemented across all projects and programmes as part of the development of the project and programme management framework and will consider how we define quality measures for project deliverables for the delivery of the next iteration of the IMTP. This will commence with a framework workshop by the end of April to determine the actions required to put this in place. | Apr-23 | Not Met | Jun-23 | Nov-23 | Feb-24 | Closed in Quarter | Last Updated 140324 - pathway framework signed off by STB on 26 Feb 24. Publiished and available on Siren here: https://nhswales365.sharepoint.com/sites/AMB-Intranet-Performance/SitePages/Project-Path-Framework.aspx. Closure proposed<br>Target date moved in quarter 3.<br>4.12.23: It was stated that this would come through the Project Path Framework document which will be updated and brought back to STB on 15th January 2024. This item will be closed when the pathway framework document is approved by the Strategic Transformation Board.<br>Target date moved in quarter<br>20.09.2023 - Since the audit a review of the approach to IMTP delivery has been undertaken and a more agile approach to IMTP and transformation delivery is being developed recognising the complexity and interrelatedness of the programme structures that are currently running.<br>A Project Path Framework is in development (due October/November 2023) to replace the current outdated Project and Programme Management framework along with a standard suite of templates. A first draft of the framework will be presented internally to the SPP team by the end of September and will then be presented to ISPG for feedback and approval. This will include a revised Programme Definition Document that includes a Quality Management section. Following approval, the current programmes will be transitioned to the new templates and the QM sections will be populated.<br>Last Updated: 17.04.23<br>Workshop with transformation team on 3rd April, outcomes to be written up and next steps agreed. |

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| 560 | 22/23 | FPC | IMTP Delivery | Reasonable | Kelsey Rees-Dykes | Rachel Marsh | Medium | | 2.1 The G2C programme board should implement a programme level deliverables plan to assure the management of dependencies in the event of individual project / workstream slippage or other development; and that this is universally implemented across the transformation programmes of the Trust. | | Currently programme level plans are included within the overarching reporting via STB. With specific plans developed at project level. We will therefore develop a detailed G2C Programme Action Plan (Milestone timeline aligned to IMTP deliverables) with project Gantt charts feeding into this timeline. | Mar-23 | Not Met | Jun-23 | Nov-23 | Feb-24 | Closed in Quarter | Last Updated 140324 - pathway framework signed off by STB on 26 Feb 24; closure proposed.<br>Target date moved in quarter 3 to Feb24.<br>4.12.23 - Key milestones under each of the projects that sit in G2C to be updated - revised date of February 2024 required. Confirmed that all Project Managers need to ensure there is an overarching deliverable plan for all projects so dates can be seen by SRO in one place.<br>20.09.2023 - Since the audit a review of the approach to IMTP delivery has been undertaken and a more agile approach to IMTP and transformation delivery is being developed recognising the complexity and interrelatedness of the programme structures that are currently running. This item will be closed when the pathway framework document is approved by the Strategic Transformation Board.<br>A Project Path Framework is in development (due October/November 2023) to replace the current outdated Project and Programme Management framework along with a standard suite of templates. A first draft of the framework will be presented internally to the SPP team by the end of September and will then be presented to ISPG for feedback and approval. RAID (Risk, Action, Issues, Decision) logs are part of the standard suite of documentation.<br>Last updated: 17.04.23<br>Focus of March planning and transformation was landing the IMTP which required additional attention from the team to meet the challenging outlook for 2023/24. Following a review of the governance and reporting into STB we are now re-setting the programme plans in line with the 2023-26 IMTP so this will form part of that work. |
| 562 | 22/23 | FPC | IMTP Delivery | Reasonable | Heather Holden | Rachel Marsh | Medium | | 3.1 Programme documentation should incorporate a standard benefit realisation plan that includes the methods to assess the identified benefits, the timing of the benefit realisation work and the criteria that will be applied to measure success. | | We would consider there to be a benefits plan in place for EMS Operational Transformation. For other programmes, this has been something that we have intended to do for some time, as we awaited the appointment of a new Head of Transformation. We recognise the need to clearly articulate and plan programme benefits and will review all programmes to determine whether current benefits plans meet the requirement of a benefits realisation plan and will identify dates to hold benefits planning workshops to finalise benefits realisation plans for each programme where this is required. | Apr-23 | Not Met | Jun-23 | Oct-23 | Feb-24 | Closed in Quarter | Last Updated 140324 - pathway framework signed off by STB on 26 Feb 24; closure proposed.<br>Target date moved in quarter 3 to Feb24.<br>4.12.23: Project Path Framework includes Benefits Realisation Plan headings for use across the Trust. To be signed off on 15th January 2024 at STB. REQUEST REVISED DATE OF Feb-24<br>20.09.23 - A Benefits Realisation Plan template has been developed and will be rolled out across the existing programmes. Due October 2023. Will propose closure once action complete<br>Last Update: 17.04.23<br>Workshop with transformation team on 3rd April, outcomes to be written up and next steps agreed. |
| 566 | 22/23 | FPC | Hazardous Area Response Team (HART) | Reasonable | Clare Langshaw/Judith Bryce | Lee Brooks | Medium | | 1.1 The Trust should engage with Welsh Government to update the content within the SLA to recognise that HART capabilities and include reference, where appropriate to National Standards | | The Trust accepts this recommendation, recognising that the SLA is provided to WAST by Welsh Government who procure the services from WAST. We will therefore seek to agree the content of the SLA | Mar-22 | Not Met | Mar 23 | Sep-23 | Mar-24 | Closed in Quarter | 250424: Action status changed to closure proposed following receipt of evidence. Emali from Clare Langshaw to Judith Bryce confirming conversations with NHS Executive and the revision of the SLA and that new arrangements supersede the SLA. Funding letter will be prepared in place of the SLA; to be progressed.<br><br>Update 22.03.2024 Will provide evidence of information shared with NHS Executive. Email sent to Clare Langshaw to send over on return from leave on Tuesday 26th March.<br><br>Update 15.03.2024 Recommend to CLOSE - information has been updated and subject to agreement period with Welsh Goverment but for the purpose of the recommendation the content has been updated.<br><br>Update 11.03.2024 The NHS Executive want the SLA in a different format, requests for information were made to WAST on 19th February and information had been submitted by Clare Langshaw. No futher correspondance recieved. No revised funding arrangement been prosposed for HART at this time.<br><br>Update 09.02.2024 - Meeting has been held with WG, HART/SORT SLA will now be hosted by the new NHS Executive that will be recoginised from 1st April. CL has been advised that the SLA will need to be rewritten to meet with the NHS Exec expectations. Second meeting to discuss SLA planned for February 2024.<br><br>Update 22.11.2023 Confirmed March 2024 is a reasonable date for SLA Target.<br>Update 27.09.2023 new SLA in draft and agreement with Welsh Governmanet that the new SLA will come into 2024/2025 financial year.<br>Last Updated: 26.06.2023 - Agreement obtained that Welsh Government will review the SLA and the process has commenced. EPRR Team has commenced the review of SLA. Proposed completion date changed from Sep23 to Mar24 as an extensives amount of work needs to be undertaken. |
| 567 | 22/23 | FPC | Hazardous Area Response Team (HART) | Reasonable | Clare Langshaw/Judith Bryce | Lee Brooks | Medium | | 2.1 The Trust should undertake a self-assessment agains the NARU key lines of enquiry review document. This could support any future "critical friend" review undertaken | | The Trust accepts this recommendation and is committed to undertaking a self-assessment aginst the NARU review document | May-23 | Not Met | Mar-23 | Mar-24 | Jun-24 | Open | 160424: (AP) Self-assessment is yet to be taken to SOT. Cannot be closed in quarter. Revised date of June 2024 applied in Q4 and can be closed off once the self-assessment has gone to SOT and received evidence.<br>Update 22.03.2024 Copy of self assessment sent to Alex Payne as evidence requested for closure. The Self Assesment is scheduled to go through SOT meeting on 9th April. Once meeting takes place, we will send over minutes of discussions for evidence of closure.<br>Update 11.03.2024 Self assessment been completed, majority of areas compliant with. Next steps will be ongoing annual review to be carried out. Recommend closure.<br>Update 24.01.2024 - Date set to undertake an internal review as mentioned on 22.11.2023. Date confirmed as: 19th February 2024.<br>Update 22.11.2023 We are looking to undertake an internal review carried out by the Specialist Operations Locality Manager against the same criteria that the English Trusts are reviewed against to ensure interoperability is maintained.<br>Update 27.09.2023 NARU still unable to support due to capacity limitations. HART uplift currently rolled out in england which is NARU's current focus. To ensure this action is undertaken an internal review will now take place in line with this action.<br>Last Updated: 26.06.2023<br>NARU has been approached, but they are not able to support this at the moment due to staff shortages. Although they are supportive of the Trust in this. Proposed completion date changed from Mar23 to Mar24. |
| 570 | 22/23 | FPC | Hazardous Area Response Team (HART) | Reasonable | Clare Langshaw/Judith Bryce | Lee Brooks | Medium | | 5.1 The Trust should consider undertaking a periodic review of the CAD codes assigned to prompt specialist response, or establishing a link between the group and HART for its input into ongoing reviews. | | The Trust accepts this recommendation and will undertake a review of CAD codes to ensure they are applicable to HART capabilities and also maximise the use of HART deployments. Any changes will be subject to CPAS approval and we will engage with CPAS to reflect this work on their work programme. | Jun-23 | Not Met | May-23 | Oct-23 | Apr-24 | Closed in Quarter | 290424: Receipt of CAD Codes at DCR (as a sub-group of CPAS) and the Directorate SLT (with the supporting evidence) satisfies closure of this action. Updated to closure proposed.<br>Update 15.03.2024 Clinical sign off has been completed (6th March 2024) and the implementation process i.e training and tech changes to the live DCR will now follow (actioned thorugh SLT), but for the purpose of this recommendation the review has been done and subject to normal procedure through the normal Trust process. Recommendation to CLOSE.<br><br>Update 11.03.2024 - Updating of codes to be provided by ICT, no implementation dates planned at this time.<br><br>Update 25.01.2024 - meetings took place in September. The HART code sets are going for consideration at the DCR review on 6th March and there they will agree governance route for approval. Further updates to follow.<br><br>Target date moved in Quarter 3<br>Update 22.11.2023 Suggest revised date to change to April 24 to account for the expected winter pressures in the coming months and EMSC capacity to support.<br>Update 27.09.2023 - Specialist ops LM has approached EMSC for support, EMSC unable to support at this time due to thier capacity, unable to move this action forward without EMSC support.<br>Last Updated: 26.06.2023 - EPRR Team linking with EMSC colleagues to progress this audit recommendation. |

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| 595 | 22/23 | FPC | Hazardous Area Response Team (HART) | Reasonable | Clare Langshaw/Judith Bryce | Lee Brooks | Medium | | 6.1 HART management should undertake periodic comparison of data extracted from the CAD system to compare against activity reported on PROCLUS to support ongoing efforts to improve data recording on that system | | The Trust accepts this recommendation and will undertake a comparison of CAD data to Proclus, with a view to improving the accuracy and system of reporting on Proclus in the future. | May-23 | Not Met | May-23 | Oct-23 | Apr-24 | Closed in Quarter | Update 25.01.2024 - Change of process has been implmented, HART activity is now reported through launchpad not CAD, this ensures activity is reported the same on Proclus as it is within the Trust. Implementation of review of HART activity will be through OM meetings. This action is recommended to be CLOSED.<br><br>Target date moved in Quarter 3<br>Update 22.11.2023 Suggest revised date to change to April 24 to account for the expected winter pressures in the coming months and EMSC capacity to support.<br><br>Update 27.09.2023 - Specialist ops LM has approached EMSC for support, EMSC unable to support at this time due to thier capacity, unable to move this action forward without EMSC support.<br>Last Updated: 26.06.2023 - EPRR Team linking with EMSC colleagues to progress this audit recommendation. |
| 596 | 22/23 | AC | Risk Management & Assurance | Reasonable | Julie Boalch | Trish Mills | Medium | 1.1 | Following the development of the risk appetite matrix, the Trust should develop and finalise its risk appetite statements | 1.1 | Accepted. Formal risk appetite statements will be developed in conjunction with the transformational BAF in 23/24; however, the risk consequence matrix is in place and includes risk appetite across a range of categories. The Trust sets out its risk appetite for patient harm in its annual report. This action forms part of the risk management transformation programme monitored at the Strategic Transformation Programme Board. Additionally, a Board Development Session is planned for February 2024. | Jun-24 | Not Yet Due | | | | Open | External consultant support has been procured who will provide us with a clear risk appetite methodology and coaching aimed at enabling us to deliver a Risk Appetite. The outputs will be Risk Appetite guidance used to complete risk Appetite statements as well as examples of how Risk Appetites enable and support the delivery of the Trust's objectives. |
| 598 | 22/23 | AC | Risk Management & Assurance | Reasonable | Julie Boalch | Trish Mills | Medium | 3.1 | Management should continue the rollout of risk management training across the Trust and seek to obtain feedback from attendees, including to capture views on the impact the training has had on their understanding of risk management principles and practice and to identify areas of further training need and improvement. | 3.1 | Accepted. Risk Management training will continue; however, the level 1 and 2 training packages will not be fully established until late 2024. Bespoke and directorate training will continue to be delivered as requested and a feedback form will be put in place at the next session. Continuous 1:1 support is delivered to Risk Officers to manage their risks. | Sep-24 | Not Yet Due | | | | Open | The risk management training for level one and two has been inlcuded as a deliverable in the IMTP risk transformation programme and will flow from the publication of the Risk Management Policy following approval at the March 2024 Audit Committee. |
| 600 | 22/23 | AC | Risk Management & Assurance | Reasonable | Julie Boalch | Trish Mills | Medium | 4.1 | The Trust should continue its work to strengthen the BAF, including to;<br>a) ensure alignment to the broader long-term strategy.<br>b) provide further assurances on the effectiveness and impact of controls and mitigating actions in reducing the strategic risks. | 4.1 | a) Accepted. This is one element of the Risk Management Transformation Programme included in the IMTP and monitored at the Strategic Transformation Board.<br>b) Accepted. A review of mitigating actions and the impact these have had on current scores forms part of the quarter 2 reports for Trust Board and Committees. This is good practice risk management and is part of each risk review discussion. The impact and effectiveness of controls and mitigating actions will continue to be strengthened and drawn out in the risk reports over the coming year. | Mar-24 | Not Met | | | | Closed in Quarter | 11042024: Discussion held with Internal Audit (on 09 April) and agreed closure based on the position indicated here. Propose closing this action on the basis that we were unable to advance all of the risk management transformation programme as expected due to Covid-19 Inquiry pressures and part of this programme has rolled forward into the 24-27 IMTP. Closure proposed.<br><br>(a) External consultant support has been procured to provide advice and guidance on the development of our strategic BAF. The consultant report has been received and an action plan is being developed by the Trust.<br><br>(b) The current BAF includes full details of the principal risks is reviewed as part of the agreed cycle. The BAF guidance document was produced in April 2024 to support the Board in interpret and challenging the data within the BAF.<br><br>Internal Audit were content to close the recommendation on this basis given the progression of work acknowledging the need to bolster the resources in the Corporate Governance Directorate to support the delivery of enterprise risk and the risk transformation programmes. |
| 604 | 22/23 | Quest | Pain Management | Limited | Duncan Robertson | Andy Swinburn | High | 1.2(c ) | The Trust should ensure all PGDs follow the Medicines Management policy, with a review undertaken every three years as a minimum. | 1.2 (c ) | The PGD development and review process is resource intensive, and pharmacist input is an essential requirement. Pharmacist Advisor availability is currently limited to 4-hours per month and does not currently meet the needs of the organisation, particularly given the uplift in advanced practitioners and extended skills (enhanced analgesia) of the paramedic workforce. We will develop an options appraisal to determine a costed and effective way forward to provide additional Pharmacist Advisor capacity | Mar-24 | Not Met | May-24 | | | Open | 170424: (AP) Not clear when received at ELT so revised date in Q4 of May24 added.<br>Last updated 04.04.2024 Recommend for closure: Options presented to Executives and recruitment commenced. |
| 605 | 22/23 | Quest | Pain Management | Limited | Duncan Robertson | Andy Swinburn | High | 2.1 | To gain assurances on the completeness of pain management recorded for patients, additional pathways within the ePCR system, should be established to extract the required data; and reported to an appropriate forum with any themes or trends highlighted within the report. | 2.1 | We propose to set up a task and finish group, to develop/design a pain management framework to support analysis and presentation of pain/analgesia related data. We anticipate this will enable a fuller picture of pain management, across a range of conditions, in addition to STEMI and Fractured Neck of Femur. The framework will be presented to the Clinical Intelligence and Assurance Group by the end of Q3 2023/24 and then through to CQGG and QUEST. There will be a co-dependency on some of the actions on the outcome of Matter Arising 3. | Dec-23 | Not Met | Jan-24 | | | Closed in Quarter | Last Updated 04.04.2024 Recommended for closure: Pain Management Framework has been presented to CQGG on the 29th February 2024. The work will now be part of BAU through the Clinical Intelligence and Assurance Group. Evidenee received and closure proposed.<br><br>Dec 23: Update 221223 from Clinical Directorate: Agreed for implementation by CIAG (done in December) and will be passed to CQGG for approval in January. T&F group is set up, they have had 3 meetings and AAA received to November CIAG. Framework and supporting documents will be presented to the December CIAG for approval and onward communication to CQGG and upwards. AAA to be submitted for evidence. (On track for December completion). Date updated in Q3 to Jan24. |
| 607 | 22/23 | PCC | Trade Union Release Time | Limited | Liz Rogers | Angela Lewis | High | 1.1 | In partnership with the trade unions the Trust should revisit the agreement and associated documentation and ensure that there is a consistent, mandated, approach throughout the Trust. | 1.1 (a) | Internal conversation on whether full time representatives are appointed in WAST<br>[see context narrative that prefaced this action in the report - too large to include] | Mar-24 | Not Yet Due | 24-Apr | | | Closed in Quarter | Updated 140324 (TM) - ELT internal discussion on this closes the action. Board Secretary was present in conversation. This recommendation should be read in the context of the audit report. The recommendation was noted but not accepted per se based on the relationship with TUPs at the current time. The management response column notes the actions committed.<br><br>To note: Regarding the wider recommendation re revisiting the Facilities Agreement, we do not intend to do this as the Agreement is working for WAST. The recent Social Partnership legislation puts a duty on the organisation to consult and engage more widely rather than reducing or introducing further controls.<br>In terms of the suggested mechanism for recording time. As per the facilities agreement the spreadsheet was included as an example. This is not mandatory and is significantly laborious and cannot be completed on an iPad. One of the senior TUPs has trialled it and we note (alongside his line manager) how difficult it is to use. TUPs are clear that it is their responsibility to maintain accurate records of their TU duty time which can be requested by the organisation. In the spirit of partnership working, relationships are based on trust and responsibility.<br>Work on an electronic timesheet continues and this may be the long term solution, alongside the replacement to ESR. In addition a quarterly report from finance and a quarterly report from Resources will be produced to track activity. Proose to close this action. |
| 608 | 22/23 | PCC | Trade Union Release Time | Limited | Liz Rogers | Angela Lewis | High | 1.1 | In partnership with the trade unions the Trust should revisit the agreement and associated documentation and ensure that there is a consistent, mandated, approach throughout the Trust. | 1.1 (b) | Broader discussion with TU reps regarding maintenance and development of clinical skills whilst undertaking TU duties with the aim of reaching a shared understanding<br>[see context narrativethat prefaced this action in the report - too large to include] | Mar-24 | Met | | | | Closed in Quarter | 21.03.24 LR Discussion with key TU partners. 99% of TU reps undertake shifts in their substantive posts. TUPs recognise the importance of this in terms of having authenticity with thier members and understanding their roles. Where a TUP is not undertaking active duties there is justification for this and it is being managed on a case basis.<br>Propose closure. |

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| 609 | 22/23 | PCC | Trade Union Release Time | Limited | Liz Rogers | Angela Lewis | High | 1.1 | In partnership with the trade unions the Trust should revisit the agreement and associated documentation and ensure that there is a consistent, mandated, approach throughout the Trust. | 1.1 (c ) | Regular discussions with senior TU reps in WAST re time for TU duties, trends and peaks in activity<br>[see context narrativethat prefaced this action in the report - too large to include] | Mar-24 | Met | | | | Closed in Quarter | Amended the date of 'ongoing' in the original deadline to March 24 and will review the conversations that have taken place at that time.<br><br>20.03.24 LR work on building effective partnerships is being successfully delivered and is ongoing. This has included conversations about the wellbeing of TUPs who undertake significant work in addition to thier contracted working hours in thier substantive posts. Examples of discretionary effort has been shared (where time has not been claimed).<br>The organisation manages attendance at Committee meetings, project groups etc by having nominated reps at meetings.<br><br>A report will be generated quarterly from GRS, and Shifttrack alongside finance reports to monitor TU activity on a quarterly basis. Proposed clsoure on the basis that this is BAU from 01.04.24. Evidence of emails ro confirm reporting have been shared as evidence. |
| 611 | 22/23 | PCC | Trade Union Release Time | Limited | Liz Rogers | Angela Lewis | High | 2.1 | A standardised process to formally request trade union time should be agreed and appropriate monitoring mechanisms put in place to ensure practices are applied and managed consistently. The process should also incorporate the method of approval and payment / TOIL as well as the management of refusals. | 2.1 (b) | The comments of audit colleagues are noted and accepted. Whilst there was a template provided, reps were advised that they needed to maintain a personal record but flexibility was given on how this was to be done. The audit feedback will be shared with TU partners for information and clarification. The current spreadsheet can not be completed on an iPad. Also managers are often not able to respond to a request as soon as it is submitted due to shift patterns and operational pressure<br>**Action:** Revisit manager's responsibilities in signing off TU time with managers across WAST.<br>[see context narrativethat prefaced this action in the report - too large to include] | Dec-23 | Met | | | | Closed in Quarter | 040124: Board Secretary reviewed evidence of notices to staff and proposed closure.<br><br>This action refers to the action in the audit report to revisit manager's responsibilities in signing off TU time with managers across WAST. Managers have been reminded of their responsibilities under the Facilities Agreement in terms of checking timesheets. |
| 612 | 22/23 | PCC | Trade Union Release Time | Limited | Liz Rogers | Angela Lewis | High | 2.1 | A standardised process to formally request trade union time should be agreed and appropriate monitoring mechanisms put in place to ensure practices are applied and managed consistently. The process should also incorporate the method of approval and payment / TOIL as well as the management of refusals. | 2.1 (c ) | The comments of audit colleagues are noted and accepted. Whilst there was a template provided, reps were advised that they needed to maintain a personal record but flexibility was given on how this was to be done. The audit feedback will be shared with TU partners for information and clarification. The current spreadsheet can not be completed on an iPad. Also managers are often not able to respond to a request as soon as it is submitted due to shift patterns and operational pressure<br>**Action:** Engagement with the senior TU partners will be undertaken with the aim of reaching agreement on implementing a standardised simplified approach (in the context of IA within WAST). | Sep-24 | Not Yet Due | | | | Open | |
| 613 | 22/23 | PCC | Trade Union Release Time | Limited | Liz Rogers | Angela Lewis | High | 3.1 | A standardised process to formally record facility time, and in sufficient detail, should be agreed and implemented. | 3.1 (a) | WAST do not currently have the systems to record this information centrally and to do this manually will take more administrative support which is not good value for money. Most TU reps are based in Operations and are recorded in GRS. Only a handful are working outside of the GRS system.<br>**Action:** We will review whether the information could be held in ESR effectively and what the maintenance of this would be and the ease of collecting it. It needs to be in one place for ease of reporting and management. If this is not a realistic option (in terms of cost), we will explore options for alternative methods of recording total time. | Nov-23 | Not Met | Mar-24 | Dec-24 | | Open | Target date moved in quarter 3 to quarter 4 (to December 2024).<br>Dec 23 - The management response to this item was:-<br>'We will review whether the information could be held in ESR effectively and what the maintenance of this would be and how easily could be be accessed and collected. It needs to be in one place for ease of reporting and managment. It this is not a realistic option (in terms of cost) , we will explore options for alternative methods of recording total time.'<br>This is wrapped up in the wider challenges in terms of TU relationships and therefore we want to treat with sensitivity.<br>Facility Time is recorded in GRS and Shift Track. We don't have any reps who are not using one or other of those systems. 111 and other areas are likely transferring to GRS so all will be captured in one system. Also the potential work around electronic timesheets will also impact on record keeping. There is a potential option to record TU time in ESR but we are in the early stages of exploring this but we will give it due consideration. Our ESR lead is currently away from work. Propose an extension to March 24 when we will likely have more clarity on electronic timesheets and moving all colleagues on shifts into GRS.<br><br>20.03.24 LR update - work on electronic timesheets is ongoing. The ESR system is going to be replaced and the current options for recording time are unlikely to work well. Recommend that this is extended in line with the implementation of electronic timesheets and TUPs continue to record time and complete their Ops timesheets in the usual way and record TU activities in diaries etc until then. (Please see comments above re Social Partnership and partnership working as these are very relevant). Propose a change in date to Dec 24 re the electronic timesheet due to the sensitivity regarding negotiations with TU partners. |
| 614 | 22/23 | PCC | Trade Union Release Time | Limited | Liz Rogers | Angela Lewis | High | 3.1 | A standardised process to formally record facility time, and in sufficient detail, should be agreed and implemented. | 3.1 (b) | WAST do not currently have the systems to record this information centrally and to do this manually will take more administrative support which is not good value for money. Most TU reps are based in Operations and are recorded in GRS. Only a handful are working outside of the GRS system.<br>**Action:** We will review the recording of time in shift track for 111/ CSD colleagues | Nov-23 | Met | Mar-24 | | | Closed in Quarter | Closure proposed in line with narrative update.The management response to this item was:-<br>'We will review the recording of time in shift track for 111/CSD colleagues'<br>Please see comments above and proposed extension to March 24.<br><br>21.03.24 LR update - This has been checked with the resources team. CSD TU time off is recorded in GRS and 111 TU partners time is recorded in Shift Track. Reports on time off can be pulled from the system on an as and when basis. We have only a handful of reps in 111. Propose closure. With effect from Q1 2024/25 we will generate quarterly reports for monitoring fro Shift track and GRS. |
| 615 | 22/23 | PCC | Trade Union Release Time | Limited | Liz Rogers | Angela Lewis | Medium | 4.1 | Accurate and timely management information detailing the time spent and cost of facility time, both on an individual basis and in total for the Trust should be generated. This information should be reviewed on a regular basis and action taken where necessary. | 4.1 | This is acknowledged. Our aim is to be able to provide this level of detail. However it is dependant on agreeing a standardised method of recording the time spent that is adopted by all TU's, and identifying a corporate system that will collate this information and produce accurate reports, alongside costs in a meaningful way. | Mar-24 | Met | | | | Closed in Quarter | Closure proposed in line with narrative update<br>21.02.24 LR - Reports on time off for TU activity can be generated from Shift Trak,GRS and Finance can generate the costs from this information. Quarterly reports have been requested from Finance and the Resources Teams. This will start on 1st April 2024 with the first quarter being 01.04.24-30.06.24. Propose to close this action. Emails with Finance and Resources leads forwarded to confirm as evidence. |
| 622 | 22/23 | FPC | IM&T Infrastructure | Reasonable | Aled Williams | Jonny Sammut | Medium | 1.1 | WAST should schedule a physical stocktake to ensure the asset register is 100% accurate. | 1.1 | With the majority of corporate staff remote working since Covid it has been difficult to conduct a physical audit. Also given the range of equipment provided to staff for home working (laptop, dock and monitors) we will have to develop a new way of undertaking a physical audit. | Apr-24 | Not Yet Due | | | | Open | 20/03/2024 - This recommendation is now linked with the implementation of the new service desk software has been delayed due to contract finalisation and work associated with CAS replacement.<br>Work is now underway with the new system in build and is expected to go-live in Jun-24 and a review of assets will be conducted as part of this implementation.<br>in parallel work is ongoing to undertake a physical audit of WAST sites when resources are available. However we still considering option for physical stocktake of remote workers where it does not involve a visit staff home address |
| 623 | 22/23 | FPC | IM&T Infrastructure | Reasonable | Robert Walker | Jonny Sammut | Low | 2.1 | The contract management SOP should be appropriately reviewed and authorised and communicated to relevant staff. | 2.1 | The Contract Management SOP has been approved at ICT SMT and will now be presented to Digital Leadership Group for approval, following which it will be communicated to staff across the Trust | Sep-23 | Not Met | Dec-23 | Jan-24 | | Closed in Quarter | 31012024: Update from DoDS - Link to Siren Notice now Contract Management SOP published; can be closed in Q4 reporting - subject to Board Secretary being satisfied (AP). Link: https://nhswales365.sharepoint.com/:u:/r/sites/AMB-Intranet-News/SitePages/Contract-management-SOP---Digital-notice.aspx?csf=1&web=1&e=sNLI9D.<br><br>Update from DoDS 08.01.24: We have signed off the SOP via SLT and Digital Leadership Group, the communications is currently under draft and will be issued in the next two weeks. CGM has asked that a copy of the notice/comms be provided when available, at which point the action can be updated as 'closure proposed'. It has missed the Q3 reporting period however, so will have to be captured in Q4. Revised date applied in line with this update to Jan--24.<br>Last updated 06/12/23: approved by DLG comms to go out Trust-wide on Siren in Dec-23. Board Secretary reviewed DLG action/decisions log. |

