

Bundle Audit, Risk and Assurance Committee (Open) 12 September 2024

Agenda attachments

- ITEM 00 Agenda
- 0 09:30 – OPENING ITEMS
- 1 Chair's Welcome, Apols and Quorum
- 2 Declarations of Interest
 - ITEM 02 Board Member Register of Interests
- 3 Minutes of the Last Meeting: 10 July 2024
 - 2024-07-10 Draft ARAC OPEN Minutes
- 4 Action Log & Matters Arising:
 - ITEM 04 Action Log
 - ITEM 04.1 Audit Committee AAA Report June and July 2024
- 5 09:35 – Chair's Report on Continuous Committee Effectiveness
- 5.1 FOR APPROVAL, ASSURANCE AND DISCUSSION
- 6 09:50 – Internal Audit Progress Report and IA Reports:
 - Item 6.1 Volunteers Governance*
 - Item 6.2 Disciplinary Case Management Compassionate Practices*
 - Item 6.3 Risk Management*
 - ITEM 06 WAST_2425_Internal Audit Progress Report_September 24
 - ITEM 06.1 WAST 2324-11_VGovernance_Final Internal Audit Report_for Trust – Copy
 - ITEM 06.1 WAST Disciplinary Case Management Compassionate Practices Final Internal Audit Report for Trust issue
 - ITEM 06.3 WAST-2324-01-Risk Management_Final Internal Audit Report
- 7 10:20 – Audit Wales Update Report
 - ITEM 07 WAST Audit Committee Update 12092024
- 8 10:35 – Risk Management and Board Assurance Framework
 - ITEM 08 Executive Summary Risk Management Report ARAC 120924
 - ITEM 08.1 240807_WAST_Risk Advisory Guidance Document_Final_TO CLIENT
 - ITEM 08.2 WAST-2324-01-Risk Management_Final Internal Audit Report
- 8.1 11:05 – COMFORT BREAK
- 9 11:20 – Audit Tracker
 - Note – Full trackewr circulated by e mail*
 - ITEM 09 Audit Tracker – Q1 Reporting – April-June Reporting – SBAR for ARAC
 - ITEM 09.1 Audit Tracker ARAC
 - ITEM 09.1a Audit Wales
 - ITEM 09.1b note
- 10 11:35 – Policy Report
 - ITEM 10 Executive Summary Policy Report AC 120924
- 11 11:45 – Quality and Performance Management Framework
 - ITEM 11.1 QPMF Terms of Reference v.4 – Approved by ELT 220524
 - ITEM 11 QPMF Update SBAR Audit Committee 202409 (Final)File replaced
- 12 12:00 – Assurance to ARAC on Speaking Up Safely Arrangements at WAST
 - ITEM 12 Speaking Up Safely Assurance from PCC Chair
- 13 12:10 – Losses and Special Payments
 - ITEM 13 Executive Summary SBAR Losses and Special Payments
 - ITEM 13.1 Annex 1 – Losses Special and Payments 2024-25 M2-4
- 14 12:15 – All Wales Audit Committee Chairs Update
 - ITEM 14 Chairs of Audit Committees Operating Arrangements Final
- 14.1 CONSENT ITEMS
- 15 Cycle of Business Monitoring Report and Committee Priorities
 - ITEM 15 Audit Committee Priorities and Cycle Monitoring Report
 - ITEM 15.1 ARAC CoB Monitoring report
 - ITEM 15.1a ARAC CoB notes
- 15.1 CLOSING ITEMS

- 16 Reflections and Summary of Decisions/Actions
- 17 Any Other Business
- 18 Date & Time of the Next Meeting: 21 November 2024 at 09:30

Length of Meeting:	02:55	Agenda Status:	[OPEN] AUDIT, RISK AND ASSURANCE COMMITTEE - 12 September 2024					Deadline for Papers:
Time	Mins allotted	Agendum	Title	Format	Item for	Item requested by	Paper prepared by	Item presented by
OPENING ITEMS								
		1	Chair's Welcome, Apols and Quorum	Verbal	Information	Standing	n/a	Chair
09:30	00:05	2	Declarations of Interest	Verbal	To State Conflicts	Standing	n/a	Chair
		3	Minutes of the Last Meeting: 10 July 2024	Paper	Approval	Standing	n/a	Chair
		4	Action Log & Matters Arising: Item 4.1 Committee Highlight Report 7 June 2024 and 10 July 2024	Paper	Discussion	Standing	n/a	Chair
09:35	00:10	5	Chair's Report on Continuous Committee Effectiveness	Paper	Discussion	Standing	n/a	Chair
FOR APPROVAL, ASSURANCE AND DISCUSSION								
09:45	00:30	6	Internal Audit Progress Report and IA Reports: Item 6.1 Volunteers Governance Item 6.2 Disciplinary Case Management Compassionate Practices Item 6.3 Risk Management	Paper	Assurance	CoB	Internal Audit	Osian Lloyd 6.1 Internal Audit/ Judith Bryce 6.2 Internal Audit / Angela Lewis 6.3 Internal Audit /Trish Mills
10:15	00:15	7	Audit Wales Update Report	Paper	Assurance	CoB	External Audit	Fflur Jones
10:30	00:30	8	Risk Management and Board Assurance Framework	Paper Presentation	Assurance	CoB	Gov	Julie Boalch
11:00	00:15	COMFORT BREAK						
11:15	00:15	9	Audit Tracker	Paper	Assurance	CoB	Gov	Trish Mills
11:30	00:10	10	Policy Report	Paper	Assurance	CoB	Gov	Julie Boalch
11:40	00:15	11	Quality and Performance Management Framework	Paper	Assurance	CoB	SPP	Rachel Marsh
11:55	00:10	12	Assurance to ARAC on Speaking Up Safely Arrangements at WAST	Paper	Assurance	CoB	Gov	Trish Mills
12:05	00:05	13	Losses and Special Payments	Paper	Assurance	CoB	FinCor	Chris Turley
12:10	00:05	14	All Wales Audit Committee Chairs Update	Paper	Discussion	Ad Hoc	Gov	Chair
CONSENT ITEMS								
12:15	00:00	15	Cycle of Business Monitoring Report and Committee Priorities	Paper	Assurance	CoB	Gov	Trish Mills
CLOSING ITEMS								
		16	Reflections and Summary of Decisions/Actions	Verbal	Discussion	Standing	n/a	Chair
12:15	00:10	17	Any Other Business	Verbal	Discussion	Standing	n/a	Chair
		18	Date & Time of the Next Meeting: 21 November 2024	Verbal	Information	Standing	n/a	Chair
12:25	02:55	CLOSE						

LEAD PRESENTERS

Name	Position
Julie Boalch	Assistant Director of Corporate Governance & Risk/Deputy Board Secretary
Peter Curran	Non-Executive Director and Committee Chair
Fflur Jones	Audit Wales
Osian Lloyd	Head of Internal Audit
Trish Mills	Director of Corporate Governance/Board Secretary
Chris Turley	Executive Director of Finance and Corporate Resources
Judith Bryce	Assistant Director of Operations
Angela Lewis	Director of People and Culture

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended	Left Trust
BROOKS, Lee	Executive Director of Operations	Partner employed by Welsh Ambulance Services NHS Trust	Any Other Interest	July 2019		
		Member of the Order of St John	Any Other Interest	01 March 2023		
		Volunteer – St John's Ambulance Cymru	Any Other Interest	06 April 2023		
		Council Member – St John's Ambulance Cymru Gwent Council	Any Other Interest	06 April 2023		
CURRAN, Peter	Non-Executive Director * Chair of the Audit Committee * Member of the Finance and Performance Committee * Member of the Remuneration Committee	Trustee of Action for Children [1097940]	Position in Charity or Voluntary Organisation	01 February 2021		
		Company Director - Action for Children [04764232]	Directorships	01 February 2021		
		Company Director - Action for Children (Wales) Ltd [10011497]	Directorships	05 April 2022		
		Trustee of National Youth Arts Wales [1170643]	Position in Charity or Voluntary Organisation	06 May 2021		
		Company Director - National Youth Arts Wales [10449512]	Directorships	06 May 2021		
		Non-Executive Director for Taff Housing	Position in Charity or Voluntary Organisation	01 May 2022		
		Company Director - Team Police Ltd [12518812]	Directorships	01 January 2022		
		Independent Board Member of the Project Board - National Contemporary Art Gallery for Wales	Any Other Interest	01 January 2024		
		Interim Finance Director for Torfaen Leisure Trust	Directorships	01 September 2023	29 February 2024	
		Interim Independent Member – Kaplan International Colleges UK Ltd [05268303]	Directorships	01 March 2024		
		Independent Member – Kaplan Open Learning (inc member of the Audit & Risk Committee)	Directorships	21 March 2024		
		DAVIES, Kevin	Non-Executive Director * Member of Academic Partnership Committee * Member of Audit Committee * Member of Finance & Performance Committee * Member of Quality, Patient Experience & Safety Committee * Member of Remuneration Committee	Colonel Commandant Queen Alexandra's Royal Army Nursing Corps	Any other interest	May 2020
Charity Trustee – Queen Alexandra's Royal Army Nursing Corps Association	Position in Charity/Voluntary Organisation			28 January 2021		
Patron Motivation and Learning Trust	Position in Charity or Voluntary Organisation			2014	December 2023	
Chair ABF The Soldiers Charity (Glamorgan)	Position in Charity/Voluntary Organisation			2015		
Honorary Colonel 203 (Welsh) Multi-Role Medical Regiment (Commanding Officer's Principal Advisor)	Any Other Interest			01-Apr-24		
Member Royal College Nursing	Any other interest			1978		
DENNIS, Colin	Chair of Trust Board and Non-Executive Director * Chair of Remuneration Committee	Chair - Citizen Housing [Charity] (previously WM Housing Group)	Position in Charity or Voluntary Organisation	01 January 2015		
		Company Director - Citizen Treasury PLC (previously WM Housing Treasury Ltd)	Directorships	29 August 2017		
		Company Director - Citizen Treasury Vehicle Ltd	Directorships	04 September 2017		
		Chair - North Devon Homes	Position in Charity or Voluntary Organisation	01 October 2021		
		Company Director - North Devon Homes	Directorships	01 April 2022		
		Chair - Green Square Accord (Housing Association)	Position in Charity or Voluntary Organisation	26 March 2024		
		Company Director - LowCarbonLiving Homes Ltd [04207671]	Directorships	26 March 2024		
		Company Director - Green Square Estates Ltd [8719365]	Directorships	26 March 2024		
		Managing Director (Employed) at My Choice Healthcare Limited.	Any Other Interest	01 June 2019		
EVANS, Bethan	Non-Executive Director * Chair of Quality, Patient Experience & Safety Committee * Member of Charity Committee * Member of Finance & Performance Committee * Member of People & Culture Committee * Member of Remuneration Committee	Non-Executive Board Member at RHA (Social Housing Organisation - Community Benefit Society)	Position in Charity or Voluntary Organisation	01 November 2019		
		Company Director - My Choice Healthcare South Wales Limited	Directorships	11 March 2020		
		Company Director - Moorlands Rehabilitation (Staffordshire) Limited.	Directorships	20 December 2019		
		Company Director - Springfield (Bargoed) Limited.	Directorships	12 March 2020		
		Company Director - Homes of Excellence Limited	Directorships	19 March 2021		
		Company Director - Victoria House Care Property Limited	Directorships	05 March 2020		
		Company Director - My Choice Healthcare (Four) Limited	Directorships	27 April 2022		
		Company Director - Luk Ros Property Limited	Directorships	12 March 2020		
		<i>(Previously called Homes of Excellence Healthcare Limited, Company name changed 12.08.2022 - #12513139)</i>	Directorships	12 March 2020		
		Company Director - Hawthorn Court Property Limited	Directorships	27 April 2022		
		<i>(Previously called My Choice Healthcare (Three) Limited, Company name changed 12.08.2022 - #13371375)</i>	Directorships	27 April 2022		
		Company Director - Ocean Living Property Limited	Directorships	22 July 2022		
		Company Director - Hawthorn Court Care Limited	Directorships	22 July 2022		
		Company Director - Glyncomel Property Limited	Directorships	01 July 2022		
		Company Director - My Choice Healthcare (Two) Limited	Directorships	01 July 2022		
		Company Director - Carmarthen Care Limited	Directorships	02 January 2024		
		Company Director - Towy Castle Property Limited	Directorships	01 September 2023		
HITCHON, Estelle	Director of Partnerships and Engagement	Nil Declaration				

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended	Left Trust
JACKSON, Ceri	Non-Executive Director & Vice Chair of the Trust Board * Chair of Charity Committee * Chair of the People and Culture Committee * Member of Audit Committee * Member of Quality, Patient Experience & Safety Committee * Member of Remuneration Committee	Management Consultant primarily working in third sector	Interest in Companies and Securities	01 May 2019		
		Associate Director of SamKat Consulting Ltd in my capacity as self-employed management consultant	Directorships	01 June 2021		
		Charity Trustee - Stroke Association Trustee, Chair Wales Advisory Group.	Position in Charity or Voluntary Organisation	08 October 2020		
		Charitable Company - Stroke Association - Company Director	Directorships	08 October 2020		
KILLENS, Jason	Chief Executive	Honorary Professor - Swansea University	Personal or Departmental Sponsorship	2019		
		Member of the Order of St John	Any Other Interest	2009		
LEWIS, Angela	Director of Workforce and Organisational Development [12 September 2022]	Nil Declaration				
MARSH, Rachel	Executive Director of Strategy, Planning and Performance	Nil Declaration				
MILLS, Patricia (Trish)	Board Secretary	Nil Declaration				
PARRY, Hugh	Trade Union Partner	Nil Declaration				
ROWAN, Hannah	Non-Executive Director * Chair of Academic Partnership Committee * Member of Charity Committee * Member of People & Culture Committee * Member of Remuneration Committee	Director, St Martin's Associates (Business consulting and coaching)	Directorships	04 April 2022		
		Non -Executive Director Qualifications Wales (regulator for all non degree qualifications in Wales)	Any Other Interest	01 April 2021		
		Trustee MAE Cymru (Christian charity which champions gender equality in church of Wales)	Position in Charity or Voluntary Organisation	13 November 2021	November 2023	
		Elected member, The governing body of the church in Wales (Parliament of church in Wales - voting member)	Any Other Interest	01 April 2021		
		Relative (Parent) is a Non-Executive Director for Social Care Wales	Any Other Interest	01 April 2017		
SAMMUT, Jonathan (Jonny)	Director of Digital Services [appointed 26.09.2023]	Fellow of the British Computer Society – FBCS	Any Other Interest	04 March 2024		
		Panel Member of the UK CIO Advisory Panel – Digital Health	Any Other Interest	05 July 2023		
		Federation of Informatics Professionals - Leading Practitioner	Any Other Interest	25 April 2024		
		Geldards LLP	Any Other Interest	03 March 2009		
		Membership of the Law Society	Any Other Interest	01 January 2006		
SINGH, Anoop Joga (Joga)	Non-Executive Director * Chair of the Finance & Performance Committee * Member of the Audit Committee * Member of People & Culture Committee * Member of Remuneration Committee	Membership of the Employment Lawyers Association	Any Other Interest	01 January 2006		
		Member of the Fairness, Inclusion & Respect Committee for the Institute of Civil Engineers in Wales	Position in Charity or Voluntary Organisation	01 March 2018	31 December 2023	
		Independent Member of the South Wales Police Ethics Committee, 2 – 3 days a year.	Any Other Interest	01 March 2018		
		Strategic Advisor to College of Paramedics	Any Other Interest	01 January 2020		
		Treasurer of Royal Gwent Hospital League of Friends.	Position in Charity or Voluntary Organisation	01 February 2022		
SWINBURN, Andrew (Andy)	Executive Director of Paramedicine	Nil Declaration				
TURLEY, Christopher	Executive Director of Finance and Corporate Resources	Treasurer of Royal Gwent Hospital League of Friends.	Position in Charity or Voluntary Organisation	01 February 2022		
TURNER, Damon	Trade Union Partner	Nil Declaration				
WILLIAMS, Liam	Executive Director of Quality and Nursing [from 01 August 2022]	Chair/Director - Thornbury Carnival Community Interest Company Voluntary	Position in Charity or Voluntary Organisation	01 August 2019		
		Member Royal College Nursing	Any Other Interest	01 August 2022		
		Committee member Royal College Nursing, Nurses in Management and Leadership Forum Steering Committee	Position in Charity or Voluntary Organisation	01 August 2022		



GIG
CYMRU
NHS
WALES

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

WELSH AMBULANCE SERVICES UNIVERSITY NHS TRUST

UNCONFIRMED MINUTES OF THE OPEN MEETING OF THE AUDIT, RISK AND ASSURANCE COMMITTEE OF THE WELSH AMBULANCE SERVICES UNIVERSITY NHS TRUST HELD ON WEDNESDAY 10 JULY 2024 VIA TEAMS

Meeting Commenced at 09:00

PRESENT:

Peter Curran	Non-Executive Director and Committee Chair
Ceri Jackson	Non-Executive Director and Vice Chair of the Trust Board
Joga Singh	Non-Executive Director

IN ATTENDANCE:

Julie Boalch	Head of Risk/Deputy Board Secretary
Christian Fox	Trade Union Partner
Jill Gill	Head of Financial Accounting
Jason Killens	Chief Executive Officer
Angela Lewis	Director of People and Culture
Osian Lloyd	Head of Internal Audit, NWSSP
Rachel Marsh	Executive Director of Strategy, Planning and Performance
Trish Mills	Director of Corporate Governance/Board Secretary
Steve Owen	Corporate Governance Officer
Madrún Parry-Jones	Finance Graduate (Observer)
Alex Payne	Corporate Governance Manager
Yvonne Thomas	Audit Wales
Chris Turley	Executive Director of Finance and Corporate Resources
Damon Turner	Trade Union Partner
Liam Williams	Executive Director of Quality and Nursing
Carl Window	Local Counter Fraud Manager

APOLOGIES:

Judith Bryce	Assistant Director of Operations
Kevin Davies	Non-Executive Director
Fflur Jones	Audit Wales

35/24 PROCEDURAL MATTERS

The Chair welcomed all to the meeting noting the apologies of Judith Bryce, Kevin Davies and Fflur Jones.

Minutes:

The Minutes of the Audit Committee meeting held on 7 June 2024 were approved.

Committee Highlight Report

The Committee highlight report of 7 June 2024 was received for information.

RESOLVED: The Committee.

(1) Noted the apologies of Judith Bryce, Kevin Davies and Fflur Jones.

(2) Approved the Minutes of 7 June 2024.

(3) Received the Committee Highlight report of 7 June 2024

36/24 2023-24 ANNUAL ACCOUNTS AND ANNUAL REPORT

2023-24 Annual Audited Accounts

Chris Turley presented the Committee with the final audited accounts for 2023/24 noting that they have been prepared to comply with International Financial Reporting Standards (IFRS) adopted by the *European Union, in accordance with HM Treasury's FReM by the Welsh Ambulance Services NHS Trust under schedule 9 section 178 Para 3 (1) of the National Health Service (Wales) Act 2006 (c.42) in the form in which the Welsh Ministers, with the approval of the Treasury, directed. The following areas were highlighted:

1. Draft accounts were submitted by the Trust on 03 May 2024, in line with the timescales for 2023-24.
2. There was a retained surplus of £0.085m for the 2023/24 financial year which was comprised of; total Income of £306.835m, and net Expenditure of £306.750m. There was an increase of income from patient care activities last year of £8.8m, and an increase in total income of £10.4m. The increase from last year of total net expenditure was also c£10.4m.
3. The Trust had met its financial duty to break even over the three years 2021/2022 to

2023/2024.

4. Expended Capital Investment funds of £25.301m (including IFRS16 leases funding), thereby utilising 100% of the Trust's Welsh Government set Capital Expenditure Limit.
5. The Trust had achieved the Public Sector Payments Policy (PSPP) of 96.4% within 30 days against the 95% target.
6. The financial statements were free of material misstatements; there were a number of corrected and a very small number of agreed uncorrected misstatements. The corrected misstatements were reflected in the accounts and all misstatements reported within the auditors ISA 260 report. None of the corrected misstatements affected the disclosed surplus of £0.085m.

Audit Report, 2023-24 Accounts (Inc. Letter of Representation)

Yvonne Thomas, on behalf of Audit Wales (AW), provided their report (ISA 260) that indicated it was the intention of the Auditor General for Wales to issue an unqualified certificate and report on the 2023/24 financial statements, citing that they provided a true and fair view of the Trust's finances in the 2023/24 financial year.

In terms of significant issues, as detailed on page six, two misstatements were identified which remain uncorrected. These do not impact the Trust's retained surplus position for the year-end, nor do they affect the audit opinion. Yvonne Thomas took the opportunity to thank Chris Turley, Jill Gill, and the wider Finance Team for their co-operation in completing the audit.

Comments:

The Committee recognised the very high standards set in completing the accounts and understood that the list of adjusted items likely stood out because of these high standards. However, in the context of a budget exceeding £300m, the number of adjustments was relatively low. Although there was no performance measure in the report, Members were confident that it would reflect positively.

Members also understood that the Finance Team were committed to continual improvement and performance. Regarding the two uncorrected misstatements, the Committee accepted the position regarding the misstatements not being material and that they did not affect the final position. The Committee were content to endorse the 2023/24 Annual Accounts and recommend for Trust Board approval, and to recommend that the

Letter of Representation as described in the AW report be signed by the Trust's Chair and Chief Executive Officer.

In his closing remarks, the Chair received final assurance from Yvonne Thomas that there was nothing else she would like to bring to the Committee's attention that has not already been disclosed and reported in the ISA 260.

2023-24 Annual Report

Trish Mills explained that the Annual Report had been prepared in accordance with Welsh Government's 2023-24 Manual for Accounts. Previous iterations of this report have been circulated to the Board for review and comment. Audit Wales and the Welsh Government have reviewed the report, and any feedback and comments have been addressed.

A Task and Finish Group was formed to produce the Annual Report. Trish Mills extended her thanks to Julie Boalch and Alex Payne for leading this group. Additionally, Trish Mills appreciated the close liaison and support from the Strategy, Planning and Performance Team and the Quality Team, as well as contributions from other members of the group, including Finance, People & Culture, and Communications.

Trish Mills further added that the requirement for an annual Duty of Quality Report was re-established this year as part of the Duty of Quality requirements under the Health and Social Care (Quality and Engagement) (Wales) Act 2020. While key elements of quality were contained in both parts of the annual report, there was a separate Duty of Quality report for endorsement by the Committee, which Liam Williams would present. It was important for the Task and Finish Group to include quality representation to ensure consistency of messaging and avoid duplication across the reports.

The Annual Report was divided into two parts, as usual. Part one - the Performance Report - reviewed the Trust's performance for 2023-24, providing an overview of its long-term strategy and the Integrated Medium-Term Plan (IMTP) for 2023-24. It also covered performance across four quadrants: Our Patients, Our People, Finance and Value, and Partnerships and System Contributions. The second section of the first part offered a more detailed integrated delivery and performance analysis.

Part two of the Annual Report – the Accountability Report - included the Directors' Report, the Statement of Accounting Officers' Responsibilities, and the Governance Statement. Additionally, it contained a remuneration table that had been reviewed by the

Remuneration Committee. This report was also audited by Audit Wales and contained the staff report. Key disclosure statements were contained in the Accountability Report, in particular at page 100, which was the Statement of Directors' Responsibilities in respect of the accounts, which will be signed by order of the Board and will be finalised on Friday after the Board meeting.

Comments:

The Committee thanked all concerned for this commendable piece of work, and acknowledged the assurance provided within it. It was further recognised that the Finance & Performance Committee received regular updates on many of the elements included in the report, especially regarding the Integrated Medium Term Plan (IMTP) and performance updates. These updates ensured regular scrutiny throughout the year.

Members appreciated the reflection from an equality and EDI (Equality, Diversity, and Inclusion) perspective, particularly regarding the protected characteristics of the Equality Act 2010, which listed the types of discrimination. It was important for the Trust to consider and reflect on its work over the past 12 months in this area. For instance, there was limited coverage on BAME (Black, Asian, and Minority Ethnic) issues in the report, while areas like learning disabilities and dementia were more prominently featured. This reflection highlighted both significant progress and potential gaps that the Trust may need to address moving forward.

While the current Annual Report was excellent and a significant achievement, this consideration suggested areas for potential improvement in future reports. Trish Mills added that integrating the Strategic Equality Plan into the Task and Finish Group for next year's Annual Report was an excellent opportunity to highlight the Trust's commitment to advancing equality and diversity. Focusing on this area will enhance the comprehensive nature of next year's report and demonstrate the Trust's dedication to these important initiatives.

Following a query in terms of how the Well-being of Future Generations (Wales) Act 2015 would feature going forward, Trish Mills added that integrating the objectives of the Act into the IMTP was crucial, and it would be a focus for the 2024/25 reporting. Even though the Trust was not yet classified as a public body under which this Act applies, aligning its actions with the principles of the Act allowed the Trust to showcase commitment to sustainable practices and long-term thinking. This expansion in next year's report will provide a more comprehensive view of how the Trust will be contributing to the well-being of future generations.

RESOLVED: The 2023/24 Annual Accounts and the 2023/24 Annual Report were endorsed for approval by the Trust Board and the Letter of Representation was approved for signature by the Trust's Chair and Chief Executive.

37/24 2023/24 DUTY OF QUALITY ANNUAL REPORT

Liam Williams presented the report as read, highlighting that the annual report provided a comprehensive overview of the care provided both at a system level and to some extent at the Trust level. It also outlined the journey ahead for the next year, offering insights into the challenges the Trust anticipated in maintaining quality and safety for patients over the coming months.

As this was the first report, it was understood that Welsh Government may provide more structured guidance next year. This could involve reviewing best practices and providing clearer directives, which would help the Trust achieve greater consistency in reporting.

Liam Williams advised the Committee it was important to highlight that the report has undergone thorough review within various groups in the Trust, including the Executive Leadership Team and the Quality, Patient Safety and Experience (Quest) Committee. Notably, Welsh Government did not issue prescriptive instructions in terms of the reporting structure, which provided the Trust with some flexibility in its creation. This freedom has been positive for the team, allowing it to celebrate and present the work in a more meaningful way.

One of the team's key priorities was to ensure the report was accessible and not merely a document that goes through electronic governance processes. The Team aimed for it to be a living document that truly reflected the Trust's efforts and challenges. Liam Williams was keen to point out that the team had succeeded in bringing quality to life in this report, effectively showcasing the excellent work undertaken while also addressing significant challenges such as patient harm and safety issues.

In terms of external assurance, Liam Williams further advised the Committee that following approval by the Board, the report will be submitted to Welsh Government, and it was anticipated that feedback may be received through that channel. It was also likely that the Chief Nurse and Chief Medical Officer would have specific insights and perspectives on the content presented.

Comments

The Committee were advised by Ceri Jackson that the report received positive feedback from the Quest Committee, particularly regarding its approach and the incorporation of lived experiences. This recognition from Committee Members was valuable as it indicated that the Trust's efforts to make the report accessible and reflective of stakeholders' experiences have been successful.

Members also heard from Joga Singh, who found it to be a positive and informative read, especially given that he was not on the Quest Committee and does not regularly see this type of content. He added that the structure and layout of the report made it clear and accessible while providing substantial information. Including patient stories and perspectives from staff beyond the executive level was important as it was not just about presenting opinions; it was about sharing real life experiences and showcasing the breadth of meaningful work being done across the Trust.

The Committee were content to endorse the report for Trust Board approval.

RESOLVED: The 2023/24 Duty of Quality Annual report was endorsed by the Committee for Trust Board approval.

38/24

FURTHER AMENDMENT TO THE SCHEME OF RESERVATION & DELEGATION (SoRD) OF POWERS

Trish Mills advised there had been some recent adjustments to the Scheme of Reservation, particularly around the approval of tenders and quotations. These changes have been reviewed by the Committee, which endorsed them with the intention of clarifying and consolidating information.

Most of the changes pertained to delegations within the Trust's authority (tables A and B), while those reserved to the Board remain unchanged as prescribed. One notable update was the delegation to the Director of People and Culture, with a note added to specify it would apply to the Director of People once the role was filled, ensuring continuity.

Trish Mills was seeking endorsement of these amendments for Board approval this month. Additionally, the Committee were asked to note the withdrawal of Governance Practice Note 005 which provided guidance on the delegation of board approved awards which would be more effectively incorporated into the Scheme of Reservation and Delegation (SoRD) as notes and footnotes.

The Committee endorsed the changes to the SoRD of Powers and recommended their approval to the Board. They also noted the withdrawal of Governance Practice Note 005.

RESOLVED: The Committee:

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

- (2) **Noted the withdrawal of Governance Practice Note 005 that was approved by this Committee on 30 April 2024.**

39/24 REFLECTIONS & SUMMARY OF DECISIONS AND ACTIONS

The Chair commented that the Committee had efficiently gone through a significant amount of work today, a testament to the high quality of the reports produced.

He emphasised three key points from the discussion. Firstly, the quality of the reports highlighted the extensive effort invested by the teams involved, which deserved recognition. Secondly, the effective monitoring and scrutiny arrangements throughout the year have undoubtedly facilitated the current review process, making it smoother and more efficient. Thirdly, he noted a commendable spirit of collaboration between internal teams and audit colleagues. While auditors provided external scrutiny and professional checks, there was a palpable sense of constructive partnership in the interactions. This collaborative approach not only enhanced adherence to standards like the Future Generations Act but also reflected positively on the confidence external stakeholders have in the Trust. It was essential to remain focused on continuous improvement and maintain this momentum and commitment to excellence going forward.

RESOLVED: The above was noted.

Meeting concluded at: 09:55

Date of Next Meeting: 12 September 2024

ACTION LOG

WELSH AMBULANCE SERVICES UNIVERSITY NHS TRUST - AUDIT, RISK AND ASSURANCE COMMITTEE - As at 5 September 2024

Ref	Date	Agenda Item	Action Note	Responsible	Due Date	Progress/Comment	Status
Minute Reference 27/24	7 June 2024	Risk Management and Board Assurance Framework	Following a discussion by the Committee, there will be consideration of a dedicated risk in relation to risk 424 [<i>Resource availability (revenue, capital and staff capacity) to deliver the organisation's Integrated Medium-Term Plan (IMTP)</i>] in respect of the inclusion of <i>fleet/vehicle</i> , to consider the requirements against the Strategic Outline Plan and the funding requirements.	Chris Turley and Julie Boalch	12 September 2024	<u>Update for 12 September 2024</u> Consideration of an update to the narrative of 424 to reflect this. Alongside this, it is likely that a separate risk will be developed alongside the updated Fleet Procurement Strategy, to encapture funding and other fleet risks in the future. This is now in progress so it is suggested that this action is closed	Complete
Minute Reference 28/24	7 June 2024	Audit Tracker	The Governance Team will consider the development of 'spotlight' communications for colleagues in the Trust regarding the monitoring and management of Audit actions. This will be considered with the development of Tracker 3.0 (transition to the SharePoint solution).	Trish Mills	12 September 2024	<u>Update for 12 September 2024:</u> The communications required when the Tracker 3.0 is rolled out will be prepared as necessary; however the relevant Directorate Points of Contact receive ongoing support from colleagues in the Corporate Governance Team as required and through formal Directorate Points of Contact Meetings. RECOMMENDATION: Proposed for closure. Given this ongoing engagement it is recommended that this action be closed.	Complete



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AUDIT, RISK AND ASSURANCE 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 these meetings can be found by following this [link](#) to the Committee page on the Trust website.

Trust Board Meeting Date	25 July 2024
Committee Meeting Date	7 June 2024 and 10 July 2024
Chair	Peter Curran

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

- The 10 July meeting **endorsed the 2023-24 Annual Accounts and Annual Report**, as well as the **Letter of Representation**, and the **Duty of Quality Annual Report 2023-24**. Of note:
 - The final audited accounts demonstrated that the Trust has:
 - A retained surplus of £0.085 million for the 2023/24 financial year;
 - Met its financial duty to break even over the 3 years 2021/2022 to 2023/2024.
 - Expended Capital Investment funds of £25.301 million (including IFRS16 leases funding), thereby utilising 100% of the Trust's Welsh Government set Capital Expenditure Limit;
 - Achieved Public Sector Payments Policy (PSP) of 96.4% within 30 days against the 95% target.
 - The financial statements were free of material misstatements; there are a number of corrected and a very small number of agreed uncorrected misstatements. The corrected misstatements were reflected in the accounts and all misstatements reported within the auditors ISA 260 report. None of the corrected misstatements affect the disclosed surplus of £0.085 million.
 - Audit Wales provided their report (**ISA 260**) that indicated it is the intention of the Auditor General for Wales to issue an unqualified certificate and report on the 2023/24 financial statements, citing that they provide a true and fair view of the Trust's finances in the 2023/24 financial year.
 - The **Duty of Quality Annual Report**, a requirement under the Health and Social Care (Quality and Engagement) (Wales) Act 2020, was received and it was noted that the Quality, Patient Experience and Safety Committee had received this in May.



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2. The committee expressed appreciation for the teams responsible for developing these reports, recognising their dedication to transparency and responsible management. The committee acknowledged that the early availability of the documents, combined with continuous monitoring and examination by the board committees throughout the year, facilitated a seamless approval at this meeting
3. The draft **2023/24 Head of Internal Audit Opinion** was received at the June meeting and was subsequently finalised for inclusion in the 2023/24 Annual Report. The opinion found that 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. The committee were assured that this was a very comfortable and positive level of assurance and has remained stable over the last few years.

ADVISE

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

4. The **Scheme of Reservation and Delegation of Powers** was presented again to the July meeting for a further amendment following approved amendments in April. The amendments which were endorsed by the Committee provide clarity around the approval of contracts by the board and authorization for tenders. The Board will have this item before it at its 25 July meeting for approval.
5. A **pre-meet** was held with Audit Wales, Internal Audit and the Committee Chair ahead of the June meeting.
6. **Governance Practice Notes** renewals were approved for Private Board and Committee Business (No. 002) and for Chairs Action (No. 003). These notes draw out with more specificity the application of those parts of the Standing Orders that deal with these two issues. This provides clarity and process.
7. Members **reflected** in the June meeting that despite capacity limitations, the future goals regarding scrutiny and assurance are optimistic and supported. They appreciated the pre-meetings with the Chair and auditors, as well as the display of quality improvement during the pre-meetings involving the committee Chair and Non-Executive Directors. Reflections from the July meeting included the spirit of collaborative with which the Trust, Audit Wales, and Internal Audit work to on the end of year reports, providing additional confidence and assurance for all parties.

ASSURE

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

8. Progress against the **2023/24 Internal Audit Plan** was received at the June meeting. At that time there were three remaining audits for the 2023/24 audit plan, two of which had been completed by the July meeting and all of which would be presented to the September committee meeting. The following **Internal Audits** reviews were completed during the quarter and presented to the Committee in June:



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- **Follow Up Audit – reasonable assurance.** 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.
 - **Clinical Audit – reasonable assurance.** The purpose of this audit was reviewing the process for clinical audit including how it is used by committees of the Trust to support assurance. The committee commended this result given that a previous audit had returned limited assurance in this area.
9. At the June meeting the **Audit Wales Update** was received and progress against the audit of the Trust's 2023/24 financial statements and annual report noted with no escalations. Planned work for the Trust for 2024 includes a national deep dive into financial efficiencies and a follow up of the Review of Quality Governance Arrangements, both of which are underway and will be reported in September. The core Structured Assessment brief for 2024 is being considered by the Trust. A deep dive review of investment in digital systems to support service resilience and transformation is being scoped for the Autumn.
- The review of unscheduled care report part two (accessing urgent and emergency care) is underway and will come to the committee in September.
10. The Board will recall previous AAA reports from this and other Committees noting that the number of **Policies** within their review date fell below reasonable levels during the Covid-19 pandemic as the policy work plan was largely paused and efforts directed to support the response. The Committee has oversight of the work plans to review and update these policies and agreed a prioritisation list for 2023/24 and 2024/25. At the June meeting the committee commended the teams and policy owners in the significant shift in the work programme, with 34% of Trust owned policies now within their review date compared to 14% overall reported to Committee in July 2023, rising to an expected 42% in Q2.
11. The **losses and special payments** made during the period 1st April 2024 to 30th April 2024 amounted to £44.63K net payments. The rationale for the reporting will be reviewed, noting it is required under the Standing Financial Instructions.
12. In private session in June the committee received the counter fraud update 01 March 2024 to 01 June 2024 as well as the report on **tenders and single tender waiver requests**. The **Local Counter Fraud Service (LCFS)** provided an update on its work in tackling fraud, bribery and corruption in the Trust and presented the Counter Fraud Annual Report for 2023-24 and the Annual Work Plan for 2024-25. The Work Plan includes the planned activities for 2024-25 and the Annual Report summarises the work completed throughout 2023-24. It was noted that throughout 2023-24 the volume of referrals to the counter fraud service for investigation has doubled; a trend observed throughout the NHS in Wales, potentially due to an increase in awareness of counter fraud and therefore an increase in reporting. The Committee noted that there are currently 39 recorded ongoing investigations by LCFS. The Committee discussed the themes and trends observed regarding the cases, including the impact of investigatory activity on staff well-being. The Committee approved the Counter Fraud Service's Annual Report from 2023-24 and Workplan for 2024-25.



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13. An update was received on the revised **Audit Tracker** in June. The committee noted excellent engagement with Directorates on the revised Tracker 2.0, for Q4, with the result that of the total of 162 internal audit actions on the Tracker, 64 have been closed in quarter. The committee noted that of those that were not closed there is more information on how the risk that was raised by the recommendation are being mitigated in the narrative. It was noted that reporting of the audit tracker is developing to enable the Audit Committee to monitor overall progress in a more meaningful way.
14. The **Committee’s cycle of business** monitoring report was reviewed in June with annual filings being received at an extraordinary meeting in July.

RISK MANAGEMENT

The Committee is responsible for the review of the risk management framework and received assurance in June on the principal risk activity in Quarter 1. Specific updates were provided in relation to the movement in scores on Risk 163 from 20 to 16 and Risk 424 from 16 to 12; Risk 543 and Risk 283 achieved their target scores and will be managed at a directorate level with Risk 458 being closed from all registers. Two new risks were included on the Corporate Risk Register: Risk 542 at a score of 16 and Risk 623 at a score of 15.

The Committee reviewed progress against the Risk Management Transformation Programme noting that the Trust had commissioned external support from BDO to provide advice and guidance to the team in three key areas; development of a strategic BAF that reflects more closely the Trust’s strategic objectives against its long-term strategy – Delivering Excellence: Vision 2030, the development of a series of strategic risks and risk appetite statements and consideration of a different approach to articulating, managing and monitoring the Trust’s highest scoring risks, 223 and 224.

COMMITTEE AGENDA FOR MEETING IN JUNE

Internal audit update and related audits	Audit Wales update report	Risk management and board assurance framework
Audit tracker	Policy report	Review of governance practice notes
Losses and special payments	Committee priorities and cycle of business monitoring	

COMMITTEE AGENDA FOR MEETING IN JULY

2023-24 Annual Accounts and Annual Report and Recommendation to Trust Board	Duty of Quality Annual Report	Further amendment to the Scheme of Reservation and Delegation of Powers
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COMMITTEE ATTENDANCE						
Name	30 April 2024	7 June 2024 ¹	10 July 2024 ²	12 Sep 2024	21 Nov 2024	6 Mar 2024
Peter Curran						
Kevin Davies						
Joga Singh						
Ceri Jackson						
Chris Turley						
Audit Wales	Fflur Jones ³	Fflur Jones	Yvonne Thomas			
Julie Boalch						
Judith Bryce						
Christian Fox						
Angie Lewis						
Osian Lloyd						
Trish Mills						
Liam Williams						
Carl Window						
Damon Turner						

	Attended
	Deputy attended
	Apologies received
	No longer member

¹ Jason Killens and Jonny Sammut joined this meeting

² Jason Killens and Rachel Marsh joined this meeting

³ Darren Griffiths and Amy Lord also attended

Internal Audit Progress Report

Audit, Risk and Assurance Committee

September 2024

Welsh Ambulance Services University NHS Trust

NWSSP Audit and Assurance Services



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Cydwasaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services
Partnership
Audit and Assurance Services



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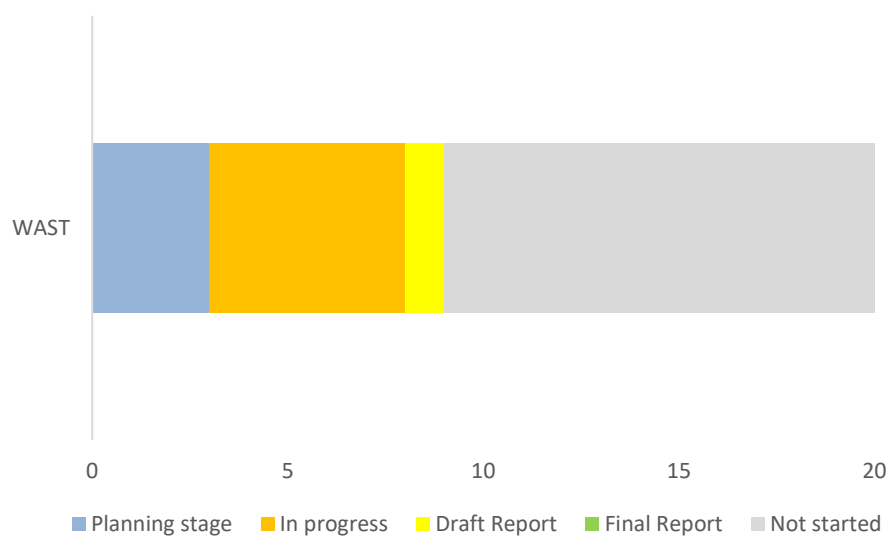
1. Introduction

The purpose of this report is to:

- highlight progress of the 2024/25 Internal Audit Plan to the Audit, Risk and Assurance Committee; and
- provide an overview of other activity undertaken since the previous meeting.

2. Progress against the 2024/25 Internal Audit Plan

There are 20 reviews in the 2024/25 Internal Audit Plan, and overall progress is shown below.



Detailed progress in respect of each of the reviews in the 2024/25 Internal Audit Plan is summarised in Appendix A.

3. Proposed changes to approved plan

No further changes are proposed in respect of the 2024/25 Internal Audit Plan.




4. Engagement

The following meetings have been held/attended during the reporting period:




- observation of Board and Committee meetings;
- audit scoping and debrief meetings;
- liaison with senior management; and
- liaison with external regulators.

5. Key Performance Indicators

Correct on 31 August 2024

Indicator	Status	Actual	Target
Operational Audit Plan agreed for 2023/24		March	By 30 June
Audits reported over planned		1	2
Work in progress		5	
Report turnaround: time from fieldwork completion to draft reporting [10 days]		1 out of 1	80%
Report turnaround: time taken for management response to draft report [15 days]	N/A	0 out of 0	80%
Report turnaround: time from management response to issue of final report [10 days]	N/A	0 out of 0	80%

Key:

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

6. Recommendation

The Audit, Risk and Assurance Committee is invited to note the above.

Appendix A: Progress against 2024/25 Internal Audit Plan

Review	Status	Rating	Key matters arising	Anticipated Audit Committee ¹
Risk Management and Assurance	Not started			June 2025
Follow Up	Not started			June 2025
Procurement and Contract Management	Not started			March 2025
Vehicle Accident Management	Not started			November 2024 / March 2025
Integrated Quality and Performance Management Framework	In progress			November 2024
Seasonal Forecasting and Modelling	Not started			June 2025
Exposure to Fumes	In progress			November 2024
Public Engagement and Community Involvement	In progress			November 2024
Rollout of Penthrox	Not started			March 2025
Overtime Controls	In progress			November 2024
Start of Shift Procedure	Not started			June 2025
Emergency Nurse Communications System Implementation	Not started			June 2025
111 Wales Website	Not started			March / June 2025
111 Digital Operations	Planning			November 2024 / March 2025
Data Quality	Draft report			November 2024
Resourcing Policy	In progress			November 2024

¹ May be subject to change

Review	Status	Rating	Key matters arising	Anticipated Audit Committee ¹
Occupational Health and Wellbeing Support	Planning			March 2025
Speaking Up Safely	Planning			June 2025
Capital & Estates				
Capital Systems	Not started			June 2025
Energy Management	Not started			March 2025

¹ May be subject to change

Volunteers Governance

Final Internal Audit Report

June 2024

Welsh Ambulance Services University NHS Trust

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Review reference:	WAST-2324-11
Report status:	Final
Fieldwork commencement:	26 January 2024
Fieldwork completion:	30 April 2024
Debrief meeting:	30 April 2024
Draft report issued:	08 May 2024
Management response received:	31 May 2024 / 05 June 2024
Final report issued:	05 June 2024
Auditors:	Osian Lloyd, Head of Internal Audit; Felicity Quance, Deputy Head of Internal Audit; Jonathan Jones, Audit Manager
Executive sign-off:	Lee Brooks, Executive Director of Operations
Distribution:	Judith Bryce, Assistant Director of Operations; Jennifer Wilson, National Volunteer Manager; Jonathan Johnston, National Volunteer Manager (Interim); Trish Mills, Director of Corporate Governance/Board Secretary, Duncan Robertson, Assistant Director Clinical Development
Committee:	Audit Risk & Assurance 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.

Disclaimer notice - please note:



This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Risk & Assurance Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services, and addressed to Non-Executive Directors or officers including those designated as Accountable Officer. They are prepared for the sole use of the Welsh Ambulance Services University NHS Trust and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with the Welsh Ambulance Services University NHS Trust. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Executive Summary

Report Opinion

		Trend
<p>Reasonable</p> 	<p>Some matters require management attention in control design or compliance.</p> <p>Low to moderate impact on residual risk exposure until resolved.</p>	 2018/19

Assurance summary¹

Objectives	Assurance
1 Volunteer Strategy	Reasonable
2 Policies and procedures	Reasonable
3 Volunteer recruitment, onboarding, clinical oversight and fundraising.	Reasonable
4 Oversight and escalation of key issues and risks.	Reasonable

Purpose

To review the adequacy and effectiveness of the Trust’s governance and operational management of volunteer activities

Overview

We have issued reasonable assurance on this area. The matters requiring management attention include:

- Action is ongoing to mitigate the risk relating to volunteer fundraising and further guidance to address this and donation management is required.
- Governance framework documents have been developed, which could be enhanced to improve their robustness.
- The mechanism to monitor Volunteer Car Service (VCS) recruitment could be enhanced for clearer oversight of process.
- Poor compliance with vehicle checks within VCS.
- Inconsistencies in VCS expenses processes across regions, and Central and West validation records not available.
- Limited oversight of Community First Responders mentoring arrangements.
- Greater alignment with Association of Ambulance Chief Executives National Volunteering Strategy across volunteer development and quality indicators.
- There could be improved Volunteer Steering Group monitoring of strategic actions and policies.

¹The 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	Alignment with AACE National Strategy	1,3	Design	Medium
2	Volunteer Steering Group compliance with terms of reference	1	Operation	Medium
3	Operations Manuals enhancements	2	Design	Medium
4	Volunteer fundraising and financial guidance	2,4	Design	Medium
5	Safeguarding training compliance	3	Operation	Medium
6	CFR mentoring arrangements	3	Operation	Medium
8	VCS recruitment oversight and monitoring	3	Operation	Medium
9	VCS records completeness	3	Operation	Medium
10	VCS expenses validation	3	Operation	Medium

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

1. Introduction

- 1.1 The Welsh Ambulance Services NHS Trust (the 'Trust') approved its Strategy for Volunteering 2021-2026 ('the Strategy') in September 2021. Recognising the important contribution volunteers make in enhancing the service provided to and experience of patients, in roles such as Community First Responders (CFRs) who attend appropriate 999 calls within their own community, and Volunteer Car Service Drivers (VCSs), who use their own vehicles to support the Non-Emergency Patient Transport Service (NEPTS) in transporting patients to and from hospital appointments.
- 1.2 The Strategy sets out the Trust's vision and key priorities for volunteering:
- Build awareness and embed a culture of volunteering;
 - Enhance training, support, communication and involvement of volunteers; and
 - Increase volunteer contribution and diversity.
- 1.3 A paper was presented to the Trust Charitable Funds Committee (now Charity Committee) in June 2021 which highlighted the lack of oversight of the receipt and use of donations in relation to CFRs. In 2020, a Trust Local Counter Fraud Specialists (LCFS) investigation highlighted similar themes. The Strategy action plan includes '*Review governance arrangements for Volunteer Fundraising and independent Community First Responders (CFR) charities, support the WAST Charity team to ensure funds are raised and spent in accordance with charitable purpose*' for completion by / in year three.
- 1.4 This review did not include review of the Trust Charity/Charitable Fund accounts noting the return to independent examination by Audit Wales for 2022/23, provided to the Trust in December 2023.
- 1.5 The risks considered during the review were:
- Poor volunteer experience resulting in a reduction in their contribution to the Trust;
 - Impact on patient care and experience; and
 - Fraudulent use of charitable funds.

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	-	6	1	7
Total	-	9	1	10

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: The Trust's Volunteer Strategy provides effective direction across key areas of governance, recruitment, retention and support of volunteers.

2.3 As per para 1.1 the Trust approved the Strategy in September 2021. Review of the supporting action plans to deliver its implementation identified that there have been specific areas of focus for each year:

- Year one - culture, training, and increasing volunteer contributions and diversity.
- Year two – governance, engagement and value
- Year three – people, processes, and service delivery.

Actions for years four and five were discussed at a January 2024 meeting of the Volunteer Steering Group (VSG). The Volunteer Management Team were reviewing the feedback alongside the development of timescales. We were advised an updated action plan would be provided to the executive lead in June 2024.

2.4 An update on progress in implementing the strategy was received by the People and Culture Committee (PCC) in August 2023. This outlined year one and two achievements whilst noting that some progress had been impacted by the service's response to the COVID-19 pandemic. Comparison of the structure between 2022 and 2024 indicates that there has been a number of changes within Volunteer Management and the wider team, but this has been accompanied by investment, noting additional recruitment and roles expand the teams from 16 staff in 2022 to 29 in 2024.

2.5 Review of the *Year Three Strategy Highlight report* (dated January 2024) confirmed status updates were provided against all original actions, alongside an additional 12 actions included following a review of annual priorities (as per 2.3) undertaken by the Volunteer Management Team (VMT) in 2023. Good progress is noted with 18 actions completed, 30 ongoing or underway, and 6 listed as deferred.

2.6 The Strategy includes actions to develop robust governance arrangements for the service. The original intention, as per year two of the action plan, to develop a

Volunteer Policy has been adjusted to focus on governance frameworks for each volunteer role, and includes the refreshment of the Volunteer Steering Group (VSG) undertaken and completed in 2022. The governance framework documents have a number of associated actions such as the development of a volunteer code of conduct, problem solving process, and service handbooks (also known as Operations Manuals). For further details of the governance framework documents refer to **audit objective two**.

2.7 The National Council of Volunteering Organisations (NCVO) issued guidance in 2021 in relation to the retention of volunteers. This highlighted areas including motivation, communication, valuing contributions, removing barriers and ensuring opportunities exist for development. We note progress has been made across a number of these areas with achievements including:

- recognition of volunteers within the rebranded WAST awards;
- two volunteer conferences in 2023;
- volunteer access to Trust occupational health and wellbeing services;
- CFR role development through the rollout of Pentrox and Paracetamol.

Review of the status of the action plan noted that some areas have been deferred, including the development of a protocol for Trust staff volunteering, and the formal accreditation of training qualifications – both of which are to be addressed within the remaining two years of the Strategy.

2.8 The Association of Ambulance Chief Executives (AACE) developed a *National Strategy for Volunteering* in 2023. Review and comparison of the national strategy against that of the Trust's highlighted alignment across the key themes of recruitment, recognition, training, and volunteer experience. The national strategy also suggests the requirement for a one-to-one Development & Wellbeing template and a Quality Assurance Framework, and their inclusion could further enhance the Trust's alignment with national good practice. **See MA1**.

2.9 The 2022 Audit Wales Structured Assessment reported that the original Strategy had not been financially costed. Discussion with VMT provided an outline of the route for approval for service developments within the Directorate, and for the recent piloting of the Community Welfare Responder (CWR) role there has been use of external sources of funding from NHS Charities Together, demonstrating a clear approach to addressing the Audit Wales concern.

2.10 As noted in para 2.6 the Strategy actions included the re-establishment of a VSG, for which the terms of reference (ToR) were approved in August 2022, and reviewed in January 2023. The ToR outline purpose, objectives, membership and quorum. Meetings have been held on quarterly basis, in line with its ToR, and meetings reviewed (June 2023 – November 2023) were quorate.

2.11 However, review of the meeting agendas did not identify the purpose of '*advise and recommend to VMT changes required to Trust wide policies*'. Further, '*the monitoring of delivery of strategic priorities*' – whilst it is clear this could have featured within the January 2024 VSG meeting, there could be use of the highlight

report (para 2.5) to support formal monitoring. This would also provide a balance to the discussion of operational issues which have predominantly featured within the group meeting minutes reviewed. **See MA2**

Conclusion:

2.12 The Trust's Volunteers Strategy and supporting action plan contains content to address governance, recruitment, retention and support, with clear outline of progress and those areas deferred. There is alignment with that of the AACE National Strategy, and other external good practice, but there could be further action to include volunteer development plans and quality assurance framework. The VSG has been re-established although we have identified enhancements to strengthen its operation. We assign this objective **reasonable** assurance.

Objective 2: A framework of appropriate policies and procedures to support the management of volunteers is in place.

2.13 Discussion with the National Volunteer Manager highlighted the development of Framework documents to provide both an outline of service processes, and to offer a clear source of guidance to volunteers. An operation manual has been developed for both the Community First Responder (CFR) and the VSCD (Volunteer Car Service Driver) role. Following the successful pilot of a new Community Welfare Responder (CWR) role in early 2024, there is intention to develop an Operations Manual, which will build upon the CWR Scope of Practice document produced as part of its pilot.

2.14 We note both documents were approved at an Operations Directorate Senior Operations Team (SOT) meeting in November 2023.

2.15 The CFR Operations Manual was issued to volunteers in March 2024, and the VCS Operations Manual was due to be released in mid-April 2024. Draft versions of both were provided to us ahead of distribution. Review of the manuals has confirmed that they are formatted in line with Trust branding, include an outline of the Volunteer Team structure, and contain detail of Trust responsibilities; but there is not an outline of where volunteer responsibility sits within the Trust. **See MA3**

2.16 Developed alongside the Operations Manuals are volunteer agreements, which include reference to recruitment checks, training, scope of practice, social media/information governance, operational detail such as ID cards/driving, and need for volunteers to inform the Trust where there is a change in circumstance which may impact the ability or suitability to volunteer. Consideration could be given to include an expectation to comply with Trust policies. **See MA3**

2.17 Review of framework content against key areas also noted the following:

<u>Key area</u>	<u>Content Summary</u>
<u>Recruitment</u>	<ul style="list-style-type: none"> • Both Operations Manuals contain <ul style="list-style-type: none"> ○ high level flowcharts relating to the recruitment stages that volunteers would progress through and use of TRAC.

	<ul style="list-style-type: none"> ○ reference role specific training or eLearning requirements. ○ include internal team tasks against the recruitment stages and the training /e-learning requirements.
<u>Onboarding & Training</u>	<ul style="list-style-type: none"> • Access provided via eLearning Wales website to complete the 14 topics set by the UK Core Skills Training Framework. • CFR recruitment is aligned to its training schedule developed on an annual basis (2023-24 - 17 training courses, increasing to 23 courses for 2024-25). • CFR - 5-day initial training course aligns with the good practice syllabus referenced in AACE's CFR Governance Framework alongside additional provision of Pentrox and Paracetamol training. • VCS - driving assessment and highway code check, recently introduced face to face induction training comprising training and administrative requirements.
<u>Clinical Oversight</u>	<ul style="list-style-type: none"> • Inclusion of the Trust <i>Scope of Practice & Clinical Standards Guideline for Ambulance Staff Grades</i> setting out the boundaries of practice for CFRs and a skills matrix of CFR approved practice. Due to the format of inclusion as a pdf file the skill matrix document is not accessible to CFRs. See MA3 • AACE <i>CFR Governance Framework</i> guidance lists some situations or environments which CFRs should not be knowingly sent to. The CFR Operations Manual (Section 13.3) includes only that deployment is <i>via auto allocation of the Computer Aided Dispatch</i> system. Dispatch codes are included as an appendix, these were last reviewed in conjunction with the Clinical Directorate and the Trust Clinical Prioritisation Assessment Software Group (CPAS) in June 2023. There has since been an update following a recent technical change in categorisation which has resulted in code amendments. See MA3
<u>Fundraising & Financial Guidance</u>	<ul style="list-style-type: none"> • Guidance provided for the areas of gifts, gratuities and hospitality with a copy of the Trust Standards of Business Conduct policy within the appendices of both manuals. • Expenses information varies between the two manuals, the CFR Operations Manual provides an expenses form and the validation process in use by the team. Whilst the VCS manual does not reference either, we note such is covered during induction. • As per para 1.3, there has been concern at the lack of oversight for CFR fundraising and use of donations. Further detail on action undertaken by the Trust can be found within audit objective four, however our review noted that the Operations Manuals contained no content in relation to these areas. See MA4

Alternative Responders

2.18 Responder roles have been developed in a number of instances, with external organisations in set geographic areas including St John Ambulance Cymru (alternative responder scheme in Rhayader, Powys), and Mid and West Fire and Rescue Services (individual schemes for Falls responder, and Out of Hospital Cardiac Arrest). Service level agreements are in place with each provider to set out arrangements for activation, training, and concerns management. We are also informed an agreement with Airbus for the facility in Broughton is under development.

Criteria/Timescales

2.19 Review of both Operations Manuals highlighted timescales relating to both the Trust management of volunteers, and volunteers own responsibilities. This includes a new requirement that volunteers provide a minimum number of hours (16) per month, which is comparable to that of ambulance Trusts elsewhere in the UK; and that of other voluntary roles such as special constables within the Police Service. Discussion with VMT indicated that the time commitment would result in a reduction in active CFRs, however it is felt that the benefits of engagement from CFRs will provide a balance.

2.20 Should a volunteer fail to retain compliance with the mandatory requirements of the role, the Operations Manuals state that *they could be temporarily or permanently stood down*. A compliance process which sets out the stages and triggers has been developed, but it is not included within either manual. **See MA3** Inclusion of this may assist in volunteer awareness of their responsibilities and processes in place.

2.21 There has also been development of a 'Volunteer Problem Solving' process to provide a set procedure for the management of issues or concerns raised by volunteers. A copy of the process is included within both manuals, but review of the document noted that it does not contain a timescale for the completion of any review. Examples of similar procedures identified in use by other ambulance Trusts specified targets of between 20-28 days. Discussion with management outlined that feedback from its recent roll out had highlighted a need for timescales to be clarified. **See MA3**

Communications

2.22 Volunteers are currently not provided with NHS Wales email accounts although we are informed that this will be considered within the updated Strategy action plan. Currently, communications from the volunteer team, such as notices of procedural changes or operational updates, are through a variety of methods including social media channels.

2.23 Regular meetings take place on a regional basis between Operations staff and CFR Co-ordinators (a volunteer role within each CFR Team supporting communications, logistics, and resources/rotas). Meeting coverage includes performance, procedural updates, training and common issues.

- 2.24 The VCS Operations Manager has undertaken a number of 'meet the manager' sessions, which has provided an opportunity to address areas highlighted within an online survey of drivers in autumn 2023. The Team has addressed concerns through establishment of central email addresses and phone numbers, a uniform audit to ensure standardisation, user guidance for electronic devices, and the introduction of MiST.
- 2.25 Discussion with the Alternative Responder Operations Manager noted that feedback from CWRs was captured as the pilot progressed. Changes were made to address issues highlighted in rotas and communication with the Clinical Service Desk, both during the pilot and within longer term actions.

Conclusion:

- 2.26 The Operations Manuals developed for CFR and VCS roles provide guidance across areas of operational processes, including relating to recruitment, onboarding/training, and oversight. We have identified areas where further detail could be made to their content, and a gap remains within the area of fundraising and financial guidance. Noting this we assign **reasonable** assurance to this objective.

Objective 3: There are systems and processes in place to provide appropriate oversight of the management of volunteer activities, including recruitment, onboarding, clinical oversight, and fundraising.

CFR – Recruitment & Onboarding

- 2.27 CFR recruitment is aligned to a training schedule developed on an annual basis. Discussion with management, and review of the schedule, confirmed an approach which considered red call performance, established CFR team locations/resilience and service development.
- 2.28 We selected a sample of 15 CFRs (recruited during 2023) and reviewed documentation retained within the CFR database. All reviewed contained valid onboarding requirements of ID checks, DBS clearance, occupational health screening outcomes, and information on driver's license validity/points, and insurance details. We note that the team process checks as a cohort and, as such, volunteer applications may not progress to checking until the cohort is filled. However, review of key dates within the process did not identify significant delays linked to any individual step.
- 2.29 We reviewed a sample of 25 CFRs (expanded from the sample in 2.28 to include additional longstanding CFRs) confirming retention of training records. Pentrox and Paracetamol, which were rolled out to CFRs in 2023, feature within initial training and MiST (Pentrox only). Noting this there were four entries within the database that did not include evidence to demonstrate that an assessment had been completed as required by the Trust Methoxyflurane Protocol. No recommendation raised noting the internal audit plan for 2024/25 includes a review to assess the roll out of Pentrox.

CFR - Oversight

- 2.30 In May 2022, an internal review of processes identified 8 active CFRs where the Trust did not have any record of DBS clearance, and a further 40 which had expired. The same review identified 34 CFRs non-compliant with safeguarding training. Actions taken to address this resulted in all CFRs undergoing DBS checks; and a reduction of safeguarding non-compliance to 7 CFRs by July 2022.
- 2.31 DBS clearance features within quarterly compliance reports produced for the CFR Team and review of the CFR database in February 2024 did not identify any CFR with expired DBS clearance.
- 2.32 Review of a February 2024 eLearning report identified 30 CFRs with safeguarding competency which had expired (*note: this reflects lapsed competencies and not a gap in training linked to recruitment*). Entries within CFR database included notes of prompts to individuals, and a bulletin had been issued in February 2024 to highlight the key areas where compliance is required, indicating ongoing management action to address this area. **See MA5**
- 2.33 The CFR Operations Manual sets out the Trust's recommended approach to mentoring for new CFRs. This includes a 'buddying' period for newly trained CFRs, and completion of an Emergency Medical Services Rideout shift within three months of completing training. Discussion with management outlined that the arranging of buddy shifts is through CFR co-ordinators, and no rideout records could be provided for the sample of 15 CFRs recruited in 2023, suggesting this approach is yet to be embedded. **See MA6**
- 2.34 At the completion of each volunteer shift CFRs are encouraged to complete an 'Activity and Welfare' submission through a Microsoft Form link. This return includes date of activity, number of hours provided, if the CFR attended a cardiac response; and to indicate their mindset at shift completion with the options of '*thriving, surviving or struggling.*' Any cardiac response or struggling response should prompt a welfare contact from the CFR team.
- 2.35 Review of the 2,200 forms returned during the period September 2023 – March 2024 noted 870 did not complete the mindset field. We note of the responses submitted, 59% responded as thriving, and only 126 responses listed a cardiac response (66)/surviving(52)/struggling(6). Review of a sample of 10 entries where the response registered either a concern for welfare or raised a query, noted:
- Seven could be evidenced through a related TEAMS entry or CFR file note, although one was as a result of contact for another issue; and
 - Three held no evidence of contact. **See MA7**

CFR - Fundraising/expenses

- 2.36 For further detail relating to fundraising see **audit objective 4**. The CFR Operations Manual includes the expenses procedure which states mileage relating to patient activity can be claimed, as well as any service support provided at the request of the Trust, and a meal allowance for initial recruitment training or service support. A sample of five of the 15 claims for the South East region (period of

November to December 2023) were reviewed and entries and mileage were confirmed as accurate.

VCS – Recruitment & onboarding

- 2.37 There have been two previous internal audit reports issued in respect of VCS Governance Arrangements (2018/29: Limited Assurance and 2019/20: Follow Up, Reasonable Assurance) with the latter noting some of the changes recommended would require time to embed.
- 2.38 Discussion with the VCS Operations Manager highlighted the current focus was to increase VCS numbers and raise the profile of the service. Our previous internal audit report had noted the development of a Communication and Engagement Plan to assist in recruitment. There is no current equivalent in place, however we were informed the team's recent focus has been supporting recruitment in the North and South Central regions, to pilot a scheme of pairing VCSD with oncology patients. We were also informed of agreement to use Trust social media channels to raise awareness of the VCS role, which had recently commenced.
- 2.39 There have also been some recent changes to VCS recruitment through the adoption of the NHS TRAC system which automates some of the previous employment checks. Internal process documents have been updated to reflect these changes and to outline responsibilities between the VCS Administrative Team and the training co-ordinator who liaises with the Trust driving school to coordinate assessments. As per para 2.17 there has been a new standardised induction introduced as part of this process.
- 2.40 We were informed that a 6-week target has been set within the team to process recruitment checks. A revised monitoring spreadsheet was introduced in 2023, and this captures the various recruitment stages, but does not capture all the elements outlined within the process document. **See MA8**

VCS - Oversight

- 2.41 The VCS Team are in the process of moving away from paper records, and will use a combination of the Ambulance Care electronic Cleric system and spreadsheets to monitor driver status, and recruitment. The introduction of a new volunteer electronic management system 'Assemble' will provide the team with a single system for maintaining volunteer records. Assemble was originally expected to be introduced in September 2023, and a phased rollout is planned to take place during 2024.
- 2.42 The internal review undertaken in May 2022 (see para 2.30) identified 68 VCS with expired DBS clearance, and 54 drivers out of compliance with safeguarding training. Action had been taken to address this, improving the position to two drivers requiring DBS clearance, and 13 to complete training by July 2022.
- 2.43 Cleric is currently used to capture VCS volunteer information, including in relation to DBS clearance, MOT, drivers licence and insurance. Additionally, Cleric includes road tax details, but this has only recently been populated January 2024, and does not feature within current reporting.

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- 2.44 On a monthly basis the VCS Administrative Team and Volunteer Compliance officer review a Cleric extract report against driver status from the VCS active driver spreadsheet to produce a VCS Dashboard report on driver compliance. There are data quality issues within the Cleric report i.e. inclusion of inactive drivers duplicate entries etc; therefore validation checks are required. The migration of VCS records to Assemble should address the data quality issues identified with reporting intended to be solely based upon returns from that system.
- 2.45 An exercise undertaken in April 2023, prior to the introduction of validation processes, had indicated around 60% of DBS entries within Cleric were out of date or blank. Compliance has improved significantly within the following period, and this has been sustained since.
- 2.46 There has been the introduction of MiST training for VCS, which we are informed has been welcomed by longer serving volunteers, and review of the course content shows alignment with the areas within the induction training day for new recruits (para 2.17). The VCS Driver database is used to monitor attendance, however no record of attendance or confirmation documentation could be provided for a sample of 7 records requested. **See MA9**
- 2.47 We were informed there have been challenges in the introduction of eLearning for VCS, with some volunteers unfamiliar with accessing the system. The team has also experienced delays in gaining access to the systems reporting functionality, and was required to undertake quality assurance checks of the data at the time of fieldwork due to discrepancies being highlighted by volunteers. A bulletin has been issued to prioritise the completion of an initial seven modules by April 2024, with the remaining to be completed by June 2024. **See MA5**
- 2.48 As detailed in the VCS Operations Manual, it is the responsibility of the respective volunteer to maintain their vehicle in a safe and road legal condition with a 'Vehicle Checklist Review' form to be completed. However, within a sample of 10 drivers from the North region, only 3 vehicle check forms could be provided. **See MA9**

VCS Expenses

- 2.49 Processing of expenses includes the comparison of submitted mileage to journey reports produced from the Cleric system:
- mileage summary papers are compiled listing each driver and a percentage variance from the Cleric report; and
 - a further validation paper is completed where individual journeys are reviewed to establish variance in mileage against the Cleric total.

It was outlined that variations in totals are inevitable due to ad hoc additional jobs, diversions to routes, and drivers returning home due to gaps in allocated jobs, therefore a 10% tolerance level has been adopted.

- 2.50 Expense payment schedules, mileage summary working papers, and validation papers were requested for all regions for the period October 2023 – December 2023. No summary or validation papers could be provided for the Central and West

region as the staff member responsible was absent and the documents were not saved centrally. **See MA10**

- 2.51 Review of documents provided for the North and South East regions confirmed validation had been undertaken, however there was inconsistencies of approach noted between each region, and with the level of check set out within a guidance document supplied by the VCS Manager. **See MA10**

Conclusion:

- 2.52 There are arrangements in place to provide oversight of volunteer activities within both CFR and VCS teams. We have highlighted areas where arrangements could be strengthened, to ensure consistency and where gaps in record keeping should be addressed. We assign this objective **reasonable** assurance.

Objective 4: There are arrangements to identify and escalate risks relating to volunteering; and actions from associated internal and external reports.

Directorate Performance Reporting

- 2.53 Compliance reports are prepared internally within the team for both CFRs (quarterly), and VCS (monthly) outlining status against DBS clearance, driver's license, insurance, and MOT. The service also compiles activity information to inform the monthly meetings held between the Assistant Director, National Operations and Support and the Executive Director of Operations.
- 2.54 Review of CFR activity data reported noted inclusion of number of responses, stand downs, red response performance against 8/9/10 minute targets, red and amber median times, non-conveyance rates and average and longest time spend on scene.

Table 1 – CFR Activity Reporting Comparison

CFR Performance	May 2022	October 2022	May 2023	October 2023
Responded Incidents	833	875	949	997
Red Incident Responses	151	244	244	344
Red median response time	8:47	8:12	8:40	8:15
Amber median response time	29:21	45:55	18:19	26:49

- 2.55 Discussion with the CFR Operations Manager advised that following the recent roll out of ePCR to CFRs, the Trust now has a wider range of clinical data relating to CFR attended calls. Noting the intention of AACE to develop volunteer quality assurance framework, the Trust should consider the quality or outcome measures applicable to the CFR role to complement current activity reporting. **See MA1**
- 2.56 VCS activity reported includes number of journeys completed, mileage, and the services percentage contribution to the Trust overall patient transportation.

Table 2 – VCS Activity Reporting Comparison

VCS D Performance	May 2023	August 2023	October 2023
Journeys completed	3580	3687	3693
Miles completed	117,832	123,739	124,144
Monthly VCS contribution	7.1%	7.4%	7.4%

2.57 In addition to the activity above, the VCS activity is monitored against Ambulance Care key performance indicators, with measurable time related standards for inbound and outbound journeys for renal, oncology, outpatient and discharged patients. Performance between 2023/24 (Q3) and 2022/23 (Q3) has remained broadly consistent, with only one indicator highlighting a drop of performance of over 5% (renal outbound).

Reporting to Committee

2.58 The Operations Directorate provide quarterly reports to Trust committees, and updates in relation to volunteers are provided under the National Operations and Support heading. In November 2022 the quarterly report to the People and Culture Committee provided a summary outline of progress against the Volunteer Strategy. As per para 1.3, in August 2023, the PCC received a dedicated report on the strategy achievements and action status. Meeting minutes include the positive reception from committee members noting the benefits and positive impact they provide to the organisation.

Risk and actions related to internal and external reports

2.59 The main risk recorded relating to volunteering has been the lack of oversight in relation to CFR fundraising and use of donations:

- A Trust Local Counter Fraud Specialist investigation report in December 2020 identified charitable funds had been used for personal purchases. A recommendation was raised to develop a policy to ensure that CFR teams have clear guidelines on the operation of charitable accounts.
- A Charity Committee report issued in June 2021 (para 1.3) highlighted the reputational risk from CFR fundraising and sponsored activities undertaken without the Trust's knowledge.

2.60 Historically CFR fundraising and donations were used to purchase uniform, kit and equipment which the Trust did not provide. There has since been investment to provide these required items to support CFR activity.

2.61 A Charity Committee task and finish group was put in place between 2022-2023 with a remit to review wider Trust charitable fund management, policies and procedures, including consideration of fundraising. However, it was unable to progress the fundraising element, and a corporate risk is in the process of being developed. **See MA4**

2.62 Initial informal enquiries were made at the Volunteer conferences in October 2023, and following this the CFR team co-ordinators were contacted to establish the extent of fundraising activities, balances, and account arrangements. Responses were received from 86 of 204 CFR teams, which reported around £60k being held

in funds (circa £10k of which raised within the previous 12 months) and a number of variations in arrangements and processes. **See MA4**

- 2.63 The Board Secretary confirmed that the Charity Committees view was that CFR fundraising was a Trust, rather than a Charity, responsibility. Following Executive Leadership Team discussion in February 2024, the Trust is currently seeking advice from an external legal provider. Discussion with the interim National Volunteer Manager indicated once received a further task and finish group would be established to develop a volunteer fundraising Standard Operating Procedure. **See MA4**
- 2.64 Audit Wales review of WAST Charitable Funds for 2021-2022 was the first full audit of accounts undertaken since 2014-15 and raised four recommendations. Review of the latest version of the audit recommendation tracker confirmed two recommendations are closed, and timescales are included for the remaining outstanding actions.

Conclusion:

- 2.65 There is regular internal reporting of volunteer activity, alongside wider updates against the delivery of the strategy. Actions are underway to seek external guidance to inform the Trust's approach to mitigating the risks raised by CFR fundraising and donation management. There is also clarity in ownership between the Trust and the Trust Charity, although the ownership of a corporate risk is yet to be determined. We assign this objective **reasonable** assurance.

Appendix A: Management Action Plan

Matter Arising 1: Trust alignment with AACE National Strategy (Design)		Impact	
<p>The Association of Ambulance Chief Executives (AACE) developed a National Strategy for Volunteering in 2023. Review and comparison of the national strategy against that of the Trust's highlighted alignment across the key themes of recruitment, recognition, training, and volunteer experience. The national strategy also suggests the requirement for a one-to-one Development & Wellbeing template and a Quality Assurance Framework, and their inclusion could further enhance the Trust's alignment with national good practice.</p> <p>Discussion with the CFR Operations Manager advised that following the recent roll out of ePCR to CFRs, the Trust now has a wider range of clinical data relating to CFR attended calls. Noting the intention of AACE to develop volunteer quality assurance framework, the Trust should consider the quality or outcome measures applicable to the CFR role to complement current activity reporting.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> Potential to ensure fuller alignment between the Trust and national strategies 	
Recommendations		Priority	
1.1	The Trust should consider options to address volunteers development. This may not be as formal as a PADR process but should demonstrate the consideration of volunteers improvement needs.	Medium	
1.2	The Trust should undertake a review of outcomes and measures now available through the roll out of ePCR to consider indicators which would complement the current performance activity captured.		
Agreed Management Action		Target Date	Responsible Officer
1.1	The Trust accepts this recommendation and will consider options to address volunteer development. This will be assessed during the forthcoming financial year.	March 2025	Jennifer Wilson, National Volunteer Manager

1.2	Trust Volunteer leads and clinical leads will review and recommend clinical outcome measures for CFRs as well as recommending where these data items will be reported. This action can be held at the Clinical Intelligence and Assurance Group.	Nov 2024	Duncan Robertson, Assistant Director, Clinical Development
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Matter Arising 2: Volunteer Steering Group Compliance with Terms of Reference (Operation)		Impact	
<p>The Volunteer Strategy actions included the re-establishment of a Volunteer Steering Group, for which the terms of reference (ToR) were approved in August 2022. The ToR outline purpose, objectives, membership and quorum. Meetings have been held on quarterly basis, in line with its ToR, and meetings reviewed (June 2023 – November 2023) were quorate.</p> <p>However, review of the meeting agendas did not identify the purpose of <i>'advise and recommend to VMT changes required to Trust wide policies'</i>. Further, <i>'the monitoring of delivery of strategic priorities'</i> – whilst it is clear this could have featured within the January 2024 VSG meeting, there could be use of the highlight report to support formal monitoring. This would also provide a balance to the discussion of operational issues which have predominantly featured within the group meeting minutes reviewed.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> Group failure to operate in line with agreed objectives. 	
Recommendations		Priority	
2.1	Management should establish a link between the VSG and the Trust Policy review group to allow sight of any relevant policies and allow for volunteer input to be provided, where applicable.	Medium	
2.2	The regular inclusion of the Strategy action plan within VSG agendas should be accompanied by formal papers including action status and timescales.		
Agreed Management Action		Target Date	Responsible Officer
2.1	The Trust agrees that VSG is an appropriate mechanism for the volunteer voice when developing appropriate and relevant policies; We will seek to design a mechanism to support input from VSG for relevant policies.	Nov 2024	Jennifer Wilson, National Volunteer Manager

2.2	Not accepted - The VSG has no formal accountability, nor is it a decision making group. Whilst the Trust supports the monitoring of the action plan through VSG, it is felt that a more formal approach may be a deterrent to membership.		
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Matter Arising 3: Operations Manuals Content (Design)	Impact
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Review of the CFR and VCS Operations Manuals and associated documents highlighted the following points for enhancement:

Potential risk of:

- The robustness of the governance framework could be impacted by gaps within its design.

Subject area	Content
Executive Responsibility	Each manual includes an outline of volunteer team structure but not an outline of where volunteer responsibility sits within the Trust. <i>The inclusion of detail relating to executive and volunteer team responsibilities would enhance the robustness of the manuals.</i>
Volunteer agreement	Individual volunteer agreements have been developed for each volunteer role. It includes volunteers should 'be aware of, and respectful of applicable WAST policies and procedures.' <i>As a signed agreement there is opportunity to strengthen the wording to include an expectation to comply with Trust policies.</i>
CFR Clinical Guidance	The CFR Operations Manual includes a skills matrix for clinical roles. A copy of the dispatch codes which generate CFR deployment are included as an appendix within the CFR Operations Manual, however these are not the latest version in use. <i>It could offer greater clarity to volunteers to include a copy of the skills matrix in place of the deployment codes.</i>
Compliance process	There are triggers for non-compliance with the mandatory elements of the role, but this is not included within either manual. <i>Inclusion of this may assist in volunteer awareness of their responsibilities and processes in place.</i>
Problem Solving Process	The Volunteer Problem Solving process for the management of volunteer issues or concerns does not contain a timescale for the completion of any review. Examples of similar procedures identified in use in other Ambulance Trusts specified targets of between 20-28 days. <i>The Trust should introduce a timescale related to the Problem Solving Process.</i>

Recommendations	Priority
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3.1	The Trust should consider addressing the highlighted enhancements to Operations Manuals outlined above.
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Medium

Agreed Management Action	Target Date	Responsible Officer
3.1 The Operations Manuals were recently published in February 2024. The Trust will review the Operations Manuals and will incorporate any amendments into this review process.	February 2025	Jennifer Wilson, National Volunteer Manager

Matter Arising 4: Volunteer Fundraising and Financial guidance (Design)	Impact
<p>Concerns relating to the lack of oversight in relation to CFR fundraising and use of donations have been noted within a Trust LCFS investigation in 2020 and a Charity Committee report in June 2021.</p> <p>In late 2023, CFR team co-ordinators were contacted to establish the extent of fundraising activities, balances, and account arrangements. Responses were received from 86 of 204 CFR teams which included, circa£60k being held in funds (with circa £10k having been raised within the previous 12 months). Responses also set out variations in arrangements including:</p> <ul style="list-style-type: none"> • Type of account in use for donations/fundraising – business (1), personal (1) and joint team (20) • Teams with a constitution which references fundraising (11), those who do not (24), and those unsure (27) • Teams with a process to apply to spend funds (14), those responding unknown (28) • Teams who provide updates internally on purchases/use of funds (21), those responding unknown (17). <p>The CFR and VCS Operations Manuals currently contain no guidance in relation to fundraising or donation fund management.</p> <p>The Board Secretary confirmed that following Executive Leadership Team discussion in February 2024, the Trust is currently seeking advice from an external legal provider with intention to inform further communication to CFRs. Discussion with the interim National Volunteer Manager indicated once received a further task and finish group would be established to develop a volunteer fundraising Standard Operating Procedure.</p> <p>A Charity Committee task and finish group in place between 2022-2023 with a remit to review wider Trust charitable fund management had identified that a corporate risk relating to fundraising should be developed.</p> <p>An initial populated risk template was provided to us with some detail around controls and gaps, but the finalising of the risk has been paused awaiting the outcome of the legal advice above. Discussions also highlighted that while it has been agreed that CFR fundraising is a Trust rather than Trust Charity risk, the risk holder within the Trust is still to be agreed.</p>	<p>Potential risk of:</p> <ul style="list-style-type: none"> • Misuse of charitable donations and reputational risk to the Trust.
Recommendations	Priority

4.1	The Trust should ensure the distribution of received guidance in relation to fundraising to the full CFR population.	Medium	
4.2	The development of a fundraising standard operating procedure should include consideration of the need for periodic returns on fundraising activity and use of funds.		
4.3	The Trust should consider the development of good practice documents to support donation fund management, which could be incorporated into CFR team constitutions and processes.		
4.4	The Trust should prioritise the completion of a Volunteer fundraising risk, including clarifying the ownership of the risk within the Trust.		
Agreed Management Action		Target Date	Responsible Officer
4.1	On receipt of any guidance on fundraising, the National Volunteer Manager will within one month, convene a Task and Finish Group, under the governance of the Operations Directorate. The T&FG will be tasked with cascade of any guidance to volunteers	March 2025	Jennifer Wilson, National Volunteer Manager
4.2 - 4.3 - 4.4	The T&FG will be responsible for execution of the actions described at 4.1-4.4. Any issue escalation to be reported through ADLT to ELT, noting it is not yet possible to determine the outputs from the T&FG, including the risk owner.	March 2025	Jennifer Wilson, National Volunteer Manager

Matter Arising 5: Safeguarding Training compliance (Operation)		Impact
<p>Non-compliance with safeguarding training by CFR and VCS had been identified within an internal review of processes in 2022 with subsequent action to address this.</p> <p><u>CFR</u></p> <p>Review of a February 2024 eLearning report identified 30 CFRs with an expired safeguarding competency. Entries within CFR database included notes of prompts to individuals, and a bulletin had been issued in February 2024 to highlight the key areas where compliance is required.</p> <p><u>VCS</u></p> <p>Review of an April 2024 eLearning report identified only 7/32 North region drivers had safeguarding compliance listed. A further 21 drivers were confirmed to be in compliance based upon the 2022 internal review which had required the submission of paper returns.</p> <p>We were informed there have been challenges in the introduction of eLearning for VCS, with some volunteers unfamiliar with accessing the system. The team has also experienced delays in gaining access to the systems reporting functionality, and was required to undertake quality assurance checks of the data at the time of fieldwork due to discrepancies being highlighted by volunteers. A bulletin has been issued to prioritise the completion of an initial seven modules by April 2024, with the remaining to be completed by June 2024.</p> <p>2022 returns for Central and West and South East were not available for comparison.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> Volunteers lack of awareness of safeguarding practice and procedures.
Recommendations		Priority
5.1	The Trust should incorporate Safeguarding training compliance within the established one to one reporting template.	Medium
5.2	Trust management should ensure that gaps in compliance with safeguarding training are addressed for both CFR and VCS roles.	
Agreed Management Action		Target Date
		Responsible Officer

5.1	This finding relates to refresher training compliance. The Trust will incorporate safeguarding training compliance into the established one to one reporting template.	September 2024	Jennifer Wilson, National Volunteer Manager
5.2	The Trust will ensure that gaps in safeguarding compliance are addressed for VCS and CFRs.	September 2024	Jennifer Wilson, National Volunteer Manager

Matter Arising 6: CFR Mentoring Arrangements (Operation)		Impact	
<p>The CFR Operations Manual sets out the Trust's recommended approach to mentoring for new CFRs. This includes a 'buddying' period for newly trained CFRs, and completion of an Emergency Medical Services Rideout shift within three months of completing training.</p> <p>Discussion with management outlined that the arranging of buddy shifts is through CFR co-ordinators, and no rideout records could be provided for the sample of 15 CFRs recruited in 2023, suggesting this approach is yet to be embedded.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> New volunteers may not receive adequate support impacting confidence and experience. 	
Recommendations		Priority	
6.1	The Trust should consider mechanisms to monitor the uptake of the mentoring arrangements outlined within the CFR Operational Manual.	Medium	
Agreed Management Action		Target Date	Responsible Officer
6.1	The Trust will consider mechanisms to monitor the uptake of the mentoring arrangements.	November 2024	Jennifer Wilson, National Volunteer Manager

Matter Arising 7: CFR Welfare and Activity Returns (Operation)		Impact
<p>At the completion of each volunteer shift CFRs are encouraged to complete an 'Activity and Welfare' submission through a Microsoft Form link. This return includes date of activity, number of hours provided, if the CFR attended a cardiac response; and to indicate their mindset at shift completion with the options of 'thriving, surviving or struggling.' Any cardiac response or struggling response should prompt a welfare contact from the CFR team.</p> <p>Review of the 2,200 forms returned during the period September 2023 – March 2024 noted 870 did not complete the mindset field. We note of the responses submitted, 59% responded as thriving, and only 126 responses listed a cardiac response (66)/surviving(52)/struggling(6).</p> <p>Review of a sample of 10 entries where the response registered either a concern for welfare or raised a query, noted:</p> <ul style="list-style-type: none"> • Seven could be evidenced through a related TEAMS entry or CFR file note, although one was as a result of contact for another issue; and • Three held no evidence of contact. <p>At present the team divides the response to completed forms across the operations assistant, manager, and trainer roles.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> • Volunteer concerns and welfare may not be addressed where returns are missed
Recommendations		Priority
7.1	The Trust should introduce a process which includes responsibility for allocation of calls or timeframes for addressing these.	Low
7.2	Where a submission has resulted in discussion of any welfare or performance concerns an entry should be maintained within the CFRs individual record.	