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| 624 | 22/23 | FPC | IM&T Infrastructure | Reasonable | Wyn Morris | Jonny Sammut | Medium | 3.1 | The process for clearing all PRTG/system alerts should be formalised and documented. It would typically include<br>•A shared mailbox, all alerts go to one place<br>•Prioritisation guidelines for all calls.<br>•Scheduled review times for technicians and managers.<br>•Process for storing cleared alerts for periodic analysis to assist with trend /cause identification<br>If there are too many alerts for this to be considered reasonable then the parameters for their production could be reconsidered so that a lower number of what could be considered higher priority alerts is generated. | 3.1 | Agreed, will look to formalise the process and provide some ownership to the defined process | Dec-23 | Not Met | Jun-24 | | | Open | Linked with implementation of House on the Hill ITSM software. Date moved in Q4 to June24.<br><br>20/03/2024 - This recommendation is now linked with the implementation of the new service desk software has been delayed due to contract finalisation and work associated with CAS replacement.<br>Work is now underway with the new system in build and is expected to go-live in Jun-24 and automation of PRTG alerts is a key part of this implementation.<br><br>Target date moved in quarter 3<br>Last Updated 06/12/23: Technical solution still to be designed but likely solution superceded by implementation of new Service Desk platform which will address this need in core requirements. Timeline June 2024.<br>18/12/23: Contract for new service desk software signed 15/12/23, Draft implementation plan produced with full implementation expected to take 6 months, individual modules are yet to be priortiesed |
| 625 | 22/23 | FPC | IM&T Infrastructure | Reasonable | Tony Raine | Jonny Sammut | High | 4.1 | Switches should be identified within the asset register. | 4.1 | This work was underway prior to the audit but the member of staff is on long term sick. As our switches are configured not to respond to general network sweeps it is a manual task to collate and add this information to the CMDB. | Mar-24 | Not Met | Sep-24 | | | Open | Linked with implementation of House on the Hill ITSM software. Date moved in Q4 to Sept24.<br><br>20/03/2024 - Work completed and list producedand waiting on the implementation of the new service desk software which has been delayed due to contract finalisation and work associated with CAS replacement.<br>Work is now underway with the new system in build and is expected to go-live in Jun-24. |
| 626 | 22/23 | FPC | IM&T Infrastructure | Reasonable | Tony Raine | Jonny Sammut | High | 4.2 | A process for patching of unpatched switches or other network components should be established. | 4.2 | We will look to develop a risk based patching procedure for network switches and devices | Mar-24 | Met | Apr-24 | | | Open | Target date changed in Q4 to April 2024 based on advice from Board Secretary.<br><br>20/03/2024 - Process for assessing and patching switches now in place. Risk assessment carried out on existing estate and replacements switches purchased for priority devices. Propose closure now process is in place. |
| 627 | 22/23 | FPC | IM&T Infrastructure | Reasonable | Tony Raine | Jonny Sammut | High | 4.3 | A mechanism to deal with/isolate equipment that cannot be brought up to the required security specification should be defined. | 4.3 | This will be included in the above patching procedure | Mar-24 | Met | Apr-24 | | | Open | Target date changed in Q4 to April 2024 based on advice from Board Secretary.<br><br>20/03/2024 - Risk assessment carried out on existing estate and replacements switches purchased for priority device not able to be brought up to minimum . Propose closure now process is in place. |
| 628 | 22/23 | FPC | IM&T Infrastructure | Reasonable | Aled Williams | Jonny Sammut | Low | 5.1 | Consideration should be given to how long the switch to the disaster recovery site will take and if automation is a practical option. | 5.1 | There are differing requirements for fail over of Trust systems in DR terms with some also only supporting a manual failover process to the DR site. The Trust infrastructure is being refreshed during 2023-2024 and we will look to areas where it can improve failover where practicable or required | Dec-23 | Not Met | | | | Closed in Quarter | Propose closure as ssytems are all migrated to the new infrastructure and automated DR in place where practicable.<br><br>20/03/2024 - In the new infrastructure the primary and backup sites are the same and can cater for all local system running on the solution.<br>Should the DR site need to be invoked all system have been categorised into 6 recovery profiles which prioritise the order of recovery for these systems . A decision has been made not to automate the lowest priority systems to ensure orderly recovery.<br><br>Target date moved in quarter 3.<br>22/11/23: CAD will always have aspects that need manual intervention with MIS. Trust infrastructure refresh in the process of migrating (Dec-23) which will improve capability for failover. Next to agree failover requirements, during annual review Business Impact Analysis (BIA). CONSIDER REVISED DATE TO JUN-24 DEP ON 111 project solution. |
| 629 | 22/23 | FPC | IM&T Infrastructure | Reasonable | Aled Williams | Jonny Sammut | Medium | 6.1 | A review should be undertaken to ensure that the assessment of the criticality of the services is still valid.<br><br>The backup site capacity should then be reviewed to ensure all the required services can be hosted and what systems have priority and their restoration order. | 6.1 | The Trust server, storage and backup infrastructure is being refreshed during 2023-2024 and we will look to align capacity and to improve failover where practicable and affordable | Mar-24 | Met | | | | Closed in Quarter | Propose closure as all systesm assessed as part of migration activity and systems appropriately classified to RPO/RTO profiles.<br><br>20/03/2024 - In the new infrastructure the primary and backup sites are the same and can cater for all local system running on the solution.<br>All systems have one of four agreed RPO profiles which ensure it he recovery site is up to date. Should the DR site need to be invoked all system have been categorised into 6 recovery profiles which prioritise the order of recovery for these systems. |
| 631 | 22/23 | PCC | Health & Safety | Reasonable | Nicola White | Liam Williams | Medium | 1.1 | Management should ensure that all policies and procedures that relate to health and safety arrangements, are updated as soon as possible. | 1.1 (b) | Policies and Procedures will be updated in line with the Health and Safety Management System (HSMS). The HSMS will be reviewed to articulate the timeframe for the review of arrangements. | Sep-23 | Not Met | Feb-24 | | | Closed in Quarter | 3.4.24 The Health & Safety Management System SBAR was tabled at Senior Quality Team on 20 March 2024 but as meeting was not quorate it was re-submitted to Senior Quality Team on 3 April 2024 and approved. Proposed for closure; prposed closure accepted.<br><br>Target date moved in Q4 to April given the approval route in the Jan 24 update. Evidence of approvals from SOT will close this off<br>Update 30.1.24: The Health and Safety Management System has been formatted into the current document template and the approval routes have been identified i.e., Senior Quality Team (21 Feb 2024 and then 20 March 2024) for approval and then Senior Operational Team (26 March 2024) for noting<br><br>Target date moved in quarter 3<br>11.12.23: Revised target date of February 2024 (previously indicated December 2023) as Health & Safety Management System is not scheduled to be submitted to Senior Leadership Team Meeting until January/February 2024 (no date set as yet). SLT paperwork will be shared as evidence once tabled.<br>Target date moved into quarter<br>28.11.23 Health & Safety Management System reviewed. To be submitted to Quality, Safety & Patient Experience Directorate Meeting, Senior Operations Team Meeting and Senior Leadership Team Meeting once approved by the Assistant Director of Quality Governance. The majority of policies are in date so will be Business as Usual. Possible extension request for December 2023.<br>28.09.2023: Proposed revised date Nov-23. HSMS review highlighted approval route changes that have to be agreed before other procedures can be reviewed and approved.<br>HSMS reviewed and proposed edits being considered. The Health & Safety Policy is expected to be presented at People and Culture Committeeon on 16 November 2023 for ratification. The HSMS review is underway. Expectation of seeking approval at ADLT in November 23. The HSMS requries approval before other procedures can be developed/reviewed and approved. |
| 632 | 22/23 | PCC | Health & Safety | Reasonable | Graham Stockford | Liam Williams | Medium | 1.2 | Once approved, policies and procedures should be circulated to all staff. | 1.2 | Policies and Procedures will be issued via corporate communication platforms. | Mar-24 | Met | | | | Closed in Quarter | Last Updated 140324 (TM)<br>Propose closure of this action. When policies are approved they are communicated in line with the Policy the Development of Policies. Roll out of all policies and procedures will be in line with the HSMS. |

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| 636 | 22/23 | PCC | Health & Safety | Reasonable | Graham Stockford | Liam Williams | High | 3.1 | Monitoring of compliance against health and safety legislation and that corrective action is taken promptly, where applicable, should be undertaken.<br>Areas to consider should include:<br>•Ensuring that risk assessments of the required standard are in place across all Trust sites, are periodically reviewed, and appropriately stored;<br>•Wider circulation of inspection reports and a completed action plan to be shared with all action owners;<br>•Determine the follow up process to ensure that corrective action has been taken;<br>•Provide a clear audit trail of where non-compliance has been identified, recording the action that is proposed along with action owners and target dates; and confirmation when the corrective action has been taken; and<br>•Issue of clear, documented guidance clarifying the roles and responsibilities of those involved. | 3.1 (a) | Develop performance indicators around sharing inspections outcomes within 10 working days. | Dec-23 | Not Met | Jan-24 | | | Closed in Quarter | 3.4.24 The Health and Safety Inspection Key Performance Indicators SBAR was tabled at Senior Quality Team on 20 March 2024 but as meeting was not quorate it was re-submitted to Senior Quality Team on 3 April 2024 and approved. Proposed for closure; prposed closure accepted.<br><br>Last Update 5.3.24: On track. Spreadhseet of all inspections and feedback proforma being prepared. To be submitted to Senior Quality Team on 20 March 2024 for approval<br><br>What will close the action: Creation of Performance Indicators on sharing inspection outcomes<br>What will you provide as evidence for the closure: Performance Indicators<br>Is date reasonable: Request revised date of End of March 2024 due to current workload within team<br><br>Target date moved in quarter 3<br>28.11.23 A centralised document library (excel spreadsheet) identifies review periods required for major legislative Policies and Procedures. It also identifies Trust wide Risk Assessments and review dates. Inspection Reports are sent out to respective Duty Operational Managers, with a meeting scheduled for 28.11.23 to ascertain how to manage actions going forward. The proposal is a Teams channel to notify responsible individuals of the actions from the Audits, which will include action owners and target dates. SOP currently in development. Extension request for January 2024. |
| 637 | 22/23 | PCC | Health & Safety | Reasonable | Graham Stockford | Liam Williams | High | 3.1 | Monitoring of compliance against health and safety legislation and that corrective action is taken promptly, where applicable, should be undertaken.<br>Areas to consider should include:<br>•Ensuring that risk assessments of the required standard are in place across all Trust sites, are periodically reviewed, and appropriately stored;<br>•Wider circulation of inspection reports and a completed action plan to be shared with all action owners;<br>•Determine the follow up process to ensure that corrective action has been taken;<br>•Provide a clear audit trail of where non-compliance has been identified, recording the action that is proposed along with action owners and target dates; and confirmation when the corrective action has been taken; and<br>•Issue of clear, documented guidance clarifying the roles and responsibilities of those involved. | 3.1 (b) | Update the Health and Safety Management System to reflect new design. | Dec-23 | Not Met | Feb-24 | | | Closed in Quarter | 3.4.24 Link to Health and Safety Management System to reflect new design shared 12 March 2024. Health & Safety Management System SBAR approved at Senior Quality Team 3 April 2024. Proposed for closure; prposed closure accepted.<br><br>Target date moved in Q4 to April given the approval route in the Jan 24 update. Evidence of approvals from SOT will close this off<br>Update 30.1.24: The Health and Safety Management System has been formatted into the current document template and the approval routes have been identified i.e., Senior Quality Team (21 Feb 2024 and then 20 March 2024) for approval and then Senior Operational Team (26 March 2024) for noting<br><br>Update 5.3.24: Completed. Propose closure of this action<br><br>What will close the action: Linked to Trust Ref 631<br>What will you provide as evidence for the closure: Link to updated Health and Safety Management System<br>Is date reasonable: Yes<br>Target date moved in quarter 3<br>11.12.23: Process for updating audits needs to be placed into a procedure - Not started. Propose new target date of February 2024 |
| 638 | 22/23 | PCC | Health & Safety | Reasonable | Leanne Smith | Liam Williams | High | 3.1 | Monitoring of compliance against health and safety legislation and that corrective action is taken promptly, where applicable, should be undertaken.<br>Areas to consider should include:<br>•Ensuring that risk assessments of the required standard are in place across all Trust sites, are periodically reviewed, and appropriately stored;<br>•Wider circulation of inspection reports and a completed action plan to be shared with all action owners;<br>•Determine the follow up process to ensure that corrective action has been taken;<br>•Provide a clear audit trail of where non-compliance has been identified, recording the action that is proposed along with action owners and target dates; and confirmation when the corrective action has been taken; and<br>•Issue of clear, documented guidance clarifying the roles and responsibilities of those involved. | 3.1 (c ) | Explore a digital solution to advise relevant managers of their compliance and actions. | Mar-24 | Met | | | | Closed in Quarter | Last Update 140424 (TM) Closed on the basis of the narrative below that a digital solution has been explored and is now with the digital team and will need to undergo prioritisation by them and QSPE<br><br>Update 27.2.24: The Quality, Safety & Patient Experience Directorate have provided funding to procure a contractor Business Analyst to work within the Digital Directorate and principally liaising with the Infection, Prevention & Control Team; and, the Health & Safety Team to develop a clear set of user requirements across the full range of their portfolio (i.e. to document the full range of audit/inspection requirements) and related/necessary technical specification. These user requirements will be transformed into a set of high level technical design requirements and enable the fast track development of an Internal Audit Tool via an in house Development Team.<br><br>What will close the action: Confimation from the Digital Director that this work is being explored and progressed<br>What will you provide as evidence for the closure: Evidence of a clear set of user requirements and technical specification and a commitment from the Director of Digital that the Audi Tool will form part of the wider Digital Directorate Strategy proposition for the business. Leanne Smith to provide an email confirming this<br>Is date reasonable: Yes, in relation to the development of a clear set of user requirements and technical specification |
| 643 | 22/23 | FPC | Savings & Efficiencies | Reasonable | Navin Kalia | Chris Turley | Medium | 1.1 | Guidance should be developed to clearly outline:<br>- Roles and Responsibilities (including assessments, approvals, monitoring and reporting arrangements).<br>- Documentation to be used within the savings process to ensure that key elements are included, e.g. impact, risks, success measures, timescales, etc.<br>- Escalation process to be followed (when, to whom and actions to be taken) where savings are not | 1.1 | Guidance on roles and responsibilities, documentation and escalation to be developed and shared by Financial Sustainability Programme. | Jul-23 | Not Met | Dec-23 | Feb-24 | | Closed in Quarter | 11042024: Updated status to closure proposed, as evidence of receipt of the FSP Delivery Framework taken to STB in January received. Paper, agenda and minutes from the meeting of STB received and reviewed by Corprate Governance (AP).<br><br>Update 22-03-24:<br>Financial Sustainability Programme Delivery Framework presented to STB January 2024 for noting and comment. Document is Live Document and will continue to be updated to reflect 2024/25 objectives. Document outlines roles, responsibilities, and reporting arrangements, as well as scheme updates via workstreams. Scheme Scoping Document developed to capture risks, quality, clinical, and financial risks and included in Appendix. Governance and Escalation clearly defined in Framework. Proposed for closure.<br><br>December 2023 Update: Target date moved in quarter.<br>Update 12.12.23 - Draft Financial Sustainability Programme Delivery Strategy document developed which covers off guidance on roles and responsibilities, documentation and escalation - to be shared with relevant stakeholders over the coming months. Action to be closed off when document presented to STB on 15.1.24. |
| 645 | 22/23 | FPC | Savings & Efficiencies | Reasonable | Jason Collins | Chris Turley | Medium | 2.1 | A formal programme of financial training should be provided to budget holders to allow them to effectively carry out their role. | 2.1 | Key objective for WAST FM Team (and wider Finance teams) for 23/24 will be to undertake a series of Finance Training to Board Members, Budget Holders and other non-financial staff. This will be delivered by several methods such as face to face training, TEAMS sessions and induction. | Dec-23 | Not Met | 24-Mar | Jun-24 | | Open | Target date moved in quarter three and four (to June24).<br>Update 12.12.23 - this has commenced with formal training to board members / TU partners taken place in April 23 and training sessions held with Operational Managers in November 23. Training to budget managers will now be captured in Quarter 4 to include any potential updates to finance system rollouts being undertaken by NHS Wales. In the interim all budget managers have assigned Senior Finance Business Partners who support and informally train on all finance related matters. UPDATE 21.03.24 ... formal training to budget holders is slightly delayed due to the national rollout of the Qlicksense finance tool to all organisation which will incoporate BI dashboards and WAST Finance Team will deliver the formal training alongside training for this new package. Informal support continues as all Budget Holders / Managers are assigned a Senior Finance Business Partner as first line of contact |