7.3	The Trust should consider approaches to encourage the full completion of welfare returns to include a response of thriving, surviving, or struggling.		
Agreed Management Action		Target Date	Responsible Officer
7.1	The Trust will introduce a process which includes the responsibility to a named individual for allocation of calls and timeframes for addressing these concerns.	October 2024	Jennifer Wilson, National Volunteer Manager
7.2	This process will also include the documentation of any follow up action on the CFR individual record.	March 2025	Jennifer Wilson, National Volunteer Manager
7.3	The Trust will consider approaches to encourage the full completion of welfare returns.	October 2024	Jennifer Wilson, National Volunteer Manager

Matter Arising 8: VCS Recruitment Oversight and Monitoring (Operation)		Impact
<p>VCS recruitment has recently included the adoption of the NHS TRAC system which automates some of the previous employment checks. Internal process documents have been updated to reflect these changes and to outline responsibilities between the VCS Administrative Team and the training co-ordinator who liaises with the Trust driving school to coordinate assessments.</p> <p>We were informed that there has recently been adoption of an internal 6-week target set within the team for the processing of recruitment checks. A revised monitoring spreadsheet was introduced in 2023, and this provides coverage of the recruitment stages, but we did note some variation in the completeness of data entry across the regions.</p> <p>Following induction the volunteer is transferred to a 'recruited' tab which holds additional key dates between recruitment and the driver activation, but this includes removal of prior data entered against the process. There is currently little opportunity to review the process over an extended period and identify any common issues and compliance with the new six-week target.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> • Issues in recruitment may not be identified; • Prolonged recruitment process impacting number of volunteers available.
Recommendations		Priority
8.1	Management should ensure key dates and stages are completed within the VCS Recruitment spreadsheet. The spreadsheet should be modified to include forecast dates aligned to the six-week recruitment check completion target.	Medium
8.2	Monitoring arrangements should include the retention of key recruitment dates for a period following recruitment to allow the review of process for any steps which cause delays or blockages.	
Agreed Management Action		Target Date
		Responsible Officer

8.1	The Trust will ensure that key dates and stages are completed on the VCS recruitment spreadsheet, including the modification to support forecast dates aligned to the six-week target.	October 2024	Jennifer Wilson, National Volunteer Manager
8.2	The Trust will ensure that monitoring arrangements will include the retention of recruitment dates for a determined period to support the review process.	October 2024	Jennifer Wilson, National Volunteer Manager

Matter Arising 9: VCS Record Completeness (Operation)		Impact	
<p>The VCS team are in the process of moving from the retention of paper records, to combined use of the Ambulance Care electronic Cleric system alongside their own spreadsheets. The introduction of a new volunteer electronic management system 'Assemble' will provide the team with a single system for maintaining volunteer records. Assemble was originally expected to be introduced in September 2023, and a phased rollout was imminently expected as fieldwork closed in April 2024.</p> <p>There has been the introduction of MiST training for VCS, which we are informed has been welcomed by longer serving volunteers, and review of the course content shows alignment with the areas within the induction training day for new recruits. The VCS Driver database is used to monitor attendance, however no record of attendance or confirmation documentation could be provided for a sample of 7 records requested.</p> <p>As detailed in the VCS Operations Manual, it is the responsibility of the respective volunteer to maintain their vehicle in a safe and road legal condition with a 'Vehicle Checklist Review' form to be completed. However, within a sample of 10 drivers from the North region, only 3 vehicle check forms could be provided.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> Unchecked vehicles may not meet or be maintained to Trust standards, resulting in poor patient experience or harm. 	
Recommendations		Priority	
9.1	As part of the migration of VCS records onto Assemble the Trust should undertake a records stocktake, and address any subsequent gaps identified.	Medium	
9.2	Noting the gap in vehicle check records, there should be inclusion of a completion of vehicle check forms as part of MiST course arrangements.		
Agreed Management Action		Target Date	Responsible Officer
9.1	Following the introduction of Assemble, the Trust will undertake a records stock take and address any gaps identified.	March 2025	Jennifer Wilson, National Volunteer Manager

9.2	The Trust will introduce a system to include the completion of vehicle check lists for VCS volunteers.	September 2024	Jennifer Wilson, National Volunteer Manager
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Matter Arising 10: VCS Expenses validation (Operation)		Impact
<p>Processing of expenses includes the comparison of submitted mileage to journey reports produced from the Cleric system:</p> <ul style="list-style-type: none"> • mileage summary papers are compiled listing each driver and a percentage variance from the Cleric report; and • a further validation paper is completed where individual journeys are reviewed to establish variance in mileage against the Cleric total. <p>It was outlined that variations in totals are inevitable due to ad hoc additional jobs, diversions to routes, and drivers returning home due to gaps in allocated jobs, therefore a 10% tolerance level has been adopted.</p> <p>Expense payment schedules, mileage summary working papers, and validation papers were requested for all regions for the period October 2023 – December 2023. No summary or validation papers could be provided for the Central and West region as the staff member responsible was absent and the documents were not saved centrally.</p> <p>Review of documents provided for the North and South East regions confirmed validation had been undertaken, however there was inconsistencies of approach noted between each region, and with the level of check set out within a guidance document supplied by the VCS Manager.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> • Non-compliance with process, inconsistent approaches across regions.
Recommendations		Priority
10.1	The Trust should confirm a consistent selection criterion for the selection of claims to be validated which includes risk assessment and adequate coverage of outliers.	Medium
10.2a	Noting the unavailability of summary and validation documents for the Central and West region management should obtain and review documents to confirm the undertaking of checks.	
10.2b	There should also be periodic checks to ensure documents are saved in a shared accessible location.	

Agreed Management Action		Target Date	Responsible Officer
10.1	The Trust will agree a consistent selection criterion for validation of checks, to include risk assessment and coverage of outliers.	October 2024	Jennifer Wilson, National Volunteer Manager
10.2a	The Trust will satisfy itself that Central and West records are subject to appropriate checks and validation.	July 2024	Jennifer Wilson, National Volunteer Manager
10.2b	The Trust will ensure that periodic checks are undertaken to ensure documents are saved in a shared accessible location.	October 2024	Jennifer Wilson, National Volunteer Manager

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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



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Shared Services
Partnership
Audit and Assurance Services

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership](#)

Disciplinary Case Management - Compassionate Practices

Final Internal Audit Report

June 2024

Welsh Ambulance Services University NHS Trust



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Executive sign-off:	Angela Lewis, Director of People and Culture
Distribution:	Julie Stokes, Head of People Services; Karen Jones, Deputy Head of People Services; Hilary Caffrey, People Business Leader; Amanda Jones, People Services Partner; Anna Stein People Services Partner;
Committee:	Audit & Risk Assurance 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.

Disclaimer notice - please note:


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Executive Summary

Report Opinion

	Trend
<p>Reasonable</p>  <p>Some matters require management attention in control design or compliance.</p> <p>Low to moderate impact on residual risk exposure until resolved.</p>	N/a

Assurance summary¹

Objectives	Assurance
1 Policies and guidance	Substantial
2 Compassionate practices within the disciplinary process	Limited
3 Disciplinary process compliance	Reasonable
4 Reporting arrangements	Reasonable

Purpose

To assess the adequacy of the arrangements in place for the management of the disciplinary process. To focus on the demonstration of compassionate leadership principles, in addition to compliance with the Trust's defined disciplinary processes.

Overview

We have issued reasonable assurance on this area. We found clear alignment of content between the Trust IMTP, People and Culture Plan, and compassionate practice action plan. We identified good compliance with some All-Wales policy timescales, noted reductions in case length against those of prior years, and that case outcomes indicated appropriate use of Fast-Track and Formal investigations.

The matters requiring management attention include:

- Progress has been made against the compassionate practices action plan, but there are delays in the completion of some actions and timescales require revision.
- Compassionate practices training targeted senior operations managers, but we found gaps against those involved in cases within our sample.
- A document checklist is in place to support formal investigation hearings, however not for other processes, and we identified gaps in case file completeness.
- No appeals were heard within the 28-day target, an All-Wales policy timescale.
- Electronic staff records for employees who resign during an investigation are not updated to reflect the final disciplinary outcome.

Key Matters Arising

	Objective	Control Design or Operation	Recommendation Priority	
1	Compassionate practices action plan	2	Design	Medium
2	Compassionate practices training	2	Operation	Medium
4	Compliance with All-Wales policy timescales	3,4	Operation	Medium
5	Case management document retention	3	Operation	High
6	Electronic staff record process end status	3	Operation	Medium

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

1. Introduction

- 1.1 The Welsh Ambulance Services NHS Trust (the 'Trust') adopted the All-Wales Disciplinary Policy in 2017 which provides the mechanism for disciplinary issues, and states that all employees will be treated fairly, and with dignity and respect.
- 1.2 The Trust's People and Culture Plan 2023-2026 (approved May 2023) contains the objective: *'Improve the effectiveness and safety of our internal disciplinary, capability and resolution processes, learning from Just Culture principles and further embedding Compassionate Practices for All'*. This followed a report presented at the People and Culture Committee in May 2022 highlighting learning taken from recent disciplinary cases, and included recommendations to work within the principles of 'just culture' to improve the timeliness and quality of investigations.
- 1.3 The Trust has also launched its *'Compassionate Practices for All'* training to managers in November 2022, which focuses on explaining the ethos of compassionate practices and ensuring that colleagues are treated fairly and compassionately, and their best interests are protected during difficult processes such as investigations.
- 1.4 The risks considered during this review were:
- i. Non-compliance with the All-Wales Disciplinary Policy and Procedure, exposing the Trust to the risk of litigation.
 - ii. Impact on the welfare of those involved in the process, including staff, investigative officers, HR colleagues and witnesses, due to lengthy investigations and/or insufficient support.
- 1.5 In order to ensure the confidentiality of those involved within the disciplinary process, case file review were undertaken in conjunction with members of the People Services teams, and partial extracts of the case management tracker document were provided to support audit review. Our sample was selected from the 44 cases which had been closed in 2023.

2. Detailed Audit Findings

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

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	-	2	2	4
Operating Effectiveness	3	5	-	8
Total	3	7	2	12

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 are appropriate policies, guidance and plans in place to support the Trust's disciplinary process.

2.3 As per para 1.1, the Trust adopted the All-Wales Disciplinary Policy ('the policy') in July 2017 following its approval by the Welsh Partnership Forum. A supplementary '*Key Changes Document*', noted as developed in partnership with Trade Union representatives, was introduced by the Trust alongside the policy. The document included detail on the Trust '*Scheme of Delegation for Disciplinary Policy*', setting out the expected delegation of officers / banding applicable to the relevant stages of disciplinary case progression (informal discussion, initial assessment/fast track, disciplining, and disciplinary officers).

2.4 The policy was due for review in March 2020 and we are informed that the Trust is represented in the All-Wales process currently underway to review this.

2.5 The Trust has a dedicated intranet page, accessible to all staff, which contains a *disciplinary managers toolkit* and includes 23 template process documents and letters to support compliance with the policy.

2.6 Review of the Trust toolkit content against a sample of other NHS Wales organisations found it provides a good range of supporting documentation for the key stages of the process and for any required formal investigation. We did identify those other toolkits reviewed included additional supporting guidance notes for managers, but recognise the Trust has an action to review its toolkit within the compassionate practices plan. At the close of fieldwork, it was reported that there is intention to trial guidance currently in use by another NHS organisation.

2.7 There are three associated IMTP actions to deliver the People and Culture Plan objective as per para 1.2. These include:

1). Improve employee experience and avoid unnecessary escalations through the training and support of Trust managers in compassionate practices.

2). Coach managers on compassionate approaches to reduce the volume of disciplinaries, increasing the speed of cases, and closing cases at an appropriate stage.

3). Evaluate the impact of compassionate practices in terms of behaviour change, timeframes, and impact on those involved.

2.8 An initial compassionate practices action plan was developed by the People and Culture team in June 2023, and revised into its current version in September 2023, to which additional detail within actions was included and extension applied to some timescales for completion. Review of the content demonstrated alignment with the IMTP actions (para 2.7). Progress in delivering the action plan is considered under **audit objective 2**.

Conclusion:

2.9 The Trust has adopted the All-Wales Disciplinary policy, with a range of documentation available to support its implementation. Strategic and operational actions have been developed to develop a compassionate practices approach to disciplinary case management. Noting this, we assign this objective **substantial** assurance.

Objective 2: The Trust provides sufficient support, guidance, training, and resources to enable the adoption of compassionate practices within the disciplinary process.

2.10 Representatives from the People Services team who are involved in the development of the compassionate practices action plan, and in the management of employee relations cases, highlighted the key message that compliance with policy and process remains important. However, there is recognition that there needs to be greater consideration of the impact on the person and how those involved within cases can be supported.

2.11 The Compassionate Practices action plan ('the action plan') contains nine objectives with 36 individual corresponding actions, although there are some areas of crossover between these. Timescales (for objectives) within the initial action plan were targeted for 2023 and we note that some have been extended into 2024 when the plan was revised. Individual actions, however, do not have assigned target dates. Review of the action plan identified evidence of actions underway across most objectives:

- 16 actions completed.
- 7 in progress.
- 13 yet to commence (5 related to objective four, see para 2.16).

In addition, the plan does not contain action leads, with ownership sitting with the People Services Partner leading on the area. **See MA1**

2.12 Training is delivered by Health Education and Improvement Wales (HEIW) as part of a national programme on compassionate practices. Supporting materials set out the concept of avoidable employee harm, common themes from employee experiences noting the impact on the individual, organisations, and dangers of failing to learn from these.

2.13 The action plan includes targeting of senior managers from the Operations Directorate to complete compassionate practices training, and we note the use of an ESR report to define these. Over half of the managers identified have attended a session, but the training provision could be extended to also include those involved in undertaking an initial assessment (IA). Additionally, our review of individuals involved in the sample of 23 disciplinary cases tested (for further details refer to **audit objective 3**) identified around half had yet to attend training. **See MA2** Feedback is sought from attendees at the point of training, but there is not yet a mechanism to capture any learning from practice as set out within the action plan. **See MA2**

- 2.14 Objective three within the action plan relates to the *'initial assessment to be fair, thorough and unbiased, leading to appropriate outcomes for all and reduced employee harm.'* Actions include the revision of IA documentation, and a revised IA form was being piloted at the time of fieldwork. Our review of content identified additional prompts to consider employee mindset, the applicability of policies and procedures, and generally suggests the adoption of a risk assessment approach. We note a prompt to share the completed IA with the People Services team has been removed; however based on our review of cases (refer to **audit objective 3**), management should consider retaining its inclusion. **See MA5**
- 2.15 Outside of the trial of the updated IA form there has also been revision of the letter which accompanies it. Our review of content could identify adjustment of language and a clearer outline of available support within this, but the letter was yet to be piloted. Further changes to the toolkit to reflect the Trust's intent to demonstrate compassionate practices are not yet in place.
- 2.16 Objective four within the action plan includes review of other key templates, process documents and guidance. Due to capacity within the People Services team this has not commenced, however the target date for completion (28 February 2024) within the action plan was yet to be updated. **See MA1**
- 2.17 Objectives two and nine include the review of employee relations data to identify trends and themes, and this has been shared with the People and Culture Committee on a six-monthly basis (August 2023 and February 2024). The corresponding report has included high level outline of the actions within the action plan, but this has not included detail on timescales or completion. **See MA1**

Conclusion:

- 2.18 The Trust has identified key actions to support the adoption of compassionate practices within the disciplinary process. Intent to deliver and enhance the disciplinary process through compassionate practices is clear, however delivery is not in line with the outlined timescale, which will have impacted the extent to which change has been embedded. Roll out of the training has included senior members of the Trust and senior managers of the Operations Directorate, but we identified there could be greater coverage of those involved in case management. We assign this objective **limited** assurance.

Objective 3: Disciplinary actions are undertaken promptly in accordance with policy, in a way that is fair, consistent and without discrimination;

- 2.19 The People Services team maintain a tracker spreadsheet to manage and monitor progress of disciplinary cases. Review of the tracker identified that it includes key fields for capture of contacts, process dates and timescales relating to suspension length (if applicable), investigation period, and overall case duration. Additional fields have recently been introduced to identify if an allegation is of a sexual nature, in line with the Trust's wider sexual safety programme, or if it is related to protected characteristics. Our review of reporting arrangements (see **audit objective 4**) has outlined opportunities to enhance the tracker further to capture compliance against key timescales. **See MA3**

2.20 We undertook sample testing of ten fast-track investigations, ten formal investigations, and five appeals to assess compliance with policy and noted the following:

Fast Track investigations

2.21 Fast track cases sampled resulted in either a verbal or first written warning being issued, which is in line with the outcomes defined in the policy for such investigations.

2.22 Good compliance was noted with the required timescales set out within the All-Wales Policy, where cases were generally resolved within a month following IA taking place. Areas of non-compliance have been detailed within Appendix A. **See MA4**

Formal Investigations

2.23 Outcomes could be verified against the detail held within case files; and good compliance was noted against All-Wales timescales. There is no defined target for completion of formal investigations, but the average length of an investigation within our sample was 87 days (length ranged from 34 – 204 days). We note that one NHS Wales organisation has adopted a good practice target of 90 days. Some isolated examples of non-compliance are listed within Appendix A. **See MA4**

2.24 Appointment of Disciplining officers met the requirements of the Trust's local Scheme of Delegation. We also noted investigating officers (IO's) had received relevant training or were suitably experienced (para 2.33 refers to future IO arrangements).

Appeals

2.25 Outcomes could be verified against the detail within case files. However, no appeal was heard within the 28-day timescale set out in the policy, and for two instances, hearing outcomes were not issued within the 7-day target set by the policy.

2.26 Good compliance was noted in relation to the following aspects of the policy:

- intention to appeal which was received in line with timescales (14 days) for all cases;
- all appeal officers met the policy and trust scheme of delegation requirements for seniority and
- circulation of appeal documents ahead of the hearing met the policy timescale (7 days) for all cases.

Case file documentation

2.27 We identified a number of gaps within process documentation when reviewing our sample of case files. Discussion with the People Services team highlighted that formal investigation cases are subject to a checklist review to confirm completeness of the documentation, prior to the disciplinary hearing, but this is not in place for fast-track reviews and does not include the closing stage documentation following the hearing. **See MA5**

Electronic Staff Record (ESR)

- 2.28 Section 20 of the policy states that *an accurate record of all disciplinary events should be maintained on ESR*. We identified only one instance within our sample where ESR had not been updated with a case outcome. Discussion with the People Services team highlighted that where an employee resigns during a disciplinary process, it would be the resignation rather than the process outcome which would be recorded within ESR. **See MA6**

Internal and External referrals

- 2.29 The policy contains requirements for referral in relation to the Disclosure and Barring Service (DBS), and Counter Fraud. These had been complied with where identified within our sample.

Conclusion:

- 2.30 Review of a sample of case files confirmed that the Trust generally manages disciplinary cases in line with the requirements of the All-Wales Policy. However, there is mixed compliance with target timescales contained within the policy, particularly for fast-track investigations; and in the completeness of documentation within case files and employee records. We assign this objective **reasonable** assurance.

Objective 4: Effective reporting arrangements are in place, including actions to understand the impact of compassionate leadership principles on the disciplinary process.

Operational arrangements

- 2.31 The People Services team schedule fortnightly meetings to monitor case progress through review of content within the case management tracker. We are also informed that this meeting would consider outcomes following case closures and subsequent debriefs of participants which took place, although we note these are not formally documented.
- 2.32 As part of the compassionate practice action plan (Objective Six - *Support the development of the People Services team*) the People Services team has recently established dedicated reflection time each month, for sharing of learning from internal and external cases; and sexual safety sessions were held during 2023 to align with the Trusts 'Speaking Up Safely' agenda.
- 2.33 Discussion with People Service management outlined that both 'Speaking Up Safely' and the work to establish the Trust's 'Sexual Safety Guiding Principles' had contributed to increasing the number of concerns reported and resulting in higher disciplinary case numbers. Three fixed term dedicated investigator posts are being introduced, on an initial two-year basis, to assist in managing the increasing caseloads, and focus on cases where allegations are of complex nature. Additionally, the People and Culture Directorate is reviewing its service structure and the resource allocated to managing the employee relations process.

Committee reporting

- 2.34 Review of People and Culture Committee papers and minutes (September 2022 – February 2024) noted regular reporting of the total disciplinary case within the Workforce Performance Scorecard. The most recent update reported 30 active cases (December 2023) in comparison to a prior high of 49 (September 2021) and low of 12 (January 2023). The in-committee meeting also receives an update at each meeting on the number of employees suspended for over four months, and updates on suspension status are subsequently provided to the Trust Board through the committees highlight report.
- 2.35 The compassionate practices plan (Objective Two - *Analysis of existing employee relations data, including demographic review, to ensure no unintended bias*) includes an action to review disciplinary data, since 2020, to identify baseline measures. To support this, as per para 2.17, there has been reporting of trends and themes to the People and Culture Committee, initially in August 2023 and followed in February 2024. Indicators within these reports have sought to demonstrate the impact of compassionate practices through comparisons of:
- decreases in number of overall cases and case length,
 - allegation type to allow for comparison to other Trust priorities, such as sexual safety, and empowerment of staff to speak up in relation to concerns,
 - increase in number of cases closed with no further action.

Noting the above, there could be a corresponding focus on the timescales defined within the policy to demonstrate commitment to meeting these. **See MA4**

- 2.36 We note other NHS Wales Organisations have recently commenced a best practice review which is to include historic review of employee relations data. Comparison of intended reporting against that in place by the Trust within its themes and trends report highlighted good alignment, however we note there is intention to undertake review of employee banding, length of service and further granular detail in relation to outcomes which the Trust may wish to consider.

Conclusion:

- 2.37 There is regular reporting of the number of cases to the People and Culture Committee and this has been supplemented by the recent introduction of six-monthly reporting on trends and themes. This should contribute to understanding the impact of compassionate practices, however there could be further sight of policy timescales within reporting. Noting this, we assign this objective **reasonable** assurance.

Appendix A: Management Action Plan

Matter Arising 1: Compassionate Practices Action Plan (Design)	Impact
<p><u>Action Plan timescales</u></p> <p>The compassionate practices action plan ('the action plan') contains nine objectives with a corresponding 36 individual actions, although there are some areas of crossover between these. Review of the plan noted:</p> <ul style="list-style-type: none"> ○ Of the nine objectives listed, 7 include target dates for completion, and five have missed their target dates. Timescales within the initial action plan were targeted for 2023, a revised action plan extended target dates for four objectives into 2024. ○ Individual actions listed under the objectives do not have assigned target dates, so whilst we note actions underway for nearly all objectives, target dates have not been met and the majority of actions were still to be completed. ○ Objective four includes review of other key templates, process documents and guidance for both People Services representatives and Trust managers. The review of documentation was yet to start at the time of fieldwork due to capacity within the People Services team, however the timescale was yet to be updated with a revised target date. <p><u>Action plan oversight</u></p> <p>The People and Culture Committee receives a six-monthly report on employee relations trends and themes. As part of this report there has been high level outline of the actions within the action plan, but this has not included detail on proposed timescales or individual action completion.</p>	<p>Potential risk of:</p> <ul style="list-style-type: none"> • Improvements in case management and associated employee wellbeing may be impacted by lack of resource and delivery of compassionate practices action plan.
Recommendations	Priority
<p>1.1 The compassionate practices action plan should be reviewed to ensure timescales are reasonable and capture both the planned changes and implementation periods.</p>	<p>Medium</p>

1.2	Revised timescales should feature within the updates provided to the People and Culture Committee to ensure awareness of any delays to plan implementation.		
Agreed Management Action		Target Date	Responsible Officer
1.1	Undertake a review of the action plan with an aim to move to implementation of several of the outstanding actions, closing those that have been completed.	31/08/2024	Karen Jones, Deputy Head of People Services
1.2	Ensure all outstanding actions have a realistic completion date. To provide a regular update on plan to People & Culture Committee.	31/08/2024	Karen Jones, Deputy Head of People Services

Matter Arising 2: Compassionate practices training (Operation)		Impact	
<p><u>Training attendance</u></p> <p>Objective one within the compassionate practices action plan is to <i>'deliver compassionate practices training to managers directly involved in undertaking employee investigations'</i>. Actions to deliver this include targeting of managers from the Operations Directorate through the use of an ESR report to identify those with a senior managerial role. At the date of fieldwork 32/57 (56%) of those within the report had attended.</p> <p>Our own review of individuals involved in the 23 disciplinary cases sampled, during fieldwork, noted circa half had attended the compassionate practices training, but this included only 4/15 individuals who had undertaken the initial assessment.</p> <p><u>Training feedback</u></p> <p>The compassionate practices action plan includes <i>'track learner at 3 and 6 months to review effectiveness of training/learning.'</i> We were provided with examples of feedback taken from the training session work, rather than post training as detailed within the action plan.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> • Those previously involved in disciplinary cases could lack training in compassionate practices. • Feedback from attendees is not currently captured, resulting in missed opportunities to identify changes in practice. 	
Recommendations		Priority	
2.1	The Trust should review the case management tracker to identify individuals that have previously been involved in undertaking initial assessments as a priority group for attending future compassionate practices training sessions.	Medium	
2.2	Post training feedback should be sought in line with the original action, to capture attendees learning from the training and identify any changes in practice.		
Agreed Management Action		Target Date	Responsible Officer
2.1	Managers identified requiring training will be contacted with available dates to attend. Training is sourced via HEIW and not internally delivered. Therefore, training dates are limited.	30/09/2024	Karen Jones, Deputy Head of People Services

2.2	Contact will be made with HEIW as the training provider to confirm evaluation process.	30/09/2024	Karen Jones, Deputy Head of People Services
	Introduce a disclaimer that all investigating Officers complete to ensure they have undertaken all relevant training including compassionate practice.	30/09/2024	Karen Jones, Deputy Head of People Services

Matter Arising 3: Disciplinary Case Tracker (Design)		Impact
<p>The People Services team maintain a case tracker spreadsheet for the management of case progression. Review of the tracker identified that there are key fields for capture of contacts, process dates, timescales relating to suspension length (if applicable), investigation length, and overall case duration. Fields have recently been introduced to identify if an allegation has a sexual nature or is related to protected characteristics.</p> <p>Our review of equivalentents highlighted some further areas where detail is included in the case notes column but which could be captured separately to enhance the Trust’s ability to undertake thematic review. This includes:</p> <ul style="list-style-type: none"> Recording employee sickness status/periods Summary outline of reasons for delay. <p>Additionally, while the current format includes key process dates it does not specifically capture whether the associated timescales have been met for:</p> <ul style="list-style-type: none"> Completion of a Fast-Track investigation within one month of an initial assessment, and 10-day target for a Discipling Officer to make a decision following receipt of an investigation report. Appeal hearings taking place within 28 days. 		<p>Potential risk of:</p> <ul style="list-style-type: none"> Opportunities to identify themes and trends in case management may be missed. Non-compliance with policy exposing the Trust to the risk of litigation.
Recommendations		Priority
3.1	To enhance the thematic review of disciplinary case management the Trust should consider the inclusion of the good practice elements of sickness status/periods and reasons for delay.	Low
3.2	For performance management, the case management tracker should incorporate the measurement of timescale compliance within the fields in use.	

Agreed Management Action		Target Date	Responsible Officer
3.1	Sickness status and reason for delay will be added to the tracker as per recommendation	31/08/2024	Karen Jones, Deputy Head of People Services
3.2	Time scales will be added to the tracker as per recommendation	31/08/2024	Karen Jones, Deputy Head of People Services

Matter Arising 4: Compliance with policy timescales (Operation)	Impact
<p>The All-Wales Disciplinary Policy contains a number of timescales for key stages relating to the fast-track investigation, formal investigation, and appeal stages. Our sample testing identified:</p> <p><u>Fast-track investigations (10 sampled)</u></p> <ul style="list-style-type: none"> The policy states fast-track investigations should be completed within one month of the initial assessment, three of the ten cases did not meet this timescale. The policy requires that the employee is given as a minimum 7 days written notice of the fast-track hearing, we identified one occasion where the hearing took place the day following the initial assessment. <p><u>Formal investigations (10 sampled)</u></p> <ul style="list-style-type: none"> Minor non-compliance with policy timescales was noted including: disciplining officers 10-day timescale to decide upon further action (1), 21 day deadline for documentation to be provided to employee ahead of a hearing (1), and 7 day timescale for informing employee of hearing outcome (1). We noted the period required for formal investigations varied between 34-204 days. The policy does not include a target in this regard, but we have noted some NHS Wales organisations using 90 days as a good practice measure. <p><u>Appeals (5 sampled)</u></p> <ul style="list-style-type: none"> No appeal was heard within the 28-day timescale set out in the policy, with difficulties noted in agreeing suitable dates for appeals officers and trade union representatives. Appeal hearing outcomes were not shared in line with policy timescales (7 days) on two occasions. We are informed that on both occasions the delay to issuing outcome letters was communicated with relevant parties, but this was not captured within the content of the letters shared with us. <p>We note that whilst a number of indicators are reported in relation to employee relations and case management, compliance with key timescales listed above do not feature. The case management tracker contains fields for key stages but does not specifically capture whether the associated timescales have been met.</p>	<p>Potential risk of:</p> <ul style="list-style-type: none"> Extended case duration could adversely impact the wellbeing of those involved within the process. Non-compliance with policy exposing the Trust to the risk of litigation.

Recommendations		Priority	
4.1	Management should consider approaches to ensure timescales are met as set out within the All-Wales policy, such as provisional appeal dates being agreed at the disciplinary hearing.	Medium	
4.2	The Trust should include key timescales for each process to be periodically included within reporting provided to the People and Culture Committee for assurance that cases are being progressed in line with agreed All-Wales timescales.		
4.3	The Trust should establish its own expected timescale for formal investigations to be undertaken and ensure the officers tasked with undertaking these are aware of this.		
Agreed Management Action	Target Date	Responsible Officer	
4.1	The Trust will continue to monitor compliance against All Wales Policy and ensure any delays are kept to a minimum by proactively securing dates for hearings/appeals etc at the earliest opportunity and note any reason for delays. People Business Leaders will monitor compliance relevant to their Directorates.	31/08/2024	Karen Jones, Deputy Head of People Services
4.2	ER tracker will include times scale compliance against each case. Any non-compliance will be supported with rationale. This will be monitored by the Deputy Head of People Services and People Business Leaders on a monthly basis.	31/08/2024	Karen Jones, Deputy Head of People Services
4.3	With the investment of three full time investigating officer roles (interviews 14/06/2024), when in post will support dedicated investigation with a focus on complexity and agreed time scales.	31/08/2024	Karen Jones, Deputy Head of People Services

Matter Arising 5: Case Management documentation (Operation)				Impact																				
<p>When undertaking our review of a sample of case files, there were a number of gaps noted within the process documentation maintained. Discussion with the People Services team highlighted that formal investigation cases are subject to a checklist review prior to the disciplinary hearing, but this is not in place for fast-track reviews; and would not include the closing stage documentation following the hearing.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="background-color: #d9e1f2;">Gaps in document retention</th> <th style="background-color: #d9e1f2;">Fast-Track</th> <th style="background-color: #d9e1f2;">Formal Investigation</th> <th style="background-color: #d9e1f2;">Appeal</th> </tr> </thead> <tbody> <tr> <td>Initial Assessment copy retained</td> <td>5/10</td> <td>10/10</td> <td style="background-color: #d3d3d3;"></td> </tr> <tr> <td>Initial Assessment outcome letter retained</td> <td>5/10*</td> <td>8/10</td> <td style="background-color: #d3d3d3;"></td> </tr> <tr> <td>Hearing outcome letter retained within People Services case file</td> <td>6/10</td> <td>1/9**</td> <td>6/6*</td> </tr> <tr> <td>Hearing outcome letter retained within employee personal file</td> <td>0/10</td> <td>1/9**</td> <td>0/6</td> </tr> </tbody> </table> <p>*total includes dated draft copy ** one sampled formal investigation did not proceed to a hearing.</p> <p>A revised IA form was being piloted at the time of fieldwork, review of content noted a prompt to share the completed IA with the People Services team has been removed.</p>				Gaps in document retention	Fast-Track	Formal Investigation	Appeal	Initial Assessment copy retained	5/10	10/10		Initial Assessment outcome letter retained	5/10*	8/10		Hearing outcome letter retained within People Services case file	6/10	1/9**	6/6*	Hearing outcome letter retained within employee personal file	0/10	1/9**	0/6	<p>Potential risk of:</p> <ul style="list-style-type: none"> Gaps in documentation could compromise the Trust’s defence in any internal or external review of outcomes.
Gaps in document retention	Fast-Track	Formal Investigation	Appeal																					
Initial Assessment copy retained	5/10	10/10																						
Initial Assessment outcome letter retained	5/10*	8/10																						
Hearing outcome letter retained within People Services case file	6/10	1/9**	6/6*																					
Hearing outcome letter retained within employee personal file	0/10	1/9**	0/6																					
Recommendations				Priority																				
5.1	<p>The Trust should develop a checklist to ensure the completeness of case files for each element of the disciplinary process. This should include end process retention requirements for both People Services and the employee record.</p>			High																				



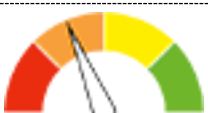
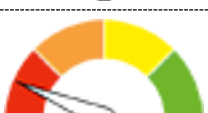

5.2	Following development of the checklists, the People Services team should incorporate a periodic check of adherence of a sample of recently closed cases.		
5.3	Any revision to disciplinary toolkit template documentation should retain direction that completed copies should be shared with the People Services team.		
Agreed Management Action		Target Date	Responsible Officer
5.1	Implement a checklist to ensure all required documentation is maintained for a disciplinary process. Checklist should be signed off by the People Business Leader/ People Services Business Partner for their directorate on completion of all stages of the process.	31/07/2024	Karen Jones, Deputy Head of People Services
5.2	Undertake periodic audits on the compliance with checklist.	31/07/2024	Karen Jones, Deputy Head of People Services
5.3	Update as required using version control for disciplinary tool kit available on Siren.	31/07/2024	Karen Jones, Deputy Head of People Services

Matter Arising 6: Electronic staff record end process (Operation)		Impact	
<p>Section 20 of the policy states that <i>an accurate record of all disciplinary events should be maintained on the electronic staff record (ESR)</i>.</p> <p>Discussion with the People Services team highlighted that where an employee resigns during a disciplinary process it would be the resignation, rather than the disciplinary process outcome, recorded within ESR. One example of this was identified within our sample.</p> <p>This could limit the effectiveness of any subsequent check against an application should the individual apply for an NHS post.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> Incorrect status within ESR could result in previously dismissals being missed in future application checks. 	
Recommendations		Priority	
6.1	The People Services team should ensure that ESR records accurately reflect the outcome of disciplinary processes, and should review the case management tracker to identify any historic records which require amendment.	Medium	
Agreed Management Action		Target Date	Responsible Officer
6.1	On completion of all disciplinary hearings, People Services representative to ensure that ESR accurately reflects the outcome of dismissal. Contact with NWSSP payroll may be required to make the changes to past cases ensuring accurate information is recorded.	31/08/2024	Karen Jones, Deputy Head of People Services

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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



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Partneriaeth
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Gwasanaethau Archwilio a Sicrwydd
Shared Services
Partnership
Audit and Assurance Services

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership](#)

Risk Management

Final Internal Audit Report

August 2024

Welsh Ambulance Services University NHS Trust

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Auditors:	Osian Lloyd, Head of Internal Audit; Felicity Quance, Deputy Head of Internal Audit; Donna Morgan, Audit Manager
Executive sign-off:	Trish Mills, Director of Corporate Governance/Board Secretary
Distribution:	Julie Boalch, Head of Risk/Deputy Board Secretary; Marinela Stoicheci, Risk Officer; Jonathan Sweet, Head of Service (Operations); Toni-Marie Norman, Business Manager (Operations); Jen Lloyd, Business Manager (Clinical Directorate)
Committee:	Audit and Risk Assurance 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.

Disclaimer notice - please note:



This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit and Risk Assurance Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services, and addressed to Non-Executive Directors or officers including those designated as Accountable Officer. They are prepared for the sole use of the Welsh Ambulance Services University NHS Trust and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with the Welsh Ambulance Services University NHS Trust. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Executive Summary

Report Opinion

		Trend
<p>Reasonable</p> 	<p>Some matters require management attention in control design or compliance.</p> <p>Low to moderate impact on residual risk exposure until resolved</p>	 2022/23

Assurance summary¹

Objectives	Assurance
1 Risk Management Policy	Reasonable
2 Risk identification and assessment	Reasonable
3 Risk management and evaluation	Reasonable
4 Risk monitoring and scrutiny	Reasonable

Purpose

To assess the effectiveness of the Risk Management and assurance arrangements in place within directorates.

Overview

We have issued reasonable assurance on this area.

Through our review of risk management arrangements at both Corporate and Directorate (Operations and Clinical (Paramedicine)) level, we have noted the continued development and delivery of the Trust's risk transformation programme.

Processes are in place for the recording and monitoring of risks throughout the Trust, however the audit trail for the management of local and directorate risks is not always available.

The matters requiring management attention include:

- Better demonstrate the impact of risks on the achievement of strategic / directorate objectives and priorities.
- Completion of risk assessments.
- Evidencing the management and review of risks at directorate and service level.
- Development of summary risk reports at both the directorate and service level.

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

Key Matters Arising

	Objective	Control Design or Operation	Recommendation Priority	
1	Impact of risks on the achievement of strategic & directorate objectives and priorities	2,3	Design	Medium
2	Completion of risk assessments at directorate and service level.	2,3	Operation	Medium
3	Risk register records maintained outside Datix	2,3	Operation	Medium
4	Evidencing risk review activity undertaken at directorate and service levels	2,3,4	Operation	Medium
5	Directorate and service level risk reporting	2,3,4	Design	Medium

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

1. Introduction

- 1.1 Effective risk management enhances strategic planning and prioritisation, assists with the achievement of objectives, and strengthens the ability to be agile to respond to challenges, and should be an integral part of all organisational activities to support decision-making.
- 1.2 The Board Assurance Framework (BAF) is designed to provide a structure and process that enables Welsh Ambulance Services University NHS Trust (the 'Trust') to focus on the risks that might compromise it achieving its strategic goals, which are set out in its Long-Term Strategy 'Delivering Excellence', and as part of its Integrated Medium-Term Plan (IMTP). In recent years work has been carried out to develop and improve the format and content of the BAF.
- 1.3 The Trust's Risk Management Transformation Programme has been designed to strengthen and positively impact the development of its future strategic ambitions, as highlighted in the 2023-26 IMTP. Areas of focus include the delivery of a risk management framework as a key enabler of its long-term strategy and decision making.
- 1.4 The Trust's principal risks are set out in its Corporate Risk Register (CRR) and on the BAF. These are reviewed and monitored by the Assistant Directors Leadership Team, the Executive Leadership Team, Board Committees, and the Board in accordance with the national risk review schedule. The Trust also operates directorate and local registers where risks are managed locally and, where necessary, are considered for escalation through the risk reporting structure for inclusion on the CRR. The Audit and Risk Assurance Committee retains oversight of the risk management process and framework.
- 1.5 In undertaking the review, we considered whether there were unintegrated and inconsistent approaches to identifying, assessment and monitoring of risks at both Directorate and Local level resulting in:
 - Ineffective and inefficient use of resources;
 - Failure to achieve strategic, operational, and financial objectives; and
 - Exposure to reputational damage and a negative impact on patients and staff.
- 1.6 As part of the review, we have considered the corporate arrangements as well as those of the sampled directorates of Operations and Clinical.

2. Detailed Audit Findings

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

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	--	2	-	2
Operating Effectiveness	-	3	-	3
Total	-	5	-	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: The Risk Management Policy and associated guidelines and procedures provide clear guidance to ensure that the system is robust and working effectively.

- 2.3 One of the deliverables underpinning the Trust's Risk Transformation Programme was to develop a Risk Management Policy and supporting procedures; and Board approval of the Risk Management Policy (the Policy) was evidenced in March 2024.
- 2.4 Included within the Policy is the approach to risk management within the Risk Management Framework, and details of the respective responsibilities for strategic and operational risk management for the Board and staff throughout the organisation. The Policy also outlines that risk management is an integral and positive part of the Trust's culture; and how it ensures the Trust meets its legal obligations in respect of risk management.
- 2.5 Section 3.6 of the Policy outlines how it aligns to the Trust's strategic objectives, which aligns to the ongoing wider piece of work around the development of the Trust's strategic BAF.
- 2.6 Supporting the Policy are the Corporate Governance Directorate Risk Management Guidelines ('the Guidelines'), which were developed and approved in October 2023. The purpose of these Guidelines is to support staff by providing a clear process to identify, describe, report, and monitor both new and existing directorate risks.
- 2.7 Included within the Guidelines are risk assessment forms, scoring matrices and frequency of review details. Additionally, the processes for treating, escalating, and closing risks are outlined.
- 2.8 A staff announcement has been circulated to communicate that the Policy has been approved. The Policy and supporting Guidelines are also available on SharePoint, and management advised that they intend to publish a further Corporate Governance Notice via Siren to continue to promote the framework for staff to use in managing risks.
- 2.9 Guidance on Interpreting the BAF was issued in April 2023.

- 2.10 The Audit Wales 2023 Structured Assessment stated that *'the Trust has reasonable arrangements for overseeing corporate risks, but it needs to reframe the BAF as a tool that brings together all relevant information on the risks to achieving strategic objectives.'* We note that the Trust has appointed an external consultant to support the progress of the Risk Transformation Programme, advising on best practice in areas such as the strategic BAF, risk appetite and exploring options for digitising the BAF. This work does not impact the operation of the existing BAF.
- 2.11 Engaging with the consultant will address the recommendation raised in our prior year audit report (issued July 2023, Reasonable Assurance), which stated that *'following the development of the risk appetite matrix, the Trust should develop and finalise its risk appetite statements'*.

Conclusion:

- 2.12 The Risk Management Policy and Corporate Governance Directorate Risk Management Guidelines have been approved and are operational at the Trust. The team intends to publish a Corporate Governance Notice to inform staff of these documents and to ensure implementation. Noting this and the ongoing work to develop the BAF and risk appetite statements, we assign this objective **reasonable** assurance.

Objective 2: Corporate and directorate level risks are appropriately identified and assessed.

- 2.13 The Trust's risk management process provides a structure for identifying and managing risks at all levels in the organisation. There are three tiers at which risks may be identified, managed, controlled, and monitored, these being:
- Tier 1 - Corporate
 - Tier 2 – Directorate
 - Tier 3 – Local: site or service / operational.
- 2.14 As outlined in the Guidelines a range of techniques can be used to identify risk, and this might include specific methods advised or delivered by the risk management and compliance functions.
- 2.15 The Guidelines further state that *'the main purpose of a risk assessment is to prioritise the organisation's most important risks. Risks should be assessed on the likelihood of the risk materialising and impact / consequence of its occurrence on Trust objectives. Controls and assurances in place to manage / mitigate the risk should also be considered.'*
- 2.16 We understand that a programme of developing new risks takes place outside of Datix (the All-Wales system for recording and monitoring risks) through the population of risk assessment forms that facilitate the *'if, then resulting in'* format. This acknowledges that the system does not have a section to outline the nature, level, and impact of the risk on strategic objectives. It is also acknowledged that the Trust does not perceive the system as being fit for purpose for their current direction of travel in risk.

Corporate Risks

- 2.17 The process for identifying and assessing corporate risks is embedded within the Trust. As stated in the Audit Wales 2023 Structured Assessment *'the Trust's BAF maps the organisation's corporate risks against the deliverables of its Integrated Medium-Term Plan (IMTP)'*. Corporate/Principal risks are usually identified at a directorate level initially or can be identified at a Board level; and are escalated to the Head of Risk / Deputy Board Secretary once they hit a score of 12, or above, for consideration at Assistant Director Leadership Team (ADLT); and subsequently Executive Leadership Team (ELT) for inclusion on the Corporate Risk Register (CRR).
- 2.18 For the purposes of this audit, risk assessment forms were requested for a sample of five risks on the CRR. We note that the Guidelines state that *'The Board defines as "high" any risk that has the potential to damage the organisation's objectives.'* We could confirm the completeness of the trail for inclusion on Datix but noted that the detail of the risk assessment forms didn't confirm the potential impact on the achievement of the Trust's strategic objectives and priorities. See **Matter Arising 1**.
- 2.19 We note that the ongoing work on the BAF as part of the Risk Transformation Programme with the Trust appointed external consultant will be key to this development.

Directorate and Local Risks

- 2.20 The Guidelines also state that *'each Directorate needs to identify operational and strategic risks through the completion of risk assessments and for ensuring that risk assessments are completed on an ongoing basis.'* As per para 1.6, risk management arrangements within two directorates have been reviewed during this audit – Operations and Clinical.
- 2.21 The Guidelines further state that *'All risks must be scored using the Trust's risk matrix.'* The Trust's risk matrix features on the risk assessment templates, and within Datix, to ensure consistency in approach. From review of the risk registers, all risks had been scored.

Directorate Risks - Operations

- 2.22 Directorate level risks are captured on the Operations Directorate risk register held on Datix. However, we are advised that at the time of audit, there are no risks currently at this level due to them either being escalated to the CRR or deescalated to local / service risk registers (refer to **audit objective 3** for further details on evaluation and management of risks).
- 2.23 Whilst there has been a restructure within Operations in 2021, we note that different processes at varying levels of maturity continue to operate at a local level in terms of risk management obligations, and identification and assessment of risks.
- 2.24 We were informed that emerging risks would be identified by an individual who would typically be the risk owner, who would add the details of the risk to the local

risk register / Datix as appropriate. A risk assessment is not completed, contrary to the Guidelines, as per para 2.20. See **Matter Arising 2**.

- 2.25 The risks are managed by risk owners that hold responsibility for escalating risks to the Senior Operations Team (SOT) as relevant. SOT supports the Senior Leadership Team (SLT) in the day-to-day leadership and management of the Operations Directorate.
- 2.26 Whilst the risk assessment forms were not completed, this process is being undertaken to an extent via the risk assessment section within Datix (which requires details including risk description / risk owner / RAG rating / score etc.) for four of the eight local risk registers: Integrated Care, Emergency Medical Services (EMS) Co-Ordination, Ambulance Care and Emergency Planning Risk and Resilience.
- 2.27 We are advised that completion of a risk assessment form would not be necessary for local or directorate risks. It was suggested that the risk be input straight onto Datix to avoid duplication. However, this is not confirmed at the Guidelines (see para 2.20). Furthermore, this deviation from practice may become problematic for those risk registers held outside of Datix where the information is less consistent and complete (see para 2.28).
- 2.28 A further four local risk registers are in place for EMS Response, covering the localities. These are held within separate Excel spreadsheets outside of Datix (See para 2.41). At our 2021/22 report we recommended that *'the Trust consider the issues identified above regarding risk management occurring outside of Datix and develop guidance to support the escalation criteria and processes which can be implemented across the organisation'*. Review of the internal audit recommendation tracker confirms that such was closed given the Guidelines, required, had been developed. However, risk registers are still held outside of Datix but we do acknowledge that the availability of resourcing, within the Risk team, to support the use of recording local and directorate risks is limited. See **Matter Arising 3**.

Directorate Risks - Clinical

- 2.29 We understand that emerging risks would be identified by a Lead (usually a clinician) / Manager / Project Manager. They would become the risk owner and bring to the attention of the Business Manager, who manages the Clinical Directorate Risk Register on Datix. A meeting will then be held between the Business Manager and the risk owner to evaluate and assess the risk.
- 2.30 Review of the current open risks for this directorate (at the date of fieldwork, 12 directorate and three local) noted that, contrary to the requirements of the Guidelines, no risk assessment forms had been completed. See **Matter Arising 2**. Similarly to the process outlined at para 2.26 above, reliance is instead placed on the risk assessment section of Datix to assess, evaluate and complete risk details.
- 2.31 All Clinical risks were captured on Datix for ongoing monitoring and management at both local and directorate level. We note that Datix entries require updating to align with the information at the risk reports, which outline details of 'open'

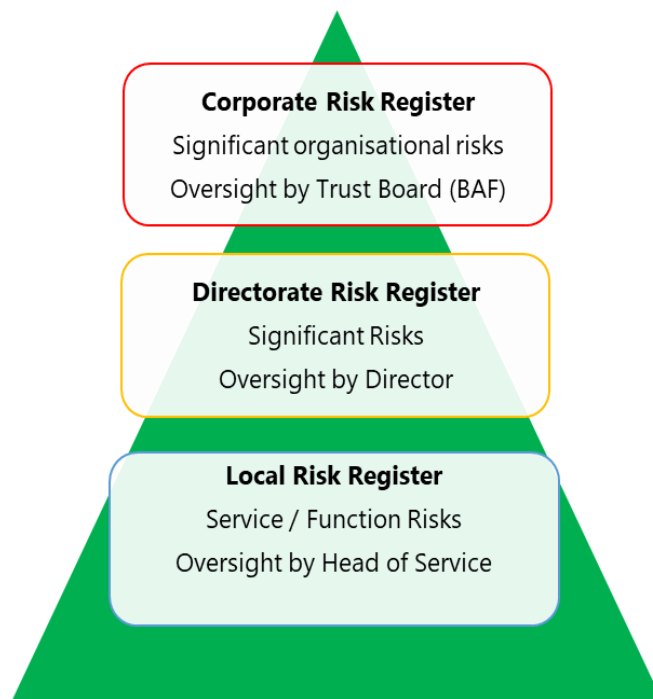
directorate and local level risks – see para 2.51 and **Matter Arising 4**. We also noted that the volume of risks within this directorate was manageable, with deep dive reviews focusing on three risks being undertaken monthly at the Clinical Directorate Business Meetings (for further details, refer to **audit objective 3**).

Conclusion:

2.32 Although the Trust risk management process is well established, inconsistencies were noted in the application of the Guidelines in relation to the completion of risk assessment forms for local and directorate risks and the recording and scoring of these on Datix. However, we do note that there are appropriate mitigating actions in place, including the capture of risks at local risk registers. Accordingly, we have assessed a **reasonable** level of assurance for this objective.

Objective 3: There is appropriate management and evaluation of corporate and directorate level risks identified (e.g. risk score, mitigating actions, target dates, responsible owners, escalation / de-escalation and impact on strategic objectives).

2.33 As noted in 2.13 above, there are 3 Tiers at which risks may be identified, managed, controlled, and monitored. Risks within the Datix Risk Registers are categorised (type) and managed as below:



Corporate/Principal Risks

2.34 The Trust's principal and strategic risks are set out in its CRR. Entries are assigned a lead Executive for ownership, and each is also assigned to a specific Committee for oversight and assurance.

2.35 Corporate/principal risks are monitored and reviewed at the monthly ADLT (for risks that should potentially be escalated to the CRR) and ELT meetings (to monitor

and manage risks on the CRR), ahead of presentation to the Board and Committee structures. Frequency of review varies in line with scores applied to risks, with higher scoring risks subjected to review more frequently, including deep dives where applicable, and in accordance with the risk review schedule.

- 2.36 Discussions around risk score (including changes to the score), mitigating actions, target dates, risk owners, potential for escalation or de-escalation and impact on strategic objectives are discussed at these meetings, with updates clearly highlighted.
- 2.37 Any issues discussed at ELT are fed back to the ADLT group to ensure a complete audit trail. ELT ultimately determine if a risk should be included on the CRR. It is also the deciding body should a risk need to be de-escalated to the directorate risk register.

Directorate and Local Risks

- 2.38 Directorates are responsible for managing both their directorate and local risks and escalating to the Head of Risk / Deputy Board Secretary for inclusion on the CRR as per para 2.17.
- 2.39 We were informed that risks are considered for escalation when it is known it spans several directorates or is a high-level risk, scoring 12 and above. The Business Manager or Risk Owner escalates these risks to the Head of Risk / Deputy Board Secretary, who also intends to review the top Directorate risks on a quarterly basis although we note that capacity has prevented the achievement of this more recently.

Operations Risk Register

- 2.40 There are no 'open' or 'active' risks within the Directorate risk register at present (see 2.22). However, Datix requires updating to reflect this position noting that several outdated directorate level risks were recorded as 'open' at the time of audit. See **Matter Arising 4**.
- 2.41 Currently there are eight local risk registers, four of which (those covering the localities) are being maintained in individual excel spreadsheets rather than centrally within Datix, as reported in our 2021/22 report. We found that these risk registers did not mirror the information that would be included on Datix (e.g. they did not have review or target dates to facilitate regular review, including ensuring that the mitigating actions are up to date). See **Matter Arising 3**.
- 2.42 In addition, the information held on Datix does not accurately capture the latest position in relation to risks, reflecting changes made by the relevant risk owners. For example, the table in **Appendix B** highlights that a significant number of risks had missed their target and review dates. However, we acknowledge that the review date field on Datix is not updated automatically post a risk review having taken place. We were also unable to confirm that risks were being reviewed in line with required frequencies. Accordingly, oversight by Senior Leaders may be difficult. See **Matter Arising 3**.

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- 2.43 We acknowledge that Operations is a complex area noting it covers numerous territories and functional areas. Historically individual areas have undertaken risk management arrangements in isolation. However, since the Operations Governance structure has been established, monthly, structured Business Management Team meetings are taking place, to facilitate appropriate review and escalation of local level risks in a consistent manner. See **objective 4** for further details on monitoring and escalation of risks.
- 2.44 We note that the Directorate is planning a large data cleansing exercise of all local level risks at SOT (targeted end May 2024) to gain assurance that risks have been accurately identified, are still relevant and to eliminate duplicate risks. Datix will then be updated accordingly, allowing for risks to be monitored centrally. Senior leaders will also gain access to emerging risks locally, should the need arise. We are advised that it will also be determined whether the eight local risk registers could be consolidated into one register.
- 2.45 Noting that the information on Datix and the local risk registers was not up to date and recognising that the detail captured at **Appendix B** was not readily available, we had to seek further clarification to confirm the total number of risks and their status. It would therefore be beneficial to develop summary risk reports / enhance the level of information presented within existing reports at local and directorate level, similar to the format presented at Board and Committees. See **Matter Arising 5**. We are advised that this level of reporting is planned to follow the cleansing exercise at the end of May 2024.
- 2.46 Noting that risk assessment forms have not been used consistently, and noting that completion of information on Datix may be inconsistent by users, there may be some training needs which need to be considered within the Directorate. See **Matter Arising 2**.
- Clinical Risk Register
- 2.47 As noted at para 2.29, at the date of fieldwork, risk assessment forms were not completed for directorate or local risks within the Clinical Directorate. See **Matter Arising 2**. However, upon identification of directorate and local risks, relevant information is uploaded directly onto Datix.
- 2.48 As per para 2.43, review of the risk register on Datix demonstrated that the information held on the system was outdated. Similarly to the Operations Directorate, a significant number of risks appear to have missed their target and review dates, and we cannot confirm that other information such as mitigating actions does not require further review - see **Appendix B** and **Matter Arising 4**.
- 2.49 We were also unable to confirm that risks were being reviewed in line with required frequencies. Three of the twelve risks on the Directorate risk register had a high score which should be reviewed monthly, and seven of the risks with moderate scores should be reviewed quarterly, in line with the Guidelines. (Lower scoring risks may be reviewed bi-annually). However, it was difficult to gain assurances that this was completed from the information on Datix and the action and decision logs from the business meetings. See **Matter Arising 4**.
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- 2.50 Whilst we recognise that risks are regularly reviewed, discussed and evaluated at the monthly Clinical Directorate Business meetings (see **objective 4** below for further details on monitoring and escalation of risks), there is a need for Datix to be updated to reflect the discussions held. See **Matter Arising 4**.
- 2.51 Similarly to 2.45 above, we considered it would be beneficial to enhance the summary risk report that has been developed by the Directorate (see **objective 4** below). See **Matter Arising 5**.
- 2.52 We also recognise the importance of the ongoing work to define the risk appetite statements is key to address these areas moving forwards.

Conclusion:

- 2.53 Review of Datix noted that there is demonstrable, active management of risks at the corporate level. There are issues evidencing the management of risks at a directorate level, with Datix not being updated to reflect reviews undertaken. However, recognising that risk activity is regularly discussed at directorate and local levels, and there are plans in place to review the arrangements supporting the consistency and completeness of risks through a cleansing exercise, we assign this objective **reasonable** assurance.

Objective 4: Risks are actively monitored and scrutinised at an appropriate level within the Directorates.

- 2.54 Local and directorate level risks are assigned a lead for ownership and the risk is assigned to a relevant Group (Business Management Team / SOT) for oversight and assurance.

Operations Directorate

- 2.55 Individual risks are discussed at the weekly SOT and SLT meetings and Alert, Advise, Assure (AAA) highlight reports are issued following the formal meetings.
- 2.56 The Directorate risk register is included at the weekly SOT meetings. However, we note that at the time of audit, there are no 'open' risks at this level currently (since October and November 2023 - although Datix requires updating to reflect this position).
- 2.57 Corporate risks relating to the Operations Directorate are also reviewed at the weekly SLT meetings. The SOT supports the directorate's SLT and has the role of reviewing the Directorate risk register and relevant risks held on the CRR (including controls and mitigating actions), escalating to SLT as required. Membership of SOT includes heads of service alongside resourcing, finance, quality improvement, clinical lead and the Operations Directorate Business Managers.
- 2.58 Operations is an agenda item at ADLT. An AAA highlight report is also prepared for discussion beyond the Directorate at ELT, to consider the escalation of risks for inclusion at the CRR. Recent examples of the escalation process in operation can be evidenced via two new risks in development relating to the governance around the volunteers in the volunteering sector, and staff retention within EMS

Coordination (and the ability to put sufficient capacity in call handling environments in particular).

- 2.59 As per para 2.41, there are currently eight local risk registers in place, which are reviewed at the monthly Business Management Team meeting led by the Business Manager (Operations).
- 2.60 An AAA Highlight report is published following each Business Management Team meeting. Where a risk scores sufficiently highly it is the risk owners' responsibility through the Business Management Team Meeting structure to highlight this. All risks requiring review for escalation, would feature in the AAA Report for onward consideration by the SOT.
- 2.61 Further to 2.45 above, we consider the development of a risk report summarising the risks held within each local risk register, capturing further details and status updates, similar to the format presented at Board and Committees, would enhance monitoring arrangements at this level. See **Matter Arising 5**. We are advised that this level of reporting is planned to follow the cleansing exercise at the end of May 2024.

Clinical Directorate

- 2.62 The Directorate risk register includes corporate, directorate and local risks, held centrally on Datix.
- 2.63 Local and directorate risks are discussed at the monthly Clinical Directorate Business meetings, and noted in the action / decision logs, with deep dives being undertaken on three risks per meeting (usually prioritised by longest outstanding risks, or those with highest priority) to ensure effective monitoring of the risks.
- 2.64 Action / decision logs and Summary Risk Management Reports support the operation of the Business meetings (which are not formally minuted). These capture discussions on risk and include recommendations for risks that may require escalating / deescalating.
- 2.65 A summary risk report is then provided which includes updates such as closed, transferred or escalated risks for ongoing monitoring within the Clinical Directorate.
- 2.66 Recent examples of the process in operation can be evidenced via the May 2024 Summary Risk Management Report, where it was noted that the team discussed risks 581 (Delivery of Clinical Directorate BAU) and 535 (Deterioration in Clinical Indicator Performance following transition from Digital Pen to Electronic Patient Clinical Record (EPCR)).
- 2.67 Similarly to para 2.61, we have recommended enhancements to the summary report to better evidence risk review activity. See **Matter Arising 5**.

Conclusion:

- 2.68 Risks are actively monitored and scrutinised at an appropriate level within the directorates reviewed, however we have identified risks and associated mitigating actions that appear overdue for review and have passed their target dates. The recording of some local risks within the Operations Directorate outside of Datix

could prevent effective oversight, but we note that plans are in place to review such and record appropriately. The development of a summary highlight report for directorate and local level risks, similar to the format currently presented at Board and Committee level, would enhance and better evidence risk review activity. Accordingly, we assign this objective **reasonable** assurance.

Appendix A: Management Action Plan

Matter Arising 1: Impact of risks on the achievement of strategic and directorate objectives and priorities (Design)		Impact
<p>As outlined in the Risk Management Guidelines a range of techniques can be used to identify risk, and this might include specific methods advised or delivered by the risk management and compliance functions.</p> <p>The Guidelines further state that <i>'the main purpose of a risk assessment is to prioritise the organisation's most important risks. Risks should be assessed on the likelihood of the risk materialising and impact / consequence of its occurrence on Trust objectives. Controls and assurances in place to manage / mitigate the risk should also be considered.'</i></p> <p>Review of the risk assessment forms developed by the Trust, that facilitate the <i>'if, then resulting in'</i> format, identified that they could be enhanced to capture the objectives and priorities that are impacted.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> Lack of consideration of potential impact on strategic and directorate objectives and priorities, which may jeopardise their achievement.
Recommendations		Priority
1.1	The Trust should consider amending the risk assessment form to capture the strategic and directorate objectives and priorities impacted by each risk.	Medium
Agreed Management Action		Target Date
1.1	<p>The RAF and BAF already have sections to capture the strategic objectives, however there was a timing issue with the new IMTP to facilitate the inclusion of such. These will be included going forward.</p> <p>At this stage of the risk management maturity at the Trust we will not include the directorate objectives and priorities impacted by each risk but is something we can look to do when we have an appropriate electronic risk management system.</p>	30 August 2024
		Responsible Officer
		Head of Risk

Matter Arising 2: Completion of risk assessments at directorate and service level (Operation)		Impact	
<p>Our audit identified that the risk assessment form developed by the Trust is not being completed for directorate and service level risks.</p> <p>The Risk Management Guidelines state <i>each Directorate needs to identify operational and strategic risks through the completion of risk assessments and for ensuring that risk assessments are completed on an ongoing basis.</i></p> <p>Whilst reliance is placed on this process being undertaken, in some instances, via the risk assessment section within the Datix system (which requires details including risk description / risk owner / RAG rating / score etc.), the system does not capture the full level of detail required.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> Inconsistent approach to assessment of risks. 	
Recommendations		Priority	
2.1	Risk assessment forms should be completed for all risks.	Medium	
2.2	User / training requirements needed to support managers / risk owners through this transition should be considered to ensure that individuals feel competent to complete risk assessment forms and upload the information onto Datix.	Medium	
Agreed Management Action		Target Date	Responsible Officer
2.1	It may be that risk assessment forms do not need to be completed for all risks if they are developed directly on Datix. However, a siren notice will be issued to remind colleagues of the correct templates to use, support available and direct them to the risk management framework; and the narrative included in the Risk Management Guidelines will be updated accordingly too.	30 August 2024	Head of Risk

2.2	Resourcing for the risk team is limited at this time, therefore the full programme of training and education will be in line with the risk transformation programme. However, the Corporate Governance Directorate will develop a virtual roadshow to senior directorate meetings and ADLT to provide information and signposting on risk management (as well as audit, policy, FOIs etc).	31 March 2025	Head of Risk
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Matter Arising 3: Risk register records maintained outside Datix (Operation)		Impact
<p>Four local risk registers are in place for EMS Response, covering the localities. These are held within separate Excel spreadsheets outside of Datix. At our 2021/22 report we recommended that 'the Trust consider the issues identified above regarding risk management occurring outside of Datix and develop guidance to support the escalation criteria and processes which can be implemented across the organisation'. Review of the internal audit recommendation tracker confirms that such was closed given the Guidelines, required, had been developed. However, risk registers are still held outside of Datix but we do acknowledge that the availability of resourcing, within the Risk team, to support the use of recording risks is limited.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> Inconsistent monitoring, management, and escalation of risks within the Trust.
Recommendations		Priority
3.1	All risks should be uploaded and managed on Datix.	Medium
Agreed Management Action		Target Date
3.1	<p>Datix is not currently fit for purpose. Therefore, agreeing that all risks should be uploaded and managed on Datix is not possible at this time.</p> <p>What is accepted is that there should be an agreed approach within local and directorate risk registers i.e. either all on Datix and managed there with appropriate reporting, or outside of Datix with an audit trail of identification, development, review, escalation, and closure.</p> <p>Resourcing in the risk team currently is challenging and it is therefore impossible in a timely way to agree to this recommendation. Propose that the MA related to the EMS local risk register is dealt with in action 4.1 with SOT and that the recommendation that all risks are uploaded and managed on Datix is deferred until such time as a way forward is agreed on whether changes will be made to Datix on an All-Wales basis, or whether Health Boards and Trusts will be procuring their own solutions.</p>	31 January 2025
		Responsible Officer
		Head of Risk

Matter Arising 4: Evidencing risk review activity undertaken at the directorate and service level (Operation)	Impact
<p>There are no 'open' or 'active' risks within the Operations Directorate risk register at present. A review of the Directorate risk register identified that at the time of audit, Datix required updating to reflect this position noting that several outdated directorate level risks were recorded as 'open' which is an audit trail issue.</p> <p>Currently there are eight local risk registers in the Operations Directorate. However, the information held was not accurate and required updating. A significant number of risks had missed their target and review dates. In summary (see Appendix B):</p> <ul style="list-style-type: none"> • A total of 55 risks were included on the Emergency Plan Risk and Resilience, 111 (Integrated Care), EMS Co-Ordination and Ambulance Care local risk registers: <ul style="list-style-type: none"> ○ 47 of 55 risks were noted as past their target date; and ○ 46 of 55 risks were noted as past their 'next review date'. • A total of 38 risks were included on the EMS Response locality risk registers. No target or review dates were included for these risks. <p>A review of the Clinical Directorate and local risk register on Datix also identified that the information held was outdated. In summary (see Appendix B):</p> <ul style="list-style-type: none"> • A total of 12 risks were open on the Directorate Risk Register: <ul style="list-style-type: none"> ○ 9 of 12 risks were noted as past their target date; and • 12 of 12 risks were noted as past their 'next review date'. A total of 3 risks were currently open on the Local Risk Register: <p>We were also unable to confirm that risks and associated mitigating actions are being reviewed in line with required frequencies. Whilst we recognise that risks are regularly reviewed, discussed and evaluated at the monthly Business meetings, there is a need for Datix to be updated to reflect the discussions held.</p>	<p>Potential risk of:</p> <ul style="list-style-type: none"> • Inconsistent monitoring, management, and escalation of risks within the Trust.

Recommendation		Priority
4.1	We recommend the Trust consider arrangements to support the consistency and monitor the completeness of directorate registers.	Medium
Agreed Management Action		Responsible Officer
4.1	<p>The risk team will work with the clinical and operations team with respect to the risks set out here particularly and either develop a plan to manage these risks externally to Datix but with an appropriate audit trail whilst an electronic risk management system is procured, or to use Datix for the capture of the operations and clinical risks with appropriate and user-friendly reporting for their purposes. This will be evidenced by a record of this being agreed by SOT and the appropriate clinical directorate meeting.</p> <p>The data cleansing exercise to be undertaken by the Operations Directorate, as referenced at para 2.45, will also assist in managing the accuracy of the risk register.</p>	<p>Target Date: 31 October 2024</p> <p>Responsible Officer: Head of Risk</p>

Matter Arising 5: Directorate and service level risk reporting (Design)		Impact
<p>Noting that the information on Datix and the local risk registers are not kept up to date and recognising that the detail captured at Appendix B is not readily available, we had to seek further clarification to confirm the total number of risks and their status. It would therefore be beneficial to develop summary risk reports at service and directorate level, similar to the format presented at Board and Committees, to improve and enhance monitoring arrangements at this level. The report could capture changes to the risk (e.g. description / score / escalation / mitigating actions etc.) as well as an update of those risks that are past their target and review dates.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> Inconsistent monitoring, management, and escalation of risks within the Trust.
Recommendation		Priority
5.1	A summary risk report, similar to the format presented at Trust Board and Committees, should be developed and reported at directorate and service level.	Medium
Agreed Management Action		Target Date
5.1	<ol style="list-style-type: none"> It is accepted that an appropriate overarching risk report is beneficial for local and directorate risks, however the risk team will look at what reporting can be drawn from Datix currently, noting the limitations it has. This management action is closely aligned to the work that the team will do for action 4.1. Operations are developing a dashboard to be reported to SOT which highlights the total number of risks, how many risks at each level, review compliance (% in-date and overdue), and requesting all risks be reviewed so that any no longer relevant can be closed or replaced as appropriate, and up-to-date mitigation (controls and treatments) are recorded for any which are still applicable and need to remain open. 	31 October 2024
		Responsible Officer
		<ol style="list-style-type: none"> Head of Risk Deputy Business Manager

Appendix B: Local and Directorate Risk Totals

	Name of Risk Register	Format	No. of Open Risks	No. of Risk Assessments Completed	No. of High Risks	No. of Medium Risks	No. of Low / Very Low Risks	No. past Review Dates	No. past Target Dates
Operations Directorate									
1	*Directorate Risk Register	Datix	0	0/0	0/0	0/0	0/0	0/0	0/0
2	Emergency Plan Risk and Resilience	Datix	21	0/21	0/21	6/21	15/21	21/21	21/21
3	111 (Integrated Care)	Datix	13	0/13	1/13	8/13	4/13	8/13	6/13
4	EMS Co-Ordination	Datix	9	0/9	1/9	5/9	3/9	5/9	8/9
5	Ambulance Care	Datix	12	0/12	0/12	9/12	3/12	12/12	12/12
6	Ems Response - BCU	Excel	19	0/20	5/20	12/20	3/20	No review date recorded	No target date recorded
7	EMS Response - South Central	Excel	7	0/7	2/7	5/7	0/7	No review date recorded	No target date recorded

	Name of Risk Register	Format	No. of Open Risks	No. of Risk Assessments Completed	No. of High Risks	No. of Medium Risks	No. of Low / Very Low Risks	No. past Review Dates	No. past Target Dates
8	EMS Response - Central	Excel	5	0/5	1/5	3/5	1/5	No review date recorded	No target date recorded
9	EMS Response – South East	Excel	7	0/7	2/7	5/7	0/7	No review date recorded	No target date recorded
Clinical Directorate									
1	Directorate Risk Register	Datix	12	0/12	2/12	7/12	3/12	12/12	9/12
2	Local Risk Register	Datix	3	0/3	0/3	1/3	2/3	3/3	3/3


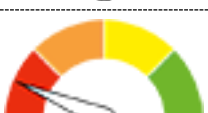
*There are currently no ‘active’ risks on the Operations Directorate Risk Register.

Note - One of the Clinical (Paramedicine) risks had no rating as it was decided that this risk should be escalated to the Corporate Risk Register (Emerging Risk Advanced Paramedic Practitioner).

Appendix C: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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



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Shared Services
Partnership
Audit and Assurance Services

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership](#)

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

Date issued: August 2024

Document reference: 4447A2024

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

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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 Services University NHS Trust. We presented our most recent Audit Plan to the committee on 7 June 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	Audit work is complete, and our closing 'Audit of Accounts Report' has been issued. The accounts were certified by the Auditor General on 12 July 2024 and laid with the Senedd shortly afterwards.	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	<p>This work examines different aspects of the urgent and emergency care system in three parts:</p> <ul style="list-style-type: none"> • Part One: Flow out of hospital (not applicable to the Trust). • Part Two: accessing urgent and emergency care. • Part Three: national arrangements and leadership structures. 	<p>Part Two: Drafting</p> <p>Part Three: Scoping</p>	November 2024
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	Clearance - draft report issued	November 2024

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
		Arrangements, which was reported to the committee in September 2022.		
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.	Clearance - draft report issued	November 2024
Structured Assessment - core	Director of Corporate Governance / Board Secretary	<p>This work will review the following core areas:</p> <ul style="list-style-type: none"> • Board and committee effectiveness, cohesion, and transparency. • Corporate systems of assurance. • Corporate planning arrangements. • Corporate financial planning arrangements. <p>This work will also seek to provide an update on the Trust's progress in addressing audit recommendations made in previous structured assessment reports.</p>	Fieldwork underway	November 2024

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
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.

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

Title	Publication Date
<u>Community Pharmacy Data Matching Pilot</u>	May 2024
<u>From firefighting to future-proofing – the challenge for Welsh public services</u>	February 2024

Additional information

- 7 **Exhibit 4** provides information on corporate documents published by Audit Wales since the last committee update. Links to the documents on our website are provided. There are no relevant Audit Wales consultations currently underway.

Exhibit 4 – Audit Wales corporate documents

Title	Publication Date
<u>Annual Report and Accounts 2023/24</u>	August 2024



Audit Wales

1 Capital Quarter

Tyndall Street Cardiff, CF10 4BZ

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English.
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Ymddiriedolaeth Brifysgol GIG
Gwasanaethau Ambiwylans Cymru
Welsh Ambulance Services
University NHS Trust

AGENDA ITEM No	8
OPEN or CLOSED	Open
No of ANNEXES ATTACHED	6

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

MEETING	Audit, Risk and Assurance Committee
DATE	12 September 2024
EXECUTIVE	Trish Mills, Director of Governance / Board Secretary
AUTHOR	Julie Boalch, Assistant Director of Corporate Governance & Risk
CONTACT	Julie.Boalch@wales.nhs.uk

EXECUTIVE SUMMARY

1. The purpose of the report is to provide a detailed progress report on the risk management transformation programme, assurance and a high level synopsis of the 2023/24 Internal Audit Risk Management Review and assurance in respect of the management of the Trust's principal risks.

Risk Management Transformation Programme

2. BDO were commissioned to support the team to progress the Risk Transformation Programme, as set out in the 2024/25 Integrated Medium Term Plan (IMTP), advising on best practice areas such as the development of a strategic Board Assurance Framework (BAF), risk appetite statements as well as exploring options for digitising the BAF. The report issued by BDO is included for Members consideration.
3. The next steps and the direction of travel for the Risk Transformation Programme are drawn out throughout the report which includes the plans to reposition the Trust's highest rated Risks 223 and 224.

2023/24 Internal Audit Risk Management Review

4. The 2023/24 Risk Management Internal Audit review has concluded which focussed primarily on the Trust's enterprise risk management arrangements. The Trust received a reasonable assurance rating; however, it is acknowledged that there are challenges with the current digital platform and the limitations it has in enabling effective and consistent risk management or which supports the way in which we have evolved in our risk management practices.

Board Assurance Framework

5. A summary of the principal risks (Annex 1) and a detailed description contained within the Board Assurance Framework (BAF) (Annex 4) is included in the report.
6. 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 scoring matrix (Annex 2).
7. The principal risks are updated as at 07 August 2024 which have been reviewed during this reporting period in line with the agreed schedule (Annex 3). Focus has been given to the risk ratings, controls, assurances, gaps, and mitigating actions identified and taken to support risks to achieve their target score.
8. Updates are highlighted in blue on the BAF which show changes to actions, controls, and assurances.
9. 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.
10. A workshop has been established for the 6 September 2024 with the Risk Owners and teams to consider a different approach to managing and monitoring those areas that are within the Trust's control and those that are not. The outcome of this will be reported through the next round of governance.
11. **Risk 424** *Resource availability (revenue, capital and staff capacity) to deliver the organisation's Integrated Medium-Term Plan (IMTP)* has reduced in score to 8 (2x4) and this will now be de-escalated to the Directorate Risk Register for ongoing management. This risk is linked closely with financial duties outlined in **Risk 139**.
12. Members are asked to note the closure of **Risk 619** relating to the replacement CAS System from all registers. This risk was reported in closed sessions of the Finance & Performance Committee and Trust Board; however, the risk has been mitigated in full and therefore closed.
13. 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.

14. 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.

RECOMMENDATION: Members are asked to consider and discuss the contents of the report and:

- 1) Support the direction of travel for the next stage of the Risk Management Transformation Programme: specifically,**
 - a. the development of a new Strategic Board Assurance Framework template based on the private healthcare example.**
 - b. the intention to commission external resources to develop the risk appetite statements.**
- 2) Note the plans to reposition Risks 223 and 224.**
- 3) Receive assurance on the 2023/24 Internal Audit Risk Management Review.**
- 4) Note the reduction in score for Risk 424 from 12 (3x4) to 8 (2x4). The risk will be de-escalated to the Directorate Risk Registers for ongoing management.**
- 5) Note the closure of Risk 619 from all registers having been fully mitigated.**
- 6) Receive assurance on the review and attention to the principal risks, including their review at ADLT, ELT and at relevant Committees.**
- 7) Note the ratings and mitigating actions for each principal risk.**

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:

Assistant Directors Leadership Team (22 July 2024)
Executive Leadership Team (07 August 2024)
Audit, Risk and Assurance Committee (12 September 2024)
Trust Board (26 September 2024)
Quality, Safety & Patient Experience (05 November 2024)
People & Culture Committee (14 November 2024)
Finance & Performance Committee (19 November 2024)

REPORT ANNEXES

SBAR report.
Annex 1 - Summary table describing the Trust's Principal Risks.
Annex 2 – Scoring Matrix
Annex 3 – Frequency of Risk review

Annex 4 - Board Assurance Framework
 Annex 5 – BDO Risk Report
 Annex 6 – Internal Audit Report – Risk Management

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

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

SITUATION

1. The purpose of the report is to provide a detailed progress report on the risk management transformation programme, assurance and a high level synopsis of the 2023/24 Internal Audit Risk Management Review and assurance in respect of the management of the Trust's principal risks.

BACKGROUND

2. The Risk Management Transformation Programme is reported and monitored through the Corporate Governance Directorate's Local Directorate Plan and through to the Strategic Transformation Board and the Audit, Risk & Assurance Committee for oversight.
3. Principal 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 ELT is in support of the direction of travel and next steps for the Risk Management Transformation Programme.
6. The ELT approved the principal risk activity described in this paper and considered the full review of each risk undertaken throughout August and September 2024 by Risk Owners and the ADLT.

Risk Management Transformation Programme

7. The Risk Management Transformation Programme has entered its third and final year as far as the Integrated Medium Term Plan (IMTP) is concerned. However, the Committee will see that there is a substantial programme of work to be undertaken with respect to the next stage of our enterprise risk management, as highlighted in the 2023/24 Internal Audit Review.

8. This is in addition to a strategic risk programme which is likely to span an additional 2-3 years to properly embed and is supported by recommendations made by our external consultants, BDO. It is expected that this next tranche of work will be included in the 2025-2028 IMTP as an enabling initiative.
9. BDO was commissioned to support the Trust 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) Provided best practice guidance design and build a strategic BAF that reflects the Trust's future strategic ambition and provides clarity on the strategic risks that would prevent us from achieving our organisational objectives.
 - 2) Provided 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 to consider the repositioning of 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.
10. A comprehensive, report from BDO (Annex 5), provides clear guidance and advice on each of these areas and makes recommendations as to what should be done now, next and later. This has been instrumental in shaping an outline work plan for the next phase of the risk transformation programme.

Current Risk Management Arrangements

11. The current BAF, in use at WAST, outlines our principal risks at a corporate level, and whilst it is linked to the IMTP actions that deliver the strategic objectives, it does not currently set out the risks directly correlated to our strategic objectives. Essentially it is a corporate risk register (CRR) which identifies, assesses, and monitors the key risks that we face as an organisation. However, it does not currently include a robust mechanism to provide assurance to the Board on the effectiveness of the controls in mitigating these risks.
12. It is important to differentiate between the two key areas of risk: the enterprise (or operational) risks which are those risks that are managed at a local, directorate and corporate level across WAST, and strategic risks which are those that could impact the organisation's ability to achieve its long term strategic objectives. The Board would primarily focus on strategic risks given these influence the direction of travel for the Trust's strategy; Delivering Excellence; Our Vision for 2030.

13. By focussing on both enterprise and strategic risk, the Trust will ensure it has a comprehensive risk management approach across all levels of the organisation supported by planned improvements which include a digital repository.
14. The key piece of work to undertake now is the development of a new BAF template that links strategic risks to each of the six strategic objectives (a strategic BAF).
15. It's important to note that our Auditors are included in the risk transformation programme discussions and are encouraged by the Trust's proposals to take a different approach in the development of a strategic BAF.

Strategic Board Assurance Framework

16. The strategic Board Assurance Framework (BAF) is a high level tool that provides the Board with assurance that the key risks to the Trust's strategic objectives are being managed effectively. It consolidates all relevant information on these risks and serves as a methodology for the Board to oversee these risks.

The Six Strategic Objectives



17. Whilst the strategic BAF is a logical extension of our current risk management arrangements, its focus is different. The strong risk culture at WAST puts us in a favourable position to make this strategic transition given the good understanding of risk management at all levels of the Trust.
18. The strategic BAF will map the main sources of assurances against the controls using a first, second and third line of assurance approach.

19. Another key element of it will include the development of risk appetite statements. These will define the level of risk that the Trust is willing to take or accept in pursuit of its strategic objectives to ensure better outcomes for our patients, our people and communities and in working with our partners and stakeholders.
20. The Trust's current BAF has evolved through an iterative process over the past two years in line with the transformation programme and is ready to take the next step.

Benefits to the Board

21. The goal is to provide the Board with a high level document that includes two key components: a dashboard of all strategic risks aligned with the strategic objectives, including risk appetite, and a map of the various assurance activities in place to mitigate or manage these risks.
22. Together, these two components will provide the Board with a comprehensive view of risks and the effectiveness of the controls in place to manage them.
23. The strategic BAF will align with the latest practices and further support the Board to discharge its responsibility for ensuring effective risk management processes are in place and enable it to maintain oversight of those risks within the Trust's strategic context.
24. Implementation of the new BAF, coupled with regular progress reports against delivery of the long-term strategy, will provide the Board with clear and comprehensive oversight of both the strategy and its risks. The new version will provide the Board with the information needed to support its strategic decision making.

Next Steps

25. There are several aspects that will need to be progressed to achieve these benefits for the Board including:
 - 1) determining the final format and template of the strategic BAF.
 - 2) developing risk appetite statements against the strategic objectives.
 - 3) Developing a suite of strategic risks.
26. BDO has provided examples of a good BAF template (pages 52–54 of their report), which will inform our design of the strategic BAF template. Training and guidance will be developed to ensure effective use of this tool by Executives and the Board.

27. External resources will be brought in to add pace to the programme and assist with the develop the risk appetite statements and the development of a suite of risk appetite statements.
28. Discussions with system partners in Wales and peers in University Hospitals of North Midlands are ongoing to inform the development of a digitally enabled strategic BAF and to ensure it is not developed in isolation of the work required to ensure we have a fit for purpose digital system for enterprise risk.
29. Governance and future reporting proposals for the strategic BAF and enterprise risk management are in development making use of tools such as the LDP and reporting through existing structures such as the Strategic Transformation Board given the correlation of the strategic risks to the Trust's long term strategy and reported progress against its delivery.
30. A timetable of informal, engagement and training sessions are planned to focus on the development of the risk appetite statements and will include the Executive Leadership Team, Assistant Directors Leadership Team, our Board and Auditors with a Board Development Session scheduled for February 2025.
31. A work plan encompassing the next stages of the risk management transformation programme is being developed utilising a change management methodology and engaging workstreams such as the Trust's Project Pathway Framework. It is essential to provide training and engage widely at all levels of the Trust.

Electronic System

32. The current BAF is manually updated and managed which limits the ability to monitor risk movement and status effectively. Exploring the implementation of an electronic system to digitise the BAF providing dynamic reporting arrangements is a priority and pivotal to the whole risk management programme.
33. The current digital risk management platform; Datix, has limitations in supporting the evolution of our risk management and reporting processes. It is important to transition to a new electronic solution that supports both enterprise risk management and the strategic BAF.
34. The Trust is exploring the Once for Wales solution and the options to build our own platform with the support and expertise of digital colleagues inside and outside of the Trust.

Internal Audit Review

35. The 2023/24 Risk Management Internal Audit review (Annex 6) focussed primarily on the Trust's enterprise risk management arrangements. The Trust received a reasonable assurance rating; however, there are improvements needed.
36. The report highlights the continued development and delivery of our risk transformation programme and notes that whilst recording, monitoring and reporting of risk is done well, a clear audit trail for the management of local and directorate risks is not always available or held centrally.
37. Usability issues with the current Datix system contribute to inconsistencies in risk recording, management and reporting across all tiers of risk registers.
38. The team are in the process of recruiting a Band 7 Risk Manager to support the enterprise risk management work including the transition to an electronic solution given the limitations of the current one.

Principal Risks

39. 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.
40. 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.
41. Despite a slight decrease in the number of handover lost hours in June and July 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.
42. The risks continue to be reported to the Trust Board, with a 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.

43. 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.
44. 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.
45. To support the continued, detailed review and mitigation of these risks, a workshop has been established for the 6 September 2024 with the Risk Owners and teams to consider a different approach to managing and monitoring those areas that are within the Trust's control and those that are not. The outcome of this will be reported through the next round of governance.
46. The Quality, Patient Experience and Safety Committee (QUEST) reviewed both risks at its meeting in August 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.
47. 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.
48. 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 and the early, positive indications discussed at the People & Culture Committee in August 2024 showing that levels are on a downward trajectory.
49. Risk 163 *Maintaining Effective & Strong Trade Union Partnerships* – The score remains static at 16 (4x4) this quarter. The programme of engagement and relationship building will continue throughout 2024/25. Work is underway to deliver the action plan in partnership. At the People & Culture meeting in August 2024, Trade Union partners noted the excellent partnership working at WAST and recognised the structures are embedding well.

50. 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. Whilst the risk remains static, it is inextricably linked to several of the metrics measured and discussed at the People & Culture Committee.
51. 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.
52. Risk 424 *Resource availability (revenue, capital, and staff capacity) to deliver the organisation's Integrated Medium-Term Plan (IMTP)* has further reduced in score to 8 (2x4) and which is closely linked with Risk 139 *Failure to Deliver our Statutory Financial Duties*. This is due to the reasonable revenue position for 2024/25; however, separate risks may be considered in the future relating to capital funding and vehicle/fleet.
53. 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*; Whilst 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.
54. Risk 558 *Deterioration of staff health and wellbeing in as a consequence of both internal and external system pressures*, 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* and Risk 139 *Failure to Deliver our Statutory Financial Duties in accordance with legislation* all remain unchanged in this period.
55. Risks 542 *Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan* at a score of 16 (4x4) continues to be reviewed and remains unchanged, similarly, to Risk 623 *Failure to comply with Data Protection Legislation* at a score of 15 (3x5).

RECOMMENDED

56. Members are asked to consider and discuss the contents of the report and:
 - 1) Support the direction of travel for the next stage of the Risk Management Transformation Programme: specifically,
 - a. the development of a new Strategic Board Assurance Framework template based on the private healthcare example.

- b. the intention to commission external resources to develop the risk appetite statements.
- 2) Note the plans to reposition Risks 223 and 224.
- 3) Receive assurance on the 2023/24 Internal Audit Risk Management Review.
- 4) Note the reduction in score for Risk 424 from 12 (3x4) to 8 (2x4). The risk will be de-escalated to the Directorate Risk Registers for ongoing management.
- 5) Note the closure of Risk 619 from all registers having been fully mitigated.
- 6) Receive assurance on the review and attention to the principal risks, including their review at ADLT, ELT and at relevant Committees.
- 7) Note the ratings and mitigating actions for each principal risk.