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| 646 | 22/23 | FPC | Savings & Efficiencies | Reasonable | Jason Collins | Chris Turley | Medium | 2.2 | Training records should be maintained to confirm attendance, which should be monitored to identify non-attendance so this can be followed up. | 2.1 | Schedule of Training and who has attended to be recorded. | Dec-23 | Not Met | 24-Mar | Jun-24 | | Open | Target date moved in quarter three and four (to June24).<br>Update 12.12.23 - As per audit ref 645, formal training has commenced and a log of attendees has commenced and this will be further updated during quarter 4 roll out of formal training to budget managers. UPDATE 21.03.24 ... as per audit ref 645 ... list has commenced but will be added to when formal training is rolled out to allign with new finance system |
| 647 | 22/23 | FPC | Savings & Efficiencies | Reasonable | Navin Kalia | Chris Turley | Medium | 3.1 (a) | Savings and efficiency plans should be enhanced using SMART criteria to define success and provide realistic timescales. | 3.1 (a) | Will be evidenced by project management principles being applied to every individual savings schemes as it is identified and its ongoing monitoring. | Mar-24 | Met | | | | Closed in Quarter | Update 22-03-24 Continuation of sentences already populated. Example project management techniques applied to schemes such as Admnitrative and Corporate Services Review and Services Review (PIDs attached). Documents provided as evidence in email to Alex Payne. Recommended closure. Proposed closure accepted.<br><br>Financial Sustainability Programme provides a central vehicle for generating, scoping, and monitoring areas of improvement required to achieve financial sustainability by establishing workstreams against realistic targets. Each scheme presented is assessed and scoped from inception to delivery individually. The FSP maintains a forum for scoping and planning. Formal approval for improvement opportunties, in particular those that may have staff impacts, are approved via STB and ELT. |
| 648 | 22/23 | FPC | Savings & Efficiencies | Reasonable | Navin Kalia | Chris Turley | Medium | 3.1 (b) | Noting the expected future financial challenges, there should be prioritisation and recording of recurring funding against one-off savings to assist with financial sustainability. | 3.1 (b) | Impact of Non-recurring schemes in 23/24 will be addressed by FSP and as part of WAST Financial Plan for future financial years. | Mar-24 | Met | | | | Closed in Quarter | Update from Finance: The 2024/25 Financial Savings Plan identified is a balance of recurrent and non-recurrent opportunities and target areas. The organisation tries to emphasise the delivery of more recurrent savings where possible and in such endeavour is pursuing service review & admin efficiencies currently. - Recommmend to close as this is a BAU issue and all savings plans throughout all NHS organisations will always have an element of recurrent and non-recurrent saving schemes. Financial Tracking in place with attached RAG Rating. Forward planning encompass' a 'plan on a page' for each scheme. Performance reported and assured via F&P and STB - Recommmend to close as process is in place. Proposed closure accepted. |
| 649 | 22/23 | FPC | Savings & Efficiencies | Reasonable | Navin Kalia | Chris Turley | Medium | 3.1 (c ) | A log should be implemented to enhance the current process recording changes to the savings programme, during the financial year, from that originally approved. | 3.1 (c ) | Schedule of 23/24 agreed plans and any additions will be controlled through FSP. | Mar-24 | Met | | | | Closed in Quarter | Update from Finance: Financial Tracking in place with attached RAG Rating. Forward planning encompass' a 'plan on a page' for each scheme. Performance reported and assured via F&P and STB. Financial Performance monitored monthly and reported to Welsh Government with full reconciliation of savings schemes applied to financial monitoring.- Recommmend to close as process is in place. Proposed closure accepted. |
| 650 | 22/23 | Quest | Records Management | Reasonable | Jonny Sammut | Jonny Sammut | High | 1.1 | Management should ensure that a full review of current resources, how resource is used and time required to complete all legislative duties is undertaken, to identify gaps and risk areas upon which capacity and resilience can be measured. | 1.1 | Previous time & motion study showed significant variance in the tasks undertaken, and similar pressure is felt across records service community in NHS Wales with increasing complexity. A risk will be captured around legislative duties. Exploration of digital tooling to support better tracking of activity in the RM team is already being taken forward, and the ways of working of the team is under continuous review for improvement. | Dec-23 | Not Met | Jan-24 | May-24 | | Open | 12042024: Revised date of May 2024 (in quarter 4) added following update below.<br>Last Updated 22/03/2024: risk drafted and reviewed by Health Informatics Senior Management Team. To be logged on Datix - this will close the action.<br>Taget date moved in Quarter 4 to May24.<br>Update 18/12/23: Risk register training conducted for team in Dec, to enable creation of this risk. Digital tooling has been explored and is progressing through procurement process. A demo is to be arranged for the team in January-24. Expected risk action to be completed in January-24 (after passing through relevant governance routes within Digital). |
| 652 | 22/23 | Quest | Records Management | Reasonable | Leanne Smith | Jonny Sammut | High | 1.2(b) | The IG reports should include a measure of the complexity of requests. | 1.2(b) | Additional metrics will be included in the IG & InfoSec KPI report, representing complexity of and utilisation in legislative duties. | Jan-24 | Met | | | | Closed in Quarter | Last update 140324 (TM) Board Secretary has seen evidence of complex case reporting in IGSG from January.<br>Update 18/12/23: to help identify and define complex cases, employee requests are now being tracked to understand effort / length of time typically required for such responses. This will inform a metric that can be built into the reporting for Information Governance Steering Group from January-24. Additional work required still to understand how a case which **becomes** complex is logged, e.g. fire & police requests. |
| 653 | 22/23 | Quest | Records Management | Reasonable | Leanne Smith | Jonny Sammut | Medium | 2.1(a) | A record management improvement plan should be developed, based on a formal assessment of records throughout the Trust. | 2.1(a) | Additional fixed-term support will be sought to conduct the assessment and craft an improvement plan.<br>The risk of not developing an improvement plan in 2023-24 will be included in the risk being developed as per action 1.1. | Sep-24 | Not Yet Due | | | | Open | |
| 654 | 22/23 | Quest | Records Management | Reasonable | Judith Birkett | Jonny Sammut | Medium | 2.1(b) | A record management improvement plan should be developed, based on a formal assessment of records throughout the Trust. | 2.1(b) | A Digital Notice re records management will be published on the intranet to increase awareness of individual staff responsibility. | Dec-23 | Not Met | Jan-24 | Apr-24 | | Open | Last Updated 25/03/24: a Records Managment Improvement Plan has been developed, approved by Assistant Director of Digital, and is already being progressed. This will be shared with Information Governance Steering Group for awareness in April 2024. Date changed in Q4 to April24.<br>Target date moved in Quarter 3 to January-24.<br>Update 18/12/23: materials have been developed to help raise awareness of records management. These are being finalised, with a plan to share and put on the Records Siren page with a living FAQ sheet. Plan to release this in January-24. |
| 655 | 22/23 | Quest | Records Management | Reasonable | Judith Birkett | Jonny Sammut | High | 3.1(a) | A formal agreement for storage of records should be developed. This should set out the responsibilities and requirements for management of health records. | 3.1(a) | Additional temporary resource to be sought (from Jan-24) to conduct review of DCC stored boxes and retention schedules. A forecast of storage requirements at DCC will be created to inform a decision on if/when it will be possible to move these records into WAST-managed storage (e.g. at VPH). | Apr-24 | Not Yet Due | | | | Open | |
| 656 | 22/23 | Quest | Records Management | Reasonable | Judith Birkett | Jonny Sammut | High | 3.1(b) | A formal agreement for storage of records should be developed. This should set out the responsibilities and requirements for management of health records. | 3.1(b) | Should [following the review at 3.1a being evaluated] we still need space at Denbigh County Council then we will pursue an agreement with them for those storage, retention and disposal. In the meantime, we will ask for the policies and procedures the Council have in place for their receipt, retention and destruction of records and confirm that this is the way they treat our records. That should provide some assurance on the issues in the matter arising. | Sep-24 | Not Yet Due | | | | Open | |
| 657 | 22/23 | Quest | Records Management | Reasonable | Leanne Smith | Jonny Sammut | Medium | 4.1 | Records should be moved into the new storage area. | 4.1 | RSAM to review suitability of the VPH storage facility and access management arrangements.<br>If appropriate, secure transfer of the records from Pontypool to VPH will require budget approval beyond the funds available for Records Services (to be discussed with Corporate Governance & Finance). | Jan-24 | Not Met | Jun-24 | | | Open | Date changed in Q4 to Junee 2024 in line with update.<br>Last Updated 25/03/24: request for date extension to Jun-24. VPH storage facility still to be assessed for feasibility. |
| 658 | 22/23 | Quest | Records Management | Reasonable | Judith Birkett | Jonny Sammut | Medium | 5.1 | The records management improvement plan noted in MA2 should include a programme of identification and assessment of all records storage areas within the Trust. | 5.1 | The risk of not fully assessing storage areas in 2023-24 will be acknowledged in the risk being developed as per action 1.1. A Trust-wide request will be made to gather intel on what paper records are being stored across the organisation and where. This will inform the improvement plan of how to assure these storage areas. | Sep-24 | Not Yet Due | | | | Open | Last Update 25/03/24: a risk has been developed regarding the overall compliance of records management. Further risks are in development, to capture the specifics of storage areas. |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 659 | 22/23 | Quest | Records Management | Reasonable | Judith Birkett | Jonny Sammut | High | 6.1 | The records management improvement plan noted in MA2 should include an assessment of the disposal of records (both physical and digital) and ensure that records are removed as appropriate. | 6.1 | Agreement that this is needed, but dependency on the assessments of MA2 and MA5, for which additional fixed-term expert support would be required.<br>There is however an individual staff responsibility and asset owner responsibility to ensure records are disposed of correctly, which will be included in the Digital Notice of action 2.1. | Dec-23 | Not Met | Feb-24 | | | Closed in Quarter | Last Updated 25/03/24: The Improvement Plan (action 654) includes an item for records disposal. Additionally, records management training, including a topic on disposal, has been created. This training has already been delivered to locality admin staff in Operations, and will be delivered to other teams, with a recording available on Siren for broader awareness. Propose closure accepted.<br>Target date moved in Quarter 3 to February-24.<br>Update 18/12/23: materials have been developed to help raise awareness of records management. These are being finalised, with a plan to share and out on the Records Management intranet page. Plan to release this in January-24.<br>An Information Asset Owners forum is also planned to be established from February-24. |
| 606 | 22/23 | PCC | Senior Paramedic Role | Reasonable | Greg Lloyd | Andy Swinburn | Medium | 1.1 | Periodic analysis of GRS data should be undertaken to ensure all SPs are adhering to the recommended split of their shifts. | 1.1 | A GRS report will be generated using a randomised sample of the SP group; and this report will be submitted to the SP Steering Group. | Jan-24 | Not Met | May-24 | | | Open | Last Updated 04.04.2024 The report has been requested but has not yet been sent to Greg Lloyd but he should get it for the steering group in April - it will likely have to be a manual report run each time as someone has to break down the shifts for the group. Report to be shared as evidence once available. Revised date proposed to May24. Changed in Q4 to May24. |
| 608 | 22/23 | PCC | Senior Paramedic Role | Reasonable | Greg Lloyd | Andy Swinburn | Medium | 2.1(b) | A review of allocation of Ps and Ts is undertaken to ensure consistency across Wales. | 2.1(b) | A review of options for reducing variances in the size of SP teams will be presented to the quarterly SP Steering Group. | Jan-24 | Not Met | May-24 | | | Open | 170424: Action remaining opent until business received at Steering Group. Date revised in Q4 to May24.<br>Last Updated 04.04.2024 Recommended for closure: the main issue was in one particular area that we have now recruited into so that has reduced the team size, the additional four SPs were allocated according to the average size of the team in each of the operational areas so size variance is now at an acceptable level. This will be monitored in the Steering Group (as per updated below) and action taken again should the levels change in future. |
| 609 | 22/23 | PCC | Senior Paramedic Role | Reasonable | Greg Lloyd | Andy Swinburn | Medium | 2.2 | Arrangements should be put in place for the appropriate escalation of issues with ratios and ensure regular monitoring through an appropriate forum. | 2.2 | Team sizes and ratios will form part of a report into the quarterly SP Steering Group. | Jan-24 | Met | | | | Closed in Quarter | Last Updated 04.04.2024 Recommended for closure: This was an email from Sonia (Operations) but the action is complete as the Steering group now provides a AAA into SOT, the most updated list below.<br><br>Area Team Size now Additional SP<br>BCU 1:33 1:31<br>Powys 1:34 1:27<br>ABUHB 1:35 1:31<br>CTM 1:35 1:31<br>CV 1:29<br>SB 1:23<br>HD 1:32 |
| 611 | 22/23 | PCC | Senior Paramedic Role | Reasonable | Greg Lloyd | Andy Swinburn | Medium | 3.1 | Training status for all SPs should be collated and captured with regular reporting within an appropriate forum to monitor progress. | 3.1 | Updated reports on education progress of the SP cohorts to be brought together into a single progress report. This will be presented through the Clinical Directorate Business meeting and the Senior Operations Team. | Jan-24 | Not Met | May-24 | | | Open | Last updated: 04.04.2024 Report to be pulled together (and shared as evidence for closure) for next steering group. Revised date proposed in Q4 of May24. |
| 612 | 22/23 | PCC | Senior Paramedic Role | Reasonable | Darren Panniers | Andy Swinburn | Medium | 3.2 | A training plan, and expected timeline for the required clinical skill enhancements should be established. | 3.2 | An Extended Skills Working Group has been established to deliver four new areas for skill development during 2024. The first meeting is in November 2023 with two priorities already agreed (sedation for post ROSC patients and the management of ABD). The workplan and draft terms of reference have been shared with Audit for information. These skills will initially be for the SP group only until an assessment and audit is completed for further consideration on safety and efficacy. | Dec-23 | Not Met | May-24 | | | Open | Last Updated 04.04.2024 Steve Magee is leading this group with Huw Jackson, a timeline has yet to be identified and Jen Lloyd will pick this up with the team to implement though work has started with the identified skills. Revised date proposed of May24 in Q4.<br><br>201223 - update received however further queries raised on training plan by Board Secretary |
| 613 | 22/23 | PCC | Senior Paramedic Role | Reasonable | Darren Panniers | Andy Swinburn | Low | 4.1 | The terms of reference should be reviewed to:<br>▪Include a defined pathway for escalation of issues;<br>▪Update membership to ensure representation from each locality; andNov<br>▪Define quoracy. | 4.1 | The SP steering group has changed to a quarterly meeting and the terms of reference are being updated to reflect the audit findings. An Alert/Assure/Advise report will be completed and submitted to the Senior Operations Team | Nov-23 | Not Met | Feb-24 | May-24 | | Open | Last Updated 04.04.2024 Darren Panniers chairs the group and has seen the ToR but they need approval at SOT which we hope to do after the next meeting in April (and shared for evidence). Revised date proposed of May24 in Q4.<br><br>Target date moved in quarter 3.<br>201223 - Meetings to finalise TOR in January |
| 614 | 22/23 | PCC | Senior Paramedic Role | Reasonable | Greg Lloyd | Andy Swinburn | Medium | 5.1 | The Trust should undertake a lessons learned exercise on the development and evolution of the SP role. | 5.1 | A review on the evolution of the role will be completed to highlight any lessons that can be learned for future role development. | Feb-24 | Not Met | May-24 | | | Open | Last Updated 04.04.2024 Not yet commenced. Jen Lloyd to send reminder to Greg Lloyd for discussion at Steering Group. Revised date proposed of May24 in Q4. |
| 615 | 22/23 | PCC | Senior Paramedic Role | Reasonable | Greg Lloyd | Andy Swinburn | Medium | 5.2 | The Trust should report regularly on the impact and effectiveness of the SP role, including analysis of their utilisation across Wales and the achievement of the wider IMTP objective. | 5.2 | A report including number of rideouts undertaken and the outcomes (action plans/issues resolved during the shift/documentation/CPD/NQP portfolio reviews) will be developed into a regular report into the SP Steering Group on a quarterly basis | Jan-24 | Not Met | May-24 | | | Open | Last Updated 04.04.2024 To be done for next Steering Group in April and shared as evidence for closure. Revised date proposed of May24 in Q4. |
| 616 | 22/23 | PCC | Senior Paramedic Role | Reasonable | Greg Lloyd | Andy Swinburn | Medium | 5.3 | Feedback from Paramedics and Technicians should be included as a standing agenda item on the SP Steering Group for consideration / action as appropriate. | 5.3 | Feedback through the Power BI reporting process will be included on the SP Steering Group quarterly meeting. | Jan-24 | Not Met | May-24 | | | Open | Last updated 04.04.2024 To be done for next Steering Group in April and shared as evidence for closure. Revised date proposed of May24 in Q4. |
| 623 | 23/24 | FPC | Estates Condition | Limited | Richard Davies | Chris Turley | Medium | 1.2 | The Trust should advise NWSSP:SES that the "designated person" will be re-allocated to an appropriate Board member in accordance with WHEN 07-02. | 1.2 | Designated named persons will be updated to appropriate board members. | Dec-23 | Not Met | | | | Closed in Quarter | Update 08/03/24 NWSSP -SES were informed of changes to designated persons on the 23/01/24 in line with their timelines to upadte their NHS Wales list. The action can now be closed.<br>Update 181223: Designated person will be updated by end of December. |
| 626 | 23/24 | FPC | Estates Condition | Limited | Richard Davies | Chris Turley | Medium | 3.1 | Management should review and confirm the accuracy of published backlog maintenance data with consultation with NWSSP: Specialist Estates Services. | 3.1 | Agreed, however guidance will need to be sought from NWSSP to ensure accuracy of backlog maintenance for the unique ambulance service estate within NHS Wales. Action will be closed once such guidance is sought. | Mar-24 | Not Met | Apr-24 | | | Open | Date changed in Q4 to April 2024. |
| 627 | 23/24 | FPC | Estates Condition | Limited | Richard Davies | Chris Turley | Medium | 4.1 | The Trust should review the risk categorisation within the EFPMS and engage with NWSSP: SES to ensure consistency in approach when applying risk categories to the estate backlog maintenance figures. | 4.1 | Agreed, however again guidance will need to be sought from NWSSP to ensure risk categorisation within EFPMS is appropriate for the unique ambulance service estate within NHS Wales. Action will be closed once guidance is sought. | Mar-24 | Not Met | Apr-24 | | | Open | Date changed in Q4 to April 2024. |
| 628 | 23/24 | FPC | Estates Condition | Limited | Richard Davies | Chris Turley | Medium | 5.1 | The Trust should engage with NWSSP: SES to ensure that the survey approach is appropriate noting the need for a consistent all-Wales assessment of the estate. | 5.1 | Agreed, noting that the service followed the six-facet approach to ascertain the condition of the estate, engagement is therefore required with NWSSP to further highlight the unique ambulance estate within NHS Wales. Action will be closed once this is done. | Mar-24 | Not Met | Apr-24 | | | Open | Date changed in Q4 to April 2024. |
| 630 | 23/24 | FPC | Estates Condition | Limited | Richard Davies | Chris Turley | Medium | 6.1 | Management should report progress e.g., annually, against backlog maintenance and estate investment targets to an appropriate forum (e.g., Finance and Performance Committee), including funding variances and forecast variances to targets. | 6.1 | Agreed, backlog maintenance will be reported through the Finance & Performance Committee annually in line with the EFPMS submission. | Jun-24 | Not Yet Due | | | | Open | |
| 631 | 23/24 | FPC | Estates Condition | Limited | Richard Davies<br>Joanne Williams<br>Edward Roberts | Chris Turley | High | 7.1 | The Estates Strategy should be updated to provide a funded target solution separately to eliminate "high and significant" and overall backlog maintenance profiled by year. | 7.1 | Agreed, a refreshed Strategic Outline Programme is required upon receiving guidance from NWSSP as detailed within recommendation 4. | Sep-24 | Not Yet Due | | | | Open | |

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| 632 | 23/24 | FPC | Estates Condition | Limited | Richard Davies<br>Susan Woodham<br>Edward Roberts | Chris Turley | Medium | 7.2 | Revisions to the Estates Strategy should include performance indicators linked to reducing High/Significant backlog maintenance, opportunities linked to space utilisation etc. | 7.2 | Agreed, noting that this would form part of managing facilities and through pre planned maintenance contracts to ultimately reduce high and significant backlog maintenance. | Sep-24 | Not Yet Due | | | | Open | |
| 634 | 23/24 | FPC | Estates Condition | Limited | Richard Davies | Chris Turley | Medium | 8.1 | Statutory, "high", and "significant" risk backlog maintenance items that remain unaddressed by investment proposals should be appropriately profiled at the corporate risk register and reported to management for acceptance and approval / implementation of mitigating actions. | 8.1 | As noted at MA 4, additional advice will be taken in respect of "high" and "significant" risk classifications, which may largely remove this issue. Further consideration of any residual reporting through the Corporate Risk Register will then be considered. | Mar-24 | Not Met | Apr-24 | | | Open | Date changed in Q4 to April 2024. |
| 635 | 22/23 | FPC | 111 Commissioning Final Advisory Report | Not Rated | Rachel Marsh | Rachel Marsh | N/A | 1.1 | Noting that roles and responsibilities will have changed since the national NHS 111 Wales service has been implemented, roles and responsibilities should be clearly detailed within the National Collaboration Agreement and signed by both parties (Commissioner and Trust). Opportunities should be provided for partners to reflect on their roles and functions regularly so that the Agreement can be amended to reflect any changes. | 1.1 | A new Joint Commissioning Committee will come into effect from 01/04/24. The Trust wants to wait and see what develops in this space rather than commit time to a document that could cease on the 31/03/24. | Apr-24 | Not Yet Due | | | | Open | |
| 636 | 22/23 | FPC | 111 Commissioning Final Advisory Report | Not Rated | Rachel Marsh | Rachel Marsh | N/A | 1.2 | A copy of the previous signed version of the National Collaboration Agreement should be retained in a central location and monitored to ensure roles and responsibilities are fulfilled. | 1.2 | The previously signed version will apply until the new version is agreed, so the Trust will seek to obtain and retain a copy until recommendation 1.1 is enacted. | Dec-23 | Met | | | | Closed in Quarter | Last Update 140324 (TM) Board Secretary confirms that a copy of the original agreement has not been able to be located. In any event, new commissioning arrangements begin on 1 April 2024. |
| 637 | 22/23 | FPC | 111 Commissioning Final Advisory Report | Not Rated | Rachel Marsh | Rachel Marsh | N/A | 1.3 | The Trust should ensure that it has finalised versions of the terms of reference for forums and groups where it participates within the NHS 111 Wales governance structure. | 1.3 | The responsibility for up-to-date terms of references rests with 111 commissioners, but the Trust will collaborate with commissioners and seek to ensure all relevant terms of reference are updated. The Trust will feedback to commissioners on the National Urgent Primary Care (Out of Hours) Forum and the Joint | Jan-24 | Not Met | | | | Closed in Quarter | Last Update 140324 Board Secretary confirms that new commissioning arrangement start on 1 April 2024 with the Joint Commissioning Committee and revised governance structures. This action is therefore no longer relevant. |
| 638 | 22/23 | FPC | 111 Commissioning Final Advisory Report | Not Rated | Hugh Bennett | Rachel Marsh | N/A | 2.1 | Management should ensure that all operational policies and procedures that relate to NHS 111 Wales service delivery, are updated as soon as possible. | 2.1 | The Clinical Safety Plan and the Fire Evacuation Procedure are currently being reviewed and the other documents are old versions. The reviews will be completed and the old versions of policies removed and replaced. | Feb-24 | Not Yet Due | Jun-24 | | | Open | 170424: New date added in Q4 of June 2024. |
| 639 | 22/23 | FPC | 111 Commissioning Final Advisory Report | Not Rated | Hugh Bennett | Rachel Marsh | N/A | 2.2 | Once approved, policies and procedures should be circulated to all staff. | 2.2 | Updated policies to be placed on Siren and accompanied by Siren communications and more direct staff briefings, where appropriate e.g. fire evacuation procedure. | Feb-24 | Not Yet Due | Jun-24 | | | Open | 170424: New date added in Q4 of June 2024. |
| 640 | 22/23 | FPC | 111 Commissioning Final Advisory Report | Not Rated | Rachel Marsh | Rachel Marsh | N/A | 3.1 | Develop a mechanism to enable post-implementation learning of benefits, lessons learnt and impact to service delivery to be completely captured. | 3.1 | Proceed with the planned "time out" for Executives who interface with the commissioning arrangements, 111 Senior Leadership Team and other Assistant Directors/Heads of Service who support the commissioning arrangements. | Feb-24 | Not Yet Due | Jun-24 | | | Open | 170424: New date added in Q4 of June 2024. |
| 641 | 22/23 | FPC | 111 Commissioning Final Advisory Report | Not Rated | Chris Turley | Rachel Marsh | N/A | 4.1 | Key outcomes from meetings that Trust employees attend on commissioning arrangements should be appropriately recorded and reported to ensure that there is appropriate oversight of key discussions held. | 4.1 | Action notes/minutes for the Finance Group are the responsibility of 111 commissioners. The Trust will discuss with 111 commissioners and seek a formal record of each meeting. | Dec-23 | Met | | | | Closed in Quarter | Last Update 140324 Board Secretary confirms that new commissioning arrangement start on 1 April 2024 with the Joint Commissioning Committee and revised governance structures. This action is therefore no longer relevant. |
| 642 | 22/23 | FPC | 111 Commissioning Final Advisory Report | Not Rated | Rachel Marsh | Rachel Marsh | N/A | 4.2 | Progress with delivering the commissioning framework should be reported within the Trust. | 4.2 | The Trust does report progress on the commissioning framework i.e. commissioning intentions, but recognises that internal reporting is more intermittent. Re-establish regular reporting of the commissioning intentions (every quarter) to the Trust's Strategic Transformation Programme Board. | Jan-24 | Not Met | Jun-24 | | | Open | 170424: New date added in Q4 of June 2024. |
| 643 | 22/23 | FPC | 111 Commissioning Final Advisory Report | Not Rated | Rachel Marsh | Rachel Marsh | N/A | 4.3 | The Trust should obtain written confirmation of the escalation process to be followed within the current governance structure. | 4.3 | A letter will be collaboratively drafted and agreed between the 111 Board Chair and Trust CEO to formalise the informal escalation arrangements that do currently exist. | Jan-24 | Not Met | Jun-24 | | | Open | 170424: New date added in Q4 of June 2024. |
| 644 | 22/23 | FPC | 111 Commissioning Final Advisory Report | Not Rated | Rachel Marsh | Rachel Marsh | N/A | 5.1 | The Trust's Corporate Risk Register should be amended to capture risks relating to the NHS 111 Wales commissioned arrangement or service delivery. | 5.1 | The Trust's Corporate Risk Register commissioning risks to be updated to reflect that 111 is now also a commissioned service. | Jan-24 | Not Met | Jun-24 | | | Open | 170424: New date added in Q4 of June 2024. |
| 645 | 22/23 | FPC | 111 Commissioning Final Advisory Report | Not Rated | Rachel Marsh | Rachel Marsh | N/A | 5.2 | The Gateway to Care Programme Board's risk register should be reviewed and updated to ensure that the risks documented remain current and there are appropriate mitigating controls in place. | 5.2 | Gateway to Care Programme Board's risk register to be reviewed and updated. | Jan-24 | Not Met | Jun-24 | | | Open | 170424: New date added in Q4 of June 2024. |
| 646 | 23/24 | FPC | Strategy Development | Reasonable | Alex Crawford | Rachel Marsh | Medium | 1.1 | A refresh of the Long-Term Strategy shall be considered, clearly outlining the aspects of the long-term strategy that require updating, and specifying the new developments to be included. | 1.1 | Aligned to the continued development of the future clinical service model taking place in Q1 to Q2, a clear recommendation shall be presented to ELT and respective groups outlining the specific requirements (if required) to refresh the Long-Term Strategy document. | Dec-24 | Not Yet Due | | | | Open | |
| 647 | 23/24 | FPC | Strategy Development | Reasonable | Alex Crawford | Rachel Marsh | Medium | 2.1(a) | The Trust should complete the work to revise engagement framework delivery plan and monitor its implementation. | 2.1(a) | Continue work with the Consultation Institute and internal leads to revise and finalise the Engagement Delivery Plan. The revised plan will provide further detail of the key phases of engagement, purpose and approach of the engagement activities with re-profiled timescales for delivery. | Jun-24 | Not Yet Due | | | | Open | |
| 648 | 23/24 | FPC | Strategy Development | Reasonable | Alex Crawford | Rachel Marsh | Medium | 2.1(b) | The Trust should complete the work to revise engagement framework delivery plan and monitor its implementation. | 2.1(b) | Commence implementation of the Engagement Delivery Plan (as per the approach set out and agreed timescales in the revised and approved plan). | Jun-24 | Not Yet Due | | | | Open | |
| 649 | 23/24 | FPC | Strategy Development | Reasonable | Alex Crawford | Rachel Marsh | Medium | 2.1 (c) | The Trust should complete the work to revise engagement framework delivery plan and monitor its implementation. | 2.1 (c) | Build in clear periods of 'pause and reflect' following each phase of engagement to monitor progress and delivery reporting into TSAG / ELT. | Jun-24 | Not Yet Due | | | | Open | |
| 650 | 23/24 | FPC | Strategy Development | Reasonable | Alex Crawford | Rachel Marsh | Medium | 3.1 | The benefits realisation plan should be completed to facilitate monitoring of progress against the achievement of the ambitions set out in the Long-Term Strategy – Delivering Excellence: Vision 2030. | 3.1 | Draft Benefits Realisation Framework underway. To be finalised and approved in Q1/Q2 FY2024/25, in order to facilitate consistent and standardised approach to developing and monitoring of all Trust ambitions, including the Long-Term Strategy – Delivering Excellence: Vision 2030 | Sep-24 | Not Yet Due | | | | Open | |
| 651 | 23/24 | FPC | Strategy Development | Reasonable | Alex Crawford | Rachel Marsh | Medium | 3.2(a) | The Trust should also consider opportunities to enhance reporting to demonstrate that strategic delivery programmes are having the intended impact in terms of outcome achievement. | 3.2(a) | Undertake a review of the internal programme delivery structures to determine the optimal delivery and monitoring structure. | Jun-24 | Not Yet Due | | | | Open | |
| 652 | 23/24 | FPC | Strategy Development | Reasonable | Alex Crawford | Rachel Marsh | Medium | 3.2(b) | The Trust should also consider opportunities to enhance reporting to demonstrate that strategic delivery programmes are having the intended impact in terms of outcome achievement. | 3.2(b) | Implement changes to the programme structures (identified following the initial review). | Sep-24 | Not Yet Due | | | | Open | |
| 653 | 23/24 | FPC | Strategy Development | Reasonable | Alex Crawford | Rachel Marsh | Medium | 3.1 (c) | The Trust should also consider opportunities to enhance reporting to demonstrate that strategic delivery programmes are having the intended impact in terms of outcome achievement. | 3.1 (c) | Aligned to the Benefits Realisation Plan, respective benefits and outcomes to be mapped and regularly monitored as part of the refreshed programme arrangements | Sep-24 | Not Yet Due | | | | Open | |