Annex 1 – Corporate Risk Register Summary

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

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		20 (4x5)
594 FPC	The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death.	<p>IF a major incident or mass casualty incident is declared</p> <p>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</p> <p>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.</p>	Executive Director of Operations	20 (4x5)
163 PCC	Maintaining Effective & Strong Trade Union Partnerships	<p>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</p> <p>THEN there is a risk that Trade Union partnership relationships increase in fragility and the ability to effectively deliver change is compromised</p> <p>RESULTING IN a negative impact on colleague experience and/or services to patients.</p>	Director of People & Culture	16 (4x4)
542 FPC	Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan	<p>IF there is a lack of resources and available technology and infrastructure</p> <p>THEN there will be a failure to deliver the commitments outlined in</p>	Executive Director of Finance & Corporate Resources	16 (4x4)

CORPORATE RISK REGISTER

RISK ID	NEW RISK TITLE	NEW SUMMARY DESCRIPTION	EXECUTIVE OWNER	RISK SCORE
		<p>the action plan and within the Welsh Government timelines</p> <p>RESULTING IN negative environmental and social impacts causing and reputational damage</p>		
260 FPC	A significant and sustained cyber-attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems.	<p>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</p> <p>THEN there is a risk of a significant information security incident</p> <p>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</p>	Director of Digital Services	15 (3x5)
558 PCC	Deterioration of staff health and wellbeing in as a consequence of both internal and external system pressures	<p>IF significant internal and external system pressures continue</p> <p>THEN there is a risk of a significant deterioration in staff health and wellbeing within WAST</p> <p>RESULTING IN increased sickness levels, staff burnout, poor staff and patient experience and patient harm</p>	Director of People & Culture	15 (3x5)
623 FPC	Failure to comply with Data Protection Legislation	<p>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</p>	Director of Digital Services	15 (3x5)

CORPORATE RISK REGISTER

RISK ID	NEW RISK TITLE	NEW SUMMARY DESCRIPTION	EXECUTIVE OWNER	RISK SCORE
		<p>THEN the Trust will breach its legal obligations and potentially cause the personal or sensitive data to be compromised, lost, or inappropriately used</p> <p>RESULTING IN unauthorised data breaches/loss, financial or compensatory penalties, an increased regulatory scrutiny or enforcement as well as stakeholder mistrust and reputational damage.</p>		
100 FPC	Failure to persuade EASC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience.	<p>IF WAST fails to persuade EASC/Health Boards about WAST ambitions</p> <p>THEN there is a risk of a delay or failure to receive funding and support</p> <p>RESULTING IN a catastrophic impact on services to patients and staff and key outcomes within the IMTP not being delivered</p>	Executive Director of Strategy Planning & Performance	<p>12 (3x4)</p>
424 FPC De-escalate to the DRR	Resource availability (revenue, capital, and staff capacity) to deliver the organisation's Integrated Medium-Term Plan (IMTP)	<p>IF resources are not forthcoming within the funding envelope available to WAST (link to risk 139)</p> <p>THEN there is a risk that there is insufficient capacity to deliver the IMTP</p> <p>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.</p>	Executive Director of Strategy Planning and Performance	<p>8 (2x4)</p> <p>12 (3x4)</p>

CORPORATE RISK REGISTER

RISK ID	NEW RISK TITLE	NEW SUMMARY DESCRIPTION	EXECUTIVE OWNER	RISK SCORE
139 FPC	Failure to Deliver our Statutory Financial Duties in accordance with legislation.	<p>IF the Trust does:</p> <ul style="list-style-type: none"> • 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) <p>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)</p> <p>RESULTING IN potential interventions by the regulators, qualified accounts and impact on delivery of services and reputational damage</p>	Executive Director of Finance & Corporate Resources	<p>8 (2x4)</p>

Annex 2 - Risk Scoring Matrix

Consequence:	1 Negligible	2 Minor	3 Moderate	4 Major	Catastrophic
Safety & Well-being - Patients/ Staff/Public	Minimal injury requiring no/minimal intervention or treatment. No time off work. Physical injury to self/others that requires no treatment or first aid. Minimum psychological impact requiring no support. Low vulnerability to abuse or exploitation - needs no intervention. Category 1 pressure ulcer.	Minor injury or illness, requiring minor intervention. Requires time off work for >3 days. Increased hospital stay 1-3 days. Slight physical injury to self/others that may require first aid. Emotional distress requiring minimal intervention. Increased vulnerability to abuse or exploitation, low level intervention. Category 2 pressure ulcer.	oderate injury/professional intervention. Requires time off work 4-14 days. Increased hospital stay 4-15 days. RIDDOR/Agency reportable incident. Impacts on a small number of patients. Physical injury to self/others requiring medical treatment. Psychological distress requiring formal intervention by MH professionals. Vulnerability to abuse or exploitation requiring increased intervention. Category 3 pressure ulcer.	Major injury leading to long-term disability. Requires time off work >14 days. Increased hospital stay >15 days. RIDDOR Reportable. Regulation 4 Specified Injuries to Workers. Patient mismanagement, long-term effects. Significant physical harm to self or others. Significant psychological distress needing specialist intervention. Vulnerability to abuse or exploitation requiring high levels of intervention. Category 4 pressure ulcer.	Incident leading to death. RIDDOR Reportable. Multiple permanent injuries or irreversible health effects. An event which impacts on a large number of patients.
Quality/ Complaints/ Assurance/ Patient Outcomes	Peripheral element of treatment or service suboptimal. Informal complaint/inquiry.	Overall treatment/service suboptimal. Formal complaint (Stage 1). Local resolution. Single failure of internal standards. Minor implications for patient safety. Reduced performance.	Treatment/service has significantly reduced effectiveness. Formal complaint (Stage 2). Escalation. Local resolution (poss. independent review). Repeated failure of internal standards. Major patient safety implications.	Non-compliance with national standards with significant risk to patients. Multiple complaints/independent review. Low achievement of performance/delivery requirements. Critical report.	Totally unacceptable level or quality of treatment/service. Gross failure of patient safety. Inquest/ombudsman/inquiry. Gross failure to meet national standards/requirements.
Workforce/ Organisational Development/ Staffing/ Competence	Short-term low staffing level that temporarily reduces service quality (< 1 day).	Low staffing level that reduces the service quality.	Late delivery of key objective/service due to lack of staff. Jnsafe staffing level (>1 day)/competence. Low staff morale. Poor staff attendance for mandatory/key professional training.	Uncertain delivery of key objective/ service due to lack/loss of staff. Insafe staffing level (>5 days)/competence. Very low staff morale. Significant numbers of staff not attending mandatory/key professional training.	Non-delivery of key objective/service due to loss of several key staff. Ongoing unsafe staffing levels or competence/skill mix. No staff attending mandatory/professional training.
Statutory Duty, Regulation, Mandatory Requirements	No or minimal impact or breach of guidance/statutory duty.	Breach of statutory legislation. Reduced performance levels if unresolved.	Single breach in statutory duty. Challenging external recommendations/improvement notice.	Enforcement action. Multiple breaches in statutory duty. Improvement notices. Low achievement of performance/ delivery requirements. Critical report.	Multiple breaches in statutory duty. Zero performance rating. Prosecution. Severely critical report. Total system change needed.
Adverse Publicity or Reputation	Rumours. Low level negative social media. Potential for public concern.	ocal media coverage - short-term reduction in public confidence/trust. Short-term negative social media. Public expectations not met.	Local media coverage - long-term reduction in public confidence & trust. Prolonged negative social media. Reported in local media.	National media coverage <3 days, service well below reasonable public expectation. Prolonged negative social media, reported in national media, long-term reduction in public confidence & trust. Increased scrutiny: inspectorates, regulatory bodies and WG.	National/social media coverage >3 days, service well below reasonable public expectation. Extensive, prolonged social media. MP/MS questions in House/Senedd. Total loss of public confidence/trust. Escalation of scrutiny status by WG.
Business Objectives or Projects	Insignificant cost increase/ schedule slippage.	<5 per cent over project budget. Schedule slippage.	5–10 per cent over project budget. Schedule slippage.	Non-compliance with national targets.10-25 per cent over project budget. Schedule slippage. Key objectives not met.	>25 per cent over project budget. Schedule slippage. Key objectives not met.
Financial Stability & Impact of Litigation	Small loss. Risk of claim remote.	Loss of 0.1–0.25% of budget. Claim less than £10,000.	Loss of 0.25–0.5% of budget. Claim(s) between £10,000 and £100,000.	Uncertain delivery of key objective. Loss of 0.5-1.0% of budget. Claim(s) between £100,000 and £1 million. Purchasers failing to pay on time.	Non-delivery of key objective. Loss of >1 per cent of budget. Failure to meet specification. Claim(s) >£1 million. Loss of contract/payment by results.
Service/ Business Interruption	Loss/interruption of >1 hour. Minor disruption.	Loss/interruption of >8 hours. Some disruption manageable by altered operational routine.	Loss/interruption of >1 day. Disruption to a number of operational areas in a location, possible flow to other locations.	Loss/interruption of >1 week. All operational areas of a location compromised; other locations may be affected.	Permanent loss of service or facility. Total shutdown of operations.
Environment/Estate/ Infrastructure	Minimal or no impact on environment/service/property.	Minor impact on environment/ service/property.	Moderate impact on environment/ service/property.	Major impact on environment/ service/property.	Catastrophic impact on environment/service/property.
Health Inequalities/ Equity	Minimal or no impact on attempts to reduce health inequalities/improve health equity.	Minor impact on attempts to reduce health inequalities or lack of clarity on the impact on health equity.	Lack of sufficient information to demonstrate reducing equity gap, no positive impact on health improvement or health equity.	Validated data suggests no improvement in the health of the most disadvantaged, whilst supporting the least disadvantaged, no impact on health improvement and/or equity.	Validated data demonstrates a disproportionate widening of health inequalities, or negative impact on health improvement and/or equity.

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

Annex 3 - Frequency of Risk Review

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

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:	25/06/2024	TREND	25 (5x5)
				Date of Next Review:	25/07/2024		
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	
IMTP Deliverable Numbers: 1, 2, 3, 4, 5, 6, 7, 8, 10, 14, 15, 20, 22, 24, 25, 27							
EXECUTIVE OWNER		Director of Operations	ASSURANCE COMMITTEE		Quality, Safety and Patient Experience Committee		
Risk Commentary Q1 2024/2025							
<p>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 June were 22,230 and July 19,599.</p> <p>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.</p> <p>Improvement actions led by Welsh Government and system partners include: -</p> <ul style="list-style-type: none"> 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) Alternative 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 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. 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 the action plan.			
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. This is part of the IMTP Deliverables 2024-2027.			

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death		Date of Review:	25/06/2024		TREND	25 (5x5)
			Date of Next Review:	25/07/2024			
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. 11 new onboarding courses for June to December with projection of 110 new CFRs by 3 rd December 2024. Currently 400 volunteers supporting 6500 hours every month. 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) was stood up for the duration of Winter 2023/24. Christmas Planning Meetings established from April 2024 for winter period 2024/2025.					
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: i) Letter to COO Handover Delays 30.03.2023 ii) Letter to COO Handover Delays 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. • Phase 1 delivered through St John Ambulance Cymru with a further extension in place. • 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. • Work ongoing to recruit CWR volunteers with engagement taking place with organisations across Wales. • St John Ambulance Cymru virtual ward now extended to the end of May 2024.					
24. ARA – YGC, Swansea Bay and GUH		24. ARA in GUH finished 31 st March 2024. Holding area in Swansea and YGC remains ongoing.					

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			Date of Next Review:	25/07/2024			
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	
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 / 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.		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.					
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.		26. 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.					
27. Swansea Bay Winter Actions		27. 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. <ul style="list-style-type: none"> • Palliative Care Paramedics commenced on 15/01/2024 • POS solution now in operation which is facilitating shift breaks. Palliative care paramedics have been deployed for a pilot in care homes and nursing homes. Significant reduction in overruns realised. In action, during last 2 months, 0 missed meal breaks recorded in Swansea Bay area.					
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.		5. 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		6. Performance targets for Handover with Health Boards have been introduced by the commissioner.					
7. Access to Same Day Emergency Care (SDEC) for paramedic referrals		7. 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.					
8. Mental Health users connecting via the 999 system to 111 press 2 services. Discrepancies in pathway between 111 and CSD – point of entry influences pathway.							
9. Volunteer Alternative Responder Scheme (VARS)		9. Live from June 2024 with further scheme due to rollout across Wales.					
<i>Please note that the gaps listed are not WAST's and are therefore outside of the control of WAST</i>							

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IF significant internal and external system pressures continue		THEN there is a risk of an inability and/or a delay in ambulances reaching patients in the community	RESULTING IN patient harm and death		Likelihood	Consequence	Score
			Inherent		4	5	20
			Current		5	5	25
			Target		2	5	10
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	Superseded	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. 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. APP recruitment			Assistant Director of Operations	March 2025	Aug24 – Modelling of APP growth trajectory to be modelled through the APP recruitment Steering Group for approval at ELT. Numbers to be confirmed at point of approval.		
5. IMTP Deliverables 2027-2027 – implementation of new clinical model.			Assistant Director of Operations Transformation	March 2025	Phase 1 for winter May24 – Ops engagement commenced April 2024. Temporary ADO recruited to support winter actions. Plans to deployment between October 2024 and March 2025.		
6. Overnight Falls Service extension (I) [Source: Action Plan presented to Trust Board 28/07/22]			Assistant Director of Quality & Governance / Head of Quality Improvement	Ended March 2023	The temporary extension of the SJAC contract for overnight provision was evaluated, demonstrating on available evidence a positive performance impact over the period of operation (Jan-April 2023). The evaluation report was presented to EMT on 5 April 2023. The contract extension (as a temporary arrangement) ceased on 5 April 2023. Falls service enhanced day and night provision remains in place and utilisation of resources is reviewed at weekly performance meetings by Operations SLT.		
7. 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. May24 - The review is scheduled to be presented to Trust Board end of July 2024. Milestone changed from March 2024 to August 2024.		
8. 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	May 2024 (Phase 1 is finished)	Multi phased approach commenced in Dec 2022 with St John Ambulance Cymru virtual ward responder, a digital and telehealth platform, and a Community Welfare Responder model to enhance community resilience. • Phase 1 delivered through St John Ambulance Cymru with a further extension in place and further extended until May2024		

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death		Date of Review:	25/06/2024		TREND	25 (5x5)
			Date of Next Review:	25/07/2024			
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	
							<ul style="list-style-type: none"> 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. Work is now ongoing to recruit CWR volunteers with engagement taking place with organisations across Wales.
9. Maximise the opportunity from Consult and Close:			March 2025				<ul style="list-style-type: none"> Successful resolution without ambulance (double EMS) Successful resolution without conveying to ED 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.
10. Development of new model of care		Head of Strategy Development	2024/25				May24 – during May operationalisation has commenced with expected live date ahead of winter.
11. Palliative Care Paramedic Unit		Assistant Director of Operations	Extended to May 2024 - new date TBC				Reducing demand via APPs – 15 th January Start. 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. 21/06/2024 - Unit still ongoing.
12. 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				<ul style="list-style-type: none"> Conducted in three phases Audit Wales will independently investigate and report on patient flow out of hospital: access to unscheduled care services and national arrangements (structure, governance, and support) WAST will proactively support this work and offer best practice examples from other jurisdictions that can support benchmarking and improvement activities. Expected outcomes in 2023/24.
13. Royal Glamorgan Early Diagnostic		Executive Director of Operations	August 2024				<ul style="list-style-type: none"> 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. May24 – No improvement in N2H time. Local management having discussions with Health Board for review and next steps.

Risk ID 224	Significant Handover of Care Delays Outside Accident and Emergency Departments Impacts on Access to Definitive Care Being Delayed and Affects the Trust's Ability to Provide a Safe & Effective Service for Patients		Date of Review:	20/06/2024	TREND	25 (5x5)	
			Date of Next Review:	20/07/2024			
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
IMTP Deliverable Numbers: 1, 3, 8, 14, 15, 22, 23, 24, 25, 26, 27, 30, 31							
EXECUTIVE OWNER		Director of Quality & Nursing	ASSURANCE COMMITTEE		Quality, Safety and Patient Experience Committee		
Risk Commentary Q2 2024/25 <ul style="list-style-type: none"> The risk score remains constant at 25 for quarter 2 2024/25 (almost certain & catastrophic). Internal and external assurances remain weak as there remains a daily risk of actual patient harm due to handover of care delays. JCC set a target of 15,000 hours lost by the end of Q2 and 12,000 hours lost by the end of Q3. Handover lost hours in April 2024 were 23,614 compared to 23,082 in April 2023. Eradication of handover waits of > 4 hours: there were 3,404 over four-hour patient handovers in April 2024, compared to 2,730 in April 2023. The expectation is that these would have been eradicated by end of 2023/24. Cardiff & Vale UHB has demonstrated material improvement and is a positive outlier when compared to other health boards. Recently, Welsh Government have re-iterated to Health Boards that the reduction in long handovers is a priority for this year with an expectation that over 1 hour waits would be reduced by 30% by December 2024. 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 enquiries and redress / claims. The Trust continues to receive Prevention of Future Death Reports (Regulation 28) from Coroners across NHS Wales. 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. <p>Improvement actions led by Welsh Government and system partners include:</p> <ol style="list-style-type: none"> 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 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. 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). NHS Wales eradicates all emergency department handover delays more than 4 hours (LHB CEOs) revised to March 2023/24. 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. 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) 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.				
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				

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		Date of Next Review:	20/07/2024	➔		
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
		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 <i>Right care, right place, first time Six Goals for Urgent and Emergency Care A policy handbook 2021–2026</i> . Goal 4 incorporates the reduction of handover of care delays through collective system partnership.			5. Monthly Integrated Quality and Performance Report and 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. The Trust also has a presence on all the individual goal boards.			
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 (April 2024 overall 82% - Safeguarding is 78% 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.			
14. Workshop set up by the Deputy Chief Ambulance Commissioner to respond to the findings in the Health Care Inspectorate Wales (HIW) Report <i>Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover</i> (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 <i>Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover</i> (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.			15. Monthly Integrated Quality and Performance Report, CEO Reports to Trust Board including 'Actions to Mitigate Avoidable Patient Harm Report' (last presented to Trust Board May 2024) and Board sub-committee oversight and escalation through 'Alert, Advise and Assure' reports.			

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Evidence submission to Senedd Health and Social Care Committee. Written evidence submitted during Q4 21/22 to the committee to assist their inquiry into Hospital Discharge and its impact on patient flow through hospitals. Report published in June 2022 containing 25 recommendations with recommendation six specifically WAST related stating "The Welsh Government should explain how the targets outlined in the Minister for Health and Social Service's statement of 19 May 2022 on urgent and emergency care and the Six Goals Programme to eradicate ambulance patient handover delays of more than four hours and reduce the average ambulance time lost per arrival by 25 per cent (from the October 2021 level) have been set. It should also confirm the target dates for the achievement of these targets."						
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 May 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 2024/25.				
		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.						
2.		1. 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.		2. 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.		3. Strengthening of patient safety reports and audit processes as e PCR system embeds.				

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				Current	5	5	25
				Target	3	2	6
5. Variation pan Wales / England as position not implemented across all emergency departments.		4. 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.		5. HIW approve and sign off WAST elements of recommendations.					
		External Gaps in Assurance 1. Lack of escalation and response to AQIs by the wider urgent care system and regulators					
Actions to reduce risk score or address gaps in controls and assurances		Action Owner	By When/Milestone	Progress Notes:			
1. Handover checklist implementation – Nationally WAST Quality Improvement (QI) Project		WAST QI Team (QSPE)	TBC – Paused	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Incremental improvements to quality and safety data and information to enable triangulation / collective intelligence at Trust and system level. Access to ePCR data (NEWS) now available 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. 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.	<ul style="list-style-type: none"> Monthly meetings continue to be held and networking through EDoNS. 			
4. Recruit and train more Advanced Paramedic Practitioners.		Director of Paramedicine	Q4 2024/25	<ul style="list-style-type: none"> The Trust uplifted its APP establishment by a further 15.7 FTEs in 2023/24 (funded through internal movements). For 2024/25 the Trust is funding a further uplift of 32 APPs (additional funding, not internal movements). The above uplifts will increase the APP establishment to 120.7 FTEs. 			
5. Overnight falls service extension and future modelling		Executive Director of Quality & Nursing	31.09.2024	<ul style="list-style-type: none"> Overnight falls service extension and future modelling Night Car Scheme extension agreed to 31 September 2024 (2 regional resources) <ul style="list-style-type: none"> Utilisation rates continue to be monitored: Nighttime utilisation: - <ul style="list-style-type: none"> Q2 65% Q3 64% Q4 to date 64% April 2024 - 67% Daytime utilisation: - <ul style="list-style-type: none"> Q2 57% Q3 56% Q4 to date 58% April 2024 – 54% Combined day and night Q2-Q3 58% Combined day and night Q4 to date 59% Combined day and night April 2024- 55% There is now also an additional Level1 nighttime resource through RPB and Gwent Resilience Plan ringfenced to ABUHB. AB dedicated level 1 62% for April 2024 			

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				Inherent	5	5	25
				Current	5	5	25
				Target	3	2	6
			<ul style="list-style-type: none"> The 2023 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. There is an immediate focus on the contract beyond September 2024. The 2023 EMS Demand & Capacity Review will be formally reported to Trust Board in July 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	<ul style="list-style-type: none"> Monthly updates to progress against actions following the baseline assessment and readiness returns continued. RL Datix Dashboards and KPIs under development nationally by National Quality & Safety Group. 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. 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	Q2 2024/25	<ul style="list-style-type: none"> Currently awaiting WG feedback on the submitted business case. Further meetings arranged with between the Executive Director of Quality & Nursing and Six Goals Programme/WG/. Trust has also approach WG with a smaller ask to facilitate 7 FTE CSD clinicians to provide a continuation of the Luscii solution - this would enable a proof of value pilot to further inform a business case. 				
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	<ul style="list-style-type: none"> 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. Final posts due to be recruited to and in place by July 2024. 				
9. 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	<ul style="list-style-type: none"> Conducted in three phases Audit Wales will independently investigate and report on patient flow out of hospital: access to unscheduled care services and national arrangements (structure, governance, and support). WAST will proactively support this work and offer best practice examples from other jurisdictions that can support benchmarking and improvement activities. Expected outcomes in 2023/24. The audit is proceeding. Trust awaiting the outcome. AD Commissioning & Performance has requested an update from Audit Wales. Audit Wales have confirmed this has been reprofiled into 2024/25. 				
10. Patient handover actions.	Executive Team	Under review	<ul style="list-style-type: none"> Some English ambulance services operate a system whereby handovers are mandated or forced after a certain period e.g. WMAS and LAS. This will be reviewed by the Executive team. 				
11. 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	<ul style="list-style-type: none"> Fundamentals of Care meeting, chaired by the Executive Director of Quality & Nursing held on 08.03.2024. 				

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						Inherent	5	5	25
						Current	5	5	25
						Target	3	2	6
12. Trust to produce its own six goals plan (Goal 4 links to handover of care)		Executive Director of Strategy, Planning &		• Trust to produce its own six goals plan (Goal 4 links to handover of care)					

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:	14/06/2024	TREND	20 (5x4)
				Date of Next Review:	14/07/2024	➔	
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
IMTP Deliverable Numbers: 13, 14, 15, 22, 24, 25, 26							
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 score has been reviewed mid-June and whilst results for the early part of the quarter look positive, it is important to consider the results during July and August which traditionally has seen spikes in short term absence to assess whether this improvement is maintained. The score will be considered in September 2024.							
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 (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. Compassionate Practices approach engaged. 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.			

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:	14/06/2024	TREND	20 (5x4)
			Date of Next Review:	14/07/2024	➡	
IF	THEN	RESULTING IN	Likelihood	Consequence	Score	
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	Inherent	4	4	16
			Current	5	4	20
			Target	3	4	12
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				
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; Discussion on levels of long-term sick absence is undertaken in a variety of forums including EASC, ELT and PCC.				
38. Accountability meetings on attendance management between People Services and senior ops managers to ensure this issue is given sufficient focus on priorities.		38. Meetings taking place and active discussions on operational areas experiencing high levels of absence				
39. Senior Ops Managers have accountabilities sessions on attendance management with their Heads of Service.		39. Meetings taking place and active discussions on operational areas experiencing high levels of absence				
40. Specific issues associated with muscular skeletal conditions is discussed regularly at the H&S Committee and relevant additional interventions are identified		40. It is on each agenda and outcomes are available for discussion at H&SC.				

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:	14/06/2024	TREND	20 (5x4)
				Date of Next Review:	14/07/2024	➡	
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	
41. Review of top 100 cases by the wider People & Culture Team - monthly (Wellbeing, OCC Health, People Services). This takes place to consider whether any of those cases required additional interventions.		41. Director of People & Culture receives assurance from the team following each of the monthly meetings.					
		Independent Assurance (3rd Line of Assurance)					
		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)					
		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					
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. Develop guidance and training for line managers to equip them with the confidence and skills to have meaningful and sensitive conversations related to attendance.		Head of Culture	31/01/25	Measured through ongoing participation in development sessions and feedback from TU regarding management handling of absence cases. Piloting bite size chunks in Autumn with results in January 2025.			
2. 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	31/10/24	Case studies will be published, shared and discussed at leadership meetings and evidence of good practice adopted			
3. 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	31/01/25	Discuss at P&C Business Meeting and share at ELT/PCC with recommendations.			
4. 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.			
5. 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.			
6. 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			
7. Delivery of actions to support managers handling attendance issues with skills, capability and confidence		Deputy Director, People and Culture	31.03.2025				
8. Coaching for managers on cases on one and locality basis.		Deputy Director, People and Culture	31.03.2025				
9. Increase manager support on data interpretation and analysis		Deputy Director, People and Culture	31.03.2025				
10. 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				
11. Culture work on creating the sense of team and peer responsibility / ownership		AD for f Culture Inclusion and Wellbeing	31.03.2025				
12. Analyse link between hot spots and the culture in these areas to address cultural issues		AD for Culture, Inclusion & Wellbeing	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:	14/06/2024	TREND	20 (5x4)
			Date of Next Review:	14/07/2024	➡	
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
13. Improve preventative measures and pro-active work	Deputy Director of People and Culture	31.03.2025				
14. Identify opportunities to improve roles – flexibility, control, confidence	Deputy Director of People and Culture / ADs, Operations	31.03.2025				
15. Opportunities to adapt the work environment – overruns, shift patterns, rest and recuperation	Deputy Director of People and Culture / ADs, Operations	31.03.2025				
16. Review workloads	Deputy Director of People and Culture / ADs, Operations	31.03.2025				
17. Review patterns of absence	Deputy Director of People and Culture	31.03.2025				
18. Development of a mental health referral pathway	AD for Culture, Inclusion and Wellbeing	31.03.2025				
19. Develop the team around the person model / individual support network	Deputy Director of People and Culture	31.03.2025				
20. Increase lifestyle advice and guidance	AD for Culture, Inclusion and Wellbeing	31.03.2025				
21. Undertake proactive testing to identify undiagnosed conditions	AD for Culture, Inclusion and Wellbeing	31.03.2025				
22. Review reporting on OH	AD for Culture, Inclusion and Wellbeing	31.03.2025				
23. 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:	19/07/2024	TREND	20 (4x5)
			Date of Next Review:	19/08/2024	→	
IF there is an inability of the Trust to deliver its core services because of system or organisational pressures	THEN there will be a loss of stakeholder confidence in the Trust	RESULTING IN 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: 1, 2, 3, 4, 5, 6, 7, 8, 9,10, 11, 12, 13, 16, 25, 27						
EXECUTIVE OWNER		Director of Partnerships and Engagement	ASSURANCE COMMITTEE		People and Culture Committee	
Risk Commentary Q3 2024/25						
<p>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.</p>						
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	Complete – will move to controls	Audit launched on 09 April 2024 and ran until 01 May 2024. High-level results presented at People and Culture Committee on 09 May and at Board Development on 27 June.	
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 were also 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:	25/06/2024	TREND	20	
		Date of Next Review:	25/07/2024		(4x5)	
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: 1, 5, 6, 7,14, 15, 24						
EXECUTIVE OWNER	Director of Operations	ASSURANCE COMMITTEE	Finance & Performance Committee			
Risk Commentary Q1 2024/2025						
The challenges across the unscheduled care system. Handover lost hours in June were 19,599 and July 23,220 . 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 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			
			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. 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:	25/06/2024	TREND	20 (4x5)	
			Date of Next Review:	25/07/2024	➡		
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 11 th 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. 22/02/2024 - Risk 594 has also been referenced in the context of MAI presentation to Welsh Government (6 th 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	May 24 – LB will follow up with COO network on the sharing of their action cards to WAST. March 24 – This risk was discussed at both EASC management and in the COO meeting.			
5. Ref: Control 1 of 594 – Immediate Release Protocol		Executive Director of Operations	Q2	WAST is currently reviewing the immediate release protocol and it is our aim to include the release schedule as agreed by COOs. The release protocol schedule for Health Boards to initiate in the event of a major incident is set out as follows: <ul style="list-style-type: none"> - 50% of vehicles released within 10 minutes - 75% of vehicles released within 20 minutes - 100% of vehicles released within 30 minutes 			

Risk ID 163	Maintaining Effective & Strong Trade Union Partnerships		Date of Review:	14/06/2024		TREND	16 (4x4)	
			Date of Next Review:	14/07/2024		→		
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
IMTP Deliverable Numbers: 1, 13, 14, 19, 22, 30, 32								
EXECUTIVE OWNER			Director of People & Culture		ASSURANCE COMMITTEE		People & Culture Committee	
Risk Commentary								
<p>The score remains at a 16 which is due to 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.</p> <p>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 ongoing discussions on a range of organisational change issues and currently engagement and partnership working is working well.</p>								
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.				
14. 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.				14. Action plan developed and shared with TUs. Implementation underway. A series of partnership working sessions (5) have been delivered to around 120 colleagues – managers and TU partners. Feedback from the sessions was captured and next steps were reviewed. There is an ACAS action plan which is a live doc and is reported to WASPT to update progress.				
15. Rhythm of meetings to curate and focus on relationships				15. AAA, minutes, monthly sessions with CEO, DoPC and DoO. Informal sessions with CEO, DoPC and Branch Chair and Sec on a quarterly basis. 6 weekly meetings with DoPC on other partnership forum arrangements.				

Risk ID 163	Maintaining Effective & Strong Trade Union Partnerships		Date of Review:	14/06/2024		TREND	16
			Date of Next Review:	14/07/2024		→	(4x4)
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	
GAPS IN CONTROLS		GAPS IN ASSURANCE					
1. Need to move back to business-as-usual footing		None identified					
2. Facility to manage situations where there is a failure to agree, to avoid grievance and disputes from occurring							
Actions to reduce risk score or address gaps in controls and assurances		Action Owner	By When/Milestone	Progress Notes:			
1. 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.			
2. Continue the rollout of partnership training across WAST		Deputy Director of People & Culture	Ongoing				
3. Develop the next round of initiatives based on the output from recent sessions		Deputy Director of People & Culture	30/09/24				
4. Learning and Development opportunities for TU partners e.g. shadowing, digital skills, coaching and mentoring		Deputy Director of People & Culture	31/03/25				
5. Develop consultation guidance for managers		Deputy Director of People & Culture	31/03/25				
6. Consider how we celebrate success and capture the positive learning		Deputy Director of People & Culture	31/01/25				

Risk ID 542	Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan			Date of Review:	19/07/2022	TREND ➔	16 (4x4)
				Date of Next Review:	19/08/2024		
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	5	4	20
				Current	4	4	16
				Target	2	4	8
IMTP Deliverable Numbers: 17, 18, 33							
EXECUTIVE OWNER		Executive Director of Finance and Corporate Resources	ASSURANCE COMMITTEE		Finance and Performance Committee		
Risk Commentary Challenges continue around resources and technology, and currently there is not an ability to reduce this score. Decarbonisation Programme Board will meet on 22 nd July. Noting some progress on positive movement to actions within the DAP							
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. (ii) Approved Estates SOP (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) (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 BERP Project Board				13. Minutes and papers of meeting			
				External - Independent Assurance: • 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)							

Risk ID 542	Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan		Date of Review:	19/07/2022		TREND	16	
			Date of Next Review:	19/08/2024			(4x4)	
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	5	4	20
					Current	4	4	16
					Target	2	4	8
4. NED support ended April 2022								
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	Complete – will move to controls	Workstreams are set up to manage delivery of the EFAB projects and the transport element (Transport Project Board). Links are also made into ongoing work to develop the IMTP and develop longer term strategies e.g. Fleet Vehicle Procurement Strategy 2025 – 30.				
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	30.09.24	To be further discussed with relevant Directors.				
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					

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:	23/07/2024	TREND	15 (3x5)
			Date of Next Review:	23/08/2024	➔	
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: 1, 15, 19, 24						
EXECUTIVE OWNER		Director of Digital Services	ASSURANCE COMMITTEE		Finance and Performance Committee	
Risk Commentary						
<p>The risk has been fully reviewed in the cycle and the score remains static. 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. A deep dive of the risk was undertaken during the closed session of FPC on the 16.07.2024 with no concerns raised in respect to the management of the risk.</p>						
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			

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:	23/07/2024		TREND	15 (3x5)
			Date of Next Review:	23/08/2024		→	
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	
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					
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 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 26.08.2024	Implementation of Cyber Improvement Plan actions ongoing and regularly reported into ICT SMT, DLG, IGSG and FPC.			

Risk ID 558	Deterioration of staff health and wellbeing in the face of continued system pressures as a consequence of workplace experiences			Date of Review:	23/07/2024	TREND ➡	15 (3x5)
				Date of Next Review:	23/08/2024		
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	
IMTP Deliverable Numbers: 13, 14, 21, 26							
EXECUTIVE OWNER		Director of People & Culture	ASSURANCE COMMITTEE		People & Culture Committee		
Risk Commentary							
<p>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.</p>							
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.			

Risk ID 558	Deterioration of staff health and wellbeing in the face of continued system pressures as a consequence of workplace experiences			Date of Review:	23/07/2024		TREND	15
				Date of Next Review:	23/08/2024			(3x5)
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		
11. Need to increase the education and communication with managers about stress risk assessments. Presentation developed and shared with people services. Delivery dates being agreed in conjunction with Health and Safety. With the arrival of the new OH Manager these discussions have restarted, and colleagues are directed to the stress risk assessment information and education sessions will be started in Q1 & Q2.		Lack of awareness about staff wellbeing services, this continues to be a challenge due to small team, non-wired colleagues and competing communication messages.						
		Effects of elevated reop 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 23/7/24 Final year review included in consultation process for new plan				
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 16/4/2024 Ongoing 23/7/24 Extended consultation period until end of August 2024				

Risk ID 623	Failure to comply with Data Protection Legislation		Date of Review:	07/07/2024		TREND	15 (3x5)
			Date of Next Review:	07/08/2024		➔	
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	
IMTP Deliverable Numbers: 1, 13, 14, 18, 19							
EXECUTIVE OWNER		Director of Digital Services	ASSURANCE COMMITTEE		Finance & Performance Committee		
Risk Commentary							
<p>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.</p>							
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). Funding for one of these contractors ceased in June 2024, and so only one additional contractor remains with the team (contract end date September 2024)			
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) a. Procedure for auditing Welsh Clinical Portal usage (by WAST staff) has been updated (Jun24).				3. Monthly Information Governance Steering Group which includes progress DPC, DSA and DPIA reviews (I) IG Training IG Toolkit (System for providing a level of assurance of compliance (I) Incident Reporting Accountability to ELT Development of reporting (dashboard) which supports IGSG, ELT and Finance & Performance 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 for auditing access to personal information							
9. Digital Notices / comms Ongoing (see Siren & recent Lock-screen notices)							
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 have now been two unsuccessful attempt to fill the position which has led to capacity constraints. - There are now two DPCM vacancies (following additional investment in the Digital team for				1. See 21. Further Actions (1)			

Risk ID 623	Failure to comply with Data Protection Legislation		Date of Review:	07/07/2024		TREND	15 (3x5)		
			Date of Next Review:	07/08/2024		➔			
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	Consequence	5	Score	20
				Current	3		5		15
				Target	2		5		10
24/25) and the post has been readvertised for a third time – interviews are taking place in July 2024.									
2. Unfilled and unfunded permanent DPO 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.									
8. The Confidentiality Advisory Group (CAG) notified WAST (via DHCW) in June 24 that for organisations with a 23-24 IG Toolkit outcome of "standards not met", any CAG approvals for research & non-research requests are likely to be rejected unless the organisations' IG Toolkit Improvement Action Plan can be met and evidenced by Nov 24 (instead of the original target date for this plan of Mar 25)..		8. The Confidentiality Advisory Group (CAG) required WAST to submit an IG Toolkit Improvement Action Plan (via DHCW) with adjusted timelines to show a path to a "minimum standards met" position by Nov 24. The Improvement Action Plan has been adjusted and shared, and internal stakeholders notified. This will be managed by ADLT and monitored via IGSG.							
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	Interviews 01 May 2024 were unsuccessful. Next round of interviews due July 2024 – expected in post Q3					
2. Seeking funding to recruit/upskill/resource DPO who will encourage engagement. Additional funding into Digital for 24/25 will allow a permanent DPO position to be created within the structure – a JD is yet to be developed.		Jonny Sammut	Q3 2024/25	Expected Recruitment and in post Q3					
3. Ensure compliance with the appropriate IG level training across all Directorate and Departments <ul style="list-style-type: none"> a. Demonstrate a regular series of comms on IG and DP b. Regular monitoring of training compliance through IGSG c. Targeted training compliance reporting to line manager on individuals to ensure that 85% target is reached. 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. IG training compliance still below 85% target. An Action Plan for training has been created, and a training needs analysis being progressed with L&D team. Procedures, such as audit of Welsh Clinical Portal usage, has been updated. Paper to ADLT Jun24 seeking support for increased awareness & training compliance					
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					

Risk ID 623	Failure to comply with Data Protection Legislation		Date of Review:	07/07/2024		TREND	15 (3x5)	
			Date of Next Review:	07/08/2024		➔		
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	
5. Assurance of “standards met” for all IG Toolkit requirements: gain support of all Directorates’ leadership to complete the IG Toolkit Improvement Action Plan and ensure compliance for the 24-25 IG Toolkit submission		Leanne Smith	Nov 24 for IG Toolkit Improvement Action Plan (with evidence to CAG)	Paper to ADLT Jun 24 seeking support for completion of the IG Toolkit improvement action plan. To ensure no impact to CAG approvals for WAST research, this improvement action plan must now be met and evidenced by Nov 24.				

Risk ID 100	Failure to persuade JCC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience		Date of Review:	26/06/2024	TREND	12 (3x4)
			Date of Next Review:	16/09/2024		
IF WAST fails to persuade JCC/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
				Current	3	12
				Target	2	8
IMTP Deliverable Numbers: 7, 9, 11, 12, 14, 15, 20, 24, 25, 32						
EXECUTIVE OWNER	Executive Director of Strategy, Planning & Performance	ASSURANCE COMMITTEE	Finance and Performance Committee			
Risk Commentary						
<p>From the 01 April 2024 111, emergency ambulance and Ambulance Care are all commissioned by the Joint Commissioning Committee (JCC). This is viewed as a positive development by the Trust, supporting the development of an organisational ambition.</p> <p>The ambition is appropriate levels of patient safety and good working conditions for our staff across the 111 pathway, emergency ambulance care pathway and Ambulance Care pathway. 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. A further funded 32 APPs are being recruited in 2024/25 along with 23.2 FTEs to Integrated Care. The 111-call abandonment rate has not been achieved for the last four months. Ambulance Care performance is stable.</p> <p>The 2023 EMS Demand & Capacity Review is live with an estimated completion date of July 2023 Trust Board (on target) with the draft results received by end of 23/24 and in time for the 2024-27 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 +100 FTEs, if handover can be reduced to 7,000 hours (handovers within one hour) supported by the evolved clinical response model.</p> <p>The Trust has some limited room for manoeuvre in its 2024/25 budget (see above) to put more resource into supporting the evolution of the clinical response model, but if further funding is not forthcoming, post the 2023 EMS Demand & Capacity Review, the risk may need to be revised upwards.</p> <p>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 JCC and health boards (completed).</p> <p>The previous controls are currently transitioning into the new JCC arrangements, so are currently a bit fluid. Quarter 2 should see the arrangements stabilise.</p>						
CONTROLS		ASSURANCES				
		Internal & External Management (1st Line of Assurance)				
1. JCC/WAST Forward Plan for EMS and NEPTS in place and monitored at JCC 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 (sub-committees currently under review as part of move into JCC).		2. Minutes of meetings and a standard agenda item				
3. Weekly catch up between Interim Director of 111 & Ambulance Commissioning /CEO		3. Meetings are diarised every week				
4. Collaboration between JCC and WAST on specific projects e.g. Evolving clinical model.		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 (currently paused as part of move into JCC).		5. Formal meeting with agendas, minutes, and action logs available.				

Risk ID	Failure to persuade JCC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience		Date of Review:	26/06/2024	TREND	12
100			Date of Next Review:	16/09/2024		(3x4)
IF WAST fails to persuade JCC/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
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 evolving the clinical model including commissioners		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 (approved).				
9. Governance arrangements for 111 commissioning: 111 Board, 111 Commissioning Board + 111 DAG etc.		9. Minutes of meetings and a standard agenda item				
		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. JCC remit is wider than just ambulances and will reduce the agenda time dedicated to WAST's three patient pathways.		1. A shorter provider brief will go to the JCC with more detailed discussions taking place at its sub-committees.				
2. Governance coordination between the JCC and WAST to be improved.		2. Identified need for a governance meeting between JCC and WAST to manage the overall commissioner/provider interface. Actioned, but has lapsed due to capacity and resourcing in NCCU team. This will be further reviewed as the JCC goes live in April-24 (period of transition likely to extend through Q1). This has lapsed at this time, but request to re-establish it sent to commissioners.				
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. The Welsh Government target is no waits > one hour, which equates to 7,000 lost hours.				
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 JCC in Q2 2024/25, with initial findings already shared. On advice from the CASC, formally reporting the findings of the review has been re-programmed into Q2 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 JCC/Health Boards that sufficient funding to be provided to WAST	CEO WAST	NEW Checkpoint Date	30.09.22 Additional £3m provided for +100 FTEs into Response by 23/01/23. 12/01/23 Recurrent funding for the +100 not secure. 02.05.23 Recurrent funding still not secure. 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 (currently under development). 26.06.24 Funding for a 32 FTE APPs secured for 2024/25 and 23.2 FTEs into Integrated Care. 06/08/24 WAST briefing on evolved CRM and 2023 EMS Demand & Capacity Review to JCC Board Development session in Aug-24.			
2. Agree and influence JCC/Health Board of the need for significant reduction in hospital handover hours	CEO WAST	NEW Checkpoint Date	30.09.22 4-hour handover backstop agreed and -25% reduction in handover from October 2021 baseline. 12/01/23 There has been a significant worsening picture. 02.05.23 Continued worsening picture with almost 29,000 lost in March 2023. 28.07.23 There has been some reduction, but levels remain extreme. 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			

Risk ID 100	Failure to persuade JCC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience		Date of Review:	26/06/2024	TREND	12
			Date of Next Review:	16/09/2024		(3x4)
IF WAST fails to persuade JCC/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	Inherent	4	Consequence	4
			Current	3	4	12
			Target	2	4	8
			26/04/24 This modelling has been further supplemented by modelling the Ministerial target of no handovers of more than one hour. 26/06/24 May-24 levels at 24,000, which is higher than 2023 and concerning as an indicator of the winter the Trust may expect. Trust moving at pace to evolve clinical response model, with Welsh Government full sighted on impact of handover hours on the Trust.			
3. Increased understanding of NEPTS by JCC	Executive Director of Strategy Planning and Performance	02/08/23 30/06/24 20/08/24	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 (completed). 26/06/24 Workshop results reported to newly established Interim Ambulance Commissioning Committee. 06/08/24 The WAST briefing to the JCC Board Development session in Aug-24 includes coverage of five workstreams, one of which is Health Transport, which includes NEPTS and UCS.			
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 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. 16/04/24 The new commissioning arrangements are in transition and still quite fluid at the moment. 26/06/24 Request to commissioners to re-establish this meeting. 06/08/24 Meeting now re-established.			
5. Develop and roll out the Stakeholder Influencing Plan	Director of Partnerships & Engagement 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.			

Risk ID 424	Resource availability (revenue, capital, and staff capacity) to deliver the organisation's Integrated Medium-Term Plan (IMTP)		Date of Review:	19/07/2024	TREND	8 (2x4)
			Date of Next Review:	19/09/2024		
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	2	4	8
			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 8 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 in the central Transformation team have been filled so there are better levels of support for delivery of key workstreams and delivery of mitigations listed in this BAF. Alongside this each directorate involved directly in the transformation has identified resources to support the programme. Programme structures have been revised to focus on delivery of key elements of the IMTP utilising the resources that have been put in place. There remains risk due to the need for financial savings to be delivered so this risk will remain under review as we consider any further controls required 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 14 th 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			
10. Project and programme management (PPM) framework published			10. Project Path Framework (sharepoint.com) – on Siren			
			Independent Assurance (3rd Line of Assurance)			
			2. Subject to Internal Audit			
GAPS IN CONTROLS			GAPS IN ASSURANCE			
1. Lack of a commercial contractual relationship with Commissioners (link to risk 458)			1. 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. 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 Extend to 31.12.23 as priorities have taken precedence but there is work ongoing in this space. Extend to 29.02.24 as other priorities have taken	Reviewed action and extended checkpoint date further as approach being developed for next iteration of IMTP. Work ongoing. Workshop held in Q1 and Q2 to develop new Project Path Framework. Milestone for delivery in Q3 as part of Project Path Framework. Work continues with the Commissioning and Performance Team to align performance metrics with programme/IMTP deliverables. An evaluation methodology is being trialled with Swansea University to look at benefits realisation of small, agile projects and PDSA cycles. Work continues this but will be rolled out as part of the PPF.		

Risk ID 424	Resource availability (revenue, capital, and staff capacity) to deliver the organisation's Integrated Medium-Term Plan (IMTP)		Date of Review:	19/07/2024		TREND	8 (2x4)
			Date of Next Review:	19/09/2024		↓	
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	2	4	8	
			Target	1	4	4	
		precedence but there is work ongoing in this space. As above extend to end of Feb. Extend to 30.06.24 as further resources become available / return to enable this work to be done. 30.09.2024	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. Structured assessment recommendation to put this in place. Confirmation to the Board that we will have something aligning delivery to outcomes in the next Board reporting cycle.				
2. A formal approach to service change to be developed providing secure recurrent funding with commissioners (link to risk 458)	Director of Finance	Complete	Complete in that the recurrent funding risks in the IMTP have been covered e.g. 100 WTE frontline EMS staff. Any additionality requires separate business cases.				