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| 654 | 23/24 | PCC | Retention of Staff | Reasonable | Liz Rogers | Angela Lewis | Medium | 1.1(a) | The 'Moving on Interview' process should be finalised and approved in accordance with Trust procedure. | 1.1(a) | The structure of the interview will be finalised shortly. | Mar-24 | Met | | | | Closed in Quarter | 12042024: Board Sec satisfied that progress made meets action.<br>20.03.24 LR Good progress has been made on the Moving on Conversation work and the structure of the meetings and process documentation is finalised.<br>There is a requirement to go to Policy Group to remove this from the list of policies as this is a process rather than a policy. The date for the next policy group was scheduled for April but this has been cancelled and we are awaiting a new date for the meeting. Post this meeting the rollout across the organisation can be completed as all the documentation is ready to go.<br>Extension is required purely to accommodate the Policy Group meeting. |
| 655 | 23/24 | PCC | Retention of Staff | Reasonable | Liz Rogers | Angela Lewis | Medium | 1.1(b) | The 'Moving on Interview' process should be finalised and approved in accordance with Trust procedure. | 1.1(b) | The team are still exploring opportunities to generate automatic triggers for managers and staff rather than relying on managers remembering to ask a colleague to complete. | Jun-24 | Not Yet Due | | | | Open | Update March 24 The trigger for an email reminder for managers was to be the exception form. When the exception form is submitted, then this would trigger a reminder email to complete a Moving on Conversation. There is an intermittent fault with the button and not all emails are being generated. However, work on this continues and alongside that,NWSSP have developed a new form which will be implemented which may resolve this problem for us. |
| 656 | 23/24 | PCC | Retention of Staff | Reasonable | Liz Rogers | Angela Lewis | Medium | 1.2 | The Trust should identify and confirm a clear timescale for the roll out of the 'Moving on Interview' process across the organisation. | 1.2 | Dates will be added to the action plan | Mar-24 | Met | | | | Closed in Quarter | Completed. Action Plan including dates provided as evidence. |
| 657 | 23/24 | PCC | Retention of Staff | Reasonable | Liz Rogers | Angela Lewis | Medium | 1.3 | The Trust should look to develop an appropriate training package to assist managers in the use of the new Moving on Interview Process. | 1.3 | Guidance for managers on using the process developed and signed off | Jun-24 | Not Yet Due | | | | Open | Update from Liz Rogers: March 24. Guidance for managers (process document) has been developed. Drop in bite sized sessions will be developed for managers to attend. |
| 658 | 23/24 | PCC | Retention of Staff | Reasonable | Liz Rogers<br>/ Peter Brown | Angela Lewis | Medium | 2.1 | The Trust should undertake, and report to an appropriate forum, an evaluation of the initiatives introduced to determine their impact and effectiveness in retaining staff. | 2.1 | An evaluation report will be developed in association with the 111 senior team.<br>It is noted that not all initiatives are appropriate for other areas of the organisation based on role types, culture differences and different pressures. | Sep-24 | Not Yet Due | | | | Open | |
| 659 | 23/24 | FPC | Vehicle Replacement Programme | Reasonable | Dave Holmes /<br>Andrea Davies | Chris Turley | Medium | 1.1 | Project controls should be reviewed for appropriate compliance with Prince2 principles including:<br>•effective representation of the Supplier, Customer, and Executive roles within the project management structure;<br>•delegated financial tolerances to project managers for stage / annual delivery;<br>•End-stage reports to review project controls, benefits realised, and lessons learnt, etc. | 1.1 | Agreed to be reviewed, noting that the agreed and stated approach is to a pragmatic approach and the application of an overarching Prince2 methodology.<br>The FSDG Terms of Reference and the Project Initiation Document for future projects will be reviewed with particular consideration being given to project controls including allocation of roles and responsibilities and delegated tolerances to provide clarity, with the outcome of the review being documented and any agreed changes implemented.<br>End stage / project reporting will be reviewed and developed in line with project timescales. Further narrative will be developed in the Project Initiation Document for future projects to provide clarity on such reporting.<br>This will all be reviewed through the FSDG, at which point this action will be considered closed. | Jun-24 | Not Yet Due | | | | Open | 27/03/2024: Update from Estates: Project controls will be reviewed including the FSDG Terms of Reference and the Project Initiation Document and Business Case templates. It is proposed that the outcome and recommendations of this review will be reported to the May 2024 FSDG meeting for approval, following which, will then be implemented for future business cases and projects. In readiness for this, the Project Initiation Document and Business Case Templates will be reviewed in April 2024 to identify sections which need reviewing and updating. |
| 660 | 23/24 | FPC | Vehicle Replacement Programme | Reasonable | Edward Roberts /<br>Andrea Davies | Chris Turley | Low | 2.1 | The benefit of additional purchases should be contrasted to the associated costs of retention at business cases. | 2.1 | Agreed. Benefits realisation monitoring will continue as part of project review. Further data and analysis relating to vehicle replacement versus retention will continue to be developed and included as part of this monitoring.<br>Consideration will be given to the relevance of including information on benefits realisation (performance versus targets) in future business cases where appropriate.<br>It should be noted that the agreed vehicle life cycles are identified in the SOP and then drawn down into the annual business cases, and this determines the optimal numbers. In addition, the prioritisation process which had to be undertaken for 2023/24 due to restricted funding took into account the cost of retention versus replacement for the various vehicle types in deciding what vehicles to progress. | Jun-24 | Not Yet Due | | | | Open | 27/03/2024: Update from Estates: A review of benefits realisation monitoring is to be undertaken in April 2024. It is proposed that the outcome and recommendations of this review will be reported to the May 2024 FSDG meeting for approval, following which, will then be implemented for future business cases and projects. |
| 661 | 23/24 | FPC | Vehicle Replacement Programme | Reasonable | Andrea Davies | Chris Turley | Low | 3.1 | The process of agreement of specification by relevant parties should be specified at the Project Initiation Document e.g. as involving parties such as the Vehicle Working Group and the Project Board, and user sign-off of requirements / minimum performance specifications. | 3.1 | Agreed. The process of specification agreement will be further developed and documented, and narrative included in the Project Initiation Document for future projects. A visual process map will also be included. | Jun-24 | Not Yet Due | | | | Open | 27/03/2024: Update from Estates: Documentation will be developed on the process of specification agreement including a process map. Narrative in the Project Initiation Document will be developed accordingly. In readiness for this, the Project Initiation Document and Business Case Templates will be reviewed in April 2024 to identify sections which need reviewing and updating |
| 662 | 23/24 | FPC | Vehicle Replacement Programme | Reasonable | Andrea Davies | Chris Turley | Low | 3.2 | Inspections by technical staff should be formally documented and advised to the Senior Supplier, User, and commissioning leads as part of the quality acceptance process. | 3.2 | Agreed. The inspection and quality acceptance process will be developed and documented and ratified by the FSDG. | Jun-24 | Not Yet Due | | | | Open | 27/03/2024: Update from Estates: Documentation will be developed on the quality acceptance process and will be submitted to the May 2024 FSDG meeting for approval. |
| 663 | 23/24 | FPC | Vehicle Replacement Programme | Reasonable | David Holmes /<br>Andrea Davies | Chris Turley | Medium | 4.1 | The various aspects of the procurement strategy include: (a)enhanced narrative within the business case; & (b)evaluation and approval by appropriate parties to confirm that it remains optimal (as detailed within the business case for approval) e.g. to affirm that it best aligns | 4.1 | Agreed. The current narrative describing the procurement strategy will be further detailed within future business cases to better facilitate evaluation of the procurement strategy. | Dec-24 | Not Yet Due | | | | Open | 27/03/2024: Update from Estates: Narrative on describing the procurement strategy will be developed for inclusion in future business cases. It is proposed that this will be submitted to the June 2024 FSDG meeting for review and approval. In the meantime, the business case template will be reviewed in April 2024 to highlight areas which will need updating. |
| 664 | 23/24 | FPC | Vehicle Replacement Programme | Reasonable | Andrea Davies | Chris Turley | Medium | 4.2 | Allocated duties for dialogue and negotiation on the costs and price of the specification should be delineated between procurement and project officers at the Project Initiation Document. | 4.2 | Agreed. Narrative on roles and responsibilities relating to procurement dialogue and negotiation will be developed and included in the Project Initiation Document for future projects. | Jun-24 | Not Yet Due | | | | Open | Update from Estates: Narrative on the roles and responsibilities relating to procurement negotiation will be developed and included in future Project Initiation Documents. It is proposed that this will be submitted to the May 2024 FSDG meeting for approval. In the meatime, in April 2024 the Project Intiation Docment will be reviewed to highlight areas which need updating. |
| 665 | 23/24 | FPC | Vehicle Replacement Programme | Reasonable | Trish Mills | Chris Turley | High | 5.1 | Contracts should be discretely authorised in accordance with Standing Orders. | 5.1 | Agreed. Noting that the current approach is across the Trust and not specific to fleet procurement, the Trust's Standing Orders and Standing Financial Instructions have been reviewed with regards to contract award approvals and delegated authority. As a result, a proposal to add an additional mechanism to ensure discrete Trust Board contract approval together with an amendment to the narrative relating to delegated authority for purchase order approvals will be presented to the March 2024 Audit Committee and Trust Board meetings for consideration and approval and for subsequent implementation. Such proposals will mitigate this recommendation. | Apr-24 | Not Yet Due | | | | Open | 27/03/2024: Update by Estates: The suggested amendments will now be presented at the Audit Committee meeting on 30th April 2024 and the action will be closed once approved at that meeting, noting that the amended Standing Orders and Standing Financial Instructions will be adhered to as appropriate in the future. Can be closed once the revised SO are received for approval. |
| 666 | 23/24 | FPC | Vehicle Replacement Programme | Reasonable | Edward Roberts /<br>David Holmes | Chris Turley | Medium | 5.2 | Pre-tender Estimates and variance commentary should be utilised to inform tender evaluations. | 5.2 | Agreed - Pre-tender estimates and variance commentary will be utilised for future tender evaluations. | Future BJC compilation. | Met | | | | Closed in Quarter | Last Update 140324 (TM) Propose as closed as this is business as usual and will only arise at the next fleet replacement BJC going to FPC/Board. Propose that a note is placed in the FPC cycle of business to prompt a reminder for EDOF to ensure pre-tender estimates and variance commentary is in the BJC for the tneder evaluation. |

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| 667 | 23/24 | FPC | Vehicle Replacement Programme | Reasonable | David Holmes | Chris Turley | Medium | 6.1 | Business Justification Cases should show investment to date (planned and approved) against plans of the Strategic Outline Programme, including variance commentary (for both vehicle numbers and values). | 6.1 | Agreed. A review of the existing data and narrative contained in previous business cases relating to SOP proposals will be further undertaken and consideration will be given to providing further information in future business cases as appropriate. | Future BJC compilation. | Met | | | | Closed in Quarter | Last Update 140324 (TM) Propose as closed as this is business as usual and will only arise at the next fleet replacement BJC going to FPC/Board. Propose that a note is placed in the FPC cycle of business to prompt a reminder for EDOF to ensure pre-tender estimates and variance commentary is in the BJC for the tneder evaluation. |
| 668 | 23/24 | Quest | Serious Adverse Incidents - Joint Investigation Framework | Reasonable | Wendy Herbert | Liam Williams | Medium | 1.1 | The Trust's 'Adverse Incident and Reporting Policy' should be reviewed and updated to reflect the requirements set out within the NHS Wales policy. | 1.1 | The Putting Things Right Team plan was to review relevant policies following the release of the new Putting Things Right Regulations by Welsh Government in May 2024. A recent update from Welsh Government has confirmed that the release will now be Autumn 2024. At which point the review will be undertaken. The Trust has approved policies in respect of incident reporting and management and a Putting Things Right Policy which are included on the intranet site (review dates are both April 2026). Staff also have access to User Guides on the intranet site for Datix Cymru.<br><br>The All-Wales Patient Safety Policy (NHS Executive) (May 2023) is also due review in March 2024 and will be updated internally when released nationally | Nov 24<br><br>On release from NHS Wales Exec | Not Yet Due | | | | Open | Update:<br>What will close the action: Updated version of the Putting Things Right Policy (following release of the new Putting Things Right Regulations in Autumn 2024) and adoption of the updated National Patient Safety Incident Reporting and Management Policy (adopted by WAST in June 2023 and review is due by the NHS Wales Executive by March 2023 (awaited).<br>What will you provide as evidence for the closure: Copies of both approved policies on the Intranet.<br>Is date reasonable: Dependant on release date of Putting Things Right Regulations by Welsh Government and updated National Patient Safety Incident Reporting and Management Policy by the NHS Wales Executive. |
| 669 | 23/24 | Quest | Serious Adverse Incidents - Joint Investigation Framework | Reasonable | Julie Boalch | Trish Mills | Medium | 1.2 | To allow accessibility for all members of staff, the NHS Wales policy should be made available on the Trust's intranet site. | 1.2 | To be included on the Intranet site. | Feb-24 | Met | | | | Closed in Quarter | 11042024: This Policy is now available on the Trust's Siren page (saved in this section of the Policy - National Policy on Patient Safety Incident Reporting). Julie Boalch confirmed that this action be closed and status updated to 'closure proposed'. |
| 670 | 23/24 | Quest | Serious Adverse Incidents - Joint Investigation Framework | Reasonable | Stephen Johnson | Liam Williams | Low | 2.1 | To address the requirements of steps 1 and 2 of the Joint Investigation Process, where there is a delay to raising and reviewing an incident on Datix Cymru, appropriate narrative should be included within to support this to ensure a full audit trail is captured. | 2.1 | Patient Safety Team to update the narrative on Datix Cymru as part of business as usual processes. | Mar-24 | Met | | | | Closed in Quarter | 3.4.24 The Patient Safety Team implemented this action during the audit phase and have evidence on datix to demonstrate they are updating accordingly. Proposed for closure; closure proposed accepted.<br>Target date moved in Q4 to June (end of Q1) to provide for spot checks to be completed as per below.<br>Update 5.3.24: Awareness raised and implemented as business as usual with immediate effect.<br><br>What will close the action: Implementation of updates as business as usual.<br>What will you provide as evidence for the closure: Monthly spot checks (commencing March 2024) to be undertaken.<br>Is date reasonable: Yes. Implementation commenced February 2024 (following release of Audit Report). Evidence of spot checks will be due Quarter 1. |
| 671 | 23/24 | Quest | Serious Adverse Incidents - Joint Investigation Framework | Reasonable | Stephen Johnson | Liam Williams | Low | 2.2 | To address the requirements of step 5 of the Joint Investigation Process, a periodic review of actions not completed within the action log should be undertaken to ensure that records are up to date. | 2.2 | Patient Safety Team to undertake a monthly review of the action log. | Apr-24 | Not Yet Due | | | | Open | What will close the action: Monthly review of Serious Case Incident Forum Log to identify any gaps<br>What will you provide as evidence for the closure: Serious Case Incident Forum Log (completed)<br>Is date reasonable: Yes |
| 672 | 23/24 | Quest | Serious Adverse Incidents - Joint Investigation Framework | Reasonable | Stephen Johnson | Liam Williams | Low | 3.1 | To facilitate completeness of reporting, consideration should be given to the enhancement of the SCIF/JIF data included at the Putting Things Right report. | 3.1 | The Putting Things Right Report will include additional process measures in respect of the Joint Investigation Framework within the Quarter 4 Report (January – March 2023/24) | Apr-24 | Not Yet Due | | | | Open | What will close the action: Inclusion of additional process measures in respect of the Joint Investigation Framework within the Quarter 4 Putting Things Right Report (January - March 2023/24)<br>What will you provide as evidence for the closure: Putting Things Right Quarterly Report, Quarter 4 2023/24 for the Clinical Quality Governance Group on 30 April 2024.<br>Is date reasonable: Yes |
| 673 | 23/24 | Quest | Serious Adverse Incidents - Joint Investigation Framework | Reasonable | Lucie Jones | Liam Williams | Low | 4.1(a) | The Trust should consider the opportunity to consolidate key issues and areas of learning and disseminate Trust-wide to minimise reoccurrence. | 4.1(a) | The Trust has been engaged in the All Wales Enhancing Learning Programme since September 2023 and this includes the roll out of an all-Wales framework for learning from events (including but not limited to incidents). This programme includes membership from all health boards, trusts and health bodies and considers internal and wider system learning. | Mar-24 | Not Met | | | | Closed in Quarter | 3.4.24 Approval and adoption of Framework was received at Clinical & Quality Governance Group on 25 March 2024. Proposed for closure. Evidence provided: closure proposed accepted.<br>Copy of All Wales Enhanced Learning Programme Plan (Attached)<br>Executive Summary including All Wales Framework from Learning from Events Framework which was tabled at Clinical & Quality Governance Group on 25 March 2024 - attached SBAR and Annexes; Agenda & AAA<br>There was a request from Liam for this to go directly into Clinical and Quality Governance Group for adoption by the Welsh Ambulance Servies NHS Trust (the Executive Summary details this).<br>To provide further assurance, the Welsh Risk Pool Committee met in March 2024 and Jonathan Webb will be writing to all Chief Executives to advise that the next steps will be an Implementation Plan which will be Nationally driven.<br><br>Target date moved in Q4 to April as per narrative below<br>Update 5.3.24: This National programme doesn't complete until 31.3.2024. Next steps are to be determined by the Welsh Risk Pool Committee at the March meeting in respect of resourcing a further stage of the programme.<br><br>What will close the action: Welsh Ambulance Services NHS Trust (WAST) version of the All Wales Learning from Events Framework (this is drafted but will not go through Group/Committee until the end of the programme as next steps need to be included from a national perspective at the end of March 2024).<br>What will you provide as evidence for the closure: WAST document (which will then require implementation and monitoring). Template version and evidence of WAST involvement provided for current assurance purposes.<br>Is date reasonable: Yes |
| 674 | 23/24 | Quest | Serious Adverse Incidents - Joint Investigation Framework | Reasonable | Stephen Johnson | Liam Williams | Low | 4.1(b) | The Trust should consider the opportunity to consolidate key issues and areas of learning and disseminate Trust-wide to minimise reoccurrence. | 4.1(b) | The capability to extract themes and trends from the SCIF log has already been set up by the new PTR Coordinator. This data and information will inform the PTR Quarterly Report. | Jun-24 | Met | | | | Closed in Quarter | 3.4.24 This information is already included in the Quartlery Putting Things Right Report for the Quality, Patient Experience & Safety Committee on 8 February 224. Proposed for closure; closure proposed accepted.<br><br>What will close the action: Consolidation of key issues and areas of learning into the Putting Things Right Quarterly Report<br>What will you provide as evidence for the closure: Copy of Putting Things Right Quartlery Report; Link to communications disseminating Trust wide<br>Is date reasonable: Yes - already included in submissoin for 8 February 2024 Quality, Patient Experience & Safety Commitee |

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| 675 | 23/24 | FPC | Decarbonisation | Limited | Lucinda Wassall / Joanne Williams | Chris Turley | Medium | 1.1 | The named membership in the terms of reference should be reviewed again to ensure reasonable and appropriate representation at the Decarbonisation Programme Board. | 1.1 | Noted. The membership will be further reviewed to ensure that quoracy levels outlined within the Terms of Reference are achieved. All teams will be asked to reconfirm their representatives.<br>It is however noted that the attendance is actually good in comparison to other project and programme board meetings, with it never necessarily being expected that all those invited to attend will do so at all meetings, and no issues have arisen in terms of the ability of the PB to discharge its duties due to any attendance issues.<br>This action will be considered closed once the team is assured that meetings have been, and continue to be, quorate and the updated attendance list has been ratified at the Programme Board. | Apr-24 | Not Yet Due | | | | Open | 26.03.24 - This will be considered by the Decarbonisation Programme Board at the end of April and closed at this point. |
| 676 | 23/24 | FPC | Decarbonisation | Limited | Joanne Williams | Chris Turley | High | 2.1 | Challenges and risks to the achievement of the objectives within the Trust's Decarbonisation Action Plan, along with any mitigating factors, should continue to be monitored with regular updates provided via the established governance routes through to Trust Board. | 2.1 | The DAP and Risk Register will continue to feature as standard agenda items on every Decarbonisation Programme Board.<br>Regular reporting will continue to Capital Management Board, Finance and Performance Committee and Trust Board as per the agreements set out. This action is considered closed, as it forms part of BAU practice | N/A | Met | | | | Closed in Quarter | 140324 (TM ) Closed as per action narrative. |
| 677 | 23/24 | FPC | Decarbonisation | Limited | actioned since fieldwork | Chris Turley | Medium | 3.1 | The 'Date Closed / Next Update Due' should be completed for each risk. | 3.1 | The date closed and next update due will be completed for each risk. This action has now been completed, and this is considered closed. The risk register will be reviewed on a regular basis, and any relevant new risks added as appropriate | N/A | Met | | | | Closed in Quarter | 26.03.24 - evidence provided to Alex Payne to close this action by Jo Williams on 26.03.24.<br>140324 (TM ) Closed as per action narrative. |
| 678 | 23/24 | FPC | Decarbonisation | Limited | Lucinda Wassall | Chris Turley | Medium | 3.2 | Noting the recent requirement to include medical gases within the Trust's carbon emissions, the associated risk should be reflected appropriately | 3.2 | Risk 8 on the current risk register outlines the risk of not being able to compare current emissions to baseline. The item will be updated to reflect the risk of WG further changing the scope of reporting, but will not specifically reference medical gases as this is just one specific example of the risk materialising. | Apr-24 | Not Yet Due | | | | Open | 26.03.24 - Risk register to be updated for Decarbonisation Progtramme Board in April and cklosed at this point |
| 679 | 23/24 | FPC | Decarbonisation | Limited | Joanne Williams / Richard Davies | Chris Turley | Medium | 3.3 | The development of risk 542: Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Plan should be finalised to ensure the Trust's Corporate Risk Register is appropriately reflective of prevalent risks. | 3.3 | Risk 542 will be finalised for inclusion within the Corporate Risk Register | Apr-24 | Not Yet Due | | | | Open | 26.03.24 - CRR has been updated and will go to ADLT on 8th April, ELT on 24th April and Trust Board on 30th May. |
| 680 | 23/24 | FPC | Decarbonisation | Limited | Edward Roberts Joanne Williams | Chris Turley | High | 4.1 | The Trust should develop a long-term financial model for the financial support required to support the decarbonisation programme to provide assurance to the Board regarding achievement of the Welsh Government targets. A clear timeline should be determined for undertaking this exercise, with progress monitored at a relevant forum. | 4.1 | The value of such an overarching exercise at this stage, compared to that previously undertaken and the resource required to do so needs to be considered, and as opposed to the way the Trust has looked to approach this to date. It also needs to be noted that part of the ongoing process to do so is also linked to any initial response from WG to that previously provided and the now confirmed upcoming and updated overall NHS Wales capital prioritisation work that will be progressed through 2024. Again it is not considered good value of resource to further progress anything here until this has now been completed and reported back to us.<br>In the meantime a number of other significant areas of progress continue in relation to this, including the detailed costings undertaken to ensure significant (and greater than could have been expected) funding in relation to EFAB schemes through 2023/24 and 2024/25, along with the detailed decarbonisation impacts being front and centre of all new proposed and planned developments. The cost implications of this and the impact this may have affordability of schemes, either locally through the Trust's discretionary capital funding or nationally via AWCP needs to however also not be underestimated and a balance will always need to be struck in this regard with other competing factors such as operational requirements, staff welfare and safety, etc.<br>Recent Fleet BJCs have also included cost estimates to support, where possible and currently commercially and practically available, the electrification of the Trust's fleet, and the required supporting infrastructure.<br>Examples of where other aspects of this can be further enhanced include the estate retrofit guide, which will be used as a framework to assess the impact and potential cost of estate requirements on a priority basis. This is also linked to any planned further refreshes in the overall Estates Strategy (SOP), high level information will also be used (where available) to determine | Mar-25 | Not Yet Due | | | | Open | 26.03.24 - Not yet due. |
| 681 | 23/24 | Quest | Electronic Patient Clinical Records: Clinical Compliance (ePCR) | Reasonable | Duncan Robertson | Andy Swinburn | Medium | 1.1 | To confirm accuracy of the self-certification compliance rate, management should consider capturing the method of training delivery on ESR. | 1.1 | For future training, the method of instruction will be captured as part of the ESR sign-off process (for example, classroom based, individual learning using the training materials, one to one instruction using the training zone in the application). | Jun-24 | Not Yet Due | | | | Open | Last updated 04.04.2024 Work has yet to be commence due to meeting cycles. Will be an agenda item at the ePCR Clinical Reference Group on the 28th March (agenda to be competed on the 21st March 2024). |
| 682 | 23/24 | Quest | Electronic Patient Clinical Records: Clinical Compliance (ePCR) | Reasonable | Duncan Robertson | Andy Swinburn | Medium | 1.2 | Management should obtain feedback from staff to improve the training materials. | 1.2 | We will design a survey via the ePCR CLinical Reference Group (CRG) for ePCR users to explore the reasons for this and how training materials might be improved to enhance ePCR completion. | Jun-24 | Not Yet Due | | | | Open | Last updated 04.04.2024 Work has yet to be commence due to meeting cycles. Will be an agenda item at the ePCR Clinical Reference Group on the 28th March (agenda to be competed on the 21st March 2024). |
| 683 | 23/24 | Quest | Electronic Patient Clinical Records: Clinical Compliance (ePCR) | Reasonable | Duncan Robertson | Andy Swinburn | Medium | 1.3 | Management should consider including a test in ESR to confirm competency before successfully self-certifying. | 1.3 | At the ePCR CRG WAST will discuss including a test to assess understanding at the completion of training. | Jun-24 | Not Yet Due | | | | Open | Last updated 04.04.2024 Work has yet to be commence due to meeting cycles. Will be an agenda item at the ePCR Clinical Reference Group on the 28th March (agenda to be competed on the 21st March 2024). |
| 684 | 23/24 | Quest | Electronic Patient Clinical Records: Clinical Compliance (ePCR) | Reasonable | Duncan Robertson | Andy Swinburn | Medium | 1.4 | Whilst we acknowledge there are different methods of training delivery, management should review lower viewed training modules, to confirm that the completed ePCRs are compliant with expectations in this area. | 1.4 | Through the ePCR Clinical Reference Group (CRG) we will review the lower viewed modules as set out in Appendix B of this report. This will build on knowledge discussed at the most recent ePCR CRG where a small audit has identified that the obstetric section is not being completed.<br>However, we currently have only opened access to the Welsh GP | Sep-24 | Not Yet Due | | | | Open | Last updated 04.04.2024 Work has yet to be commence due to meeting cycles. Will be an agenda item at the ePCR Clinical Reference Group on the 28th March (agenda to be competed on the 21st March 2024). |
| 685 | 23/24 | Quest | Electronic Patient Clinical Records: Clinical Compliance (ePCR) | Reasonable | Duncan Robertson | Andy Swinburn | High | 2.1 | The Trust, with continued support from Terrafix, should address the limitations and caveats relating to the dashboard reports to ensure that they provide robust information on all incidents. | 2.1 | We will review the compliance dashboards and amend the nomenclature used and recommend changes to the presentation of the data to ensure consistency and understanding. However, this is dependent on the capacity of Health Informatics to complete the work. | Sep-24 | Not Yet Due | | | | Open | Last updated 04.04.2024 Work has yet to be commence due to meeting cycles. Will be an agenda item at the ePCR Clinical Reference Group on the 28th March (agenda to be competed on the 21st March 2024). |
| 686 | 23/24 | Quest | Electronic Patient Clinical Records: Clinical Compliance (ePCR) | Reasonable | Duncan Robertson / "nominated Digital Directorate Lead" - not yet in place, TBC | Andy Swinburn | High | 2.2 | Management should ensure the tenant structure is developed to provide data at both a team and individual level to assist in identifying training needs and drive improvement in ePCR compliance. | 2.2 | Reporting into CIAG, we will set up a Task and Finish Group to write the plan to deliver the dashboards against the Tenant Structure.<br>This is a complex piece and requires input from multiple directorates. It is also dependent on the capacity within teams to deliver the dashboards, therefore the output of the T&F might be | Sep-24 | Not Yet Due | | | | Open | Last updated 04.04.2024 Work has yet to be commence due to meeting cycles. Will be an agenda item at the ePCR Clinical Reference Group on the 28th March (agenda to be competed on the 21st March 2024). |