Risk ID 139	Failure to deliver our Statutory Financial Duties in accordance with Legislation	Date of Review:		08/07/2024	TREND	8 (2x4)																
		Date of Next Review:		08/10/2024	➔																	
IF the Trust does: <ul style="list-style-type: none"> 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		<table border="1"> <thead> <tr> <th></th> <th>Likelihood</th> <th>Consequence</th> <th>Score</th> </tr> </thead> <tbody> <tr> <td>Inherent</td> <td>3</td> <td>4</td> <td>12</td> </tr> <tr> <td>Current</td> <td>2</td> <td>4</td> <td>8</td> </tr> <tr> <td>Target</td> <td>2</td> <td>4</td> <td>8</td> </tr> </tbody> </table>		Likelihood	Consequence	Score	Inherent	3	4	12	Current	2	4	8	Target	2	4	8
	Likelihood	Consequence	Score																			
Inherent	3	4	12																			
Current	2	4	8																			
Target	2	4	8																			
IMTP Deliverable Numbers: 9, 12, 15, 18, 24, 25, 30, 31, 32																						
EXECUTIVE OWNER		Executive Director of Finance and Corporate Resources		ASSURANCE COMMITTEE		Finance and Performance Committee																
Risk Commentary: Q1 2024/25 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 year to date to Month 3 of the 2024/25 Financial Year . The score is consistent with that of Qtr. 4 2023/24 due to a presented opening balanced financial plan for 2024/25 and the Month 3 2024/25 financial performance and positive savings delivery . It must be noted though that clear monitoring of a potential financial risk around workforce re-banding of EMT staff and the ability to fund / receive income may impact on the delivery of the financial plan for 2024/25 . The current challenging financial climate for all public sector organisations may also impact on WAST financial performance especially as the financial year progresses.																						
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 (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																		
GAPS IN CONTROLS				GAPS IN ASSURANCE																		

Risk ID 139	Failure to deliver our Statutory Financial Duties in accordance with Legislation	Date of Review:		08/07/2024	TREND	8 (2x4)																
		Date of Next Review:		08/10/2024	➡																	
IF the Trust does: <ul style="list-style-type: none"> 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		<table border="1"> <thead> <tr> <th></th> <th>Likelihood</th> <th>Consequence</th> <th>Score</th> </tr> </thead> <tbody> <tr> <td>Inherent</td> <td>3</td> <td>4</td> <td>12</td> </tr> <tr> <td>Current</td> <td>2</td> <td>4</td> <td>8</td> </tr> <tr> <td>Target</td> <td>2</td> <td>4</td> <td>8</td> </tr> </tbody> </table>		Likelihood	Consequence	Score	Inherent	3	4	12	Current	2	4	8	Target	2	4	8
	Likelihood	Consequence	Score																			
Inherent	3	4	12																			
Current	2	4	8																			
Target	2	4	8																			
<ul style="list-style-type: none"> Lack of formalised service contracts between Commissioner and WAST as a commissioned body 		11. 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 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 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 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 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.																		

Key - List of Strategic and IMTP objectives

Strategic Objective 1: Providing the right care or advice, in the right place, every time		BAF risks
1.	A modern, easily accessible, user-friendly and integrated digital offer	223, 224, 623, 260, 201,163, 424
2.	Rapid (111) call answering, initial triage and onward referral	223, 424
3.	Timely, high quality clinical assessment, advice and referral	223, 224, 424
4.	Seamless transfer of 111 callers to wide range of available pathways	223, 424
5.	Immediate 999 call answering, and efficient and effective dispatch of the right resource	223, 424
6.	High quality, timely, clinical triage, assessment and consultation, with personalised response	223, 424
7.	High quality, immediate or timely on scene assessment, care and conveyance where needed	223, 100, 424
8.	A range of 24/7 pathways available for further assessment or treatment, closer to home	223, 224, 424
9.	A flexible, user-centred Non-Emergency Patient Transport Service with the right capacity in place to meet demand	100,139, 424
10.	A dedicated and timely transfer & discharge service supporting HBs with their transformation agendas	223, 424
11.	A clear vision for Ambulance care services that supports wider health and care transformation	100, 201, 424
12.	A high quality, safe (NEPTS) service with improved patient experience	100, 139, 424
Strategic Objective 2: Enabling our people to be the best they can be		
13.	Culture: <ul style="list-style-type: none"> Enhance and strengthen internal capacity for delivering culture change Develop amplify employee voice to increase employee engagement Continue the implementation of our compassionate practices approach 	160, 558, 623, 201, 163, 424
14.	Capacity: <ul style="list-style-type: none"> Implement our Strategic Workforce Plan Continue to embed a culture of positive attendance management Continue our focus on 'getting the basics right.' 	100, 160, 163, 223, 224, 424, 558, 594, 623
15.	Capability: <ul style="list-style-type: none"> Grow and develop our leadership and management capability Reinforce and promote career pathways and professional development. Create an environment centred around effective, ongoing conversations ('Check Ins') 	100, 139, 160, 223, 224, 260, 594, 424
16.	Strengthen Welsh Language compliance through strong leadership, enabling Welsh language to flourish	201, 424
Strategic Objective 3: Being at the forefront of innovation and technology		
17.	The right buildings in the right place, enabling our staff to provide the best and safest care across Wales	542, 424
18.	The right fleet in the right place, enabling our staff to provide the best and safest care across Wales	139, 542, 623, 424
19.	Develop & agree Digital Plan <ul style="list-style-type: none"> Everyday essentials Security, Safety & Cyber Digital Pioneers Transformation Data, Information & Insight 	163, 260, 623, 424
Strategic Objective 4: Developing services in collaboration		
20.	Well-placed to influence system thinking / strategy development	100, 223, 424
21.	Meet the requirements of the Wellbeing of Future Generations Act	558, 424
22.	University Trust Status in collaboration with WG, embracing a 'democratised culture' of learning, research and innovation	160, 163, 223, 224, 424
Strategic Objective 5: Being quality driven and clinically led		
23.	Systems that meet the requirements of the Duty of Quality and Duty of Candour	224, 424
24.	Excellent clinical leadership	100, 139,160, 223, 224, 260, 594, 424
25.	A culture of quality improvement with robust quality management systems	100, 139, 160, 201, 223, 224, 424
26.	High quality Putting Things Right, Safeguarding and Health & Safety systems	160, 224, 558, 424
27.	Meaningful engagement and co-production with communities	223, 224, 424
28.	A risk management framework as a key enabler of our long-term strategy and decision making	No corporate/principal risks
29.	An integrated governance framework	No corporate/principal risks
Strategic Objective 6: Delivering exceptional value		
30.	Sustainable savings & efficiencies	139, 163, 224, 424
31.	Generate income alongside our core commissioned functions	139, 224, 424,
32.	A Value-Based approach across the organisation which is embedded in culture	100, 139, 163, 424
33.	Developing and implementing our plans for Environmental Sustainability and Adaptation	542, 424



WELSH AMBULANCE SERVICE NHS TRUST

RISK ADVISORY SUPPORT

August 2024

INTRODUCTION

BACKGROUND

Welsh Ambulance Service NHS Trust (WAST or Trust) is in the process of enhancing its existing risk and controls environment. To tackle the strategic and operational aspects of maturing its methodology for risk management, WAST engaged BDO LLP to provide guidance across three main areas - a Strategic Board Assurance Framework (BAF), a Risk Appetite Guide, and Risk Repositioning of two principal risks.

The BDO team worked closely with the Head of Risk/Deputy Board Secretary and Director of Corporate Governance/Board Secretary to design this guidance document which provides insights on the three (3) areas listed above.

OUR APPROACH

Section 1: Board Assurance Framework:

All Trusts are required to prepare public statements to confirm that they have done their reasonable best to maintain a sound system of internal control to manage the risks to achieving their strategic objectives. The Trust's Board Assurance Framework is based upon the identification of the Trust's strategic goals, the principal risks to delivering them, the key controls to minimise these risks, with the key assurances of these controls identified. These are monitored by the Board to resolve issues or concerns and to improve control mechanisms. The BDO team reviewed the existing BAF and identified areas of improvement which can help in transitioning BAF into the next phase as planned by the Board.

We have also provided example templates for a BAF (Refer Appendix) which can be implemented by Board while transitioning to the next phase.

Section 2: Risk Appetite Guidance

A risk appetite statement helps an organisation to understand the amount of risk it is willing to accept in pursuit of its objectives. This ensures risk decisions remain within the defined risk tolerance levels and are aligned to the Trust's strategy. The BDO team has prepared a guidance document to support WAST in successfully developing and designing risk appetite statements which are fit for the Trust. We have also set out some example statements (Appendix) which can be used as a reference when developing statements.

Section 3: Repositioning Two Principal Risks

In support of reviewing and reconsidering the position of two principal risks that have remained at their highest score on the WAST corporate (principal) risk register, BDO has provided suggestions which can be implemented for these risks. While drafting its principal risks, WAST may want to focus on the internal and external factors which may have impact on the movement of risk. While there are many external factors which may contribute to the risks, the first focal point should be the mitigations which are in control of WAST and where actions can be taken to reduce the impact to the Trust's patients, people and wider organisation. This provides clarity and assurance to the Board and executive leadership team and ensures that clear lines of accountability are established around risk management and action plans.

KEY OBSERVATIONS & RECOMMENDATIONS

We have summarised the key observations and recommendations based on our review of available documentation and discussions with key WAST stakeholders:

#	Focus Area	Observations	Recommendations
DO NOW			
1	Board Assurance Framework	The current Board Assurance Framework does not align with the strategic objectives of the Trust. The current principal risks are aligned to IMTP objectives, which are developed to be aligned to the long-term strategy. To ensure the successful implementation of the Board Assurance Framework, best practice suggests alignment of key risks to strategic objectives set out in the long-term strategy.	WAST may want to consider aligning the current Board Assurance Framework with key strategic objectives set out in the Long-term Plan (2030 - Vision) and the risks which may impact the achievement of strategic objectives.
2	Repositioning Risk	In relation to risk 223 and 224, reviewed as part of this engagement, we noted that the risk is mainly driven by external factors where WAST has limited control over the movement of these risks. The controls highlighted are also dependent on external parties. We suggest that WAST may want to focus on the factors which may be in their control and reposition the risks accordingly.	WAST may want to consider reviewing its existing principal risks and repositioning them to ensure the risks are within control of the Trust and actions can be taken to reduce the impact of the risk to the Trust.
3	Resourcing & Culture	The current corporate governance team is responsible for managing day-to-day risk activities in addition to monitoring and reporting BAF, metrics reporting, guiding the teams, driving the risk transformation program. To ensure risk becomes embedded in the organisation, WAST may want to consider increasing the capacity of the team to make it a partner for the achievement of strategic objectives. The current resources for risk management are limited with quite a few initiatives to manage, which may hamper the progress and speed of delivery of such initiatives.	WAST may want to consider empowering the corporate governance team to position them as a strategic partner within the organisation. This may involve allocating more resources to support the achievement of the vision and objectives set out by the board. This will support in embedding risk management into daily operations, ensuring it is closely aligned with strategic goals.
DO NEXT			
4	Board Assurance Framework	The current Board Assurance Framework, while very detailed, does not provide assurance over the effectiveness of controls.	WAST may want to consider reviewing the effectiveness of controls and provide assurance over the three lines to the Board and executive leadership team.
5	Risk Appetite	WAST has not developed risk appetite statements to help in decision-making. As part of the risk transformation programme, we understand that the Trust intends to develop risk appetite statements which will enhance decision making and support the achievement of strategic objectives.	WAST may want to consider designing risk appetite statements which are aligned to strategic objectives, principal risks or risk categories.
DO LATER			
6	Board Assurance Framework	WAST teams are collecting regular reports and data on performance and operations to support day-to-day activities. Currently WAST doesn't have any metrics assigned to monitor the movement of risks associated with achievement of strategic objectives.	WAST may want to consider designing metrics to support the monitoring and reporting of data and provide real-time risk movement parameters to the Board and executive leadership team.
7	Digitising the Board Assurance Framework	The current BAF is managed offline, which limits its functionality. Specifically, there is no real-time tracking available, making it challenging to monitor the movement and status of risks effectively.	WAST may want to explore the implementation of a tool that can bring the BAF online. WAST may want to consider a tool that has the capability to digitise the existing framework and offer dynamic reporting features.



BOARD ASSURANCE FRAMEWORK

WHY WAST IS LOOKING TO ENHANCE ITS BOARD ASSURANCE FRAMEWORK

WAST's current Board Assurance Framework (BAF) provides detailed information about the corporate (principal) risks; however, a BAF is a tool to assure the Board regarding the achievement of strategic objectives. Its purpose is to provide all relevant information to the Board and appropriate stakeholders regarding the principal risks which can impact the Trust and its impact on the strategy. An effective BAF is also a requirement set out by NHS Wales, WAST's external auditor, Audit Wales, and the findings of WAST's internal audit report.

Requirements set out by NHS Wales

- ▶ Boards need to be confident that the systems and processes are operating in a way that is effective and is driving the delivery of objectives by focusing on minimising risk. They need to prove that they have identified their objectives and managed the principal risks to achieving them.
- ▶ The term "Board Assurance Framework" refers to a document that brings together all relevant information on risks relating to Board's strategic objectives. This is used by the Board to assure itself that the steps are taken towards achievement of strategic objectives.

Requirements set out by Audit Wales (External Auditor):

- ▶ In the structured assessment conducted by Audit Wales in November 2023, it was recommended that the BAF should be aligned to the strategic objectives set out in "Vision 2030". The current BAF is focussed on the corporate (principal) risks, and the current corporate (principal) risks are not mapped against the strategic objectives of WAST. Therefore, the extent that the BAF provides a framework for assurances on achievement of the Trusts strategic objectives is limited.
- ▶ Additionally, the requirement to develop risk appetite statements to support the BAF and achievement of strategic objectives is also highlighted.

Requirements set out by Internal Audit

- ▶ The WAST internal audit review conducted in July 2023 highlighted the requirement of developing the appetite statements to support the BAF and achievement of strategic objectives.
- ▶ The current BAF doesn't provide assurance on the effectiveness of controls and the Board should focus on enhancing the current BAF to more strategic level.

THE BENEFITS OF A BOARD ASSURANCE FRAMEWORK

A Board Assurance Framework (BAF) brings together in one place all the relevant information on the risks that exist in relation to the achievement of the Trust's strategic objectives. A BAF forms a key component of the broader organisational approach to risk management, and focuses on risks to strategic objectives, key control measures in place to manage these risks and assurances to indicate the effectiveness of control measures which are in place to manage these risks.

The effective application of the BAF helps the Board and executive leadership team to consider collectively the process of securing assurance that promotes good organisational governance and accountability. The specific benefits include:

- Gaining a clear and complete understanding of the risks faced by the Trust in the pursuit of its strategic objectives,
- Identifying areas where existing controls are failing and, as a consequence, the risks that are more likely to occur;
- Capturing the types of assurance currently in place, and consideration as to whether they are effective and efficient;
- Identifying areas where assurance activities are not present, or are insufficient (assurance gaps);
- Identifying areas where assurance is duplicated, or is disproportionate to the risk of the activity being undertaken (i.e., there is scope for efficiency gains, reduction of duplication of effort and/or a freeing up of resource);
- The ability to better focus existing assurance resources; and
- Providing an evidence base to assist the Trust in the preparation of its annual governance statement.



BAF USED EFFECTIVELY WITHIN OTHER ORGANISATIONS

The BDO team has reviewed the best practices around Board Assurance Frameworks, assurance frameworks, solutions available online to design a holistic template for WAST to support the transition to the next phase (refer to the Appendix). Below are a few examples of BAFs in other organisations:

Item ID	Item Description	Lead	Start Date	End Date	Assurance Status	Report
Need 1	Ability to implement strategically, financial changes	Chief Executive	2014	2015	Board of Directors	1
Need 2	2014-2015 financial review and 2015-2016 budget	Chief Executive	2014	2015	Board of Directors	1
Need 3	Ability to manage financial sustainability	Chief Executive	2014	2015	Board of Directors	1

Item ID	Item Description	Lead	Start Date	End Date	Assurance Status	Report
Need 1	Ability to manage financial sustainability	Chief Executive	2014	2015	Board of Directors	1
Need 2	Ability to manage financial sustainability	Chief Executive	2014	2015	Board of Directors	1
Need 3	Ability to manage financial sustainability	Chief Executive	2014	2015	Board of Directors	1

Item ID	Item Description	Lead	Start Date	End Date	Assurance Status	Report
Need 1	Ability to manage financial sustainability	Chief Executive	2014	2015	Board of Directors	1
Need 2	Ability to manage financial sustainability	Chief Executive	2014	2015	Board of Directors	1
Need 3	Ability to manage financial sustainability	Chief Executive	2014	2015	Board of Directors	1

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Need 3	Ability to manage financial sustainability	Chief Executive	2014	2015	Board of Directors	1

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University Hospitals Sussex NHS Foundation Trust - [Datix ID-Ram_ID](http://Datix.ID-Ram_ID) (bsuh.nhs.uk)

Healthcare Charity - BDO Client

Private Healthcare - BDO Client



DEVELOPING A BOARD ASSURANCE FRAMEWORK

DEVELOPMENT OF ASSURANCE ARRANGEMENTS FOR BOARDS - WHERE YOU ARE TODAY

The purpose of assurance arrangements is to help WAST determine how it will gain assurance over the effectiveness of controls that WAST relies upon to achieve its objectives. There are six key steps to developing the Board assurance arrangements (Strategy & Objectives, Risk Management, Risk Appetite, Assurance, Control Effectiveness and Monitoring). The table below sets out a WAST self-assessment against these six key areas, alongside BDO's high-level view of good practices and areas for improvement. In the following slides, we set out a detailed view of each step and WAST's current status against BAF components.

STEPS FOR CREATING BAF	SELF ASSESSMENT*	GOOD PRACTICES	AREAS OF IMPROVEMENT
Step 1: Strategy & Objectives	MODERATE	The BAF is aligned to the Integrated Medium-Term Plan deliverables which is aligned to the 2030 Vision (long term strategy) of the Trust.	You could consider designing a plan to execute strategy by establishing clear milestones, assigning responsibilities and monitoring the progress.
Step 2: Risk Management	SUBSTANTIAL	The risks are identified at the corporate level and directorate levels. These risks are discussed regularly and updated as per the risk landscape.	The current corporate (principal) risks are operational and WAST may want to focus on aligning risks to the strategic objectives in the 2030 Vision.
Step 3: Risk Appetite	NOT DEFINED	As part of the risk transformation programme the Board is focussed on defining risk appetite for the principal risks aligned to strategic objectives.	WAST may want to focus on defining risk appetite to enhance decision-making and provide guiderails for WAST in achieving strategic objectives.
Step 4: Assurance	NOT DEFINED	The BAF provides a detailed view of the controls implemented for each risk and the gaps in controls.	The methodology for assessing the effectiveness of controls over the 3 lines may be defined and implemented to ensure effective mitigation and assurance to the board.
Step 5: Control Effectiveness	MODERATE	The BAF defines the controls implemented over the 3 lines and the gaps in assurance controls, which are monitored as part of action plan.	The controls defined in the BAF may be aligned to the three lines to provide appropriate assurance over their effectiveness.
Step 6: Monitoring	SUBSTANTIAL	The Board, committees, directorates, senior team and the corporate governance team review and monitor reports (performance reports, incident reports, incident reports, survey results, etc.) on a regular basis to assess the effectiveness of control environment.	WAST could consider designing metrics to support the monitoring and reporting of data and provide real-time risk movement parameters to the Board and executive leadership team.

* The self-assessment is based on the discussions with the Director of Corporate Governance/Board Secretary and Head of Risk/Deputy Board Secretary

STEP 1 - STRATEGY AND OBJECTIVES

Setting the Trust's strategy and objectives is the first step in designing an effective Board Assurance Framework. The focus of the Board should be on the information, evidence or assurances that relate to the achievement/potential non-achievement of strategic objectives.

DELIVERING EXCELLENCE - WAST'S STRATEGIC FRAMEWORK

"WAST's Long-Term Strategic Framework for 2030, 'Delivering Excellence' was endorsed in 2019, setting out our long-term vision for the organisation. It set out our ambition to move from being a traditional ambulance and transport service to being a trusted provider of out-of-hospital high quality care, ensuring that patients receive the 'right advice and care, in the right place, every time', with a greater emphasis on providing care closer to home. This not only ensures that patients receive safe and timely care, meeting their individual needs, and reducing unnecessary conveyances to secondary care, it also supports flow across the wider health and care system and contributes to Health Board strategies and plans. It is a whole organisational strategy, not only concerned with service models, but also with how we support and enable our employees to be the best that they can be. We also commit within the strategy to being an organisation that collaborates with our partners, stays at the forefront of innovation and technology, remains utterly focussed on being quality driven and clinically led, and delivers exceptional value. We have continued to develop our IMTPs around this strategy and its six core strategic objectives."

The BAF could focus on aligning risks against these six strategic objectives.

'Delivering Excellence' – Our long term strategy



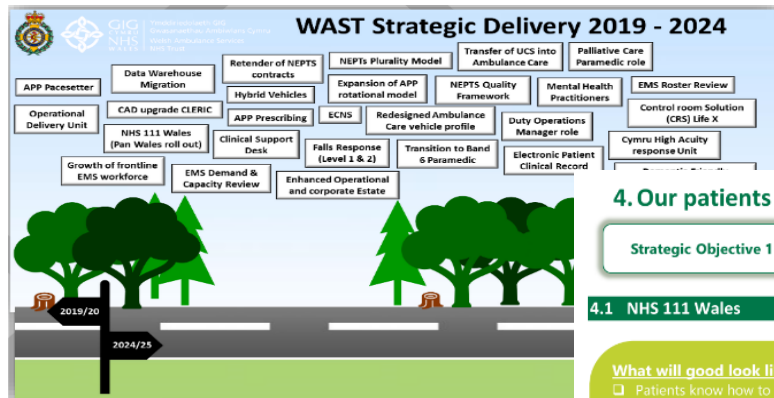
Other components of the risk management framework will not function efficiently or effectively unless there are clear strategic objectives with tangible success measures. It is therefore crucial that this is a Board priority.

STRATEGY

CURRENT STATE

Last year WAST took the opportunity to review progress against its long-term strategy - 'Delivering Excellence'. WAST has made significant progress in delivering on its strategic ambitions, some of which can be seen in the roadmap from 2019 to 2024.

But since the strategy was developed in 2019, the landscape within which WAST operates has changed considerably. Whilst WAST is confident that the broad direction of travel remains fit for purpose, its self-review identified that there was a need to develop and refine its thinking on its clinical response model which will deliver the ambition of 'providing the right care and advice, in the right place, every time'. WAST's emerging thinking is described in more detail in the IMTP. This 24-27 IMTP has started to draw out 'what good looks like' for each of the strategic objectives, some of which comprise multiple initiatives i.e. 'providing the right care and advice, in the right place, every time' includes NHS 111 Wales, Emergency Medical Services (999), and Ambulance Care (non-emergency patient transport).



4. Our patients

Strategic Objective 1 – Providing the right care or advice, in the right place, every time

4.1 NHS 111 Wales

What will good look like for 111 users in 2027?

- ❑ Patients know how to access the 111 service and choose it as their preferred gateway to care.
- ❑ Patients are confident that the service steers them safely through the complex health and care system.
- ❑ Patients are happy to comply with the information and advice that they are given.
- ❑ Patients receive timely, high quality remote clinical assessments with no further intervention needed for many.
- ❑ Where needed, patients are booked directly and seamlessly into the right service.

What will be different?

- ❑ Consistently timely – less than 5% abandonment
- ❑ Improved patient reported satisfaction.
- ❑ Increased proportion of consultations closed with no further follow up needed.
- ❑ Increased proportion of next steps seamlessly booked.

RECOMMENDATIONS TO ENHANCE

Designing a plan to execute strategy is essential for turning strategic goals into actionable initiatives. WAST may want to start by clearly defining the strategic objectives by ensuring these objectives are specific, measurable, achievable, relevant and time-bound (SMART).

WAST has already initiated the breakdown of strategic goals into actionable tasks (as shown in the figure to the left); however, the focus could be on assigning responsibilities, deadlines, and resources to each task to ensure accountability and progress tracking.

The plan may be communicated clearly to all relevant stakeholders to ensure they understand their roles and responsibilities in executing the plan and actively engage them in the process.

Monitoring mechanisms may be implemented for monitoring progress against the plan and objectives. Implement a feedback loop to solicit feedback from relevant stakeholders and adjust the plan as needed.

STEP 2 - RISK MANAGEMENT

Understanding and implementing proactive risk management is one of the key elements for implementing an effective BAF. WAST focuses on implementing a risk-based Board Assurance arrangement. The risk-based approach looks at providing assurance over the key controls in place to manage the principal risks that threaten or provide opportunity for achievement of objectives.

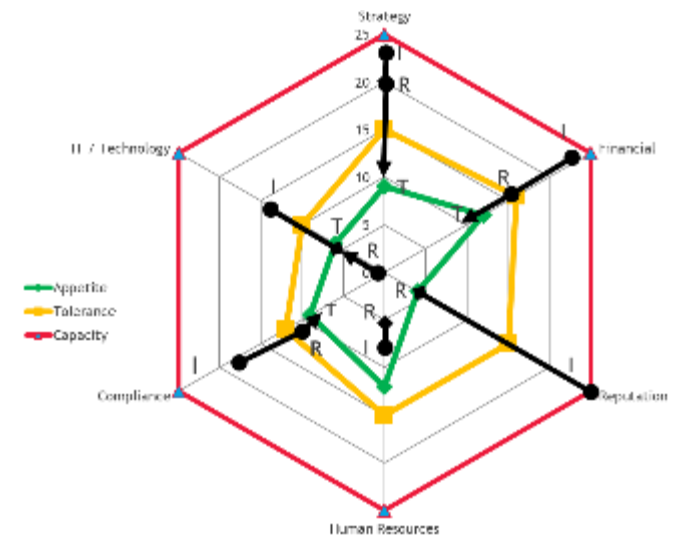
The structure of the underlying risk data should include the following key elements to ensure a strong foundation for the assurances to be mapped and to assist in the prioritising of resources:

- Clear, consistent and concise risk descriptions;
- Risks linked explicitly to strategic objectives;
- Detailed analysis of cause and effect;
- Detailed list of key controls;
- ‘Inherent’ (gross) assessment (before application of controls or mitigating actions) and ‘residual’ (net) assessment (after control application) of the risk; and
- Outline of clear planned actions and implementation dates.

The inherent and residual risk scores can help to decide on the frequency that assurance is required, and whether independent assurance is required to provide the Board with the desired level of comfort. This allows identification of the assurance appetite of the Board.

		CONSEQUENCE				
		Negligible	Minor	Moderate	Major	Catastrophic
LIKELIHOOD	Highly Unlikely	1	2	3	4	5
	Unlikely	2	4	6	8	10
	Likely	3	6	9	12	15
	Highly Likely	4	8	12	16	20
	Almost Certain	5	20	15	20	25

Aligned to "Risk Management Policy v1.0"



RISK MANAGEMENT

CURRENT STATE

A risk management transformation programme has been developed and included in the Integrated Medium-Term Plan (2023-26) (IMTP): “This programme will further strengthen and positively impact the development of the Trust’s future strategic ambition and provide clarity on the risks that would prevent us from achieving our organisational objectives.” One of the seven deliverables underpinning the transformation programme is to develop a Risk Management Policy and supporting procedures. The corporate governance team has developed the following:

- **Risk Management Policy** which was approved on 28 March 2024. The policy sets out the roles and responsibilities for risk management and the Board Assurance Framework.
- **Corporate Governance Directorate Risk Management Guidelines** approved on 25 October 2023 sets out the process for identifying, developing, and managing new and existing directorate risks
- **Guidance on Interpreting the Board Assurance Framework** approved in April 2023 set out guidance for the Board on interpreting the Board Assurance Framework highlighting the requirements, review cycles, assurance requirements etc.

The corporate governance team, with support from senior leadership, has established an effective risk culture within the organisation where risk is embedded in day-to-day operations of WAST.

- The corporate (principal) risks are monitored and reported to the Audit Committee, Board and senior leadership in line with the reporting and review schedule. All high risks (15-25) are monitored and discussed on a monthly basis (in every meeting) and an appropriate action plan is designed to reduce the impact. The medium risks (8-12) are reviewed quarterly, and low risks (1-6) are reviewed every 6 months.
- The Directorates are responsible for managing their directorate and local risks and escalating risk to the Head of Risk/Deputy Board Secretary for inclusion on the corporate (principal) risk Register. Risks are escalated, amended or removed at corporate level on the basis of a recommendation made and approval provided by the Assistant Director Leadership Team (ADLT) and the Executive Leadership Team (ELT).

RECOMMENDATIONS TO ENHANCE

WAST may want to focus on aligning their current corporate (principal) risks to strategic objectives on the BAF. A comprehensive risk assessment may be carried out to identify potential risks that could impact the achievement of strategic objectives. This may involve both internal and external factors that could affect the Trust. This exercise can be done by conducting discussions with stakeholders, conducting surveys, workshops etc. to gather the information and identify the trends.

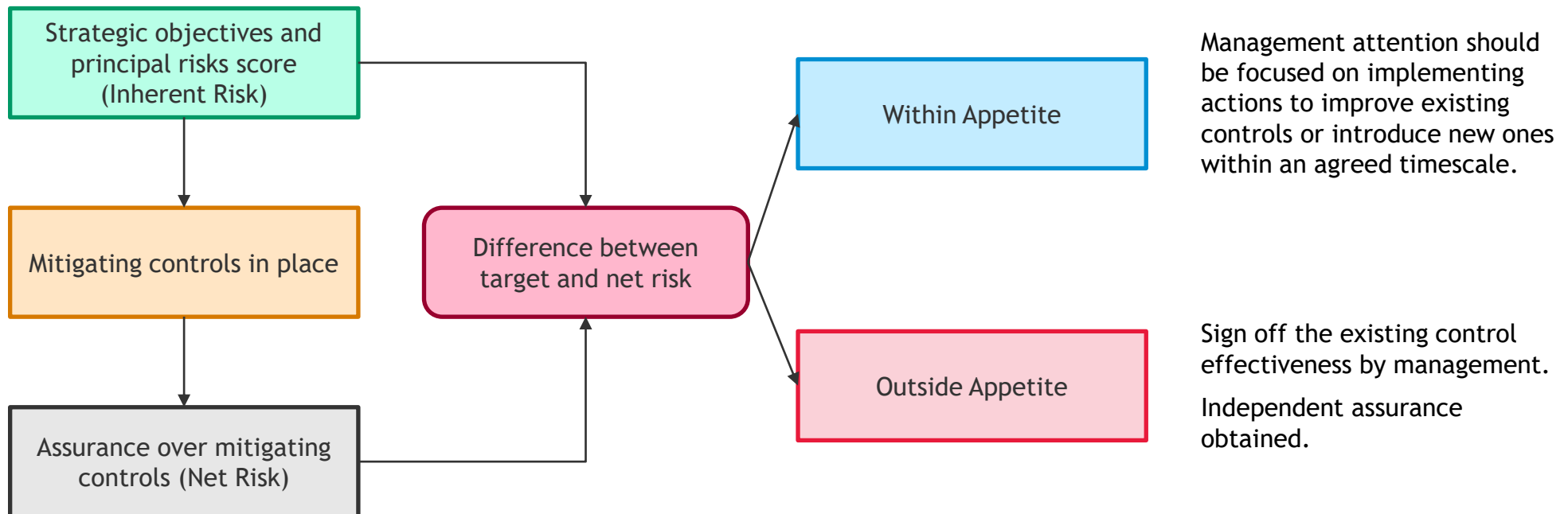
A clear link between identified risks and the strategic objectives may be established to ensure the focus and resources are directed to the relevant risks (targeted risk management efforts).

While WAST’s executive leadership team discusses the corporate (principal) risks monthly, WAST may want to focus on implementing mechanisms to continuously monitor and review both risks and strategic objectives to ensure alignment over time.

STEP 3 - RISK APPETITE

Every organisation needs to consider the level of risk it is willing to accept when seeking to achieve its strategic objectives. Risk Appetite helps capture the tolerable levels of risk in pursuit of strategic objectives and should be considered in relation to each strategic objective. It is the assessment of the upper level of risk to that strategic objective that the organisation has determined cannot be exceeded, i.e. the point at which any action necessary should be taken to reduce the risk.

The risk appetite set will relate to the combined and cumulative risk arising from all the specific individual risks associated with that objective. Determining whether a risk appetite level is in danger of being breached therefore requires a cumulative assessment of risks.



Refer to section 2 for guidance on risk appetite

RISK APPETITE

CURRENT STATE

As part of the risk transformation programme, the Board intends to develop risk appetite statements to support the decision-making for the achievement of strategic objectives. The Risk Management Policy describes the requirement of setting risk appetite statements for WAST as below:

- The Trust recognises, as a healthcare provider, that risks will inevitably occur while providing the right care and treatment to patients at the right time, as well as in enabling and empowering our people, managing its finances and resources, and striving to continue to be a quality driven and innovative service.
- The Trust's Risk Appetite may be aligned to its long-term strategy (Delivering Excellence 2030) to enable the organisation to prioritise those risks that are most relevant to achieving its objectives.
- The Trust may accept some risks if the cost of mitigation is too high or if the risk is deemed to be within acceptable limits. In such circumstances, ongoing monitoring is essential to detect any changes and prompt a reassessment of the risk.

Currently WAST has set out its risk appetite for safety and quality of services as below:

*“Whilst risk is inherent in many of the Trust’s activities, it has **zero appetite** to accept risks that materially impair the ability to deliver services to a high standard of safety and quality including physical and/or psychological harm) of its patients, workforce, and the public, and its reputation or those that may cause any loss of confidence with its stakeholders.”*

The Board is committed to developing a suite of Risk Appetite statements within its risk transformation programme, as essential components of the Trust's risk management framework. These will set out and describe the level of acceptable risk that it is willing to take in pursuit of better outcomes for our patients and local communities as well as for our employees and in working with our partners and stakeholders.

RECOMMENDATIONS TO ENHANCE

After completion of step 1 and 2, it is key for the Trust to define its tolerance for risk-taking and aligning it to their strategic objectives.

WAST may want to focus on developing clear and concise risk appetite statements that articulate the Trust's willingness to accept risk in pursuit of its strategic objectives.

Where possible, quantify risk tolerance levels using metrics, thresholds, or Key Performance Indicators (KPIs) that align with organisational objectives. This helps in making risk appetite more tangible and measurable.

BDO has set out guidance in section 2 of the document highlighting the steps to develop risk appetite statements. After successful development of risk appetite statements, having risk appetite considerations embedded in decision-making at all levels within the Trust supports effective decision making and the achievement of objectives.

STEP 4a - ASSURANCE OVER CONTROLS

The intention of a control is to provide as far as possible, a consistent environment and set of circumstances to enable the achievement of tangible strategic outcomes that have been set. There are multiple ways to assess the adequacy and efficiency of the control environment:

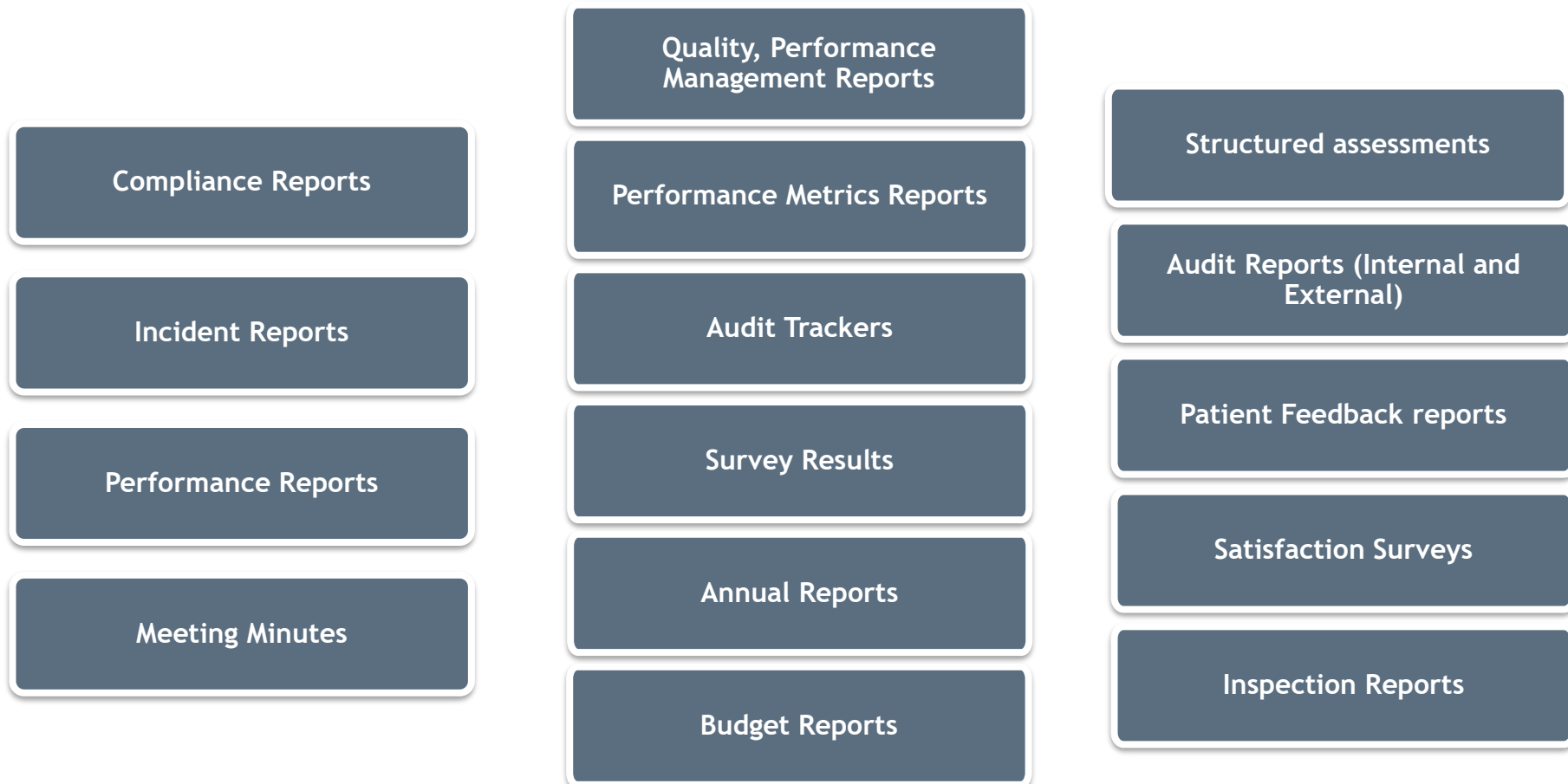
- Assurance over the 3 lines model
- Audit results
- Regulatory compliance/ compliance reports
- Performance against KPIs and KRIs
- Independent reviews or assessments
- Demonstration of tangible results.

WAST has implemented the three lines model to manage and assess the effectiveness of the control environment. Each line has a distinct role in creating a positive environment for risk management and control across the Trust. The three lines are described below:

- First line: This is operational management assurance where day to day operations take place.
- Second line: This is where the oversight of management activity takes place and is separate from those responsible for delivery. It provides guidance, monitoring, and independent assessment of risk management processes but it is not independent of the Trust's management chain.
- Third line: This relates to independent and external bodies that are separate and detached from the Trust that operate autonomously which ensures transparency, credibility, and impartiality. These are mandated and commissioned. The principal aim of this type of assurance activity, such as internal audit, Audit Wales, and Health Inspectorate Wales (HIW) is not only to assure the Board, but also to provide assurance to the public and other stakeholders.

STEP 4b - SOURCES AND TYPES OF ASSURANCES

Gaining a clear understanding of the sources of assurance can significantly clarify how the Trust receives its assurance, identify any excess or duplication, and highlight areas lacking assurance. It's crucial for the Board to ascertain that the level of assurance is appropriate to instil confidence in their decision-making. The Trust engages in a broad spectrum of assurance activities, and it's imperative for the Board to utilise this information effectively when shaping its assurance strategy. Below, we've outlined a few examples of where assurances can originate:



STEP 5 - CONTROL EFFECTIVENESS

Once sources of assurance have been identified the next step is to establish what it is telling the Trust about the effectiveness of the risk(s)/control(s) it covers.

The level of control effectiveness at the first and second line may be subjective, as it may be provided through a self-assessment approach (i.e. by the person(s) receiving the assurance or responsible for the controls or even minutes of meetings/outcomes of meetings unless expressly referred to). At the third line, it is common for independent assurance providers to issue a form of opinion or view (assurance) as to the design, operation and level of effectiveness of the controls reviewed. For each source of assurance that is identified it is possible to assess effectiveness of the controls based on the scale defined below.

Substantial	Reasonable	Limited	No Assurance	Not Applicable
Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

RISK 1	ASSURANCE ASSESSMENT		
Risk Description	ASSURANCE NEED (RELIANCE ON CONTROLS)		LIMITED
CONTROL ASSESSMENT	ASSURANCE ASSESSMENT		
	FIRST LINE OF ASSURANCE	SECOND LINE OF ASSURANCE	THIRD LINE OF ASSURANCE
Control 1	SUBSTANTIAL	LIMITED	SUBSTANTIAL
Control 2	SUBSTANTIAL	NO ASSURANCE	LIMITED
Control 3	REASONABLE	REASONABLE	NO ASSURANCE

EXAMPLE

ASSURANCE & CONTROL EFFECTIVENESS

RECOMMENDATIONS TO ENHANCE

The corporate governance team has set out a Board Assurance Framework for all corporate (principal) risks impacting WAST. The BAF describes the controls and the assurances (over 3 lines model) against each control. Currently the framework to assess the effectiveness of controls and assurances is not developed. To enhance the BAF and provide appropriate assurances to the Board WAST may want to consider:

- **Embedding the three lines model within the Trust:** As highlighted in the previous slides, WAST has adopted a 3 lines model for assurance over the controls. The model clearly highlights the roles and responsibilities and the assurances provided by each line to demonstrate the effectiveness of control environment.
- **Identifying key objectives and risks:** WAST may focus on identifying the key risks associated with the strategic objectives. The corporate governance team has identified the principal risks and plans to focus on a principal risk identification and assessment exercise.
- **Establishing Control Measures:** Identifying appropriate controls which impact the movement of risks and help in achievement of strategic objectives. The BAF currently highlights the control measures for the corporate (principal) risks and the assurances against each control. It also highlights the gaps in control and associated action plan to reduce the impact of the risk.
- **Identifying key assurances:** Maintain a comprehensive list of assurance activities, such as self-assessments, audit reports, performance reports, survey results etc. which support the controls and map them to 3 lines model. Based on risk score the assurance activities may be self-assessed by the appropriate stakeholders.
- **Documenting and Reporting:** Collate the information in timely manner and report to executive leadership team and Board to support informed decision making and governance oversight.
- **Implementing monitoring mechanisms:** WAST may establish mechanisms for ongoing monitoring and reporting of Key Risk Indicators (KRIs) and Key Performance Indicators (KPIs). These metrics may be developed in line with the strategic objectives and principal risks and progress may be tracked for monthly reporting.
- **Continuous Improvement:** Continuously evaluate the effectiveness of the assurance framework and adjust as necessary to address evolving risk landscape. Review and update policies and procedures to ensure alignment to strategic objectives.

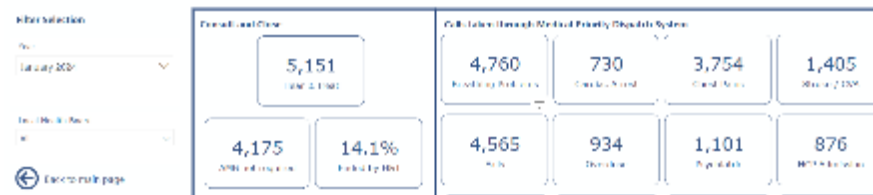
STEP 6 - MONITORING

With any data collection process, some form of validation is required to ensure the data captured is complete and consistent. Once validated, the data needs to be used to generate meaningful management information. The information can be monitored using the following:

- Performance Reports
- Key Performance Indicators
- Key Risk Indicator
- Survey Results
- Patient Safety Results etc.

The data collected may be presented in a way to engage the stakeholders and may be consistently followed within the Trust.