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| 687 | 23/24 | Quest | Electronic Patient Clinical Records: Clinical Compliance (ePCR) | Reasonable | Duncan Robertson | Andy Swinburn | High | 2.3 | The Trust should continue with its programme of Clinical Data Assurance audits to inform further upgrades required to the system to improve data quality and the accuracy of care bundle compliance reporting. | 2.3 | Clinical Audit Programme for 2024/25 has been agreed at CIAG and presented for approval to the February 2024 QuEST meeting. This is ongoing work and does not require a specific action as it is central business for the CIAT. | N/A | Met | | | | Closed in Quarter | 140324 (TM ) Closed as per action narrative |
| 688 | 23/24 | FPC | ICT Contract Management | Reasonable | Robert Walker | Jonny Sammut | Low | 1.1 | To embed the SOP into the organisation by raising awareness and providing training / workshops to relevant staff within Digital Services to provide a consistent approach to the contract management process. | 1.1 | An official notice was published on the Trust intranet on the 31st Jan 2024 to raise awareness and the SOP has been made available to access on the Trust intranet. A training / workshop schedule will be devised and delivered across Digital Services. | Jun-24 | Not Yet Due | | | | Open | |
| 689 | 23/24 | FPC | ICT Contract Management | Reasonable | Robert Walker | Jonny Sammut | Medium | 2.1 | The contract register should be developed to include all ICT related contracts and main suppliers. | 2.1 | Whilst a single register which captures all Digital/ICT related commercial spend across the organisation would be constructive it would however be disproportionate to the time and effort required to maintain and the level of material value that information would provide over and above existing purchasing information which can be generated from the Oracle financial system.<br><br>Where the requirement entails a recurring spend and an ongoing deliver of Digital/ICT services to the organisation over a set period (such as the supply of a software system) the register will be developed to provide 'a single source of truth' of the associated Digital/ICT commercial expenditure. | Oct-24 | Not Yet Due | | | | Open | |
| 690 | 23/24 | FPC | ICT Contract Management | Reasonable | Robert Walker | Jonny Sammut | Medium | 3.1 | Contract and supplier performance meetings should be subject to formal recording, wither using minutes or action notes. | 3.1 | Where a contract / supplier performance meeting is held the respective action notes are to be recorded formally. | Mar-25 | Not Yet Due | | | | Open | |
| 691 | 23/24 | FPC | ICT Contract Management | Reasonable | Robert Walker | Jonny Sammut | Medium | 3.2 | ICT contract management process should be applied to all ICT related contracts, with the ICT Contract Manager feeding into any management meetings within other areas. | 3.2 | The Contract Management [SOP] process is to be applied to all contracts listed in the contracts register. | Mar-25 | Not Yet Due | | | | Open | |
| 692 | 23/24 | FPC | ICT Contract Management | Reasonable | Robert Walker | Jonny Sammut | Medium | n/a | *This action supplements 3.1 and 3.2.* | n/a | Each contract listed in the contract register is to be classified as requiring either a Low, Medium or High level of contract management to be applied. Supplier / Contract meetings are only required to be held for those contracts classified with a Medium or High level of contract management to be applied. | Jun-24 | Not Yet Due | | | | Open | |
| 693 | 23/24 | FPC | ICT Contract Management | Reasonable | Robert Walker | Jonny Sammut | Medium | 4.1 | Action notes related to contact assessment should be recorded from the ICT SMT meetings. | 4.1 | The ICT SMT Decision Log will be utilised to record actions to be taken. | Mar-24 | Met | | | | Closed in Quarter | Propose closure as process now in place and will be a reported monthly at ICT SMT. Propose closure accepted.<br><br>20/03/2023 - Contract renewals discussed at ICT SMT 08/03/2024, some renewal activity agreed and recorded . Will be a rolling update every month at ICT SMT |
| 694 | 23/24 | FPC | ICT Contract Management | Reasonable | Robert Walker | Jonny Sammut | Medium | 4.2 | Details of end of term review and assessment should be captured on the contracts register. | 4.2 | The contracts register will be updated to capture associated commercial notes / actions taken with a contract as part of the end of term review. | Jun-24 | Not Yet Due | | | | Open | |

## Points of Contact, Directors and Owners of Audit Actions - Do Not Amend Any Column With a Red Header

## When proposing a revised 1st, 2nd or 3rd date, include the rationale for the movement and any progress on the action to date

| Trust Ref No. | Audit Wales or HIW Report | Year | Committee Assigned to | Report Title | Responsible Officer | Director | Priority Level | Rec. No. in Audit | Recommendation | Response no. in Audit | Management Response | Agreed Deadline in Report | Status | 1st revised date | 2nd revised date | 3rd revised date | Where a management action has not met the agreed or revised date, Director must inlcude here:<br>1. Date (of your update)<br>2. Proposed revised date<br>3. Reasons why action is overdue and<br>4. Progress made if not yet complete.<br>**Please add most recent update first** | Closure Status |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 106 | Audit Wales | 22/23 | QUEST | Review of Quality Governance Arrangments | Jonathan Turnbull-Ross/ Wendy Herbert/ Hugh Bennett | Liam Williams | | | R8 We found that the QuESt Committee is well served with quality information, but there are opportunities for improvement. The Trust should:<br>develop a system to triangulate learning themes across its quality assurance reports. This should ensure clarity about what improvement actions have been taken as a result and how learning has been disseminated across the organisation.<br>enhance Covid-19 reporting in the integrated quality and performance report by including information about the harm caused to patients by ongoing service pressures caused by the virus.<br>(d) work with health bodies so that there are systems to determine the outcomes for patients who have received emergency ambulance<br>services. This should particularly seek to understand the consequence and harm resulting from service failures such as long ambulance waits.<br>develop patient outcome measures to support its existing quality measures. | | d) The Trust will continue to share information and intelligence with partners that detail the consequences of system failures. Whilst particularly evident where experience or outcome is poor and results in complaint or adverse incident. The Trust will pursue patient outcome data through development of the ePCR over 2022/23. | Mar-23 | Not Met | Dec-23 | Mar-24 | Jul-24 | 250424: Date changed in Q4 to July 2024 in Inie with AW timelines for conclusion of related follow up audit.<br>15042024: This will remain open until AW confirm as part of the current quality governance audit that it can close. Daet will change in quarter (from March 2024 to new date).<br>Update 14032024 from Duncan Robertson: The Health Informatics team are currently working with DHCW to enable a flow of data relating to out of hospital cardiac arrest. This it to test the systems and processes. When complete, this learning will be applied to other presentations for analysis.<br>TM will engage with Audit Wales on a potential revised approach for this action.<br><br>201223: Given the comment below Board Secretary suggests a 'check in' date of 31 March 2024. Audit Wales will be doing a further review at that time and may wish to reframe this recommendation.<br>11.12.23 Update from Duncan Robertson: The WAST and DHCW data-sharing agreement is with the ICO and Welsh Government as part of a consultation. This will provide the legal basis to share data. No completion date has been provided, therefore the December target date will not be met. It is completely outside of WASTs gift to propose a completion date<br><br>The Putting Things Right Team are strengthening the Putting Things Right Quarterly Reports to include themes, patterns and trends.<br>REVISED DATE OF DECEMBER 2023<br>21.11.23:<br>Update 121023: Work Ongoing and will take a period to complete. Conversations continue with DHCW and the Ambulance Data Set (ADS) lead in England to define the ePCR definitions. Work is also continuing with DHCW to establish data sharing to enable joining up of patient records to report on outcome data. no timeline as yet and meeting with DHCW continue to clarify some of the definitions following discussions with the lead for the ADS in England. Trust Information Governance colleagues are working with DHCW for this.<br>26.09.23: Duty of Quality Implementation plan includes the four quadrants of quality management system as set out in the 'road map'. Quality & Performance Management Steering Group continue to monitor and review the development of 'always on' reporting in line with the requirements of the act. Additional metrics have been approved by Trust Board for inclusion in the MIQPR including PREMS/PROMS, Duty of Candour metrics. New HI post now appointed to support MIQPR move to Power BI dashboard. Proposed Revised date 31.12.23 rationale for extension is to allow BI Dashboard work to commence to allow analysts to identify how best to report 'Patient Reported Experience' measures that add value to decision making.<br>Historic Update: We continue to work with Welsh Government colleagues and NHS Executive in the development of the 'all-Wales' Quality Management System, including how the QMS will 'join up' and detail the impact of ambulance performance on HBs/patient care. The Trust PECI Team have also continued to develop the Civiva patient experience software, alongside HBs, to enable analysis of patient experiences of services. | Open |
| 106 | Audit Wales | 22/23 | QUEST | Review of Quality Governance Arrangments | Jonathan Turnbull-Ross/ Wendy Herbert/ Hugh Bennett | Liam Williams | | | R8 We found that the QuESt Committee is well served with quality information, but there are opportunities for improvement. The Trust should: develop a system to triangulate learning themes across its quality assurance reports. This should ensure clarity about what improvement actions have been taken as a result and how learning has been disseminated across the organisation. enhance Covid-19 reporting in the integrated quality and performance report by including information about the harm caused to patients by ongoing service pressures caused by the virus. work with health bodies so that there are systems to determine the outcomes for patients who have received emergency ambulance<br>services. This should particularly seek to understand the consequence and harm resulting from service failures such as long ambulance waits. develop patient outcome measures to support its existing quality measures. | | e) The Trust is often limited by data accessibility where the patient journey extends beyond the organisational boundary. The Trust will pursue patient outcome data through development of the ePCR over 2022/23, which will enable 'joining up' of patient records. Furthermore, the Trust will further consider accessibility and governance matters for wider<br>adoption of Patient Reported Outcome Measures, and Patient Reported Experience Measures. | Mar-23 | Not Met | Mar-24 | Jul-24 | | 250424: Date changed in Q4 to July 2024 in Inie with AW timelines for conclusion of related follow up audit.<br>15042024: This will remain open until AW confirm as part of the current quality governance audit that it can close. Daet will change in quarter (from March 2024 to new date).<br>Update 14032024 from Duncan Robertson: The Health Informatics team are currently working with DHCW to enable a flow of data relating to out of hospital cardiac arrest. This it to test the systems and processes. When complete, this learning will be applied to other presentations for analysis.<br>TM will engage with Audit Wales on a potential revised approach for this action.<br><br>201223: Given the comment below Board Secretary suggests a 'check in' date of 31 March 2024. Audit Wales will be doing a further review at that time and may wish to reframe this recommendation.<br>Update: 11.12.23<br>DEVELOPMENT OF EPCR: Update will be provided by Duncan Robertson via update of item d)<br>PATIENT REPORTED OUTCOME MEASURES: The Trust has defined standardised data to measure. Minimum dataset of approximately 600 definitions to agree with DHCW. Currently linking with England to assess available datasets and definitions. Data sharing agreements currently sit with DHCW and Welsh Government for approval. Instruction letters shared and awaiting response. (Leanne Hawker liaising with Alex Crawford on completion date)<br>PATIENT REPORTED EXPERIENCE MEASURES: Data survey and narrative for generalised PREMs has been standardised and feeds into the MIQPR.<br>A bespoke PREM is being developed in relation to Pain Management and Learning Disability (should be completed by end January 2024)<br><br>REVISED DATE OF MARCH 2024<br>Update 121023: PREMS live, but in development. PLICS is due to come on stream in Mar-24.<br>PROMS is in development and dependent on DCHW. Business Care Process and Project Management Pathway are relevant considerations. | Open |
| 120 | HIW | 20/21 | FPC | EMSCCC Patient Safety Review | Lee Brooks | Lee Brooks | | | 21.1 Complete the North Wales EMS CCC estate strategy and identify opportunities for improvement | | See note in column T | | Not Met | Apr-24 | | | 22/03/2024 CLOSURE PROPOSED - Bryn Tirion move is underway, financial allocations and comms in place and on the pathway to delivery. Links below show a dedicated Siren Page regarding the move and all comms sent out on Siren to colleagues to inform of progress with the project and plans.<br>https://nhswales365.sharepoint.com/sites/AMB-Intranet-Operations/SitePages/Bryn-Tirion-Relocation-Project.aspx?Mode=Edit<br>https://nhswales365.sharepoint.com/:u:/r/sites/AMB-Intranet-Finance/SitePages/Bryn-Tirion-Relocation-Project.aspx?csf=1&web=1&e=uX87Qd.<br><br>PROPOSED CHECK POINT OF APRIL 2024<br>Note - the entire EMSCCC review actions have not been transferred to the tracker, only the two identified in the 3/8/23 EMT paper. QUEST updated 10 August 2023<br>Update 030823: The Bryntirion site for EMSC in the North has been allocated some discretionary capital fundig for this financial year (23/24) to support some progress in this area. It should be noted that WAST have completed and rolled out the estate's strategy in VPH with a view to progress plans with DPP for Llangunnor now to progress with the redevelopment of the ground floor. This is at design stage currently but funding has been allocated from this year's discretionary capital budget to support this)<br>The project will likely span two years. In terms of the North Wales Estate (Bryntirion) initial work has started across departments to ensure that all elements of the work are mapped out and options are considered. The existing site requires remedial work which is considered poor investment given the site is not WAST owned. There is a technological development (Airwave replacement) required that enables a full move out of Bryntirion; early indication from the Ambulance Radio Programme (ARP) is that the roll-out of this technology is likely to be Q1 2024. A capital budget (discretionary) has been identified and allocated. | Closed in Quarter |
| 121 | HIW | 21/22 | FPC | EMSCCC Patient Safety Review | Lee Brooks | Lee Brooks | | | 12.1 Continue with the work of the CAD Phase 3 project to realign workloads within the EMSCCC for more efficient operation | | See note in column T | | Not Met | Jan-24 | Apr-24 | | 22.03.2024 Propose to move revised date to April 2024. Date moved in Q4 to April 2024.<br>Note - the entire EMSCCC review actions have not been transferred to the tracker, only the two identified in the 3/8/23 EMT paper. QUEST updated 10 August 2023<br>Update 030823: The EMS Configuration Programme recommended in Q1 2023 following being paused due to Industrial Action and Operational Pressures. Roster Reviewr of call takers is complete. The realignment of boundaries aspects of this work, which provides the necessary re-alignment of workloads has commenced and engagement with staff had taken place prior to the pause. This work has re-commenced and is currently waiting on a refresh of the data to finalise discussions with staff and TU partners.<br>The realignment of desks is currently being paused due to awaiting data. It is anticipated that this will be available in Q2 2023 and that this aspect of the project will be completed end of Q3, subject to management capacity.In addition, we continue to pursue the changes identified above that require a £750k investment however funding support for this is contingent on external investment which in the current economic climate is difficult to secure. | Open |
| 122 | Audit Wales | 23/24 | PCC | Review of Workforce Planning Arrangements | Hugh Bennett / Liz Rogers | Angela Lewis | Medium | 1.1 | Terms of Reference We found that the Terms of Reference for both the Integrated Technical Planning Group and the Forecasting and Modelling Group require review. The Trust should review these to ensure they are accurate and up-to-date, particularly to clarify what role they will play in supporting the new People and Culture Plan and developing strategic workforce plan (medium priority). | 1.1 | Chair and Vice Chair of the ITPG and Forecasting and Modelling Group will update the Terms of Reference within the context of the internal governance structures | Dec-23 | Not Met | Feb-24 | May-24 | | Date moved in Q4 to May-2024 as require approval of the respective ToR formally to close the action.<br>201223: The ToR for both the ITPG and F&M have been reviewed and are going through the governance approvals route. The ITPG will be revised by the group this week for endorsement and the F&M in January, so the due date has been revised to February 2024 to allow for these approvals to be received.<br>ToR have been reviewed and agreed by the Intergrated Technical Planning Group<br>Propose closure. Evidence - updated ToR For the ITPG and F&M groups. | Open |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 123 | Audit Wales | 23/24 | PCC | Review of Workforce Planning Arrangements | Linda Phillips | Angela Lewis | Medium | 2.1 | Workforce information systems We found that there is scope for the Trust to make better use of its workforce information by ensuring data is consistent, joined up and up to date. The Trust should work to ensure that (medium priority): | 2.1 | Use of Power BI reporting feeding into the Integrated Technical Planning Group is in development by the workforce planning team. This will be used for reporting and maintenance of the data. | Sep-24 | Not Yet Due | | | | | Open |
| 124 | dit Wales or HIW Rep | 23/24 | PCC | Review of Workforce Planning Arrangements | Hugh Bennett | Angela Lewis | | 2.1(a) | Workforce information systems We found that there is scope for the Trust to make better use of its workforce information by ensuring data is consistent, joined up and up to date. The Trust should work to ensure that (medium priority):<br>• Systems that hold workforce information including Electronic Staff Record (ESR), Global Rostering System (GRS) and finance systems interconnect, where possible. | 2.1(a) | Alongside this we are working on Integrated Planning Nexus via the Planning and Strategy team which enables our understanding of the interconnection between workforce, fleet, estate etc.<br>*Excel version* | Mar-24 | Not Met | Oct-24 | | | 210324 LR The Workforce Transformation and Planning Team now produce a highlight report on key workforce information.<br>Propose an extension to this action as the work on Nexus will be longer than expected. To date the following has been undertaken. Date moved in Q4 to October 2024.<br>Project team established<br>Initial mapping completed<br>Currently developing what the end product will look like to work backwards to the requirements<br>Complex exercise meaning timelines are difficult to estimate.<br><br>Investment in connecting GRS, ESR and Oracle would be needed to build interfaces therefore Nexus is the solution for the time being. | Open |
| 125 | Audit Wales | 23/24 | PCC | Review of Workforce Planning Arrangements | | Angela Lewis | | 2.1(b) | Workforce information systems We found that there is scope for the Trust to make better use of its workforce information by ensuring data is consistent, joined up and up to date. The Trust should work to ensure that (medium priority):<br>• Explore ways to resource the management of a system to ensure an up-to-date establishment model. | 2.1(b) | Alongside this we are working on Integrated Planning Nexus via the Planning and Strategy team which enables our understanding of the interconnection between workforce, fleet, estate etc.<br>*Potential PowerB1 version* | Sep-24 | Not Yet Due | | | | | Open |
| 126 | Audit Wales | 23/24 | PCC | Review of Workforce Planning Arrangements | Dee Udeze-Chibuzor / Liz Rogers | Angela Lewis | Medium | 3.1 | Evaluating workforce planning training We found that the Trust is strengthening workforce planning capability through training initiatives, but it will need to evaluate these to ensure they are having the desired impact. The Trust should develop an evaluation framework to measure the success of its training programme (medium priority). | 3.1 | We will implement an evaluation process to baseline where managers are pre and post training and post 3 months to measure improvement. | Jun-24 | Not Yet Due | | | | | Open |
| 127 | Audit Wales | 23/24 | PCC | Review of Workforce Planning Arrangements | Dee Udeze-Chibuzor / Liz Rogers | Angela Lewis | Medium | 4.1 | Recruitment support We found that only the emergency ambulance services department has dedicated support from the central management team for recruitment activity, due to capacity issues. While the central team can provide support on a case-by-case basis, the Trust should review opportunities to increase the corporate support offered to other departments across the organisation (medium priority). | 4.1 | The recruitment team focus primarily on EMS but do offer support where needed to other services. This would need to be agreed by ELT and the Directorates as resource would need to be moved into the team from elsewhere. Report to be produced and shared with ELT. | May-24 | Not Yet Due | | | | | Open |
| 128 | Audit Wales | 23/24 | PCC | Review of Workforce Planning Arrangements | Dee Udeze-Chibuzor / Liz Rogers | Angela Lewis | Medium | 5.1 | Metrics for People and Culture plan monitoring The Trust has recently approved the metrics to enable monitoring progress of the People and Culture Plan, however the metrics do not include targets or milestones. The Trust should work to develop targets and milestones to enable the Committee to understand the progress against the Plan (medium priority). | 5.1 | Recommendation Accepted. We will build in appropriate targets and milestones into the plan which will be frequently reviewed for delivery and effectiveness of both the plan and the measures | May-24 | Not Yet Due | | | | 210324 Query this action here as it was requested to be removed as it was not relevant to this audit and incorrect. However, the P&C Directorate Plan has milestones and measures for 2023/4 and will have for 2024/25. CGT have further narrative regarding this action. | Open |
| 129 | Audit Wales | 23/24 | PCC | Review of Workforce Planning Arrangements | Liz Rogers / Hugh Bennett | Angela Lewis | Medium | 6.1 | Benchmarking The Trust does not routinely benchmark its workforce performance metrics with other health bodies in Wales. Its performance benchmarking with other ambulance trusts is infrequent. The Trust should introduce regular workforce benchmarking with similar organisations and use this to inform relevant groups and committees on its performance and efficiency and to identify and share good practice (medium priority | 6.1 | Recommendation accepted for high level measures and will be based on what other organisations share / make available. Benchmarks need to be with ambulance sector rather than Health Boards | Jun-24 | Not Yet Due | | | | | Open |
| 130 | HIW | 23/24 | Quest | National Review of Patient Flow – a journey through the stroke pathway | Lee Brooks | Liam Williams Andy Swinburn | | 4 | Welsh Government, health boards and WAST must work collaboratively, to consider whether the Immediate Release Directions are effective or need improvements, given the high number of declined Immediate Release Directions occurring across Wales. | 4 | It is imperative to acknowledge that Immediate Release Directions are required when there is no ambulance to send to the patient. The inability to respond in a timely way is the lost capacity due to extended emergency department handover delays that in recent months absorbs between 20% to 33% of WAST conveying resource capacity. There is an argument that relying on immediate release to respond to patients is too late, as capacity is needed to respond in a timely way without relying on this mechanism.<br>The All-Wales Immediate Release Protocol is approved by the NHS Wales Chief Executive group and used by WAST when directing immediate release. Its next review is due in January. The existing script used by WAST when entering the direction to health boards includes the age and chief complaint for the patient. In a recent meeting, led by EASC representatives with health board colleagues, it was suggested that the reason for the release direction should not have to be justified by WAST, and this helps to decrease the length of the script. This would be achieved by removing the age and chief complaint for the patient. It is posited this reduces moral injury for ED staff receiving the direction (sought by health board representatives) who may then be unable to accommodate. Considering this position and if required, it would not be possible for WAST to differentiate stroke patients from others when submitting the direction to health boards and arguably inhibits clinical prioritisation.<br>WAST continues to validate immediate release directions, including providing health boards with data outputs following this process. WAST has been audited on its application of the protocol and recommendations appear in the WAST audit tracker.<br>At this stage, there is nothing more that WAST can do to progress this recommendation. Accommodating immediate release directions is a matter for health board partners whilst WAST continues with its strategy to resolve more episodes of care closer to home (as per IMTP). | N/A | Met | | | | Last Update (TM ) - narrative indicates this is a HB action so closure proposed. | Closed in Quarter |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 131 | HIW | 23/24 | Quest | National Review of Patient Flow – a journey through the stroke pathway | Liam Williams | Liam Williams<br>Andy Swinburn | | 12 | Health boards and WAST should engage with people to better understand the barriers to them accessing, or choosing, from the range of healthcare services available in Wales. Once the barriers are understood, this in turn, could be used to influence service design. | 12 | The Welsh Ambulance Service's Patient Experience & Community Involvement Team (PECI) operate a model of continuous engagement with patients, carers, service users, organisations, including the Stroke Association and Age Alliance Wales, stakeholders and the general public across Wales,. Meeting, listening to, capturing and acting on people's experiences of using the Welsh Ambulance Service, including Emergency Medical Services, Non-Emergency Patient Transport Services and NHS 111 Wales. WAST consistently aspire to work in partnership to develop services which are safe and appropriate, and to improve people's experiences and outcomes.<br><br>In 2023, the PECI Team also established a People & Community Network for the Welsh Ambulance Service. Aligned to our Quality Strategy 2021-2024 and informed by the Health and Social Care (Quality & Engagement) (Wales) Act 2020; the People & Community Network is a group of people with a shared goal: to help develop and improve the services provided by Welsh Ambulance Services NHS Trust. The Network represents the voices and opinions of patients, service users, carers, staff and wider stakeholders from across Wales, in respect of services we provide. The Network will also work with Llais, the Welsh Government's new citizen voice body, to understand people's views and experiences of health and social care, and to make sure feedback is used by decision-makers to shape services and support the continuous improvement of person-centered services.<br><br>WAST has a long-term aspiration to enhance its service offer managing more patients in the community. In delivering this, we aim to ensure greater emergency ambulance availability by supporting patients through the most appropriate part of the system in their times of crisis. | Nov-24 | Not Yet Due | | | | **Update 1.2.24**: Using the Continuous Engagement module and using multiple channels to capture feedback (Business as Usual). The Patient Experience & Community Involvement (PECI) Team are working with the Bevan Commission and Health Minister's office to review recommendations from the Bevan Commission Report produced and entitled 'A conversation with the public, challenges and opportunities for change'.<br>Once recommendation is completed, the PECI Team will use the recommendations to identify what the Trust will do in order to sustain the recommendations.<br><br>**What will close the action**: Using the Continuous Engagement Module and multiple channels to capture feedback (Business as Usual). Working with Bevan Commission and Minister's office to review recommendations from the Bevan Commission Report produced entitled 'A conversation with the public, challenges and opportunities for change'. Once recommendations are completed, the Patient Experience & Community Involvement Team will use the report to identify what the Trust need to do and internalise recommendations<br>**What will you provide as evidence for the closure**: To be included in the PECU Bi-Annual Report to the Quality, Patient Experience & Safety Committee on 7 May 2024<br>**Is date reasonable**: It is likely this will close before November 2024 | Open |
| 132 | HIW | 23/24 | Quest | National Review of Patient Flow – a journey through the stroke pathway | Andy Swinburn | Liam Williams<br>Andy Swinburn | | 13.1 | WAST must ensure that all relevant staff are fully aware of the WAST stroke pathway to minimise risks to patient safety. | 13.1 | It is noted that within the report 85% of the 44 staff involved in the survey undertaken by Health Inspectorate Wales (HIW) stated that they have received training to support and manage stroke patients. 77% of staff understood the stroke pathway however, only 49% of WAST respondents said that they always allocate or take a stroke patient to a specialist stroke unit. Considering the relatively low numbers of staff involved in this survey WAST will undertake its own clinical audit to ascertain as to widespread any short fall in adherence to the stroke pathway there may be.<br>Paramedic and Emergency Medical Technician (EMT) education is underpinned by the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) Clinical Guidelines, these are available to all EMTs and Paramedics via an app on their individually issued I-Pads. These guidelines provided comprehensive guidance to Paramedics and EMTs on the pathophysiology, signs and symptoms, assessment and management of both stroke and TIA. Included in these guidelines is recognition that acute stroke is a 'time critical' condition and that patients should be conveyed to an appropriate stroke unit. WAST has for many years had in place a pathway for patients suffering an acute stroke, this includes a pre-alert which informs the receiving unit, preparing them to receive a possible stroke patient enabling the relevant stroke teams to be ready for their arrival. It is worth noting that the only hospital with an accident and emergency department where there is not a stroke unit is the Royal Glamorgan hospital. Clearly the WAST pathway for stroke does not include this hospital. | Jun-24 | Not Yet Due | | | | | Open |
| 133 | HIW | 23/24 | Quest | National Review of Patient Flow – a journey through the stroke pathway | Andy Swinburn | Liam Williams<br>Andy Swinburn | | 13.2 | WAST must ensure that all relevant staff are fully aware of the WAST stroke pathway to minimise risks to patient safety. | 13.2 | WAST is currently working with the stroke networks in Wales in relation to the upcoming reconfiguration of stroke services and the development of Hyper Acute Stroke Units (HASU), this will potentially result in a change to the existing stroke pathways that are in place. However, to ensure that the current stroke pathway is clearly understood by WAST staff, a clinical bulletin will be circulated updating staff on the current pathways that are in place across Wales relating to stroke, this will then be updated the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) app that is available to all Paramedics and EMTs via their personal issue I-Pads.` | Dec-24 | Not Met | | | | Completed in quarter but original date of December not met. Closure proposed.<br>Last Updated 04.04.2024<br>Recommended for closure. Jon Whelan presented to ELT, unable to identify precise numbers but there was a ball park figure of 2500 amber 2s becoming amber 1 around 7 per day across Wales. This was approved, the necessary changes were actioned at 10:30 02.04.2024, MJ put out comms to our teams last week which are accessible either from Siren or the JRCLAC App<br>Update from Board Secretary 140324 - Update to WAST DCR table - alignment with other UK ambulance services and to meet clinical guidelines for stroke care paper came to ELT on 17 January 2024. ELT approved the report's recommendations subject to stakeholders to include the CASC, Welsh Government and the Stroke Association being informed of the proposed changes in advance of the change being made. It was agreed AS would draft a letter for JK's signature.<br><br>23.01.2024 - Mike Jenkins awaiting confirmation from CPAS of evidence of numbers and impact, to then go to ELT for final sign off. Action for Mike Jenkins, aiming for ELT towards end of January, expect action to be complete 31 January 2024. | Closed in Quarter |
| 134 | HIW | 23/24 | Quest | National Review of Patient Flow – a journey through the stroke pathway | Andy Swinburn | Liam Williams<br>Andy Swinburn | | 14 | Welsh Government should consider how it can support WAST to develop and implement improvements with its service delivery model, such as increasing the number of advanced paramedic practitioners across Wales, to help reduce the pressure on EDs and improve flow through healthcare systems. | 14 | While WAST recognises that this is not a recommendation for WAST, we wholly endorse this recommendation and remain ready to play our part in growing the number of APPs. | | Met | | | | Update from Board Secretary 140324 - action closed as not WAST action | Closed in Quarter |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 135 | HIW | 23/24 | Quest | National Review of Patient Flow – a journey through the stroke pathway | Andy Swinburn | Liam Williams<br>Andy Swinburn | | 15 | WAST should consider the benefits of training its paramedic staff in the use of the ROSIER stroke assessment tool, to enable staff to differentiate patients with stroke and stroke mimics, such as TIA. | 15 | WAST has previously considered the implementation of ROSIER, however the decision not to adopt was informed by a study undertaken by a large ambulance service in England that demonstrated that ROSIER was no better than the Face Arm Speech Test (FAST) in the prehospital setting.<br>As stated above clinical practice is underpinned by JRCALC, these guidelines inform the attending EMT/Paramedic to the level of assessment that should be undertaken. JRCALC does not include ROSIER as part of the recommended assessment, it does however suggest that clinician may consider using the PASTA (Paramedic Acute Stroke Treatments Assessment) structured assessment and handover as per local agreement.<br>To further inform the debate around prehospital stroke assessment, the HIW report will be presented to the WAST 'Ambulance Practice Steering Group' for consideration. As part of that consideration WAST will undertake an up-to-date literature review to ascertain to whether the previous study has been superseded. To further inform this point WAST will consult the Welsh Stroke Network for a expert view on the use of ROSSIER or indeed any other stroke tool for the pre hospital setting. In addition, within the above-mentioned clinical bulletin all EMTs and Paramedics will be reminded that if a patient remains FAST positive despite some evidence of improvement, stroke should be considered as the primary differential diagnosis, TIA should only be consider following a complete recovery, this latter point is highlighted within JRCALC Practice Guidelines.<br>To support ongoing education to all future Paramedics, WAST will seek to work further in partnership with both universities in Wales who deliver pre-registration education in developing an up-to-date syllabus for stroke education, supported by senior stroke specialists from across Wales. | Jun-24 | Not Yet Due | | | | | Open |
| 136 | HIW | 23/24 | Quest | National Review of Patient Flow – a journey through the stroke pathway | Liam Williams | Liam Williams<br>Andy Swinburn | | 17 | WAST and all health boards must work collaboratively to identify a consistent approach to ensure handover of stroke patients is made within the Welsh Government 15-minute target. This is to ensure that time critical investigations and treatment are undertaken promptly. | 17 | WAST recognises that it has a responsibility to undertake an appropriate clinical assessment of patients presenting with stroke symptoms. Where stroke is considered a potential diagnosis a pre alert should be provided to the appropriate unit to inform stroke teams of the patients' imminent arrival enabling them to be prepared for a rapid handover of care for that patient.<br>It is recognised that system pressures that exist has a direct impact on the 15-minute handover period. WAST continues to work with the health boards to minimise the impact upon service delivery to all its patients. It is worth noting that there does exist improvements across some health boards in Wales, while still accepting that there are further improvements required across all health board areas.<br>WAST will seek to work with Executive Directors of Nursing in the development of a handover standardised pathway. | Jun-24 | Not Yet Due | | | | Update 12.4.24 from LW: It is recommended that this action is closed within the Audit Tracker as with effect from April 2024 the new Clinical Networks have been implemented and are accountable for the performance and quality management of stroke care outcomes Wales. Propose for Closure accepted by Board Sec.<br><br>Update 09042024 from LW: The Executive Directors of Nursing Peer Network has been approached on several occasions to improve the opportunities for EDs and hospitals to respond effectively to pre-alerts and receipt of stroke patients as part of wider system escalation, clinical risk management and service improvement discussions. However, the Peer Network is not in a position to define each UHB and hospital's approach to resourcing the Stroke pathway; clinical and country wide leadership remains with the Stroke Network which WAST is actively engaged in and local service delivery is led by UHBs, to which WAST raises the need for improved system working on multiple fora.<br><br>14032024: Update from Alison Kelly: Query regarding the ownership of this action. May move to Andy. | Closed in Quarter |
| 137 | HIW | 23/24 | Quest | National Review of Patient Flow – a journey through the stroke pathway | Andy Swinburn | Liam Williams<br>Andy Swinburn | | 27 | Health boards and WAST must ensure that all staff associated with potential stroke patients are aware of the updated guidance for thrombolysis treatment window of between 4.5 and nine hours, as highlighted within the National Clinical Guideline for Stroke updated in April 2023. | 27 | WAST recognises that the 'National Clinical Guideline for Stroke (2023) recommends that patients suffering with an acute stroke may be treated with alteplase or tenecteplase if that treatment can be started within 9 hours of known onset, or within 9 hours of the midpoint of sleep when they have woken with symptoms. In recognising this WAST will work with stroke networks to coordinate the dissemination of this information to all staff involved in the management of patients suffering an acute stroke to ensure a consistent approach across the NHS in Wales.<br>It should be recognised that extending the time window from a 4.5 to a 9-hour window has a potential resource implication for WAST. Following the clarity from the stroke network further engagement with our commissioners will take place if necessary. | Jun-24 | Not Yet Due | | | | | Open |
| 138 | HIW | 23/24 | Quest | National Review of Patient Flow – a journey through the stroke pathway | Andy Swinburn | Liam Williams<br>Andy Swinburn | | 32(a) | WAST must consider its current response times for patients awaiting interhospital transfers for urgent thrombectomy treatment which are classified as 'Red'. This is to ensure a thrombectomy can be completed within the six-hour timescale from the onset of symptoms. | 32(a) | WAST has been working with the stroke leads and the South Wales Major Trauma Network to implement a process that supports the interhospital process for patients referred for thrombectomy outside of Wales. Patients identified for thrombectomy have their transfer arranged through the trauma desk which is situated in a WAST contact centre. The trauma desk team are contacted directly to discuss the transfer requirements of the patient and ensure we have the correct level of clinical support during the transfer and that the transfer is correctly prioritised. Red prioritisation is the highest level of response in our clinical response model, other examples in this group are cardiac arrest, choking and catastrophic haemorrhage. Welsh Government has set ambulance response targets at 65% of all calls categorised as immediately life threatening (red) to receive an emergency response within eight minutes, these standards are reported monthly by Local Health Board. | Complete | Not Met | May-24 | | | 1704 24: (AP) Awaiting receipt of the letter that was signed. Once received action can be closed. Date updated in Q4 to May2024.<br>Last Updated 04.04.2024<br>Recommended for closure, ELT approval closes the action, JK has signed the letter and receipt has been acknowledged by identified stakeholders.<br><br>Update from Board Secretary 140324 - Update to WAST DCR table - alignment with other UK ambulance services and to meet clinical guidelines for stroke care paper came to ELT on 17 January 2024. ELT approved the report's recommendations subject to stakeholders to include the CASC, Welsh Government and the Stroke Association being informed of the proposed changes in advance of the change being made. It was agreed AS would draft a letter for JK's signature. | Open |
| 139 | HIW | 23/24 | Quest | National Review of Patient Flow – a journey through the stroke pathway | Andy Swinburn | Liam Williams<br>Andy Swinburn | | 32(b) | WAST must consider its current response times for patients awaiting interhospital transfers for urgent thrombectomy treatment which are classified as 'Red'. This is to ensure a thrombectomy can be completed within the six-hour timescale from the onset of symptoms. | 32(b) | WAST will review this process in due course and ascertain its success and determine if any further actions are required | Jun-24 | Not Yet Due | | | | | Open |
| 140 | Audit Wales | 21/22 | Charity | NHS Trust Charity Audit of 21/22 Accounts Report | Navin Kalia | Chris Turley | High | 1 | **Allocation of funds between restricted and unrestricted.** The Charity has not retained supporting documents and records in respect of the 2015-16 financial year. Consequently, we have been unable to obtain sufficient appropriate audit evidence that the Charity's income for that year was correctly allocated between restricted and unrestricted income funds. Consequently, we cannot conclude that the opening balances of the Charity's income funds in this year's financial statements are not materially misstated. The value of the income in 2015-16 over which we are unable to obtain assurance is £28,000. | 1 | (a) The Charity should seek to obtain the missing supporting documents and records for 2015-16; and<br><br>(b) ensure supporting documentation and records are retained for future financial years in accordance with the Charity's data retention policy. | Mar-23 | Not Met | Jan-24 | | | 29012024: The AW Indepdent Examination Report was taken to the Charity Committee on the 18012024 and the Corporate Trustee on the 25012024. This serves as evidence of completion of this action is proposed for closure pending the updated copy of the IE from AW as it states that the records that could not be found, have since been found (AP). Closure proposed.<br><br>11012024: Update from NK: The Charity has obtained the missing supporting documents and records for 2015-16 as noted in the Independent Examination report for the 22/23 accounts from AW. Awaiting evidence and detail regarding when the action was completed. Evidence to be provided by presentation of Independent Examination reports by AW at the CC meeting on 18th Jan 2024. Recommend to close (AP). | Closed in Quarter |