Ambulance Service Indicators | Step 2 | Answer my call



Ambulance Service Indicators | Step 3 | Come to see me



Ambulance Service Indicators | Step 5 | Conveyance



MONITORING

CURRENT STATE

WAST has developed a Quality & Performance Management Framework which sets out an integrated approach to helping the Trust improve the quality of its services and outcomes for patients and achieve its ambitions and objectives by monitoring and improving the performance of people, teams, and the organisation. This initiative was taken after the Trust's Structured Assessment, internal audits, Audit Wales Quality Governance Review, and Welsh Government Duty of Quality 'self-assessment' identified the need to enhance measurement and reporting of quality and performance. The trust has set out clear objective around the below 5 building blocks:

- **Setting aspirational and stretching objectives for the whole organisation:** The Trust is committed to developing, evolving and clearly articulating its longer-term strategy and ambitions, taking into account the wider context in which it operates, and working in collaboration with internal and external stakeholders. The Trust has identified the structural hierarchy of the plans to ensure successful delivery of the initiatives which are linked to long term strategy.
- **Developing a coherent set of performance measures and targets/ standards:** The Trust has set out the guidance for the development of the metrics and monitoring mechanisms to assess whether its strategy, aims and objectives are being achieved.
- **Implementing rigorous assurance and review mechanism:** WAST aims to implement a more refined and fit-for-purpose BAF which will provide assurance to the Board on the principal risks aligned to strategic objectives. The BAF may be integrated in a tool (digitised) to ensure appropriate and efficient monitoring and reporting.
- **Enabling positive ownership and accountability throughout the Trust:** Overall accountability for quality and performance rests at the Trust Board level, but everyone in the Trust has a responsibility for quality and performance. Accountability and responsibility are detailed through a variety of management mechanisms, for example, formal schemes of delegation, job descriptions, scope of practice, plans and PADRs.
- **Providing resources, education, tools and techniques to support individuals' and teams' achievement:** The Trust acknowledges that with advancements in technology there is a need to analyse the current landscape and implement tools, resources and techniques to support the employees in their development.

RECOMMENDATIONS TO ENHANCE

The framework defines the requirements and plan for the coming years, WAST may start with identifying and defining Key Performance Indicators (KPIs) and Key Risk Indicators (KRIs) that are aligned to organisational objectives and critical success factors. Setting clear targets and thresholds for each KPI and KRI to indicate desired performance levels and acceptable tolerances. Targets provide a benchmark for performance, while thresholds define boundaries within which performance is considered acceptable.

The integration of an optimised and digitised BAF will ensure rigorous assurance and review of the risks which are aligned to the strategic objectives. This will also ensure accountability and ownership by the appropriate stakeholders within the Trust. WAST should focus on development, design and integration of the objectives set out in the Long Term Strategy.

ROLES AND RESPONSIBILITIES

Activities	Board	Senior Leadership	Corporate Governance Team	Directorates
Step 1: Strategy & Objectives	Establish strategic objectives and set direction of travel in achievement of strategic objectives.	Implement the strategic direction set by the Board and set tone from the top in achievement of strategic objectives.	Support the Board and senior leadership in setting the strategic objectives and action plan.	Implement policies and guidelines set by senior leadership to help in achievement of strategic objectives.
Step 2: Risk Management	Review and approve risk management strategies and policies.	Develop and implement policies and procedures to manage risks effectively.	Identify, assess and prioritise risks to the Trust.	Identify, assess and evaluate risks specific to areas of operation or expertise.
Step 3: Risk Appetite*	Approve risk appetite statements and provide approval on material deviations from the agreed risk appetite	Develop risk appetite statements and embed them within the Trust.	Contribute to development of risk appetite statements and stress test to see impact on the Trust.	Implement controls and processes which ensure Trust operates within risk appetite and monitor day to day adherence.
Step 4: Assurance	Reviewing assurance reports to ensure the effectiveness of internal controls and risk management process.	Monitor the assurance over the 3 lines based on data provided by directorates, corporate governance team and auditors.	Provide regular assurance reporting to senior leadership team based on data collated from directorates and other reports.	Collate and provide regular data and reports to senior leadership team and corporate governance team to assess the assurance over the controls.
Step 5: Control Effectiveness	Holding senior leadership accountable for achieving strategic objectives and managing risks effectively.	Ensure adequate resources are allocated for management of risks and achievement of strategic objectives.	Provide guidance and support to senior leadership and directorates in effective management of risks.	Develop and implement the risk mitigation plans and strategies and collect data to ensure control effectiveness.
Step 6: Monitoring	Provide oversight on the monitoring activities carried out by the directorates and corporate governance team.	Monitor and report the Trust's performance against strategic objectives and risk management goals.	Monitor and report on risk exposure and mitigation efforts.	Monitor and report risk exposure for respective directorate and escalate when exposure increases.

* Further information on risk appetite is available in section 2 of the document.

WHAT A GOOD STRATEGIC BAF CAN LOOK LIKE

The BAF may consist of three sections - a dashboard, a front sheet and a detailed view of risks on strategic objectives.

The dashboard:

- Principal risks associated with the objectives
- Mapping the principal risks on risk appetite scale
- Control effectiveness over the lines of assurance.

The front sheet:

- Strategic Objectives aligned to overarching vision of the Trust
- Principal risks associated with the objectives
- Risk Appetite of each principal risk
- Inherent Risk
- Net Risk/ Current Risk
- Target Risk
- Control Effectiveness/ Assurance Score
- Risk Owner responsible for mitigation of the risk to acceptable levels.
- Lead Committee responsible for overseeing progress in delivering strategic Objective

The Detailed View:

- The risk description (if, then, resulting in) format
- Mitigating controls in place to manage the risk
- The gaps in controls
- Sources of assurance
- Gaps in assurance
- Mitigating actions
- Linked corporate (principal) risks

Examples of BAF are highlighted in the Appendix

QUESTIONS TO CONSIDER WHEN REVIEWING A BAF

Strategic Objectives

- Are your strategic objectives SMART?

SMART objectives promote clarity, accountability and progress towards meaningful outcomes, ultimately enhancing organisational performance and success.

- Are you confident that the strategic objectives accord with the primary purpose of the Trust?

It is essential to define appropriate strategic objectives which will support in achievement of Trust's vision.

- Are all members of the Board agreed about what success against each strategic objective will look like at the year-end?

To support the long-term strategy of the organisation, short term plans should be established with defined milestones to gauge the progress against the strategic objectives.

Risk Management

- Has the Board agreed a Risk Management Strategy and Policy which is aligned to internal governance and explicitly states how it supports the achievement of strategic objectives?

The policies, procedures and guidelines should be aligned to the overall strategic objectives of the organisation and reviewed regularly to ensure they supports the achievement of strategic objectives.

- Is there a clear process and methodology for escalation of any risk which poses threat to achievement of strategic objectives? Are the risks referred to Board appropriately?

A robust escalation process is a cornerstone for effective governance and risk management. It ensures risks are promptly addressed as they arise and helps in prioritising risks based on their potential impact. Establishing a risk aware culture and empowering the organisation to raise issues is essential element of effective risk management.

Risk Appetite

- Is the risk appetite and tolerances defined against the strategic objectives?

Aligning risk appetite to strategic objectives ensure that the decisions are consistent with the organisation's mission, vision and goals. It also helps in guiding resourcing decisions and prioritising initiatives that align with overall objectives.

Assurances and Control Effectiveness

- Does the Board have a methodology for assessing the quality of the data presented regarding the existence, appropriateness or application of controls and the quality of the performance data?

Reviewing and monitoring reports on status of control implementation, independent assurance reports, self-assessments by the organisation units, key indicators and metrics can help gauge the implementation and effectiveness of controls.

- How strong is current performance against each of the success measures associated with each strategic objective?

Assurance plays a critical role in providing the Board with confidence that controls are implemented effectively contributing to sound governance, risk management and performance against the strategic objective achievement.

Monitoring

- What monitoring is in place to ensure the tracking of risk mitigations?

Developing key indicators to monitor the performance and identify early warning signs can enhance the monitoring and overall governance of principal risks and facilitate the achievement of strategic objectives.

- How does the BAF inform decisions within the organisation?

The BAF should provide reliable information, insights and assurances to the Board, enabling them to effectively oversee operations, manage risks and drive performance towards strategic objectives.



RISK APPETITE GUIDE

APPROACH TO RISK APPETITE

WAST has embarked on a journey to adopt a more formal Risk Appetite process which informs the level of acceptable risk-taking by the Trust as part of delivering on strategic objectives and overall growth plans.

The Risk Appetite statement is normally refreshed annually to align to business strategy changes and changes in principal risks relevant to the Trust.

For the period of 2024, WAST has agreed to develop a Risk Appetite process internally and put in place a high-level qualitative Risk Appetite statement which expresses the level of acceptable risk for each category of risk.

Our proposed approach to establishing a Risk Appetite statement recommends that WAST consider establishing formal risk categories which play a pivotal role in grouping similar principal risks together and ensure that appetite expressed for each risk category or principal risk aligns to the overall strategic objectives.

BDO have provided a Risk Appetite guide in line with leading practice which may be used by WAST. The six-step approach provides a high-level guide to formalising a clear Risk Appetite statement aligned to the Trust requirements and which will be approved by the Board.

As the Risk Appetite process continues to mature and evolve over time, and as part of the annual refresher process, WAST may wish to consider adopting a blend of qualitative and quantitative metrics in line with what management and the Board see fit.



DEFINING RISK APPETITE

Overview:

A Risk Appetite statement enables the organisation to make informed risk decisions which support strategic objectives. Establishing a Risk Appetite baseline helps management to monitor the level of risk exposure in line with defined acceptable risk levels which are aligned to strategic objectives.

Definition:

Risk Appetite is the amount of risk an organisation is willing to accept in the pursuit of its objectives. Where principal risks and controls (principal risks) have not been defined, Risk Appetite is normally defined per category of risk.

Risk appetite statement design:

Risk Appetite statements may be expressed as qualitative, quantitative or a combination of these measures. Qualitative measures may allow for easier and simpler positioning of Risk Appetite across the organisation. Organisations often start with a qualitative Risk Appetite and as they mature, they begin to include quantitative measures. Risk Appetite statements should be:

- **S-M-A-R-T:** The Risk Appetite statement should be specific, measurable, actionable, reliable, and timely.
- **Linked to strategic objectives:** Embedded across business-as-usual activities and linked to strategic objectives.
- **Monitored and Reported:** Actively tracked and reported across the organisation with corrective measures taken when Risk Appetite is outside of acceptable levels.



THE VALUE OF RISK APPETITE

Why do we need Risk Appetite?

Risk appetite provides a clear framework which enables management in an organisation to make informed risk decisions. By defining both optimal and tolerable positions, an organisation clearly sets out both the target for day-to-day risk taking and the maximum acceptable risk taking in the pursuit of strategic objectives. The benefits of adopting a formal Risk Appetite include:

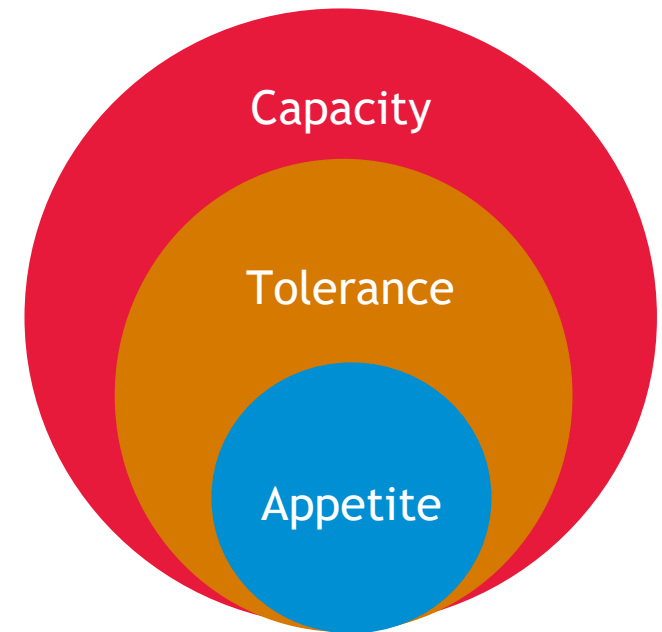
- Supporting informed decision-making.
- Reducing uncertainty.
- Improving consistency across governance mechanisms and decision-making.
- Supporting performance improvement.
- Focusing on priority areas within an organisation.
- Providing the organisation with a comprehensive view of maximum risk-taking limits approved by the Board.
- Allowing the organisation to monitor and track the level of risk as part of business as usual, which may be used to inform management and the Board.



KEY CONCEPTS ASSOCIATED WITH RISK APPETITE

Risk Appetite defines the level of risk acceptable to the organisation where it will operate during business-as-usual. Organisation should also define risk tolerance and risk capacity which identifies the boundaries of risk outside of Risk Appetite. Risk Appetite may be articulated as qualitative expressions, quantitative values or a combination of to reflect the acceptable level of risk for the organisation.

Capacity	Maximum level of risk to which the organisation can be exposed: “going beyond this point may destroy the organisation”
Tolerance	Acceptable periodic deviation from expected level of risk the organisation is prepared to withstand in pursuit of its goals: “occasional higher exposure outside of agreed Risk Appetite”
Appetite	Agreed level of risk acceptable in pursuit of strategic objectives: “limits guiding day to day risk-taking activities”



ROLES AND RESPONSIBILITIES

Activities	Board	Senior Leadership	Corporate Governance Team	Directorates
Define risk appetite	Formally define risk appetite, with input from the senior leadership team.	Define risk appetite levels for the Trust	Provide guidance and support to senior leadership team while defining risk appetite statements.	Provide inputs on directorate specific risk appetites.
Assess current risk landscape	Formally responsible for oversight of risk management. Provide feedback and inputs on the current risk landscape.	Provide inputs and ensure alignment to strategic objectives.	Gather and analyse data related to risk exposures and provide insights on current risk landscape	Provide insights on the risk exposures for each directorate to Corporate Governance team.
Develop risk appetite statements	Provide feedback on risk appetite statements ensuring risk appetite is comprehensive and aligned to strategic requirements.	Develop risk appetite statements.	Contribute to the development of risk appetite statements and stress test to see impact on the Trust.	Consulted for inputs on risk appetite statements.
Implement risk appetite	Approve final risk appetite statements.	Embed risk appetite across the Trust.	Guide directorates on risk appetite process, deviations and exceptions.	Implement controls and processes which ensure Trust operate within risk appetite.
Monitor risk appetite	Approve material deviations from the agreed risk appetite	Take corrective actions when risk appetite deviates from agreed levels.	Report risk appetite deviations to Board and executive leadership team.	Monitor day-to-day adherence to risk appetite and escalate anticipated exceptions and breaches.

SIX STAGES TO DEVELOPING A RISK APPETITE STATEMENT



* The examples below are aligned to risk categories in BAF Guidance document

STEP 1: DEFINE RISK CATEGORIES

Risk categories is a classification system which groups similar principal risks together. Once WAST has established a set of risk categories defined in line with the organisation's requirements, the next step in the Risk Appetite process will be to define the appetite range in line with the language and levels acceptable to the Board. The following example provides a selection of high-level range of risk categories commonly used when setting Risk Appetite.

Safety & Well-being -
Patients/
Employees/Public

Quality/ Complaints/
Assurance/ Patient
Outcomes

Workforce/
Organisational
Development/
Employment/
Competence

Statutory Duty,
Regulation,
Mandatory
Requirements

Adverse Publicity or
Reputation

Strategic objectives
or Projects

Financial Stability &
Impact of Litigation

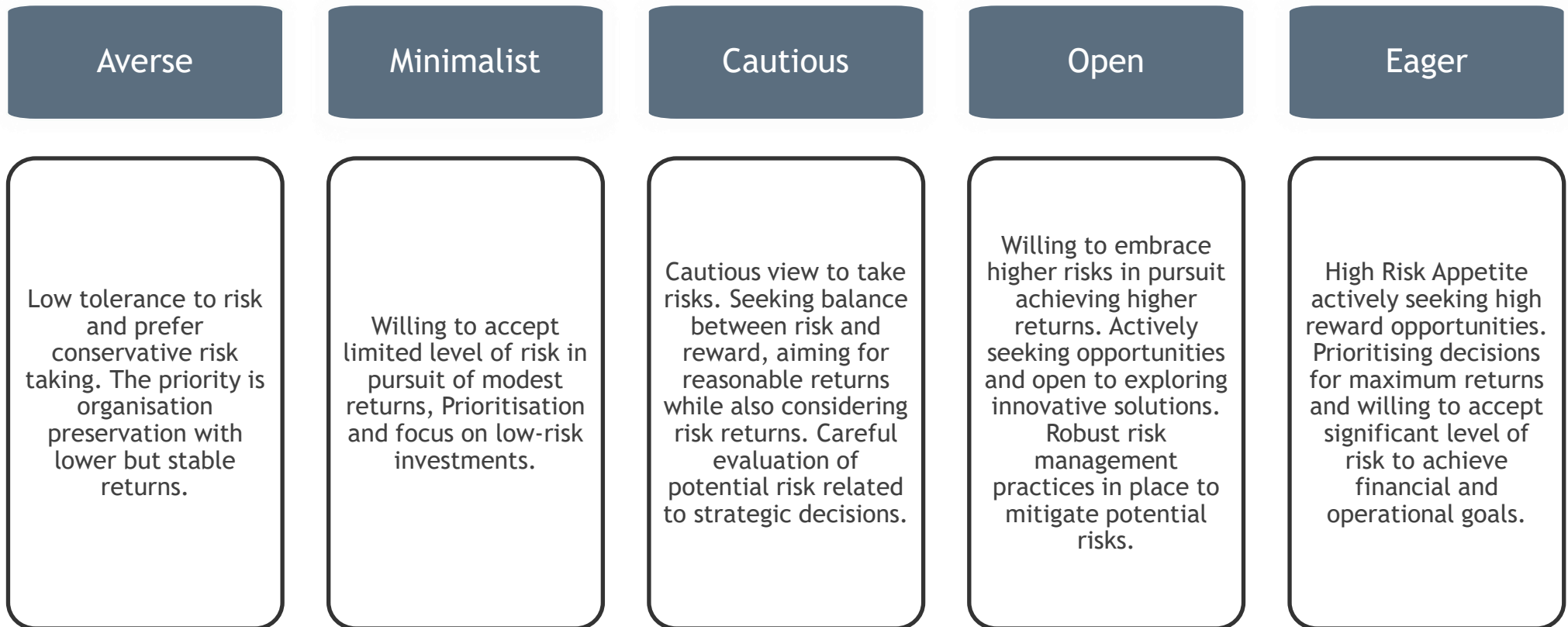
Service/ Business
Interruption

Environment/Estate/
Infrastructure

Health Inequalities/
Equity

STEP 2: ARTICULATE RISK APPETITE DEFINITIONS

The proposed Risk Appetite range of Averse to Eager will require management to clearly articulate the acceptable level of risk for each option. The same approach is followed in more granular detail where management define the appetite narrative for each risk category to ensure it clearly defines the level of risk acceptable to the organisation and Board.



STEP 3a: EXAMPLE NARRATIVE OF RISK APPETITE RANGE

The Risk Appetite statement examples below will need to be tailored to your specific organisation requirements to clearly articulate the desired level of risk taking aligned to strategic objectives. Where practical, management should aim to quantify Risk Appetite values using metrics or indicators relevant to the risk activity if such metrics are in place and available for periodic tracking and reporting.

CATEGORY	AVERSE	MINIMALIST	CAUTIOUS	OPEN	EAGER
Safety & Well-being - Patients/ Employees/Public	We are focussed on maintaining high quality and safety standards avoiding any opportunities which may lead to poor experience for patients, employees and public.	We are focussed on taking minimal risks related to quality and safety and patient experience in the pursuit of our strategic objectives.	We have a balanced approach between risk and reward. We explore beneficial opportunities while also maintaining minimal risk related to safety and wellbeing of patients, employees and public.	We are open to explore opportunities which may have a higher level of inherent risk, aimed at deliver higher returns on investments. We accept there may be some level of risk on the patients, employees and public but we actively seek ways to enhance the experience.	We pursue high risk opportunities which present significant returns and accept the high levels of risk in the short term. We strive for improvement and innovation and enhance the experience for patients, employees and public in long term while taking short term risks.
Quality/ Complaints/ Assurance/ Patient Outcomes	We aim to avoid complaints, maintaining a focus on delivering high quality services to the patients and public.	We are willing to accept minimal risk on quality, striving to address the complaints promptly and maintaining acceptable level of quality.	We are cautious to take risk and explore beneficial opportunities to enhance the quality and experience of the patients and public. We monitor the quality closely and focus on responding to complaints promptly and effectively to uphold our standards.	We are open to take risks which may have impact on customer experience while seeking opportunities to improve quality and address complaints constructively.	We pursue high risk opportunities which may have an impact on customer experience in short term while investing in innovation to enhance the experience and quality in long term basis.
Workforce/ Organisational Development/ Employment/ Competence	We are willing to take no risk and place the highest priority on the satisfaction and development of our employees. We are only willing to employ employees who exactly match the roles/ job descriptions.	We carefully assess potential risks to employee satisfaction and wellbeing, making informed decisions to maintain a positive work environment while also promoting operational efficiency. We are willing to stretch the parameters by employing people who match the roles/ job description as closely as possible.	We encourage innovation, embraces diverse perspectives, and are open to exploring new opportunities to create a dynamic and motivated workforce while being cautious of the impact of risk taking. Our hiring practices consider adaptability and soft skills to enhance the overall culture of the organisation.	We are willing to take calculated risks in implementing unconventional approaches to people management that may lead to exceptional performance and innovation. We are open to accept the possibility of workforce risks as a direct result of innovation if there is the potential for improvement in recruitment and retention and enhancing culture.	We are willing to take bold risks in challenging traditional norms, fostering an environment where people are encouraged to take risks, experiment and drive innovation. We actively see change as a positive catalyst and willing to invest in workforce development and enhancing their experience.

STEP 3b: EXAMPLE NARRATIVE OF RISK APPETITE RANGE

The Risk Appetite statement examples below will need to be tailored to your specific organisation requirements to clearly articulate the desired level of risk taking aligned to strategic objectives. Where practical, management should aim to quantify Risk Appetite values using metrics or indicators relevant to the risk activity if such metrics are in place and available for periodic tracking and reporting.

CATEGORY	AVERSE	MINIMALIST	CAUTIOUS	OPEN	EAGER
Statutory Duty, Regulation, Mandatory Requirements	We have no appetite to deviate from legal and regulatory requirements, prioritising strict adherence to all applicable laws and regulations to ensure proper conduct.	We maintain awareness around any risk of failure to comply with the legal and regulatory requirements. We have implemented robust compliance measures to ensure minimal impact on our organisation and operations.	We aim to strike a balance between complying to legal and regulatory requirements as well as being realistic that the evolving legal and regulatory landscape may lead to risks that can impact the organisation.	We maintain compliance to legal and regulatory thresholds which have high penalties and proceed to take corrective actions when challenged. We are willing to explore new avenues and markets with high risk, taking a corrective actions, when required, to reduce the impact.	We are focused on pursuing new opportunities and managing the legal and regulatory risks based on the impact and penalties on the organisation. We are willing to explore new avenues and opportunities even if it leads to higher risks.
Adverse Publicity or Reputation	We avoid any decisions which may have negative publicity or harm the reputation of the organisation.	We are willing to take minimal risks and we manage our reputation by addressing issues as they arise, aiming to maintain positive image.	We are willing to take some risk while actively monitoring our reputation and public opinions. We take steps to enhance our reputation through ethical practices and transparency.	We are willing to take risks which support the achievement of our strategic objectives while actively engaging with stakeholders to build trust and credibility, actively managing our reputation as a valued asset.	We actively seek opportunities to meet our objectives which may have negative impact on the reputation. We are willing to invest in proactive communication and independent advisors to minimise the impact and enhance public perception.
strategic objectives or Projects	We avoid any decisions which may pose risk to our strategic objectives or projects. We follow strict guidelines to ensure successful delivery and avoids alternative courses of action outside the guidelines.	Our appetite for risk taking is restricted to alternatives with no chance of loss of delivery of projects or strategic objectives. We have set out guiding principles in place to justify little flexibility in decision-making.	Our appetite for risk taking leans towards alternatives with little chance of loss or impact to delivery of projects or strategic objectives. We consider internal and external factors in decision making and work towards responding quickly to change. We have set out guiding principles that allow consideration of change factors with organisation insights to support deviations.	We examine emerging trends and considers dynamic internal and external factors in decision-making. We are receptive to calculated risk-taking and disruptive ideas based on insights to explore opportunities where the potential benefits outweigh the risks.	We evaluate risks in alternative courses of action and decision making, to optimise overall trade-offs of risk impact on objectives. We proactively take calculated risks to explore opportunities in the pursuit of objectives and willing to accept higher losses in the pursuit of higher returns.

STEP 3c: EXAMPLE NARRATIVE OF RISK APPETITE RANGE

The Risk Appetite statement examples below will need to be tailored to your specific organisation requirements to clearly articulate the desired level of risk taking aligned to strategic objectives. Where practical, management should aim to quantify Risk Appetite values using metrics or indicators relevant to the risk activity if such metrics are in place and available for periodic tracking and reporting.

CATEGORY	AVERSE	MINIMALIST	CAUTIOUS	OPEN	EAGER
Financial Stability & Impact of Litigation	We prioritise financial stability, avoiding any actions that might compromise financial health. We are willing to forego high return opportunities if it entails significant financial risks.	We are willing to accept the possibility of very limited financial loss or impact only if essential to organisation operations. We seek conservative strategies that align with financial goals while ensuring prudent risk management.	We seek safe financing options while exploring opportunities that offer reasonable risk/reward profiles. We maintain an approach which balances long-term certainty and short-term flexibility.	We actively seek financial opportunities that have potential for substantial returns. We are willing to take calculated financial risks in pursuit of higher profitability and growth, leveraging innovative financial strategies and market insights.	We are willing to explore high risk, high reward financial opportunities to achieve significant financial gains. We prioritise being agile and adaptive in rapidly changing financial landscape. We are willing to invest for the best possible return, recognising that the potential gain outweighs potential risk impact.
Service/ Business Interruption	We avoid all risks which may impact our services or organisation. We prioritise robust contingency plans to minimise impact to our processes.	We have minimal appetite for disruptions; however, we understand this may rarely happen and have measures in place to ensure business continuity (should a disruption occur) to minimise the impact on our ability to deliver the target business model and to service public needs.	We take a balanced approach to appetite for disruptions; however, we consider this a likely occurrence and emphasises proactive monitoring, agile response mechanisms and ongoing collaboration with our key stakeholders to safeguard operational stability.	We have an open risk appetite to disruptions, focusing on fostering strong relationships with stakeholders, setting up and embedding real-time tracking system and continuously assessing and monitoring vulnerabilities to minimise disruption.	We have a high-risk appetite for disruptions, acknowledging the dynamic nature of our supply chain markets. Our strategy includes investing in advanced technologies, fostering agility, and regularly stress-testing our resilience.
Environment/ Estate/ Infrastructure	We aim to meet basic environmental and infrastructural requirements to fulfil operational needs while minimising costs and environmental impact.	We prioritise compliance with environmental regulations and basic infrastructure maintenance to ensure operational functionality and safety.	We actively monitor and mitigate environmental risks while investing in sustainable infrastructure to enhance resilience and minimise our ecological footprint.	We embrace sustainability as a core value, integrating environmental considerations into all aspects of our operations and infrastructure development.	We are passionate about environmental stewardship; implementing innovative solutions and sustainable practices to minimise our environmental impact and contribute positively to the communities we serve. We are willing to take high risk to achieve this objective.

STEP 3d: EXAMPLE NARRATIVE OF RISK APPETITE RANGE

The Risk Appetite statement examples below will need to be tailored to your specific organisation requirements to clearly articulate the desired level of risk taking aligned to strategic objectives. Where practical, management should aim to quantify Risk Appetite values using metrics or indicators relevant to the risk activity if such metrics are in place and available for periodic tracking and reporting.

CATEGORY	AVERSE	MINIMALIST	CAUTIOUS	OPEN	EAGER
Health Inequalities/ Equity	We address health inequalities within the scope of our mandate.	We support initiatives to reduce health inequalities within our capacity and resources. We are willing to invest little additional resources to work on the initiatives.	We actively engage in efforts to mitigate health inequalities, willing to accept some risk in the process. We actively engage and collaborate with stakeholders to implement targeted interventions.	We advocate for equity in healthcare access and support initiatives to address health inequalities at local and systemic levels. We are open to explore opportunities to improve health equity.	We are deeply committed to reducing health inequalities, dedicating resources and expertise to drive meaningful change and promote health equity for all. We are willing to take high risk in order to achieve this objective.

STEP 5: MAP RISK APPETITE LEVELS IN RISK APPETITE DASHBOARD

Plotting the consolidated Risk Appetite survey results into a dashboard allows management and the Board to visualise the survey response as an expression of Risk Appetite for each of the risk categories agreed. The outcome will be discussed and agreed collectively by the Executive in a workshop, which would deliver a Risk appetite narrative (qualitative statements) for each risk category or principal risk. This would then be presented to the Board for approval.

Risk Appetite	AVERSE	MINIMALIST	CAUTIOUS	OPEN	EAGER
Safety & Well-being - Patients/ Employees/Public	Within Appetite	Within Appetite	Within Appetite	Outside appetite	Outside appetite
Quality/ Complaints/ Assurance/ Patient Outcomes	Within Appetite	Outside appetite	Outside appetite	Outside appetite	Outside appetite
Workforce/ Organisational Development/ Employment/ Competence	Within Appetite	Within Appetite	Outside appetite	Outside appetite	Outside appetite
Statutory Duty, Regulation, Mandatory Requirements	Outside appetite	Outside appetite	Outside appetite	Outside appetite	Outside appetite
Adverse Publicity or Reputation	Within Appetite	Outside appetite	Outside appetite	Outside appetite	Outside appetite
Strategic objectives or Projects	Within Appetite	Outside appetite	Outside appetite	Outside appetite	Outside appetite
Financial Stability & Impact of Litigation	Within Appetite	Within Appetite	Within Appetite	Within Appetite	Outside appetite
Service/ Business Interruption	Within Appetite	Within Appetite	Outside appetite	Outside appetite	Outside appetite
Environment/ Estate/ Infrastructure	Within Appetite	Within Appetite	Outside appetite	Outside appetite	Outside appetite
Health Inequalities/ Equity	Within Appetite	Within Appetite	Outside appetite	Outside appetite	Outside appetite

 Within Appetite
  Outside appetite

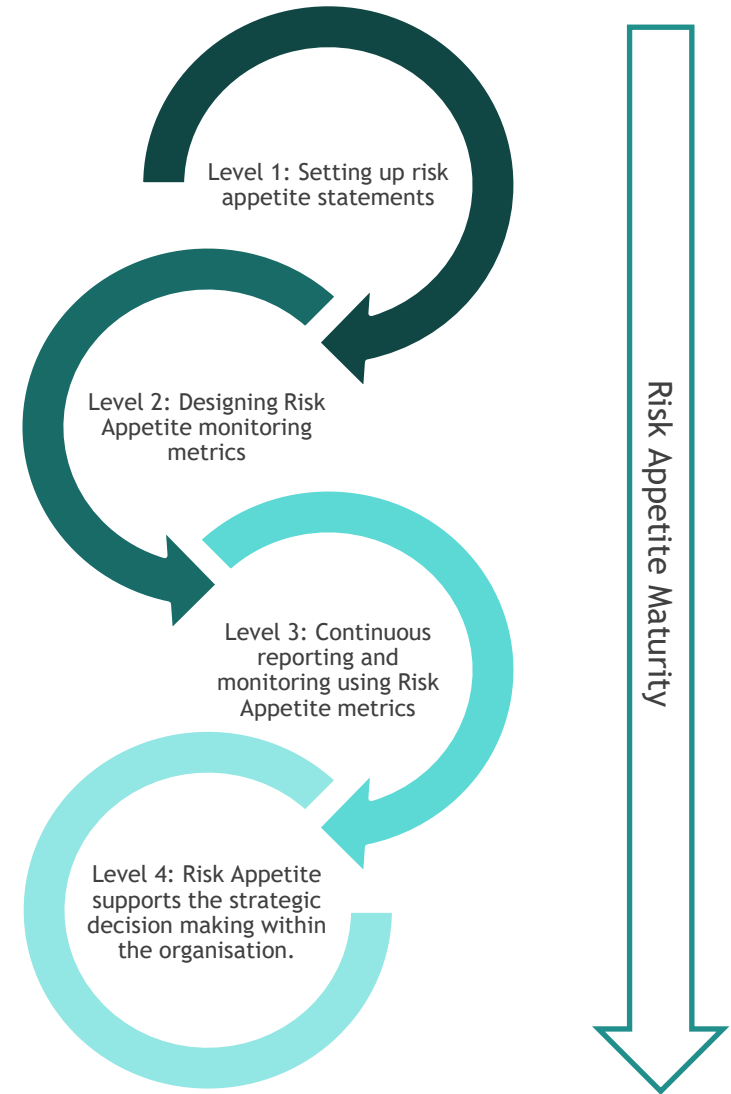
STEP 6: RISK APPETITE MONITORING AND REPORTING

Once the Risk Appetite statement has been agreed by the Board and communicated across the Trust, the risk function may consider establishing appropriate Risk Appetite monitoring and provide periodic reports to the executive and Board on the Trust's compliance with Risk Appetite limits. The outcome of monitoring Risk Appetite helps inform the Trust on whether Risk Appetite levels continue to be appropriate for the Trust or may need revision.

Management may wish to consider:

- Establishing Risk Appetite indicators linked to organisation/transacting activities.
- Assessing Risk Appetite compliance in line with agreed Risk Appetite levels.
- Incorporating bespoke Risk Appetite updates into BAU risk reporting forums.
- Escalating Risk Appetite breaches to the Board and guide the Trust on corrective actions.
- Informing the Board and Executive on anticipated Risk Appetite exceptions which may exceeded approved limits.

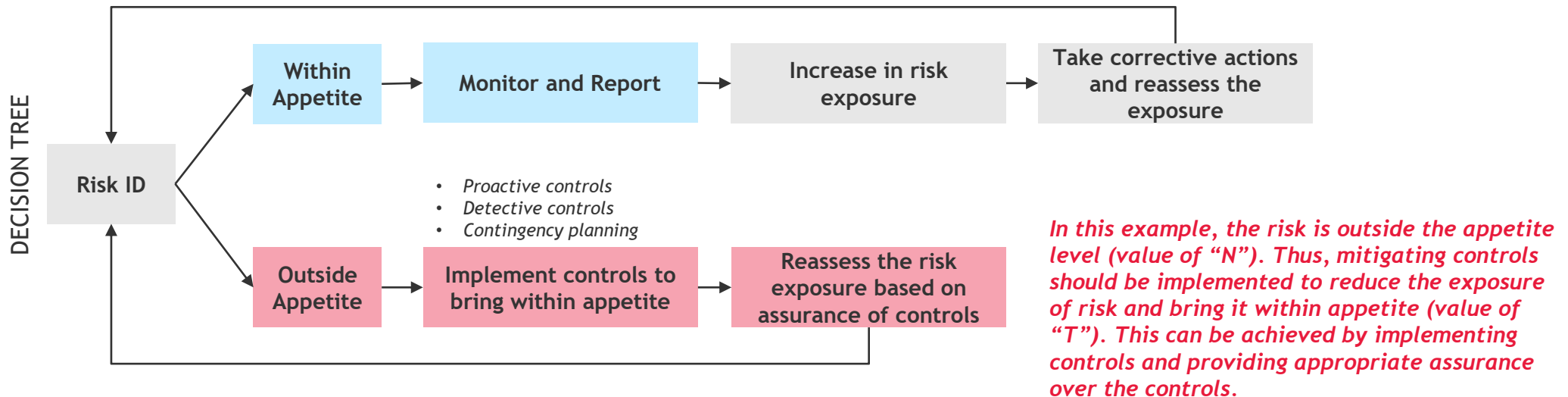
In instances where the Trust knows in advance that it may exceed Risk Appetite levels for a short period of time, the risk function may consider putting in place a formal process which guides and support organisation to prepare and communicate such anticipated Risk Appetite exceptions for Board approval. This may also include additional recommended controls for management to consider which help to mitigate the additional level of risk accepted.



IMPLEMENTING RISK APPETITE - EXAMPLE

We have set out an example explaining how risk appetite is implemented in real life and the communication plan and decision tree in case of deviations. The example below is for RISK ID “201” and we have made the assumption that the current risk appetite is “Cautious”.

Risk ID: 201	Category: Adverse Publicity or Reputation										Damage to Trust reputation following a loss of stakeholder confidence														
Risk Appetite	Cautious										We are willing to take some risk while actively monitoring our reputation and public opinions. We take steps to enhance our reputation through ethical practices and transparency.														
	AVERSE					MINIMALIST					CAUTIOUS					OPEN					EAGER				
Scale	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25
	T ←															N									





REPOSITIONING RISK

REPOSITIONING PRINCIPAL RISKS - 223 and 224

The Trust has identified two principal risks that have been rated at the highest risk level for several years and has taken proactive steps to better understand these risks, the way these are articulated and assessed in line with current organisation requirements and level of control the Trust has over these risk and mitigating controls. These risks are as follows:

- Risk 223: The Trust's inability to reach patients in the community causing patient harm and death
- 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

Based on the review of the two risks and discussions with the stakeholders, we have provided the following options for you to consider. The trust can decide to follow one option or implement elements from each option to reposition the risk more effectively.

- **Option 1: Dividing into external and internal causes and controls**

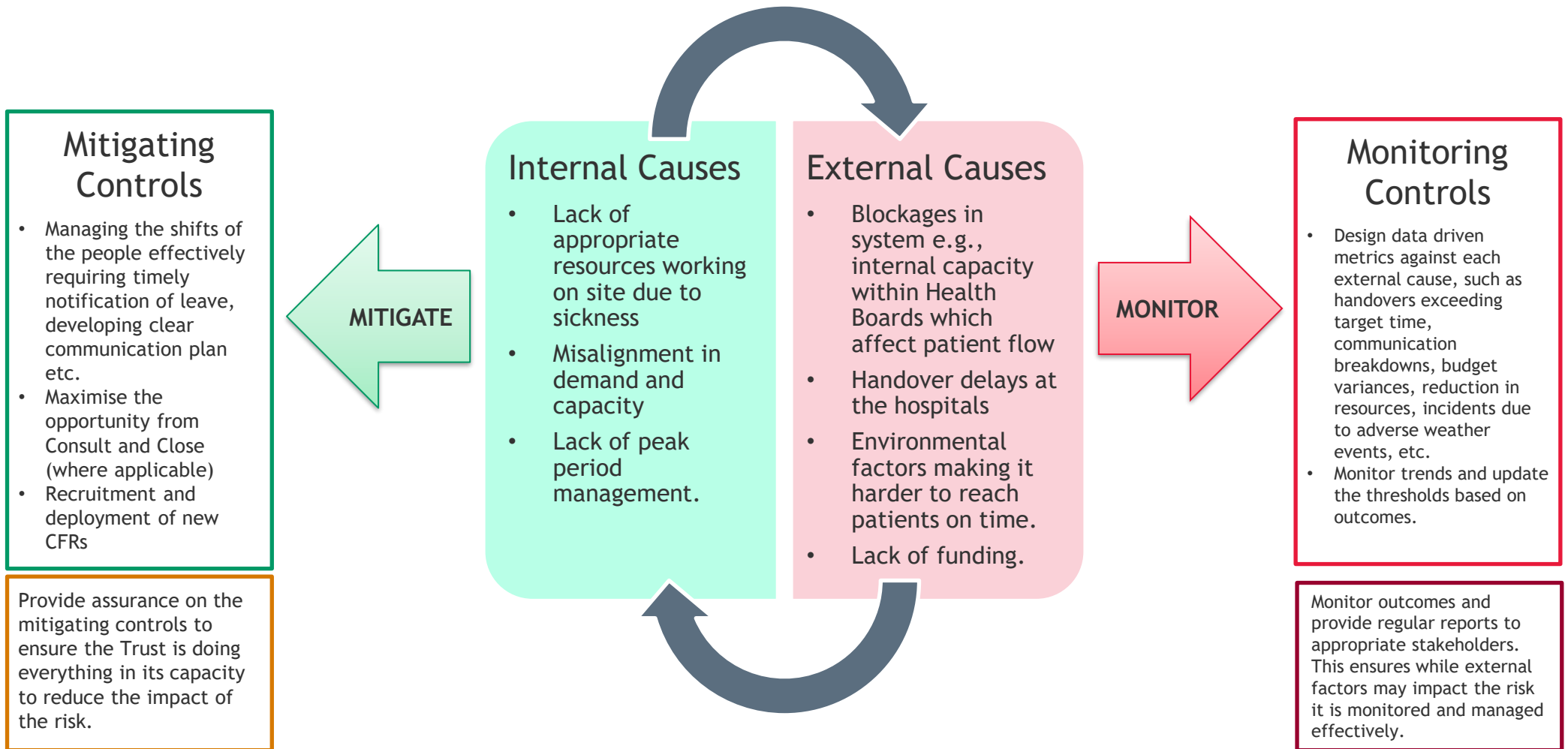
A common practice among organisations is to consider whether a risk has external causes (typically outside of the organisation's control) or internal causes (which can be more readily controlled and addressed). By repositioning risk in this way, the Trust is able to use an alternative lens for risk consideration and focus assurance and control efforts towards mitigating the risks within the control of the Trust in so far as practical and commercially possible. This means that the risk can have a high score, but assurances can be provided over the internal controls, i.e., efforts made by the risk and action owners and additional capacity added to reduce the impact. This approach also highlights if the implemented controls are aligning with the external factors affecting the risk score.

- **Option 2: Articulating risks to align to strategic objectives**

The risks can be articulated more clearly and be better aligned with the Trust's strategic objectives and operating model. This enables the Trust to better define the controls related to the risks and accept the level of risk which is outside of the Trust's control. While these risks are common to ambulance services, mitigations could be better aligned to your operating model. Articulating risks in line with the operating model will ensure that the focus of the Trust is on its strategic priorities.