| Point Ref No. | Audit Wales or HIW Report | Year | Committee Assigned to | Report Title | Responsible Officer | Director | Priority Level | Rec. No in Audit | Recommendation | Response no. in Audit | Management Response | Agreed Deadline in Report | Status | 1st revised date | 2nd revised date | 3rd revised date | Where a management action has not met the agreed or revised date, Director must inlcude here:<br>1. Date (of your update)<br>2. Proposed revised date<br>3. Reasons why action is overdue and<br>4. Progress made if not yet complete.<br>**Please add most recent update first** | Closure Status |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 141 | Audit Wales | 21/22 | Charity | NHS Trust Charity Audit of 21/22 Accounts Report | Navin Kalia | Chris Turley | Medium | 2 | **Bursary Creditors.**<br>The draft financial statements included £11,000 of Other Creditors, which was wholly in respect of the Bursary Scheme. Review of the balances identified that £8,000 related to periods up to and including the 2018-19 financial year. Testing of a sample of creditors identified balances totalling £2,750 that were no longer required. These have now been removed from the accounts, as detailed in Appendix 3. Discussions with the Charity confirmed there is currently no process to regularly review the balances to determine whether they are still required. | 2 | Review all bursary creditors on an annual basis to determine whether the creditors are still valid, and if not, remove these from the financial statements. | Mar-23 | Met | | | | 29012024:<br>Finance have sent copies of emails to staff - as below. Closure proposed.<br><br>11012024: Update from Navin: Following the 2021/22 audit, the Finance Assistant - Charitable Funds emailed all staff who had bursary accruals in the charity's accounts, asking if they still intend on doing the courses and utilising their award. As a result a further £3,077 of old awards have been removed from the accounts. The same process will be again be followed this year (February time). Finance Assistant - Charitable Funds has suggested to the Bursary team to add a 12-month time frame to the award letters in which beneficiaries have to claim their award from point in which it is awarded. This was completed in early 2023 (Jan-Feb 2023).Recommend to close. | Closed in Quarter |
| 142 | Audit Wales | 21/22 | Charity | NHS Trust Charity Audit of 21/22 Accounts Report | Navin Kalia | Chris Turley | Medium | 3 | **Harlequin system access controls**<br>Review of the access controls for the Charity's Harlequin financial system identified that there is no minimum password complexity requirement for users. | 3 | Introduce password complexity requirements for users in line with industry best practice. | Mar-23 | Not Met | Jul-24 | | | 21032024: AP discussion with Navin on the 21032024: This is the current position and the work is ongoing. Intention to be completed by July 2024 with the new Sage software coming in to use. Due date updated to July 2024 in quarter; update to be reviewed by Chris Turley. Date changed in Q4 to July 2024.<br><br>Target date moved on Q4<br>11012024: Update from Navin: ICT have been approached numerous times by the Finance Assistant - Charitable Funds to arrange a date and time with the Harlequin team, to be able to update the version we have. Due to capacity issues in the ICT team this has not beenn done. The Finance Assistant - Charitable Funds has requested moving over to SAGE as its approx.. £500 per annum cheaper and is a much better accounting system than Harlequin. Currently in the process of receiving a 30-day free trial, and how SAGE can resolve this risk item. Still open likely completion in 6 months.<br>19.03.24 - We will be moving over to SAGE mid-June, which is when our contract will end with Harlequin following our 90 day notice | Open |
| 143 | Audit Wales | 21/22 | Charity | NHS Trust Charity Audit of 21/22 Accounts Report | Navin Kalia | Chris Turley | Medium | 4 | **Harlequin system user accounts**<br>Review of live users on the Harlequin financial system at the time of audit identified a member of staff who left the employment of the Trust a number of years ago. The former employees should have been removed from the system when they left the employment of the Trust. | 4 | Remove the user from the Harlequin financial system and introduce a regular documented review of system users and their rights of access to ensure they remain appropriate. | Mar-23 | Not Met | Jul-24 | | | 21032024: AP discussion with Navin on the 21032024: This is the current position and the work is ongoing. Intention to be completed by July 2024 with the new Sage software coming in to use. Due date updated to July 2024 in quarter; update to be reviewed by Chris Turley. Date changed in Q4 to July 2024.<br><br>11012024: Update from Navin: Same as above - still open linked to ICT capacity.<br>19.03.24 - We will be moving over to SAGE mid-June | Open |
| 144 | Audit Wales | 22/23 | Audit | Structured Assessment 2023 | Trish Mills | Trish Mills | Medium | 1(a) | **Transparency of Board and committee business**<br>Opportunities exist to further enhance the transparency of Board and Committee business. The Trust should:<br>a) provide a written Chair's Report to each Board meeting. (Medium Priority) | 1 (a) | Agreed. A written Chair's Report will be provided to each Board meeting effective the January 2024 Board meeting | Ongoing | Met | | | | 12042024: Met as the Chair's Report is now written, effective January 2024. | Closed in Quarter |
| 145 | Audit Wales | 22/23 | Audit | Structured Assessment 2023 | Trish Mills | Trish Mills | Medium | 1(b) | **Transparency of Board and committee business**<br>Opportunities exist to further enhance the transparency of Board and Committee business. The Trust should:<br>b) review and publish unconfirmed minutes of committee and Board meetings within 14 days of the meeting. | 1(b) | Agreed that minutes should be drafted and approved by the Chair and Executive Lead within 14 days. However, these are not final until approved by the Board/Committee. To facilitate transparent and timely communication, it is proposed that the AAA report from the Committee Chair to the Board is published within 14 days of the meeting. These AAA reports provide a summary of the meeting and gives the attendance and agenda items also. | Ongoing | Met | | | | 120424: This recommendation has been implemented and will continue as it is now business as usual. | Closed in Quarter |
| 146 | Audit Wales | 22/23 | Audit | Structured Assessment 2023 | Trish Mills | Trish Mills | High | 2 | **Public access to key strategies and plans**<br>Publish key plans on the Trust website, including the most recent IMTP and the People and Culture Plan. | 2 | Agreed, both now on website. | Complete | Met | | | | 12042024: This recommendation is now complete; cited documents now available on the Trust's Publications page. | Closed in Quarter |
| 147 | Audit Wales | 22/23 | Audit | Structured Assessment 2023 | Rachel Marsh | Alex Crawford | High | 3 | **Clarity of IMTP objectives/actions**<br>We found that the Trust's IMTP does not include SMART actions, many do not include a specific measurable outcome and it is also unclear in the IMTP which year each action is due for delivery. However, delivery milestones are set out elsewhere. The Trust should ensure all actions set out in future IMTPs are SMART by specifying measurable outcomes and delivery milestones. | 3 | The IMTP is a three year plan. Assurance on delivery of the plan in year is to the Finance and Performance Committee and the Board via the Strategic Transformation Board. These in year actions will be SMART and wherever possible specify measurable outcomes and delivery milestones. | May-24 | | | | | | Open |
| 148 | Audit Wales | 22/23 | Audit | Structured Assessment 2023 | Rachel Marsh | Alex Crawford | High | 4 | **Oversight of IMTP delivery**<br>Whilst there have been recent improvements to the reporting of IMTP progress to Committee and Board, there is scope to provide better clarity on whether the actions delivered have achieved the intended impact. The Trust should ensure all plan delivery progress reports include information about the impact achieved. | 4 | Agreed. Consideration will be given as to how this can best be achieved, and this will be taken forward into the 2024/25 reporting processes. | Jun-24 | | | | | | Open |
| 149 | Audit Wales | 22/23 | Audit | Structured Assessment 2023 | Chris Turley | Navin Kalia | High | 5 | **Oversight of Savings plans**<br>The Trust does not clearly specify in its finance plans and reports whether savings schemes are recurrent or non-recurrent. To strengthen oversight of savings, the Trust specify whether schemes are recurrent or non-recurrent in its financial plans and reports. | 5 | Agreed. Whist not always specifically called out in the main report, the Trust is required to provide a monthly financial return to WG that details recurrent schemes. The latest return is provided as an appendix to every financial report. Consideration will be given to more explicitly calling some of this out in the main body of the report.<br>Recognising the current and future climate for the public sector and the NHS specifically, the organisation has instigated a strategy of pursuing a Financial Sustainability Program to identify increases in recurrent savings schemes via two separate working group lenses of Achieving Efficiency and Income Generation in mitigation.<br>This should also allow for greater clarity of the split between recurring and non-recurring savings within future financial plans. It is inevitable however that an element of any in year delivery of financial balance will include an element of non-recurrency, whether that be spend or savings. | Mar-24 | Not Met | May-24 | | | 170424: Update from Navin: The new financial year savings report identifying recurrent and non-recurrent savings will be produced for May Trust Board and should suffice as evidence. Jason Collins will send this to the CGT once it has been produced at the end of May. Date extended in quarter 4 to May 2024. | Open |

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

# TRUST POLICY REPORT

| | |
|---|---|
| **MEETING** | Audit Committee |
| **DATE** | 7th June 2024 |
| **EXECUTIVE** | Trish Mills, Director of Corporate Governance/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 Committee with assurance on the status of the Trust's policy work programme which aims to bring key policies up to date.

2. A work programme was established following the pandemic to address the number of policies that were not within their review date, and which had fallen to below reasonable levels during that period.

3. Since then, 34% of Trust owned policies are now within their review date compared to 14% overall reported to Committee in July 2023.

4. The work plans are progressing well, with significant levels of activity taking place to refresh existing policies and develop new ones. A reasonable number of policies are navigating the Trust's policy governance process through to approval.

5. It is expected that 42% will be within their review date after the next round of approvals in August and September 2024. This figure does not include those policies developed by NHS Wales or the NHS Employers Unit which are adopted by the Trust.

6. A detailed report on the progress of the work plans and the status of all policies is provided to the Executive Leadership Team (ELT) following each Policy Group meeting via the Alert, Advice, Assure (AAA) reports. It was agreed the Corporate Governance Team would report by exception only to Audit Committee.

7. As previously advised, the work plans were held flexibly from the outset to take account of resourcing demands, internal and external pressures, and the work programmes of Directorate Policy Leads; however, it is pleasing to report most policies are on track and those which were identified for priority review are in train or on the forward work plan for Policy Group.

**RECOMMENDATION:**

8. **Members are asked to:**
   **a) Note the update.**

| **KEY ISSUES/IMPLICATIONS** |
|---|
| 9. The key issues are set out in the Executive Summary above. |
| **REPORT APPROVAL ROUTE** |
| 10. Progress against the work plans is reported to ELT via the monthly, Policy Group AAA following each Policy Group meeting. |

| **REPORT ANNEXES** |
|---|
| N/A |

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

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| **AGENDA ITEM No** | **10** |
| **OPEN or CLOSED** | **Open** |
| **No of ANNEXES ATTACHED** | **2** |

# GOVERNANCE PRACTICE NOTES – ANNUAL REVIEW

| | |
|---|---|
| **MEETING** | Audit, Risk and Assurance Committee |
| **DATE** | 07 June 2024 |
| **EXECUTIVE** | Trish Mills, Director of Corporate Governance/Board Secretary |
| **AUTHOR** | Trish Mills, Director of Corporate Governance/Board Secretary<br>Alex Payne, Corporate Governance Manager |
| **CONTACT** | Trish.mills@wales.nhs.uk |

## EXECUTIVE SUMMARY

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

2. The Governance Practice Notes numbers 002 'Private Board and Committee business' and 003 'Chair's Action' have had some minor changes and are being presented to the Committee for approval.

**RECOMMENDATION:**

3. **The Audit, Risk and Assurance Committee is asked to approve the Governance Practice Note changes for the Private Board and Committee Business (002), and Chair's Action (003).**

## KEY ISSUES/IMPLICATIONS

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

| REPORT APPROVAL ROUTE |
| --- |
| n/a |

| REPORT APPENDICES |
|---|
| 1. Annex 1 - Governance Practice Note – Private Board and Committee Business<br>2. Annex 2 - Governance Practice Note – Chair's Action |

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

## SITUATION

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

6. The Governance Practice Notes numbers 002 'Private Board and Committee business' and 003 'Chair's Action' have had some minor changes and are being presented to the Committee for re-approval.

## BACKGROUND

7. It is good practice to review governance processes on an ongoing basis to ensure compliance with Standing Orders, and to introduce efficiencies and enhancements. Governance Practice Notes provide clarity on the application by the Corporate Governance Team and the Board of some elements of the Sanding Orders.

8. Governance Practice Notes may be internal to the Corporate Governance Team, and others will more appropriately be approved by the Audit Committee or the Executive Leadership Team depending on their wider application and impact. The other Governance Practice Notes will be reviewed and brought to the Committee in line with their review cycle.

## ASSESSMENT

9. The following Governance Practice Notes are presented for consideration:

    9.1. <u>Private Board and Committee Business Governance Practice Note 002:</u>
    This practice note provides clarity on the business that is appropriately taken into a private session of the Trust Board or its Committees and sets out the ways in which decisions made in private session are communicated in public session. The changes made are minor and serve to ensure the detail of the note is accurate.

    9.2. <u>Chair's Action Governance Practice Note 003:</u>
    This practice note provides for a streamlined approach to Chair's Actions by way of email in the majority of cases. It also provides for the ways in which they are ratified in public session of the Board thereafter. The changes made have been made to better articulate the process regarding reporting of decisions made in closed session to the public and include minor updates required.

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

## RECOMMENDATION

The Committee is asked to: -

11. The Audit, Risk and Assurance Committee is asked to approve the Governance Practice Note changes for the Private Board and Committee Business (002), and Chair's Action (003).

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# GOVERNANCE PRACTICE NOTE 002
# ~~APRIL 2023~~JUNE 2024 (v.~~32~~)

## PRIVATE BOARD AND COMMITTEE MEETIINGS

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

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

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

Matters considered appropriate for consideration in private session

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

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

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

   4.3. **Issues, the discussion of which in public would be likely to inhibit the free and frank provision of advice**[3]*.
   Examples may include matters in the initial stages of enquiry; early stages of

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

strategic thinking; sensitive 'live' issues addressed or discussed in recommendations/advice from external organisations.

4.4. **Issues, the discussion of which in public would be likely to prejudice the effective conduct of public affairs**[4]*.
Examples may include issues the Board is 'working through', where discussion in public may cause concern/alarm, or discussions about future public consultations where the Board wants to manage the timing and manner in which disclosures are made.

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

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

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

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

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

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

[4] FOI s.36(2)(c)

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

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

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

Recording and Reporting Matters Considered in Private Session

8. Minutes of public meetings will be approved at the next public session, and minutes of private meetings will be approved at the next private session. Copies of approved Committee minutes are provided to the Board for information, with private minutes in private session of the Board and public minutes in the public session of the Board.

9. When the Board or a Committee meets in private session it must formally report any decisions taken to the next meeting of the Board in public session including identifying the costs and delivery risks relating to decisions made where appropriate. With respect to the Board, such decisions will be reported in the Governance Report in public session. For Committees, these will ordinarily be reported through the Committee Chair's highlight report to the Board.

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

**Change Table**

| Date | By Whom | Change |
|---|---|---|
| 3 March 2022 | Audit Committee | v.1 approved |
| 20 April 2023 | Audit Committee | v.2 approved. Amendment to paragraph 9 to include identification of the costs and delivery risks of decisions made in private session, and reporting of decisions via the Governance Report. |
| June 2024 | Audit, Risk and Assurance Committee | |

**Review Table**

| Date | By Whom | Change |
|---|---|---|
| April 2026 | Audit Committee | |

Ymddiriedolaeth Brifysgol GIG Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services University NHS Trust

# GOVERNANCE PRACTICE NOTE 003
## ~~APRIL 2023~~JUNE 2024 (v.2~~1~~)

## CHAIR'S ACTION

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

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

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

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

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

   2.4. Once the deadline has been reached, the Director of Corporate Governance/Board Secretary will confirm the outcome to the full Board.

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

   2.6. The Director of Corporate Governance/Board Secretary will ensure that a record of the Chair's Action is formally captured in the Chair's Report at the next meeting of the Trust Board for ratification, with such ratification captured in the minutes of that meeting. The reporting of such decisions may be delayed where the business would otherwise have been considered in private session and where the timing of the

reporting of decisions made in private session must be considered, before being reported in public session.

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

Extract from Standing Orders:

***2.1 Chair's action on urgent matters***

2.1.1 *There may, occasionally, be circumstances where decisions which would normally be made by the Board need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Board. In these circumstances, the Chair and the Chief Executive, supported by the Board Secretary as appropriate, may deal with the matter on behalf of the Board - after first consulting with at least two other Independent Members. The Board Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Board for consideration and ratification.*

2.1.2 *Chair's action may not be taken where either the Chair or the Chief Executive has a personal or business interest in an urgent matter requiring decision. In this circumstance, the Vice-Chair or the Executive Director acting on behalf of the Chief Executive will take a decision on the urgent matter, as appropriate.*

**Change Table**

| Date | By Whom | Change |
|---|---|---|
| 3 March 2022 | Audit Committee | v.1 approved |
| 20 April 2023 | Audit Committee | Annual review. No changes made. |
| 07 June 2024 | Audit, Risk and Assurance Committee | |

**Review Table**

| Date | By Whom | Change |
|---|---|---|
| April 2026 | Audit Committee | |

Ymddiriedolaeth Brifysgol GIG Gwasanaethau Ambiwlans Cymru Welsh Ambulance Services University NHS Trust

| | |
|---|---|
| **AGENDA ITEM No** | **11** |
| **OPEN or CLOSED** | **Open** |
| **No of ANNEXES ATTACHED** | **1** |

# LOSSES AND SPECIAL PAYMENTS - PAYMENTS FOR THE PERIOD FROM 1ST APRIL 2024 TO 30th APRIL 2024

| | |
|---|---|
| **MEETING** | Audit, Risk and Assurance Committee |
| **DATE** | 7 June 2024 |
| **EXECUTIVE** | Chris Turley - Director of Finance and Corporate Resources |
| **AUTHOR** | Olaide Kazeem – Financial Services Project Accountant |
| **CONTACT** | Chris.Turley2@wales.nhs.uk |

## EXECUTIVE SUMMARY

In accordance with SFI's this report presents to the Committee details of Losses and Special Payments made in the month of April 2024 (**Annex 1**)

## KEY ISSUES/IMPLICATIONS

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

- period 1st April 2024 to 30th April 2024 – £44.63k – Net payments

## REPORT APPROVAL ROUTE

Audit, Assurance and Risk Committee 7th June 2024 – no action required for information under SFI's only.

## REPORT APPENDICES

Annex 1 – Summary and details of payments made for the month of April 2024

| 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 UNIVERSITY NHS TRUST**
**AUDIT, RISK AND ASSURANCE COMMITTEE**
**LOSSES AND SPECIAL PAYMENTS - PAYMENTS FOR THE PERIOD FROM 1st APRIL 2024 TO 30th April 2024**

## SITUATION

1. In accordance with SFI's all losses and special payments made are to be reported to the Committee on a regular basis.

## BACKGROUND

2. This report presents to the Committee details of Losses and Special Payments made during the month from 1st April 2024 to 30th April 2024 (**Annex 1**)

## ASSESSMENT

3. Total net Losses and Special Payments made during the period 1st April 2024 to 30th April 2024 amounted to £44.63k of net payments.

4. This relates to actual payments made less reimbursements received from the Welsh Risk Pool and does not relate to any adjustments made to the provision. During the month of April 2024 payments made exceeded the reimbursements received by £44.63k. There were no reimbursements received during the month of April 2024

5. Approximately £22.5k (50%) of the total payments in April 2024 relate to damages, whilst £10.14k (23%) and £11.55k (26%) relate to counsel fees and vehicle repairs respectively.

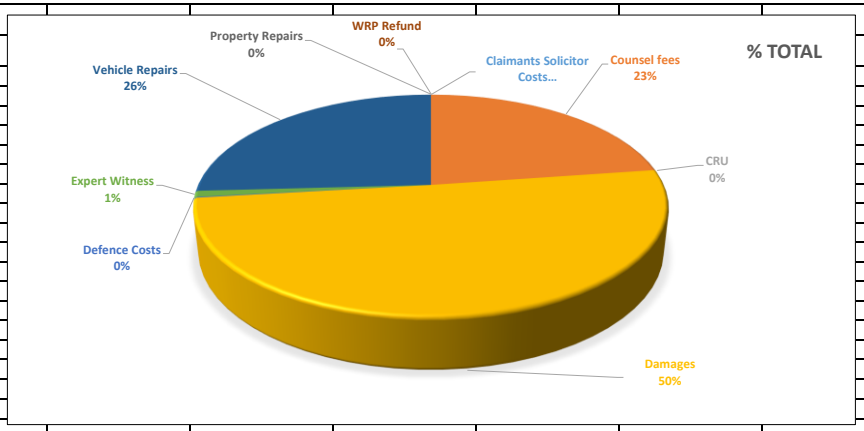
## RECOMMENDED

6. That the Losses and Special Payments Report for this period be noted.

# Welsh Ambulance Services University NHS Trust

## Losses and Special Payments

Annex 1




Summary of payments for the 1 month to 30 April 2024:

| | £ |
|---|---|
| April 2023 | 44,627.36 |
| May 2023 | - |
| June 2023 | - |
| July 2023 | - |
| August 2023 | - |
| September 2023 | |
| October 2023 | |
| November 2023 | |
| December 2023 | |
| January 2024 | |
| February 2024 | |
| March 2024 | |
| | **£44,627.36** |

Losses and Special Payments Breakdown:

| Payment Type | April | May | June | July | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | £ | £ | £ | £ | £ | £ | £ | £ | £ | £ | £ | £ | £ |
| Claimants Solicitor Costs | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | £0.00 |
| Counsel fees | 10,137.50 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | £10,137.50 |
| CRU | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | £0.00 |
| Damages | 22,500.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | £22,500.00 |
| Defence Costs | 45.92 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | £45.92 |
| Expert Witness | 398.91 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | £398.91 |
| Vehicle Repairs | 11,545.03 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | £11,545.03 |
| WRP Refund | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | £0.00 |
| Property Repairs | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | £0.00 |
| Court Refund | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | £0.00 |
| Total | **£44,627.36** | **£0.00** | **£0.00** | **£0.00** | **£0.00** | **£0.00** | **£0.00** | **£0.00** | **£0.00** | **£0.00** | **£0.00** | **£0.00** | **£44,627.36** |

| **Welsh Ambulance Services University NHS Trust** | Key | |
|---|---|---|
| **Losses and Special Payments** | MN | Medical Negligence |
| | PI | Personal Injury |
| Summary of payments for the one month to 30th April 2024: | DP | Damage To Property |
| | | |
| | | |
| | £ | |
| DP cases < £1,000 | 2,945.04 | 6 CASES |
| 23RT4PI0035 | 25,000.00 | |
| 25RT4EG0004 | 5,500.00 | |
| 25RT4DP0021 | 4,595.25 | |
| 25RT4DP0004 | 2,770.56 | |
| 25RT4DP0007 | 1,241.68 | |
| 25RT4DP0001 | 1,138.42 | |
| 25RT4EG0002 | 1,100.00 | |
| 25RT4EG0003 | 1,000.00 | |
| 22RT4PI0046 | 1,000.00 | |
| 18RT4MN0012 | 437.50 | |
| 22RT4MN0001 | 332.91 | |
| 23RT4MN0004 | 66.00 | |
| 22RT4PI0019 | - 2,500.00 | |
| | | |
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| | | |
| | | |
| | | |
| **Total** | **44,627.36** | |

**Welsh Ambulance Services University NHS Trust**

| Case Reference | Details | Amount (£) |
|---|---|---|
| 22RT4PI0046 | Counsel fees | 1,000.00 |
| 18RT4MN0012 | Counsel fees | 437.50 |
| 22RT4MN0001 | Expert Witness | 107.91 |
| 22RT4MN0001 | Expert Witness | 225.00 |
| 23RT4MN0004 | Expert Witness | 66.00 |
| 25RT4DP0001 | Vehicle Repairs | 1,085.42 |
| 25RT4DP0001 | Vehicle Repairs | 53.00 |
| 25RT4EG0001 | Defence Costs | 45.92 |
| 25RT4DP0002 | Vehicle Repairs | 56.70 |
| 25RT4EG0002 | Counsel fees | 1,100.00 |
| 25RT4DP0003 | Vehicle Repairs | 885.90 |
| 25RT4EG0003 | Counsel fees | 1,000.00 |
| 25RT4DP0004 | Vehicle Repairs | 2,770.56 |
| 24RT4DP0056 | Vehicle Repairs | 856.52 |
| 25RT4DP0005 | Counsel fees | 500.00 |
| 25RT4EG0004 | Counsel fees | 5,500.00 |
| 25RT4DP0006 | Counsel fees | 600.00 |
| 25RT4DP0021 | Vehicle Repairs | 4,595.25 |
| 25RT4DP0007 | Vehicle Repairs | 1,241.68 |
| 25RT4DP0008 | Vehicle Repairs | 10,620.98 |
| 25RT4DP0008 | Vehicle Repairs | - 10,620.98 |
| 25RT4DP0009 | Vehicle Repairs | 900.95 |
| 25RT4DP0009 | Vehicle Repairs | - 900.95 |
| 25RT4DP0010 | Vehicle Repairs | 1,516.84 |
| 25RT4DP0010 | Vehicle Repairs | - 1,516.84 |
| 25RT4DP0011 | Vehicle Repairs | 1,001.67 |
| 25RT4DP0011 | Vehicle Repairs | - 1,001.67 |
| 25RT4DP0012 | Vehicle Repairs | 5,140.25 |
| 25RT4DP0012 | Vehicle Repairs | - 5,140.25 |
| 25RT4DP0013 | Vehicle Repairs | 168.26 |
| 25RT4DP0013 | Vehicle Repairs | - 168.26 |
| 25RT4DP0014 | Vehicle Repairs | 84.00 |
| 25RT4DP0014 | Vehicle Repairs | - 84.00 |
| 25RT4DP0014 | Vehicle Repairs | 14.00 |
| 25RT4DP0014 | Vehicle Repairs | - 14.00 |
| 25RT4DP0015 | Vehicle Repairs | 273.06 |
| 25RT4DP0015 | Vehicle Repairs | - 273.06 |
| 25RT4DP0016 | Vehicle Repairs | 201.20 |
| 25RT4DP0016 | Vehicle Repairs | - 201.20 |
| 25RT4DP0017 | Vehicle Repairs | 4,795.98 |
| 25RT4DP0017 | Vehicle Repairs | - 4,795.98 |
| 25RT4DP0018 | Vehicle Repairs | 178.25 |
| 25RT4DP0018 | Vehicle Repairs | - 178.25 |
| 22RT4PI0019 | Damages | - 2,500.00 |
| 23RT4PI0035 | Damages | 25,000.00 |
| | | |
| | | |
| | | |
| **Totals** | | **44,627.36** |

Ymddiriedolaeth Brifysgol GIG Gwasanaethau Ambiwlans Cymru Welsh Ambulance Services University NHS Trust

| | |
|---|---|
| **AGENDA ITEM No** | **12** |
| **OPEN or CLOSED** | **Open** |
| **No of ANNEXES** | **1** |

# Committee Priorities & Cycle Monitoring Report

| | |
|---|---|
| **MEETING** | Audit, Risk and Assurance Committee |
| **DATE** | 07 June 2024 |
| **EXECUTIVE** | Trish Mills, Director of Corporate Governance/Board Secretary |
| **AUTHOR** | Trish Mills, Director of Corporate Governance/Board Secretary |
| **CONTACT** | Trish.mills@wales.nhs.uk |

## EXECUTIVE SUMMARY

1. This report updates the Committee on progress against the priorities it set for 2024/25 and progress against the agreed cycle of business for the Committee. There are no matters to escalate with respect to the Priorities.

2. The Committee is reminded that the priority of oversight of the development and implementation of the Quality and Performance Management Framework (QPMF) is reflected in this update. The Finance and Performance Committee continues to be responsible for the oversight of the effectiveness of the QPMF, once implemented.

**RECOMMENDATION: -**

3. **The Committee is asked to NOTE the update.**

## KEY ISSUES/IMPLICATIONS

No issues to raise.

## REPORT APPROVAL ROUTE

Not applicable

| REPORT APPENDICES |
|---|
| Annex 1 – Audit Committee Cycle of Business Monitoring Report |

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

## COMMITTEE PRIORITIES FOR 2024/25 AND CYCLE MONITORING REPORT

### SITUATION

4. This report updates the Committee on progress against the priorities it set for 2023/24 and progress against the agreed cycles of business. There are no matters to escalate with respect to the Priorities.

### BACKGROUND

5. During the course of the effectiveness reviews, it was agreed that it is good practice for Committees to set priorities for the forthcoming year. The Committee's priorities, which are set out below, were agreed by the Trust Board in May 2024 and will be tracked quarterly.

6. The Committee's Cycle of Business was approved by the Committee in April 2024. The agenda is set with reference to that cycle, together with the forward planner, action log and highest rated principal risks.

7. The monitoring report is at Annex 1. Items in green show they are cycled for a particular meeting. Items in beige indicate they are a prompt at agenda setting as they may be ad hoc items such as business cases or external reports. The blue indicates that the item is either on the agenda as scheduled or is an ad hoc item which was discussed in agenda setting.

### ASSESSMENT

8. The Committee priorities, and progress against them is as follows:

| Priority | Progress |
|---|---|
| Monitor the development of the Committee specific induction programme | • This activity will commence in 2024/25. |
| Oversight of the development and implementation of the Quality & Performance Management Framework | • The Committee received a verbal update regarding the implementation of the Quality and Performance Management Framework at its meeting in November. |

| | |
|---|---|
| | • It was agreed that an update was not required for the March 2024 meeting however the reporting for this will be actively considered for early 2024/25.<br><br>• This business will be considered for Committee / programmed in Q3 at the earliest in 2024/25. It was deferred for receipt from Q2. |

**RECOMMENDATION: -**

9. **The Committee is asked to NOTE the update.**

| PAPER | PRE or POST C'EE FORUM | FREQUENCY | Q1a | Q1b | Q2 | Q3 | Q4 | LEAD | PURPOSE | COMMENT |
|---|---|---|---|---|---|---|---|---|---|---|
| **AUDIT, RISK AND ASSURANCE COMMITTEE - CYCLE OF BUSINESS 2024/25** | | | | | | | | | | |
| For the rationale for this Committee's cycle see Note 8 | | | | | | | | | | |
| **Annual filings** | | | | | | | | | | |
| Annual accounts planning and emerging issues report | ELT | Annually | | | | | | EDOF | Assurance | |
| Annual report timetable | ELT | Annually | | | | | | BS | Assurance | |
| Audited accounts | ELT and Board | Annually | | → | | | | EDOF | Endorsement | Programmed for extraordinary meeting on 10 July 2024. |
| Annual report | ELT and Board | Annually | | → | | | | BS | Endorsement | Programmed for extraordinary meeting on 10 July 2024. |
| Head of internal audit report and opinion | ELT and Board | Annually | | | | | | Internal Audit | Assurance | |
| Audit report on accounts | ELT and Board | Annually | | → | | | | Audit Wales | Assurance | Programmed for extraordinary meeting on 10 July 2024. |
| Self-assessment against Governance Code 2017 | ELT | Annually | | | | | | BS | Assurance | |
| **Internal Audit** | | | | | | | | | | |
| Audit Plan | ELT | Annually | | | | | | Internal Audit | Approval | |
| Internal audit reports | ELT and C'ees | Quarterly | | | | | | Internal Audit | Assurance | |
| **Audit Wales** | | | | | | | | | | |
| Audit Plan | ELT and Board | Annually | | | | | | Audit Wales | Review | Q1a: Programmed as not ready for Q4 23/24. |
| Update report | N/A | Quarterly | | | | | | Audit Wales | Assurance | |
| Annual Audit Report | ELT and Board | Annually | | | | | | Audit Wales | Assurance | Q1a: Programmed as not ready for Q4 23/24. |
| Structured Assessment | ELT and Board | Annually | | | | | | Audit Wales | Assurance | |
| Other Non-Core Reports | ELT and Board | Various | | | | | | Audit Wales | Assurance | |
| **Losses & Special Payments/Single Tender Waivers** | | | | | | | | | | |
| Quarterly lossess and special payments report | N/A | Quarterly | | | | | | EDOF | Approval | |
| Tender update report and single tender waiver request | N/A | Quarterly | | | | | | EDOF | Assurance | |
| **Counter fraud** | | | | | | | | | | |
| Counter fraud update report | N/A | Quarterly | | | | | | EDOF | Assurance | |
| Counter fraud annual report | ELT | Annually | | | | | | EDOF | Assurance | |
| Counter fraud update work plan | ELT | Annually | | | | | | EDOF | Approval | |
| **Standing Orders & Standing Financial Instructions** | | | | | | | | | | |
| Standing Orders & Standing Financial Instructions | ELT and Board | Annually | | | | | | BS | Endorsement | Q2: SoRD received in April will be returned on 10 July ARAC before being taken to TB for approval. |
| Breach of Standing Orders & Standing Fin. Instructions | ELT | Ad Hoc | | | | | | BS | Discussion/Assurance | |
| Governance Practice Notes | ELT | Annually | | | | | | BS | Approval | |
| **Whistleblower, Declarations, Gifts & Hospitality** | | | | | | | | | | |
| Annual report on declarations of interest | ELT | Annually | | | | | | BS | Assurance | |
| Report on gifts and hospitality | ELT | Annually | | | | | | BS | Assurance | |
| Whistleblower report | TBC | TBC | | | | | | BS | TBC | |
| **Other** | | | | | | | | | | |
| Near Miss Report | QUEST | Annually | | | | | | TBC | Assurance | |
| Quality and Performance Management Framework | ELT | Bi-Annually | | → | | | | EDON | Assurance | *Oversight of the development/implementation of the Framework.* |
| **Policy** | | | | | | | | | | |
| Policy report | ELT | Quarterly | | | | | | BS | Assurance | |
| Policies | Policy Group | Ad Hoc | | | | | | BS | Approval | |
| Financial procedures | TBC | Ad Hoc | | | | | | EDOF | Approval | |
| **Risk Management** | | | | | | | | | | |
| Review of risk related elements in IMTP | STB | Annually | | | | | | BS | Assurance | |
| Board Assurance Framework | ELT | Each meeting | | | | | | BS | Assurance | |
| Corporate Risk Register | ELT | Each meeting | | | | | | BS | Assurance | |
| Audit Recommendation Tracker | ELT | Each meeting | | | | | | BS | Assurance | |
| **GOVERNANCE** | | | | | | | | | | |
| Escalations from Board Committees | Board Committee | Ad Hoc | | | | | | Committee Chair | Various | |
| Committee effectiveness reviews and annual reports | All Committees | Annually | | | | | | BS | Approval | |
| Audit Committee effectiveness review annual report | Audit/Board | Annually | | | | | | BS | Approval | |
| Audit Committee Review of Terms of Reference | Audit/Board | Annually | | | | | | BS | Approval | |
| Audit Committee Cycle of Business annual refresh | Audit/Board | Annually | | | | | | BS | Approval | |
| Audit Committee Review of Annual Priorities | None | Quarterly | | | | | | Chair | Review | |
| All Wales Audit Committee Chair's Meeting Report | AWACC | Bi-annually | | | | | | Chair | Review | Added 19.09.23 |
| **PROMPTS** | | | | | | | | | | |
| External Reports | n/a | As required | | | | | | TBC | TBC | |

Two Q1 meetings. Q1a is a governance meeting to take the Committee annual reports and other items as noted

EDOF - Executive Director of Finance and Corporate Resources

BS - Board Secretary

**Key: Pre-agenda setting**

- Cycled for each meeting
- Ad hoc item - prompt for agenda setting
- Reporting developing

**Key: Post-agenda setting**

- Presented as cycled
- Ah hoc / item considered - not programmed
- → Item deferred
- Reporting developing

| | | |
|---|---|---|
| 1 | **Losses and special payments** | Whilst SFIs provide for approval of these, the payments are in effect already made when they are presented to the AC. All payments are made within SFI delegated limits. Further work with DOFs and Finance Academy at the next version of the SFIs to look at whether ACs should retrospectively approve such payments. |
| 2 | **Whistleblowing** | Staff can currently raise concerns through the traditional routes of line management and escalation set out in the All Wales Procedure for Raising Concerns, and through the sensitive issues function in Datix. A new Speaking Up Safely framework is in development by the Director of People and Culture with oversight of the implementation with the People and Culture Committee in 2023/24. The whistleblowing process and arrangements for special investigations to come to Audit Committee. Propose regular verbal updates from the Chair of the People and Culture Committee in the interim.<br>See pages 39 and 40 of Audit Committee Handbook.<br>https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/512760/PU1934_Audit_committee_handbook.pdf<br>Audit Committee 25 July 2023 agreed that the whistleblowing process and arrangements for special investigations will come to Audit Committee with verbal updates from the Chair of the People and Culture Committee on arrangements. Cycled in for once per year. |
| 3 | **Near Miss Report** | NAO effectiveness review outcomes recommends AC reviews information on 'near misses' to help determine whether the systems in place are sufficiently robust to mitigate future risk events. Propose this is a report directed by QUEST<br><br>Audit Committee 25 July agreed that near misses would be monitored by QUEST. It noted that QUEST receives patient safety reporting which is predominantly based on the significant and catastrophic harm with moderate harm and near misses incorporated into thematic content. A more explicit near miss reporting will be developed, however there is limited capacity in the team to do so this year given the need to deal with the core requirements of national reportable incidents, Coroner requests and the Duty of Candour.<br>Discussions in H&S Board Development 220224 on near misses. In Datix a report of no harm is categorised as a near miss so can start looking at developing that reporting. Cycled in for once per year to revisit. |
| 4 | **Policy report** | Each Committee has included in their cycles of business a report on the policies in their remit and their currency. An overarching report is being developed for this Committee's oversight.<br><br>11.09.23: The Policies Report will be taken to AC quarterly, and it will not be necessary for a separate report for each Committee to be taken providing an update. The CoB has been updated to read that the Policies Report will be taken to the Committee quarterly rather than annually, and the CoB Monitoring report has been updated as well. |
| 5 | **TOR 3.2 (a) The Committee will support the Board with regard to its responsibilities for governance by reviewing: the policies for ensuring compliance with relevant regulatory, legal and code of conduct and accountability requirements.** | Key corporate policies include<br>- Counter Fraud Policy<br>- Charitable Funds Investment Policy<br>- Standards of Business Conduct<br>- Whistleblowing Policy<br>- Public Sector Payment Policy (All Wales)<br>- Risk Policy<br>- Data Protection Policy<br>- Health & Safety Policy<br>- Information Governance Policy<br>- Information Risk Policy<br>- Information Security Policy |
| 6 | **Local Counter Fraud** | Local Counter Fraud Specialists (LCFSs) are responsible for developing the anti-fraud, bribery and corruption culture within their respective health service areas and for investigating fraud cases within their own local health trusts and boards. The Welsh ministers and the NHS Counter Fraud Authority (NHSCFA) have entered into a service agreement under section 83 of the Government of Wales Act 2006, to ensure that appropriate provision is in place to tackle all matters connected to Fraud, Bribery and Corruption. It is the role of the LCFS to ensure regular engagement and reporting to senior members surrounding the work completed within this field, with the audit committee being recognised as an appropriate recipient to the status and developments of the service.<br>Service strands of hold to account, prevent and deter, inform and involve, and strategic governance |
| 7 | **QPMF** | Implementation of the QPMF to be overseen by AC. Outcomes from the framework remains with FPC. Cycled in twice per year for 2024/25 when it is anticipated this work will complete. |
| 8 | **Cycle of Business** | The cycle has been developed to align with the duties for the Committee set out in the terms of reference. Of note, paragraph 3.5 of the terms of reference requires the Committee's programme of work to be designed to provide assurance that:<br>a.there is an effective internal audit function that meets the standards set for the provision of internal audit in the NHS in Wales and provides appropriate independent assurance to the Board and the Accountable Officer through the Committee;<br>b.there is an effective counter fraud service that meets the standards set for the provision of counter fraud in the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Committee and ensure all reported fraud concerns and ongoing investigations are notified to the Committee;<br>c.there are effective arrangements in place to secure active, ongoing assurance from management with regard to their responsibilities and accountabilities, whether directly to the Board and the Accountable Officer or through the work of the Board's committees;<br>d.the work carried out by key sources of external assurance, in particular, but not limited to the Trust's external auditors, is appropriately planned and co-ordinated and that the results of external assurance activity complements and informs (but does not replace) internal assurance activity;<br>e.the work carried out by the whole range of external review bodies is brought to the attention of the Board, and that the organisation is aware of the need to comply with related standards and recommendations of these review bodies, and the risks of failing to comply;<br>f.the systems for financial reporting to the Board, including those of budgetary control, are effective;<br>g.the results of audit and assurance work specific to the Trust, and the implications of the findings of wider audit and assurance activity relevant to the Trust's operations, are appropriately considered and acted upon to secure the ongoing development and improvement of the organisations' governance arrangements;<br>h.progress is monitored against the requirement of the Auditors' Management Letter;<br>i.the Committee receives and reviews key Trust Annual Reports e.g., Trust Annual Report, Infection Control Annual Quality Statement; Annual Governance Statement and make recommendations to the Board for their adoption; and<br>j.the Committee reviews the content of the Corporate Risk Register and obtain assurance that control measures are in place to mitigate all identified risks. |

Ymddiriedolaeth Brifysgol GIG Gwasanaethau Ambiwlans Cymru Welsh Ambulance Services University NHS Trust

# AUDIT, RISK AND ASSURANCE COMMITTEE

# TERMS OF REFERENCE AND OPERATING ARRANGEMENTS 2024/25

## 1. INTRODUCTION

1.2 The Trust's Standing Orders provide that "*The Board may and, where directed by the Welsh Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees*".

1.2 In line with Standing Orders and the Trust's Scheme of Delegation, the Board shall nominate annually a committee to be known as the **Audit, Risk and Assurance Committee**. The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set out below.

1.3 The Board Committees play an important role in supporting the Board in fulfilling its responsibilities by:

- providing advice on strategic development and performance within the terms of reference;
- undertaking scrutiny and gaining assurance on key aspects of organisational performance, and supporting achievement of the Trust's strategic goals;
- carrying out specific responsibilities on the Board's behalf; and
- providing a forum where ideas can be explored in greater detail than Board meetings are able to allow, providing time and space to consider issues in greater depth.

Regular and timely reporting and escalations to the Board on the issues within the Committee's remit allow for more focused discussions by the Board.

## 2. PURPOSE

2.1 The purpose of the Audit, Risk and Assurance Committee ("the Committee") is to advise and assure the Board and the Accountable Officer on whether effective arrangements are in place - through the design and operation of the Trust's system of assurance - to support them in their decision taking, and in

discharging their accountabilities for securing the achievement of the Trust's objectives, in accordance with the standards of good governance determined for the NHS in Wales.

2.2 Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further.

2.3 The committee shall, in carrying out its functions and responsibilities, consider how their decisions secure an improvement in the quality of health services (the duty of quality) as outlined in The Health and Social Care (Quality and Engagement) (Wales) Act 2020. This includes but is not limited to ensuring the provision of high-quality, safe, and effective healthcare services that meet the needs of patients, service users, and their families.

2.4 The committee shall demonstrate the duty of quality through its own operating arrangements, ensuring that its processes, procedures, and decision-making mechanisms uphold the highest standards of transparency, accountability, and governance. It shall regularly review and refine its operating procedures to align with best practices and legal requirements, fostering an environment of continuous improvement. Furthermore, the committee shall monitor, assess, and report on the implementation of Health and Care Quality Standards, outcomes, and performance indicators where relevant within their remit.

## 3. DELEGATED POWERS AND AUTHORITY

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

(a) the adequacy of the Trust's strategic governance and assurance arrangements and processes for the maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical) designed to support the public disclosure statements that flow from the assurance process, including the Annual Governance Statement and the Annual Duty of Quality Report, providing reasonable assurance on:

(i) the organisation's ability to achieve its objectives.

(ii) compliance with relevant regulatory requirements, standards, quality and service delivery requirements and other directions and

requirements set by the Welsh Government and others.

(iii) the efficiency, effectiveness, and economic use of resources; and

(iv) the extent to which the organisation safeguards and protects all its assets, including its people,

and to ensure the provision of high quality, safe healthcare for its citizens:

(b) the Board's Standing Orders and Standing Financial Instructions (including associated framework documents, as appropriate) and receive a report from the Board Secretary on any non-compliance.

(c) the accounting policies, the accounts, and the annual report of the organisation, including the process for review of the accounts prior to submission for audit, levels of error identified, the ISA 260 Report 'Communication with those charged with Governance' and managements' letter of representation to the external auditors; the Committee shall approve all financial procedures.

(d) the Schedule of Losses and Special Payments.

(e) the register of Single Tender Actions.

(f) the planned activity and results of internal audit, external audit and the Local Counter Fraud Specialist (including strategies, annual work plans and annual reports).

(g) the adequacy of executive and management's response to issues identified by audit, inspection, and other assurance activity.

(h) proposals for accessing Internal Audit services via Shared Services arrangements (where appropriate).

(i) anti-fraud policies, whistle-blowing processes, and arrangements for special investigations.

(j) any particular matter or issue upon which the Board or the Accountable Officer may seek advice.

(k) the adequacy of the arrangements for Declarations of Interests, providing an annual report to the Board to this effect.

(l) arrangements for the discharge of the Trust's responsibility as bailee for patients' property.

3.2 The Committee will support the Board with regard to its responsibilities for governance (including risk and control) by reviewing:

(a) all risk and control related disclosure statements (in particular the Annual Governance Statement and the Annual Duty of Quality Report) together with any accompanying Head of Internal Audit statement, external audit

opinion or other appropriate independent assurances, prior to endorsement by the Board.

(b) the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.

(c) the policies for ensuring compliance with relevant regulatory, legal and code of conduct and accountability requirements.

(d) the policies and procedures for all work related to fraud and corruption as set out in National Assembly for Wales Directions and as required by the Counter Fraud and Security Management Service.

3.3 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit, and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness.

3.4 This will be evidenced through the Committee's use of effective governance and assurance arrangements to guide its work and that of the audit and assurance functions that report to it, and enable the Committee to review and form an opinion on:

(a) the comprehensiveness of assurances in meeting the Board and the Accountable Officers assurance needs across the whole of the Trust's activities, both clinical and non-clinical; and

(b) the reliability and integrity of these assurances.

3.5 To achieve this, the Committee's programme of work will be designed to provide assurance that:

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

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

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

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

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

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

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

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

(i) receive and review key Trust Annual Reports e.g., Trust Annual Report (including the Annual Governance Statement) and make recommendations to the Board for their adoption.

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

**Corporate Risks and Audit Recommendation Tracker**

3.6 The Committee has overall responsibility for ensuring that corporate risks are identified and are being properly managed within the Trust and that there are processes in place to address and take forward audit recommendations. Nevertheless, each risk from the corporate risk register and Board Assurance Framework and each recommendation from the audit tracker, will be presented to an appropriate Board Committee who will be responsible for ensuring that the Trust is managing and progressing each item as planned. In addition, these Committees will follow due process to escalate any issues to Audit, Risk and Assurance Committee for oversight, scrutiny and assurance.

Regular reports will be provided to individual Committees on those items for which they have responsibility for oversight and overall Trust-wide progress reports will be presented to each Audit, Risk and Assurance Committee.

**Authority**

3.7 The Committee is authorised by the Trust Board to investigate, or have investigated, any activity within its terms of reference. In doing so, it will have the right to seek any information it requires from any employee or inspect any books, records or documents relevant to its remit, ensuring patient/client and staff confidentiality as appropriate. All employees are directed to cooperate with any reasonable request made by the Committee.

3.8 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

3.9 The Committee is authorised to approve Trust wide policies in accordance with the policy for the Review, Development and Approval of Policies.

**Chair's Action**

3.10 There may, occasionally, be circumstances where decisions which would normally be made by the Committee need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Committee. This is most likely, but not exclusively, to arise with respect to approval of policies particularly given the current backlog.

3.11 In these circumstances, the Chair and the Lead Executive, supported by the Board Secretary as appropriate, may deal with the matter on behalf of the Committee after first consulting with at least two other Members (Non-Executive Directors).

3.12 The Board Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

**Access**

3.13 The Head of Internal Audit and the Engagement Leads/Audit Manager of External Audit shall have unrestricted and confidential access to the Chair of the Committee.

3.14 The Committee will meet with Internal and External Auditors and the nominated Local Counter Fraud Specialist without the presence of officials on at least one occasion each year.

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

**Sub Committees**

3.16 The Committee may establish sub- committees or task and finish groups to carry out on its behalf specific aspects of Committee business. Formal sub-committees may only be established with the agreement of the Board.

## 4. MEMBERSHIP

**Members**

4.1 The membership of the Committee will comprise:

| | |
|---|---|
| Chair | Non Executive Director |
| Members | Three further Non Executive Directors of the Board |

4.2 The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise e.g. Wales Audit Office, Internal Audit.

4.3 The Chair of the Trust shall not be a member of the Committee.

**Attendees**

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

- Executive Director of Finance and Corporate Resources (Committee Lead)
- Director of People and Culture
- Executive Director of Quality and Nursing
- Assistant Director of Operations, National Operations & Support
- Director of Corporate Governance/Board Secretary
- Deputy Board Secretary/Head of Risk
- Head of Internal Audit
- Local Counter Fraud Specialist

- Representative of the Auditor General
- Trade Union Partners (x2)
- Other Directors will attend as required by the Committee Chair

With the permission of the Chair, those in attendance may send a deputy in their place. This, however, does not affect the right of the Chair to require those listed above to attend.

**By Invitation**

4.5 The Committee Chair may invite the following to attend all or part of a meeting to assist it with its discussions on any particular matter:

- the Chair of the Trust
- any other Trust officials
- any others from within or outside the Trust
- the Chief Executive (Accountable Officer)

4.6 The Chief Executive (Accountable Officer) will be invited to attend meetings of the Committee and will attend to discuss the process for assurance that supports the Annual Governance Statement and the Annual Duty of Quality Report.

4.7 The Committee Chair may extend invitations to attend committee meetings to other Directors and/or Senior Managers, and to officials from within or outside the organisation to attend all or part of the meeting to assist with its discussions on any particular matter.

4.8 Members may send deputies in their absence who will act with their full authority. To instigate a substitution arrangement, the member of the Committee must notify the Board Secretary before the day of the meeting that he/she is unable to attend and the name of the member who will attend as the substitute.

**Member Appointments**

4.9 The membership of the Committee shall be determined by the Board, based on the recommendation of the Trust Chair, taking account of the balance of skills and expertise necessary to deliver the committee's remit, and, subject to any specific requirements or directions made by the Welsh Government.

4.10 Non Executive Members shall be appointed to hold office for a period of one year at a time, (Membership being reviewed by the Chairman of the Board on an annual basis) up to a maximum of their term of office. During this time a member may resign or be removed by the Board.

4.11 Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the Board, based upon the recommendation of the Trust Chair and, where appropriate, on the basis of advice from the Trust's Remuneration Committee.

**Secretariat and Support to Committee Members**

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

(a) arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and

(b) ensure the provision of a programme of organisational development for committee members, as part of the Trust's overall board development programme developed by the Director of People and Culture.

## 5. COMMITTEE MEETINGS

**Quorum**

5.1 At least two of the four members of the Committee must be present to achieve a quorum. In the absence of the Committee Chair, one of those in attendance must be designated as Chair of the meeting.

**Frequency of Meetings**

5.2 Meetings shall be held no less than quarterly and otherwise as the Chair of the Committee deems necessary, consistent with the Trust's annual plan of Board business and calendar of meetings. Meeting agendas, papers and minutes shall be circulated no less seven days prior to each meeting.

5.3 The Chair of Committee, External Auditor or Head of Internal Audit may request a private meeting if they consider that one is necessary.

**Withdrawal of individuals in attendance**

5.4 The Committee may ask any member or individual who is normally in attendance but who is not a member to withdraw to facilitate open and frank discussion of particular matters.

## 6. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/ GROUPS

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, the Board retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

6.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.3 The Committee, through its Chair and members, shall work closely with the Board's other committees, including where appropriate joint (sub) committees and groups to provide advice and assurance to the Board through the:

(a) joint planning and co-ordination of Board and Committee business; and
(b) sharing of information;

in so doing, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

6.4 The Committee will consider the assurance provided through the work of the Board's other committees and sub groups to meet its responsibilities for advising the Board on the adequacy of the Trust's overall framework of assurance.

6.5 The Committee shall embed the Trust's corporate standards, priorities and requirements, e.g., equality and human rights through the conduct of its business.

## 7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

(a) report formally, regularly and on a timely basis to the Board and the Chief Executive (Accountable Officer) on the Committee's activities. This includes verbal updates on activity, the submission of Committee minutes and written reports where appropriate throughout the year;

(b) bring to the Board and the Chief Executive (Accountable Officer's) specific attention any significant matter under consideration by the Committee; and

(c) ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive (and Accountable Officer) or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Trust.

7.2 The Committee shall provide a written, Annual Report to the Board and the Chief Executive (Accountable Officer) on its work in support of the Annual Governance Statement and the Annual Duty of Quality Report, specifically commenting on the adequacy of the assurance arrangements, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the committee's self-assessment and evaluation.

7.3 The Board may also require the Committee Chair to report upon the committee's activities at public meetings or to community partners and other stakeholders, where this is considered appropriate, e.g., where the committee's assurance role relates to a joint or shared responsibility.

7.4 The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any sub-committees established. In doing so, account will be taken of the requirements set out in the NHS Wales Audit Committee Handbook.

## 8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum (as set out in section 5)

## 9. REVIEW

9.1 These terms of reference and operating arrangements shall be reviewed at least annually but more frequently if required.

# AUDIT COMMITTEE
# ANNUAL REPORT 2023/24

## INTRODUCTION

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

2. As the factors underpinning effective governance can change, for example as people leave, organisations restructure, or strategy shifts, regular reviews of Board Committees ensure governance remains fit for purpose.

3. Standing Orders, Committee terms of reference, and Codes of Governance provide that Boards should routinely assess the effectiveness of their governance arrangements, of which the Board's Committees form an integral part.

4. The Committee met on 30 April 2024 and reviewed its terms of reference, responses to questionnaires completed by members and attendees, and its operating arrangements. Discussions were also held with the Committee Chair and Executive Lead ahead of that meeting. This Annual Report reflects on the effectiveness of the Committee in 2023/24 and proposes changes to terms of reference.

## PURPOSE OF THE COMMITTEE

5. The purpose of the Committee is to advise and assure the Board and the Accountable Officer on whether effective arrangements are in place - through the design and operation of the Trust's system of assurance - to support them in their decision taking, and in discharging their accountabilities for securing the achievement of the Trust's objectives, in accordance with the standards of good governance determined for the NHS in Wales. Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further.

## MEMBERSHIP AND ATTENDANCE

6. The Committee met five times in public and four times in private session as scheduled in 2023/24 and was quorate on each occasion. Pre-meets with the Chair and auditors was reinstated in 2023.

7. In 2023/24 the Committee was supported by the Chair and three Non-Executive Directors (NEDs) as members, and several prescribed attendees with good attendance.

8. The chart below illustrates attendance of members and prescribed attendees as listed in the terms of reference for 2023/24. Audit Wales and Internal Audit were in attendance and the Committee welcomed non prescribed attendees at various meetings.

9. It is not intended to change the membership of the Committee other than to add the Deputy Board Secretary/Head of Risk to the prescribed attendees given the regular risk reporting.

| COMMITTEE ATTENDANCE | | | | | |
|---|---|---|---|---|---|
| **Name** | **20 April 2023** | **25 July 2023** | **14 Sept 2023** | **30 Nov 2023** | **1 Mar 2024** |
| Martin Turner | | | | | |
| Peter Curran | | | | | |
| Paul Hollard | | | | | Kevin Davies |
| Joga Singh | | | | | |
| Ceri Jackson | | | | | |
| Chris Turley | | | | | |
| Lee Brooks | | Judith Bryce | Judith Bryce | | |
| Judith Bryce | | | | | |
| Liam Williams | Duncan Robertson | | | | Part |
| Angie Lewis | | | | | |
| Osian Lloyd (IA rep) | | | | | |
| Audit Wales rep | | Andrew Doughton | Fflur Jones | Fflur Jones | Fflur Jones |
| Paul Seppman | | | | | Christian Fox |
| Damon Turner | | | | | |
| Trish Mills | | | | | |
| Carl Window | | | | | |

| | |
|---|---|
| | Attended |
| | Deputy attended |
| | Apologies received |
| | No longer member |

## COMMITTEE VIEWS ON EFFECTIVENESS

10. The Committee's effectiveness was assessed through a review of its terms of reference, responses to a questionnaire, discussion with the Chair and Executive Leads, and at the 30 April Committee meeting. The questions differed from other

Committees in that the National Audit Office (NAO) Effectiveness Tool was used as it was in 2022/23.

11. The questionnaire provided an opportunity to rate essential and good practice areas based on ratings of 'room for improvement', 'meeting standards' and 'excelling'. Seventeen questionnaires were sent out with five responses being returned (a 29% return rate which was similar to 2023/24).

12. The responses were reviewed by the Committee on 30 April against the same questions from last year and most of the scores were an improvement from 2022/23.

13. The results highlighted the Committee's excellent performance across various areas including:

    - Financial reporting, where minimal areas for enhancement were identified.
    - Punctuality of submitted papers.
    - New practice of a recurring report from the Chair of the People and Culture Committee regarding the Trust's "speaking up safely" programme to assure the Committee on whistleblowing activity.
    - Membership was appropriate, with representation from Internal Audit and Audit Wales at meetings, and financial experience amongst the membership.
    - Members understand their role and what is expected of them when appointed.

14. Many of the areas raised as requiring improvement in the questionnaire were either already in train or were more relevant to government departments because of the nature of the NAO tool, however areas to strengthen include:

    - Committee level induction programme to be developed. This was planned for 2023/24 but was not progressed due to capacity in the Corporate Governance Team.
    - Lack of cyber and digital risk experience on the Board. The current NED campaign will seek to address this skills gap.
    - More of a focus on assurance mapping and assurance generally.
    - Reinstate NED and auditor only meetings of the Committee annually.
    - Committee Chair to meet quarterly with Audit Committee members.

15. The Committee has a cycle of business that is aligned to its terms of reference. All matters scheduled for oversight and review have been brought to the Committee and in this respect, it has discharged its responsibilities in providing assurance to

the Board aligned to its terms of reference. The Audit Wales annual audit plan and annual audit report have been carried over from Q4 into the April 2024 meeting as agreed.

16. The Committee's business in 2023/24 included the following, full details of which are in the Committee's AAA reports and minutes provided to the Board:

16.1. In July 2023 the Committee **endorsed the 2022/23 Annual Accounts and the Annual Report** which were shortly after approved by the Board. The Audit Report was also reviewed at that meeting as was the Head of Internal Audit Annual Report and Opinion. The plan for development of the 2023/24 annual filings was received in March 2024 and endorsed.

16.2. At each meeting other than in April, which is a meeting dedicated to the review of Committee effectiveness, members received an **update from Audit Wales and from Internal Audit** on their programmes of work and performance indicators (Internal Audit).

16.3. The following **Internal Audit Reports** were presented by Internal Auditors and discussed by this Committee. They were also reviewed by the Committees with specific remits over the subject area. The list below includes a mix of 2022/23 and 2023/24 Internal Audits:

- Risk Management and Assurance
- Savings and efficiencies
- Trade Union Release Time
- Pain Management
- IM&T Infrastructure
- Follow UP Action Tracker Review
- Cyber Security
- Health and Safety
- Senior Paramedic Role
- Records Management
- Technical Resilience
- Estates Assurance: Estates Condition
- Decarbonisation
- Vehicle Replacement Programme
- ePCR Clinical Compliance
- Serious Adverse Incidents Joint Investigation Framework
- Strategy Development
- Retention of Staff
- 111 Commissioning

16.4. The **2024/25 Internal Audit Plan was approved** by the Committee in March 2024, as was the Internal Audit Charter and fee.

16.5. In November 2023 Audit Wales presented the **WAST Review of Workforce Planning Arrangements** and the NHS Workforce Data Briefing from the Auditor General for Wales. The report found overall that the Trust is taking effective steps to mitigate current workforce challenges and clarify its longer-term strategic vision, however medium to longer-term resourcing is a significant and ongoing barrier.

16.6. In March 2024 the Audit Wales Update presented the **WAST 2023 Structured Assessment**. Members noted the positive report and the improvements year on year, and thanked all teams involved. The four recommendations and management actions were noted, and this Committee will monitor progress.

16.7. Two areas of **non-compliance with the Standing Orders** were discussed and escalated to the Board. The Committee was assured that both areas were being appropriately addressed in a timely way:

- The first related to the availability of Board papers ten calendar days before a Board meeting. It was noted that whilst the Trust could make continued improvements on uploads to papers to ensure they are at least seven days ahead of Board meeting, the timeliness of data and information was key and a ten day period would potentially provide outdated information, particularly when factoring in governance processes ahead of that time. The Standing Orders were later amended to provide for a seven day timeframe.
- The second related to an issue raised in the vehicle replacement programme internal audit but had wider application. This centred on the approval of individual contracts by the Board. The Audit Committee received a verbal update on the plan to address this in March 2024 and will receive amendments to the Scheme of Reservation and Delegation and a Governance Practice Note to address this at its April 2024 meeting.

16.8. Amendments to **Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation** were reviewed and endorsed for the Board. Governance Practice Notes developed for interpretation and application of some parts of the Standing Orders were also approved.

16.9. The Committee reviewed the current state of play of **Policies** in July 2023 and agreed a prioritisation plan for 2023/24 and 2024/25. Members have been updated on progress at each meeting.

16.10. In April 2023 the Committee reviewed the **self-assessment against 2017 Governance Code** and noted that there were no areas where the Trust did not comply. A self-assessment against the Governance, Leadership and Accountability elements of the Health and Care Standards was also reviewed.

16.11. In September 2023 the **Audit Process and Reporting Handbook** was presented to the Committee. The Committee approved the handbook, which includes the roles and responsibilities for management, this Committee and other Board Committees as they relate to audit reviews. A revised approach to reporting was also approved which will position this Committee to focus on the overall framework and escalations where audit management actions are not met in reasonable timescales.

16.12. In September 2023 the Committee was assured that an **induction programme** was in place for new Board members which set out the roles and responsibilities of all those who are members of or attend the Board.

16.13. In November an update was received regarding the **implementation of the Quality and Performance Management Framework** (QPMF), oversight of which transferred to this Committee from the Finance and Performance Committee in-year. Revised terms of reference are in place for the QPMF Steering Group (which reports to Executive Leadership Team), and a work plan is in place

16.14. Other than in April, the **losses and special payments** report is received at each meeting of the Committee. Likewise, **the Local Counter Fraud** update report and **tender and single tender waiver** reports are taken in private session.

16.15. The Committee received assurance from the Chair of Quest that the **clinical audit plan** had been approved and was being monitored quarterly by that Committee.

16.16. The Committee received assurance from the Chair of the People and Culture Committee that the **arrangements for whistleblowing** and speaking up safely were developing well with the All Wales Speaking Up Safety Framework in place, guardians operating at WAST, and the Work in Confidence platform operating for confidential reporting.

16.17. The **Register of Interests and the Register of Gifts and Hospitality** was received in April 2023 and the Standards of Business Conduct Policy approved in July 2023.

16.18. A **risk management and BAF** report was provided to each meeting. This Committee has oversight of the risk management transformation programme and noted delays in some deliverables given capacity in the team, however good progress against the principal risks was recognised as was the excellent risk culture at the Trust. Areas of focus for 2024/25 are to deliver a strategic BAF that reflects more closely the Trust's strategic objectives against its long-term strategy – Delivering Excellence: Vision 2030. Additionally, work will be undertaken to develop a series of strategic risks and risk appetite statements and will see the roll out of a programme of education and training across the Trust in support of the Risk Management Framework.

16.19. The **Risk Management Policy** was approved in March 2024, as was the **Local Counter Fraud Policy**.

16.20. Members **reflections** after each meeting included that papers were of good quality, concise and easy to read; presenters were clear; attendance and contributions at the meeting was excellent; focus on governance issues was welcomed; system of control was very good; good progress on risk and audit tracker; wider attendance of colleagues was welcomed; hybrid approach was considered to work well; and good focus on key audit points.

16.21. The 2023/24 Committee **cycle of business** was approved.

16.22. The **2022/23 annual effectiveness review** was conducted in the April 2023 meeting. At this meeting the Committee also reviewed the annual reports and changes to terms of reference for all Board Committee and Advisory Groups.

16.23. The **Committee's priorities for 2023/24** are reviewed at each meeting and a more detailed update appears later in this report. The Committee also reviews progress against its cycle of business at each meeting.

17. The Board received a highlight (AAA) report from this Committee by email circulation following each meeting which included alerts, advice, and areas of assurance. Where there was a shorter proximity of the meeting of this Committee and the Board meeting, that report was provided verbally by the Chair and captured in the Board's minutes. This AAA report included reporting at a high level of matters taken in private session.

18. The Committee is not serviced by any Sub-Committees or task and finish groups that this time.

## PROPOSED CHANGES TO THE TERMS OF REFERENCE

19. The Audit Committee's terms of reference were reviewed to ensure all matters within the remit of the Committee were clear and were articulated with the oversight and scrutiny role of the Committee in mind. The following changes are proposed for consideration by the Audit Committee:

    - Change of name from Audit Committee to Audit, Risk and Assurance Committee (ARAC). The National Audit Office recognises this as best practice nomenclature, and it describes more appropriately the wider remit of the Committee and the focus in 2024/25 and beyond on the strategic Board Assurance Framework and the programme of integrated governance and assurance.
    - The addition of the Deputy Board Secretary/Head of Risk to the prescribed attendees.
    - Addition of a Chair's Action provision. It is likely that this would be utilised primarily for policy approval where waiting a quarter for a scheduled meeting would cause undue delay.
    - Addition of the commitment of the Committee to continuous improvement and the duty of quality.

20. Changes in operating arrangements in 2024/25 to address issues raised in the survey will include those issues raised as areas requiring improvement at paragraph 14.

## COMMITTEE PRIORITIES:

21. The Committee received an update on progress against its priorities at each meeting. The 2023/24 priorities were:

| Priority | Progress |
|---|---|
| Review of the Board Member Induction Programme and Annex | The induction programme and annex documents were updated and reviewed by the Committee in September 2023. |
| Oversight of the development and effectiveness of the Quality & Performance Management Framework | The Committee received a verbal update regarding the implementation of the Quality and Performance Management Framework at its meeting in November. |

| Priority | Progress |
|---|---|
| | It was agreed that an update was not required for the March 2024 meeting however the reporting for this will be actively considered for early 2024/25. |

22. It is good practice for Committees to set priorities for the forthcoming year when they review their effectiveness. Accordingly, the Committee has agreed the following priorities for 2024/25:

    (a) Monitor the development of the Committee specific induction programme.
    (b) Carry over the priority to monitor the implementation of the Quality and Performance Management Framework.

23. Progress on priorities will be reported to the Committee quarterly and to the Board through its highlight report.

## NEXT STEPS

24. The next steps are to update the cycle of business with revised terms of reference

## RECOMMENDATION

25. The Trust Board is requested to

    (a) Receive and note the contents of the Committee Annual Report for 2023/24 and analysis of its effectiveness; and
    (b) Approve the changes to the Terms of Reference and operating arrangements.