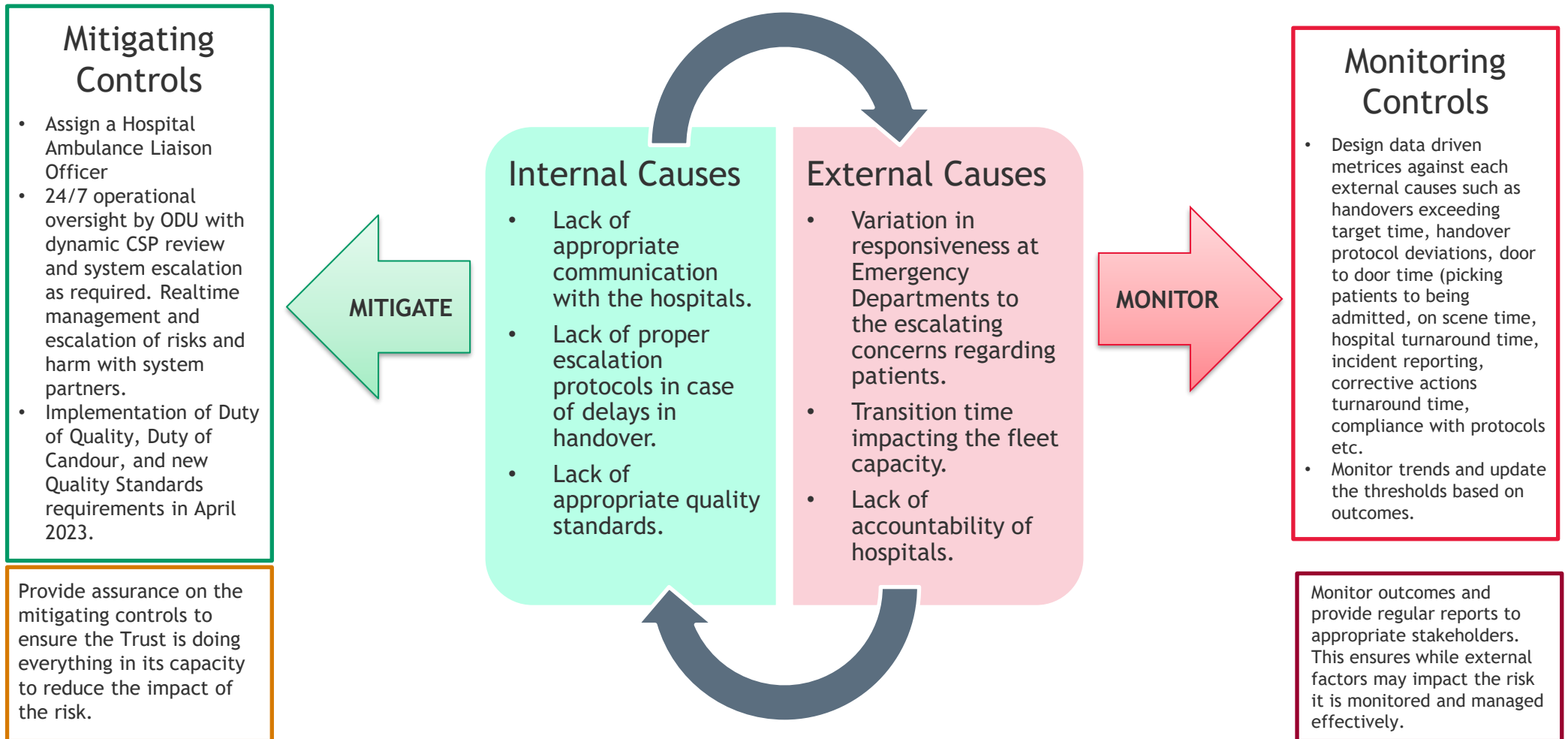
OPTION 1: DIVIDING INTO EXTERNAL AND INTERNAL CAUSES AND CONTROLS - RISK ID 223

The Trust's inability to reach patients in the community causing patient harm and death



OPTION 1: DIVIDING INTO EXTERNAL AND INTERNAL CAUSES AND CONTROLS - 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



OPTION 2: ARTICULATING RISKS TO ALIGN TO STRATEGIC OBJECTIVES - RISK ID 223

Strategic Objective	Providing right care or advice, in right place, every time.
Current Risk Narrative	The Trust's inability to reach patients in the community causing patient harm and death
Proposed Risk(s)	The trust may fail to consistently provide the appropriate level of care or advice in correct setting leading to compromise in patient safety, decreased patient satisfaction, potential legal and regulatory implications and reputational damage.

By repositioning the risk in proposed manner, the focus is to meet the strategic objective of the Trust. Inability to reach patients in the community becomes a factor which may impact the achievement of strategic objective; however, it will be driven by other factors as well, such as:

- Resources not available due to leave, sickness, etc.
- Misdiagnosis or inaccurate advice due to lack of appropriate training
- Communication breakdowns due to technical difficulties, delays in responses
- Lack of ambulances due to handover delays, road blockages etc.

This in combination with option 1 can provide appropriate control environment (both internal and external factors) and assurance to the Board on achievement of strategic objective. Whilst the risk may include an element of patient access which is outside the control of the Trust, the risk primarily deals with providing right care and advice, which sits more within the Trust's control and thus assurance can be achieved on the risk. This also provides opportunity to trust to design appropriate indicators and metrics to monitor the impact on the risk and movement of risk.

OPTION 2: ARTICULATING RISKS TO ALIGN TO STRATEGIC OBJECTIVES - RISK ID 224

Strategic Objective	Developing services in collaboration.
Current Risk Narrative	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
Proposed Risk(s)	The Trust may be unable to develop services due to insufficient collaboration with external stakeholders, resulting in misaligned service offerings, limited access to resources, decreased operational efficiency and potential gaps in emergency response capabilities.

Like risk 223, by repositioning this risk in proposed manner, the focus is to meet the strategic objective of the Trust. Handover becomes a factor which may impact the achievement of strategic objective; however, it will be driven by other factors as well such as:

- Lack of leadership support
- The culture within the organisation may not support collaboration
- Lack of appropriate allocation of resources such as trained people, budget etc.
- Lack of responses from the agencies such as hospitals, fire departments, police etc.

This in combination with option 1 can provide appropriate control environment (both internal and external factors) and assurance to the Board on achievement of strategic objective. Whilst the risk may include an elements which is outside the control of the Trust, the risk primarily deals with maintaining and enhancing collaboration, which sits more within the Trust's control and thus assurance can be achieved on the risk. The controls can focus on the efforts made by the Trust to maintain and develop services through collaboration. It also highlights the areas which hinder the collaboration.



APPENDIX

BAF EXAMPLE - FRONT SHEET

Strategic Objective:										
Lead Committee:										
Trend	Principal risks associated with the objective	Risk Appetite	Inherent Risk	Net Risk	Target Risk	Risk Owner	Assurance over 3 lines			Overall Assurance Score
							First Line	Second Line	Third Line	
	Risk 1:									
	Risk 2:									
	Risk 3:									

Lead Committee responsible for overseeing progress in delivering Strategic Objective

Front sheet should be created for each strategic objectives.

All risks associated with achievement of strategic objectives should be highlighted here

The assurance over the 3 lines (substantial, moderate, limited, none) should be highlighted here

Trend compared to last review (Increased, decreased, stable)

Risk Appetite (The acceptable risk) for each principal risk should be highlighted here (Averse → Eager)

The inherent, net and target score should be highlighted here based on risk assessment methodology

The risk owner responsible to bring the risk to acceptable level.

The overall score based on 3 lines should be highlighted here

BAF EXAMPLE - DETAILED VIEW

Trend compared to last review (Increased, decreased, stable)
 Overall Score - The net score of risk
 Overall assurance - Overall assurance of the risk based on control assurance

Highlight the strategic Objective and IMTP alignment to the risk. It is important to align each risk to strategic objectives.

STRATEGIC OBJECTIVE ALIGNMENT							
IMTP ALIGNMENT							
Risk ID	Risk Description:		Date of last review	Next Planned Review	Trend	Overall score	Overall assurance
	IF	THEN	RESULTING IN	Inherent	Likelihood	Consequence	Score
				Net			
				Target			
Existing Mitigations in place					Assurance over the lines		
	Control 1				First Line	Second Line	Third Line
	Control 2				Score	Score	Score
	Control 3				Description	Description	Description
					Score	Score	Score
					Description	Description	Description
					Score	Score	Score
					Description	Description	Description
Gaps in Controls					Gaps in Assurance		
	Actions Planned				Completion/ Milestone date	Action Owner	Progress Update
	Action Plan 1						
	Action Plan 2						
	Action Plan 3						

The risk description in IF, THEN and Resulting in format.

Risk score based on likelihood and consequence.

Highlight the current mitigations in place to achieve target risk score.

Score: The assurance over the 3 lines (substantial, moderate, limited, none) should be highlighted here
 Description: The assurances description (for each line) should be highlighted here.

Gaps identified in controls and assurances and the subsequent actions planned. Each action should have a milestone/ completion date assigned and progress update should be provided by the action owner.

BAF EXAMPLE

Example Risk Dashboard for Private Healthcare Organisation

RISK 1: QUALITY AND ASSURANCE - RISK DASHBOARD

RISK CATEGORY = Quality and assurance	RISK APPETITE	CLIENT'S RISK ASSESSMENT																																													
<p>Risk Event: Poor data quality may have adverse impact on planning, delivery and assurance</p> <p>Causes:</p> <ul style="list-style-type: none"> Multiple systems which are not interfaced to the spine Inadequate capacity, training and supervision of system users. Inconsistent or lack of ownership of information and service/department level <p>Consequences:</p> <ul style="list-style-type: none"> Efficiency Savings cannot be achieved/demonstrated Failure of service changes - inability to control costs In ability to develop future plans based on data and information that is not robust Inability to provide assurance internally and externally 	<p>Risk Appetite Rating: OPEN Risk Appetite Target: 17 "Acceptance for taking some risk (with appropriate mitigations where possible) where these decisions enhance curriculum planning and delivery."</p> <p>Gross Risk Assessment: 13 CLIENT's assessment of risk shows that the gross risk sits inside of the target risk appetite.</p> <p>Net Risk Assessment: 5 CLIENT's assessment of controls shows that the controls currently in place reduce the net risk to an acceptable level, lower than the Risk Appetite, reducing the impact by one point and the likelihood by one point.</p>	<table border="1"> <tr> <td rowspan="5">IMPACT</td> <td>5</td> <td>15</td> <td>19</td> <td>22</td> <td>24</td> <td>25</td> </tr> <tr> <td>4</td> <td>10</td> <td>14</td> <td>18</td> <td>21</td> <td>23</td> </tr> <tr> <td>3</td> <td>6</td> <td>9</td> <td>12</td> <td>17</td> <td>20</td> </tr> <tr> <td>2</td> <td>3</td> <td>5</td> <td>8</td> <td>12</td> <td>16</td> </tr> <tr> <td>1</td> <td>1</td> <td>2</td> <td>4</td> <td>7</td> <td>11</td> </tr> <tr> <td></td> <td></td> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> </tr> <tr> <td></td> <td></td> <td colspan="5">LIKELIHOOD</td> </tr> </table>	IMPACT	5	15	19	22	24	25	4	10	14	18	21	23	3	6	9	12	17	20	2	3	5	8	12	16	1	1	2	4	7	11			1	2	3	4	5			LIKELIHOOD				
IMPACT	5	15		19	22	24	25																																								
	4	10		14	18	21	23																																								
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	1	1	2	4	7	11																																									
		1	2	3	4	5																																									
		LIKELIHOOD																																													

CONTROL ASSESSMENT			ASSURANCE ASSESSMENT			
CONTROL STRENGTH REQUIRED	NONE 0%		ASSURANCE NEED (RELIANCE ON CONTROLS)	SUBSTANTIAL 62%		
KEY RISK MITIGATIONS	CONTROL STRENGTH		ASSURANCE ASSESSMENT			
	Likelihood	Impact	FIRST LINE OF ASSURANCE	SECOND LINE OF ASSURANCE	THIRD LINE OF ASSURANCE	
1	Service line management programmes	HIGH	LOW	SUBSTANTIAL	MODERATE	MODERATE
2	SLM Service plans	MEDIUM	LOW	SUBSTANTIAL	MODERATE	MODERATE
3	Strategic alignment discussions	MEDIUM	NONE	MODERATE	MODERATE	LIMITED
4	Regular reporting to the board	MEDIUM	LOW	SUBSTANTIAL	MODERATE	MODERATE
ACTUAL STRENGTH	MEDIUM	LOW	MODERATE	MODERATE	MODERATE	

CONCLUSION

CLIENT's analysis of risk and mitigations results in a movement from a gross risk (13), which is inside of the target balanced risk appetite (17), to a net score (5) within the risk appetite.

Our observation on this risk, following detailed discussions with the risk owner is that, although mitigations in place do reduce the likelihood by one point (medium strength), these may not reduce the impact by one point (low strength). As a result, the net risk score may not be at position 5 as per CLIENT's initial assessment, but in position 9.

As the risk appetite is set at 17 and the gross risk is established at 13, this suggests that the risk is sufficiently within appetite and would not require any further controls to be sufficiently mitigated. Therefore, it would not be the most effective use of resource to implement any further controls as the risk is already within appetite. We advise both the gross risk score and the risk appetite are re-evaluated. In this case, we would suggest that the gross risk likelihood and impact have been scored lower than they should be.

BAF EXAMPLE

Example Assurance Descriptions and Gaps for Private Healthcare Organisation

EXISTING RISK MITIGATIONS / CONTROLS	CURRENT CONTROL STRENGTH		THREE LINES OF DEFENCE ASSURANCES		
	Likelihood	Impact	FIRST LINE OF ASSURANCE - operational action owners	SECOND LINE OF ASSURANCE - corporate oversight	THIRD LINE OF ASSURANCE - independent assurance
5. POLICY UPDATES			MODERATE	MODERATE	MODERATE
<p>CLIENT responds to external policy updates and this feeds into the planning process. Many of these updates are annual, e.g., ESFA update regulatory requirements every year and CLIENT responds.</p> <p>CLIENT ensures that someone attends external organisation sessions for updates and then feeds back to the different teams/updates processes and policies. E.g. OTJT - 20% to 6 hrs, so updated processes and systems.</p> <p>Internally - QF is updated every year. Consult internally and approved by SLT</p>	MEDIUM	NONE	<ul style="list-style-type: none"> • Host of Quality related Policies and Procedures • Staff and student (where applicable) consultation and SLT approval • Policy Impact Assessment for staff and students 	<ul style="list-style-type: none"> • Quality related policies and procedures - Annually/bi-annually reviewed and approved by SLT • Relevant committees and meetings are informed of the information received from the external updates. Agreed actions and changes are implemented • IMPROVEMENT - Consistent action plan approach to action outcomes for external updates • GAP - Policy version history to have list of changes 	<ul style="list-style-type: none"> • When substantial changes are made by external organisations, key people in the organisation attend the updates and feedback • Awarding organisations audit Quality Assurance (including policies and procedures) on a yearly basis
6. INTERNAL REVIEW PROCESS			SUBSTANTIAL	SUBSTANTIAL	SUBSTANTIAL
<p>Every year CLIENT undertake a curriculum business planning (5 year plan) cycle, starting in October. This considers external impacts</p> <p>All the VPs go through this review and then refine it, and it is presented again in February. Questions such as; What do you do next year? How are you going to complete it (finance, resourcing)? Capital funding required? Resource required from qualified staff? Rooms? Regulations of awarding organisation? Are asked of the VP's.</p> <p>This process also looks at poorly performing courses to identify trends - root cause analysis and comparisons.</p> <p>Learning walks talk to students about delivery and staff.</p> <p>Ofsted also review this as part of their assessments (skills).</p>	HIGH	NONE	<ul style="list-style-type: none"> • Curriculum Intent Statements identifying how the curriculum meets needs: individual, local, regional and national • Departmental planning document (annual) • Business Planning - i.e. strategic and financial plans (annual) • Yearly self-assessment process at department, directorate and college level leading to an overarching Quality Improvement Plan - (clearly aligns to the strategic priorities) • Departmental Quality Improvement Plans regularly reviewed and updated - leading from the <u>self assessment</u> process and aligned to the College Quality Improvement Plan. • SUGGESTED IMPROVEMENT: A self assessment tool to track process and provide richer data in this area 	<ul style="list-style-type: none"> • Meetings with SLT for Curriculum and Business Planning (Annual) • Re-presentation in February of plans based on original planning meetings • Learning walks (3-5 a year) to review the curriculum delivery - i.e. Quality Assurance Framework 	<ul style="list-style-type: none"> • Ofsted curriculum intent, implementation & impact, as well as a skills review • Click associates to complete targeted work (where our vulnerabilities exist) • Work alongside other colleges to compare curriculum design and share good practice • College West Midlands and West Midlands Combined Authority collaboration and requirement alignment • Internal Audit on Quality Assurance • ESFA Meetings (termly) and feedback

BAF EXAMPLE

Example Dashboard for Hospitals Sussex

Board Assurance Framework (BAF) Control Template Quarter 3

Datix Ref.	Ref BAF	Risk Description	Exec lead	Trust Objective	Current risk Rating	Movement from Last Review	Lead Assurance Committee	Old BAF ref	Page of Report
Board of Directors									
Need new risk	1	Inability to implement effectively Trust strategic change plans	Chief Executive (Director Strategy & Change)	Clinical Strategy	16	↔	Board of Directors	11	4
1348	2	200 year old clinical infrastructure at RSCH and 75 years old infrastructure at HWP which is no longer fit for purpose. Failure to obtain approval FBC for 3t's development or delayed further will affect long term management.	Director Strategy & Change (Director of 3Ts)	Financial Targets Organisational and Board Development	15	↔	Board of Directors	1348	6
Need new risk	3	Challenging strategic environment prevents delivery of clinical strategy and long term clinical and financial sustainability	Chief Executive (Director Strategy & Change)	Clinical Strategy	12	↔	Board of Directors	1346	8
Finance and Workforce committee									
	4	Failure to support staff to deliver safe and high quality care because of poor uptake of appraisal and mandatory training.	Director Strategy & Change (Operational Director of HR) & Medical Director & Chief Nurse	Culture of Quality	16	↔	Finance and Workforce Committee		11

BAF EXAMPLE

Example Detailed Dashboard for Hospitals Sussex

Board Assurance Framework (BAF) Control Template Quarter 3

Datix Ref:	Objective	Clinical Strategy	Assurance Committee	Board of Directors		
Ref: 1 BAF 14/ 15	Risk Description	Inability to implement effectively Trust strategic change plans				
Cause (What might cause the risk to occur?)	<ul style="list-style-type: none"> Lack of management capacity Clinical and managerial consensus behind strategic choices Insufficient clinical and operational engagement Constraints in operational capital programme 					
Consequences (What are the possible consequences if the risk occurs?)	<ul style="list-style-type: none"> Failure to realise patient, clinical and financial benefits Loss of clinical confidence in change programmes Loss of Major Trauma status Organisational reputation Impact on revenue and capital budgets Loss of commissioner confidence Non-compliance with regulatory standards 					
Risk Owner	Chief Executive (Director of Strategy and Change)					
Initial Risk	Initial Impact 1. Insignificant 2. Minor 3. Moderate 4. Major 5. Extreme	4	Initial Likelihood 1. Rare 2. Unlikely 3. Possible 4. Likely 5. Almost certain	4	Initial Severity 16	High
Existing Controls (What existing processes / controls are in place to manage the risk?)	<ul style="list-style-type: none"> Programme Boards for EPR, 3Ts and Site Reconfiguration Governance and Assurance of Major Programmes Action plan for Booking Hub Programme risk management processes Detailed project plans Transformation Board 					
Current Risk	Current Impact 1. Insignificant 2. Minor 3. Moderate 4. Major 5. Extreme	4	Current Likelihood 1. Rare 2. Unlikely 3. Possible 4. Likely 5. Almost certain	4	Current Severity 16	High

BAF EXAMPLE

Example Detailed Risk Dashboard for Hospitals Sussex

Board Assurance Framework (BAF) Control Template Quarter 3

Action for Further Control (Summary)	Monitoring Method (Assurance)	Frequency	Action Owner	Effectiveness	Due Date / Complete
Approval of revised business case for EPR	EPR Programme Board	Monthly	Medical Director	Adequate	September 2014 (completed)
Implementation of Transformation Board as part of new executive management structure	Output of Transformation Board; Reporting to Clinical Management Board	Monthly	Chief Executive	Inadequate	December 2014
Development programme for leaders in new Clinical Structure	Development and delivery of programme	Monthly	Director of Strategy and Change	Adequate	September 2014 (in delivery)
Project mapping and prioritisation undertaken together with revised business planning process. Further work to be undertaken to revise decision-making and governance processes	Assurance process aligned with nature of projects	Monthly	Director of Strategy and Change	Inadequate	December 2014
Overall Assessment of Control Effectiveness (Adequacy of Control) - 1. Adequate, 2. Inadequate, 3. Uncontrolled 4. Outside Trust's ability to control			Inadequate		
Risk assigned to:	Chief Executive	Signed	Matthew Kershaw	Date	January 2015

To be agreed by Trust Board

Risk Appetite	Impact	4	Likelihood	2	Severity	8	Significant
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Justification for risk appetite: Need to implement and monitor effectiveness of key programmes and gain assurance that controls are adequate before the risk appetite can be reduced further.

BAF EXAMPLE - YORK HOSPITALS - DASHBOARD

Example Dashboard for York Hospitals

Goal	Strategic Risks	Original Risk Score	Residual Risk Score	Target Risk Score
Patient Care	1. Failure to maintain and improve patient safety and quality of care	25	25	6
Patient Care	2. Failure to maintain and transform services to ensure sustainability	20	20	6
Patient Care	3. Failure to meet national standards	25	20 ↔	1
Patient Care	4. Failure to maintain and develop the Trust's estate	25	16	9
Patient Care	5. Failure to develop, maintain/replace and secure IT systems impacting on security, functionality and clinical care	20	16 ₂ ↔	6
Workforce	6. Failure to ensure the Trust has the required number of staff with the right skills in the right location	25	20	9
Workforce	7. Failure to ensure a healthy, engaged and resilient workforce	20	16	6 ₁
Workforce	8. Failure to ensure there is engaged leadership and strong, effective succession planning systems in place	16	12 ↔	1
Finance	9. Failure to achieve the Trust's financial plan	25	9 ↔ ₊	6
Finance	10. Failure to develop and maintain engagement with partners	16	9 ↔	4
Finance	11. Failure to develop a trust wide environmental sustainability agenda	20	12 ₈ ↑	1
Finance	12. Failure to achieve the System's financial plan	25	9 ↔ ₊	6

BAF EXAMPLE

Example Detailed Risk Dashboard for York Hospitals

Strategic Goal: To deliver safe and high quality patient care as part of an integrated system Principal Risk: (1) Failure to maintain and improve patient safety and quality of care CRR Ref: MD 2a&b, 3, 4, 5, 6a&b, 7, 8, 10, 11 – CN 2, 7, 8, 17, 20 , 22, 23 , 24, 25, 26 – QOO 2, 3, 6, 7, 8, 17, 18, 19, 20, <u>23</u> – HR 1a&b, 4, 9, 15, 18 – CE 5a&b, 9 – DE1, 2 Lead Committee: Board (last formal review – Apr/Jun 20)(Jun 20 – Quality) Director Lead: Medical Director, Chief Nurse, Chief Operating Officer	Assurance Level		
	Original Risk Score	Residual Risk Score	Target Risk Score
	RAG Rating – 5x5	RAG Rating – 5x5	RAG Rating – 5x5
	Likelihood = 5 Severity= 5 Score: 25	Likelihood = 5 Severity= 5 Score: 25	Likelihood = 2 Severity= 3 Score: 6

Controls/Mitigation <small>(What controls/ responses we have in place to assist in securing delivery of our objectives)</small>	Assurance <small>(Where our controls/ systems on which we are placing reliance, are effective)</small>	Gaps in Control/ Assurance <small>(Where we are failing to put control/ systems in place)</small>
<ul style="list-style-type: none"> - Trust Committee/Governance Structure including <ul style="list-style-type: none"> o Assigned Director Portfolios, Structures & Teams o Ward to board nursing structures & teams o Patient Experience Steering Group o Safeguarding Children & Adults Teams & Internal & External Structures o Health & Safety Systems & Groups o Infection Prevention & Control meeting structures - Strategies, Policies & Procedures <ul style="list-style-type: none"> o Nursing and Midwifery Strategy, Patient Experience Strategy, Sign up to Safety Campaign pledges and Patient Safety Strategy. o Risk Management Framework o Performance Management Framework - Systems & Monitoring <ul style="list-style-type: none"> o Incident Reporting, SIs/Never Event Reports, Claims, Quality Priorities o CQUINs & contract monitoring o Recording of escalation systems NEWS etc o Medicines Management/EPMA implementation o National Surveys o NICE, NSF and Clinical Audit o Capital Programme o Maternity CNST 	<ul style="list-style-type: none"> - External inspections including CQC Reports - Internal Audit Programme - CQC and Choices website feedback - SHMI - National Survey Action Plans, Friends & Family Test - Premises Assurance Model, PLACE/TAPE Reports - Patient Experience Work Plan & Quarterly Reports - Quarterly Pressure Ulcer & Falls Reports - Mortality Reports – Learning from Deaths - IPC Quarterly Report & Annual Report - Patient Safety, Quality, Workforce, Finance and Performance Report to Board/Committees - Annual Complaints Report to Board - Quality Report - Patient Safety Walk Rounds - NICE, NSF and Clinical Audits/Effectiveness Reports - Safeguarding Children & Adult Reports to Board - Maternity Reports - Staffing Reports - Learning Hub Data - Health & Safety Reporting - 7 day audit – 7 day task & finish group & plan - Integrated Board Report 	<ul style="list-style-type: none"> - Implementation of 7 day working systems and controls <ul style="list-style-type: none"> - Jnr Drs Contract (National) - 2003 Consultants Contract does not facilitate 7 day working(National) - Mortality Reporting - Staffing Vacancies (CQC Report following unannounced visits – further CQC requests in Dec 19) - Infection Rates - Limited capital - Under performance against key national targets and standards - Safeguarding – specifically Adult MCA/DoLS - The potential risk of harm to patients in light of the issues raised by the CQC report/letters - Surge plan if social distancing ineffective - Critical care capacity – establishment of Nightingale Y&H facility – transfer of care

<p>ional performance meetings</p> <p>ings with each Care Group cheme signed off by MD and</p> <p>nted /DoLS – matrons audit sed by CQC ians (OPAMs) 19 actions logs EO led group</p> <p>Covid 19 returns for</p> <p>/audit- took place in Nov 19 place & no significant</p>	<ul style="list-style-type: none"> - Access & maintenance of adequate oxygen supply - Access to appropriate supply & distribution of PPE - Increased risk of secondary deaths due to services not being accessed - Possible increased risk to children & adults in community due to social distancing - Possible increased risk that some routine elements may be negatively impacted due to reduced reporting or staff absence <p>Actions (Identify plans to address gaps)</p> <ul style="list-style-type: none"> - Mortality – Team to support Medical Examiner also linked to PS & HCG Team restructure (Apr 20) - Staffing – East Coast Review looking at sustainability – CQC weekly monitoring continues (review Oct 20) - Infection Control - NHSE/I Lead Review & Report – HPV Business Case approved & machines on site (completed Jan 20) - Care Group improvement programmes & performance recovery plans developed by each Care Group (reviewed & updated monthly) - CQC Unannounced visit & Well Led responses and action plans (monthly monitoring at Board & Quality Committee) - MCA/DoLS action plans//audit- took place in Nov 19 with action plans now in place & no significant concern raised. - Safeguarding Team aware of risk to vulnerable adults & children – access to team for advice & support established during this period
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BAF EXAMPLE

Example Dashboard for Sheffield Teaching Hospitals

Version Control: January 2023 Issue


APPENDIX I

BAF SUMMARY DASHBOARD	Current Aggregated Assurance Rating	Current Risk Likelihood Rating
Strategic Risk 1: Quality of Care - Fail to provide compassionate, effective and safe patient centred care that delivers the best clinical outcomes	LIMITED	LIKELY
Strategic Risk 2: Partnership and Engagement - Fail to take a proactive role and engage effectively with partners to transform services and improve the health of the communities we serve	ADEQUATE	POSSIBLE
Strategic Risk 3: Workforce - Fail to ensure the Trust can recruit and retain the right people to deliver patient centred services and the best clinical outcomes	LIMITED	LIKELY
Strategic Risk 4: Finance - Fail to manage our finances effectively and deliver value for money to ensure the long-term sustainability of care provision	ADEQUATE	POSSIBLE
Strategic Risk 5: Infrastructure - Fail to implement appropriate, cost effective and innovative approaches to digital and estate infrastructure that support our aspirations today and for the future	LIMITED	POSSIBLE
Strategic Risk 6: Sustainability - Fail to identify and maximise sustainable ways to deliver the Trust's strategic aims and objectives	ADEQUATE	LIKELY
Strategic Risk 7: Research, Education and Innovation - Fail to ensure the Trust has the ability to deliver excellent research, education and innovation	LIMITED	LIKELY
Strategic Risk 8: Well-led - Fail to ensure appropriate and effective governance arrangements are in place that support the achievement of our Corporate Strategy (Making a Difference – The Next Chapter)	LIMITED	LIKELY

BAF EXAMPLE

Example Detailed Risk Dashboard for Sheffield Teaching Hospitals

STRATEGIC RISK OWNER COMMENTARY

	Strategic Risk 1: Quality of Care - Fail to provide compassionate, effective and safe patient centred care that delivers the best clinical outcomes	Current Risk Likelihood Rating: LIKELY	Current Assurance Rating: LIMITED
<p>The CQC report (December 2022) showed a significantly improved picture, with no concerns relating to the oversight of healthcare governance. It is therefore suggested that the assurance on Cause 1 [Inability to embed effective quality governance arrangements including learning from incidents / patient feedback] is changed from 'Limited' to 'Adequate' to reflect the improved position, while recognising the work in train to further strengthen this.</p> <p>Good progress is being made in Maternity services, as reflected in the improved CQC rating to Requires Improvement.</p> <p>As a result of dissatisfaction with the national pay award the RCN have called their members for strike action to be taken on 18 and 19 January 2023. This will result in a reduction of nursing staff to deliver patient services. During discussion at the People Committee on 12 December 2022, assurance was sought around the impact of Industrial Action and consideration requested in terms of reflecting this on the BAF. This update of the BAF addresses this request by reflecting this within the update of this Strategic Risk in the context of Cause 2 [Insufficient staffing resource] and includes controls and assurance in place.</p> <p>In terms of a broader narrative update, the Trust has submitted derogations to support delivery of critical patient services in addition to the nationally agreed derogations, strike action would impact on the Trusts ability to provide our full services to our patients. The Chartered Society of Physiotherapists have also balloted members and have a mandate for strike action. They have announced dates on 26 January and 9 February. STH has not yet received notice of strike action and we anticipate this will be 9 February. Other trade unions including the BMA and Hospital Consultants and Specialist Association are currently balloting their members for industrial action.</p> <p>A parent risk assessment has been completed for the impact of strike action on planning and delivering our services [Datix ID 4975] - this has a current risk score (post controls) of 12 and therefore is not reported on the Corporate Risk Register Report as an Extreme Risk.</p>			
Alignment of Extreme Operational Risks on the Corporate Risk Register Report			
Total number of Extreme Risks aligned		Number of Extreme Risks overdue for review	Number of Extreme Risks with actions overdue
27		9	9
Extreme Risks newly reported on the Corporate Risk Register Report <ul style="list-style-type: none"> [795] Glaucoma service: Deterioration / loss of vision due to a delay in clinic review and/or surgery [4132] Spinal injuries readmission backlogs due to lack of theatre capacity [5097] Rationing of in-line monitoring equipment for use in cardiopulmonary bypass circuits [5078] Harm to spinal patients due to reduced ability to meet patient access times 			

BAF EXAMPLE

Example Detailed Risk Dashboard for Sheffield Teaching Hospitals



BAF EXAMPLE

Example Detailed Risk Dashboard for Sheffield Teaching Hospitals

Aggregated Action Plan to address gap in control or assurance			
Action	Lead Exec	Deadline	Progress update
1	MD (Ops)	March 2023	Updated CQC report received in December 2022 which identified that 63 of the must and should do requirements were no longer applicable. There were no concerns identified in the new report on healthcare governance arrangements. The review of the Trust structure remains on track to strengthen existing arrangements, and a paper has gone to TEG. Maternity now rated Requires Improvement by CQC; advice from CQC is to consider applying for some of the conditions to be removed – this is being reviewed.
2	MD (Ops)	March 2023	An update or actions from action plan re
3	DHRSD	March 2023	A governance Track Progress workstreams Two Operativ Workforce wi our recruitme This supplm highlighting t recruit roles; Programme l employee en
4	COO / OID	February 2024	PCRPR Impror Each workstr Greenhouse stood down f embedded th

Controls and Assurances			
Controls		Assurance / Evidence	
For Cause 1: Inability to embed effective quality governance arrangements including learning from incidents / patient feedback		[where can we gain evidence that the controls we are placing reliance on are working]	
[system in place to help manage the cause / effect]		First Level	Second Level
		[Service delivery and day to day management – how do we know day to day that controls are working?]	[Independent challenge – has anyone external come in to check that the controls are working]
<ul style="list-style-type: none"> Quality Governance Policy / Framework for Delivery. Processes in place to review and learn from deaths including Medical Examiner system and Directorate Morbidity and Mortality meetings. Patient and Healthcare Governance Department in place to embed Quality Governance across the Trust. Mechanisms in place to support identification and sharing of themes and learning, (eg Safety and Risk Forum / Medical Director's Safety Message / Management Board Briefing). Clinical Effectiveness processes including Clinical Audit, NICE guidance compliance and Getting it Right First Time (GIRFT). Quality Governance Structure in place to provide oversight. Programme of external review / audit of quality governance arrangements. Development and application of Quest Dashboards. Processes in place to seek and receive patient feedback via multiple channels (eg surveys and complaints). Structures and processes in place for staff to raise or escalate issues. 	<ul style="list-style-type: none"> Directorate Governance Meetings review quality metrics. Structured Judgement Reviews reviewed at Morbidity and Morbidity meetings. Directorate Reviews co-ordinated by Director of Strategy and Planning. Serious incidents reviewed weekly by the Serious Incident (SI) Group with focus placed on overdue reports / actions. Quest Assessments reviewed by Nurse Directors Quality, Safety and Risk Dashboards monitored by Directorate Governance Teams. Patient feedback reviewed at Patient Experience Committee Clinical audit data and NICE compliance reviewed at the Clinical Effectiveness Committee. 	<ul style="list-style-type: none"> Quarterly Integrated Quality and Safety Report reviewed by Quality Committee / Board of Directors. Quarterly Learning from Deaths Reports to Quality Committee and Board of Directors. Outcome of Directorate Reviews reviewed by TEG. Incidents reported and closed reviewed by TEG. Live Quality, Safety and Risk Dashboard reviewed at Trust-level by Safety and Risk Committee. Trust Clinical Audit Programme reported to TEG through Annual Report. NICE Guidance Compliance reported to TEG through quarterly updates and Annual Report. Patient feedback reported to TEG, Quality Committee, and Board of Directors. 	<ul style="list-style-type: none"> December 2022 CQC Report including requires improvement rating for well-led. Healthcare Governance Review undertaken by external consultancy presented to Board of Directors (June 2022). Internal Audit: Directorate Risk Management - July 2021 (split opinion). Internal Audit: Patient Experience – Jan 2022 (split opinion) Internal Audit: Serious Incidents and Newer Event Actions (May 2021). Benchmarking of quality key performance indicators (KPIs) with other organisations / Model System / Public View Getting it Right First Time (GIRFT). Internal audit: NICE guidance – July 2022 (limited). AuditOne Well-led review report presented to Board (Dec 2022)
Control Lead: Medical Director (Operations)		Assurance Level: ADEQUATE ↑	
Gaps in Controls / Assurances		Actions to address gaps in controls / assurance	
Control Gap – Weakness in relation to the Healthcare Governance arrangements.		<ol style="list-style-type: none"> Delivery of CQC Action Plan including Maternity Services Improvement Programme Development and implementation of Action Plan to address agreed recommendations within Healthcare Governance Review undertaken by external consultancy. 	



For More Information

ALISA VOZNAYA

+44(0) 7436 417 715

Alisa.voznaya@bdo.co.uk

ISHANI SHARMA

+44(0) 7586 645 102

Ishani.Sharma@bdo.co.uk

JOB NUMBER

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Risk Management

Final Internal Audit Report

August 2024

Welsh Ambulance Services University NHS Trust

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Executive sign-off:	Trish Mills, Director of Corporate Governance/Board Secretary
Distribution:	Julie Boalch, Head of Risk/Deputy Board Secretary; Marinela Stoicheci, Risk Officer; Jonathan Sweet, Head of Service (Operations); Toni-Marie Norman, Business Manager (Operations); Jen Lloyd, Business Manager (Clinical Directorate)
Committee:	Audit and Risk Assurance 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.

Disclaimer notice - please note:



This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit and Risk Assurance Committee.

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Executive Summary

Report Opinion

		Trend
<p>Reasonable</p> 	<p>Some matters require management attention in control design or compliance.</p> <p>Low to moderate impact on residual risk exposure until resolved</p>	 <p>2022/23</p>

Assurance summary¹

Objectives	Assurance
1 Risk Management Policy	Reasonable
2 Risk identification and assessment	Reasonable
3 Risk management and evaluation	Reasonable
4 Risk monitoring and scrutiny	Reasonable

Purpose

To assess the effectiveness of the Risk Management and assurance arrangements in place within directorates.

Overview

We have issued reasonable assurance on this area.

Through our review of risk management arrangements at both Corporate and Directorate (Operations and Clinical (Paramedicine)) level, we have noted the continued development and delivery of the Trust's risk transformation programme.

Processes are in place for the recording and monitoring of risks throughout the Trust, however the audit trail for the management of local and directorate risks is not always available.

The matters requiring management attention include:

- Better demonstrate the impact of risks on the achievement of strategic / directorate objectives and priorities.
- Completion of risk assessments.
- Evidencing the management and review of risks at directorate and service level.
- Development of summary risk reports at both the directorate and service level.

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

Key Matters Arising

	Objective	Control Design or Operation	Recommendation Priority	
1	Impact of risks on the achievement of strategic & directorate objectives and priorities	2,3	Design	Medium
2	Completion of risk assessments at directorate and service level.	2,3	Operation	Medium
3	Risk register records maintained outside Datix	2,3	Operation	Medium
4	Evidencing risk review activity undertaken at directorate and service levels	2,3,4	Operation	Medium
5	Directorate and service level risk reporting	2,3,4	Design	Medium

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

1. Introduction

- 1.1 Effective risk management enhances strategic planning and prioritisation, assists with the achievement of objectives, and strengthens the ability to be agile to respond to challenges, and should be an integral part of all organisational activities to support decision-making.
- 1.2 The Board Assurance Framework (BAF) is designed to provide a structure and process that enables Welsh Ambulance Services University NHS Trust (the 'Trust') to focus on the risks that might compromise it achieving its strategic goals, which are set out in its Long-Term Strategy 'Delivering Excellence', and as part of its Integrated Medium-Term Plan (IMTP). In recent years work has been carried out to develop and improve the format and content of the BAF.
- 1.3 The Trust's Risk Management Transformation Programme has been designed to strengthen and positively impact the development of its future strategic ambitions, as highlighted in the 2023-26 IMTP. Areas of focus include the delivery of a risk management framework as a key enabler of its long-term strategy and decision making.
- 1.4 The Trust's principal risks are set out in its Corporate Risk Register (CRR) and on the BAF. These are reviewed and monitored by the Assistant Directors Leadership Team, the Executive Leadership Team, Board Committees, and the Board in accordance with the national risk review schedule. The Trust also operates directorate and local registers where risks are managed locally and, where necessary, are considered for escalation through the risk reporting structure for inclusion on the CRR. The Audit and Risk Assurance Committee retains oversight of the risk management process and framework.
- 1.5 In undertaking the review, we considered whether there were unintegrated and inconsistent approaches to identifying, assessment and monitoring of risks at both Directorate and Local level resulting in:
 - Ineffective and inefficient use of resources;
 - Failure to achieve strategic, operational, and financial objectives; and
 - Exposure to reputational damage and a negative impact on patients and staff.
- 1.6 As part of the review, we have considered the corporate arrangements as well as those of the sampled directorates of Operations and Clinical.

2. Detailed Audit Findings

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

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	--	2	-	2
Operating Effectiveness	-	3	-	3
Total	-	5	-	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: The Risk Management Policy and associated guidelines and procedures provide clear guidance to ensure that the system is robust and working effectively.

- 2.3 One of the deliverables underpinning the Trust's Risk Transformation Programme was to develop a Risk Management Policy and supporting procedures; and Board approval of the Risk Management Policy (the Policy) was evidenced in March 2024.
- 2.4 Included within the Policy is the approach to risk management within the Risk Management Framework, and details of the respective responsibilities for strategic and operational risk management for the Board and staff throughout the organisation. The Policy also outlines that risk management is an integral and positive part of the Trust's culture; and how it ensures the Trust meets its legal obligations in respect of risk management.
- 2.5 Section 3.6 of the Policy outlines how it aligns to the Trust's strategic objectives, which aligns to the ongoing wider piece of work around the development of the Trust's strategic BAF.
- 2.6 Supporting the Policy are the Corporate Governance Directorate Risk Management Guidelines ('the Guidelines'), which were developed and approved in October 2023. The purpose of these Guidelines is to support staff by providing a clear process to identify, describe, report, and monitor both new and existing directorate risks.
- 2.7 Included within the Guidelines are risk assessment forms, scoring matrices and frequency of review details. Additionally, the processes for treating, escalating, and closing risks are outlined.
- 2.8 A staff announcement has been circulated to communicate that the Policy has been approved. The Policy and supporting Guidelines are also available on SharePoint, and management advised that they intend to publish a further Corporate Governance Notice via Siren to continue to promote the framework for staff to use in managing risks.
- 2.9 Guidance on Interpreting the BAF was issued in April 2023.

- 2.10 The Audit Wales 2023 Structured Assessment stated that *'the Trust has reasonable arrangements for overseeing corporate risks, but it needs to reframe the BAF as a tool that brings together all relevant information on the risks to achieving strategic objectives.'* We note that the Trust has appointed an external consultant to support the progress of the Risk Transformation Programme, advising on best practice in areas such as the strategic BAF, risk appetite and exploring options for digitising the BAF. This work does not impact the operation of the existing BAF.
- 2.11 Engaging with the consultant will address the recommendation raised in our prior year audit report (issued July 2023, Reasonable Assurance), which stated that *'following the development of the risk appetite matrix, the Trust should develop and finalise its risk appetite statements'.*

Conclusion:

- 2.12 The Risk Management Policy and Corporate Governance Directorate Risk Management Guidelines have been approved and are operational at the Trust. The team intends to publish a Corporate Governance Notice to inform staff of these documents and to ensure implementation. Noting this and the ongoing work to develop the BAF and risk appetite statements, we assign this objective **reasonable** assurance.

Objective 2: Corporate and directorate level risks are appropriately identified and assessed.

- 2.13 The Trust's risk management process provides a structure for identifying and managing risks at all levels in the organisation. There are three tiers at which risks may be identified, managed, controlled, and monitored, these being:
- Tier 1 - Corporate
 - Tier 2 – Directorate
 - Tier 3 – Local: site or service / operational.
- 2.14 As outlined in the Guidelines a range of techniques can be used to identify risk, and this might include specific methods advised or delivered by the risk management and compliance functions.
- 2.15 The Guidelines further state that *'the main purpose of a risk assessment is to prioritise the organisation's most important risks. Risks should be assessed on the likelihood of the risk materialising and impact / consequence of its occurrence on Trust objectives. Controls and assurances in place to manage / mitigate the risk should also be considered.'*
- 2.16 We understand that a programme of developing new risks takes place outside of Datix (the All-Wales system for recording and monitoring risks) through the population of risk assessment forms that facilitate the *'if, then resulting in'* format. This acknowledges that the system does not have a section to outline the nature, level, and impact of the risk on strategic objectives. It is also acknowledged that the Trust does not perceive the system as being fit for purpose for their current direction of travel in risk.

Corporate Risks

- 2.17 The process for identifying and assessing corporate risks is embedded within the Trust. As stated in the Audit Wales 2023 Structured Assessment *'the Trust's BAF maps the organisation's corporate risks against the deliverables of its Integrated Medium-Term Plan (IMTP)'*. Corporate/Principal risks are usually identified at a directorate level initially or can be identified at a Board level; and are escalated to the Head of Risk / Deputy Board Secretary once they hit a score of 12, or above, for consideration at Assistant Director Leadership Team (ADLT); and subsequently Executive Leadership Team (ELT) for inclusion on the Corporate Risk Register (CRR).
- 2.18 For the purposes of this audit, risk assessment forms were requested for a sample of five risks on the CRR. We note that the Guidelines state that *'The Board defines as "high" any risk that has the potential to damage the organisation's objectives.'* We could confirm the completeness of the trail for inclusion on Datix but noted that the detail of the risk assessment forms didn't confirm the potential impact on the achievement of the Trust's strategic objectives and priorities. See **Matter Arising 1**.
- 2.19 We note that the ongoing work on the BAF as part of the Risk Transformation Programme with the Trust appointed external consultant will be key to this development.

Directorate and Local Risks

- 2.20 The Guidelines also state that *'each Directorate needs to identify operational and strategic risks through the completion of risk assessments and for ensuring that risk assessments are completed on an ongoing basis.'* As per para 1.6, risk management arrangements within two directorates have been reviewed during this audit – Operations and Clinical.
- 2.21 The Guidelines further state that *'All risks must be scored using the Trust's risk matrix.'* The Trust's risk matrix features on the risk assessment templates, and within Datix, to ensure consistency in approach. From review of the risk registers, all risks had been scored.

Directorate Risks - Operations

- 2.22 Directorate level risks are captured on the Operations Directorate risk register held on Datix. However, we are advised that at the time of audit, there are no risks currently at this level due to them either being escalated to the CRR or deescalated to local / service risk registers (refer to **audit objective 3** for further details on evaluation and management of risks).
- 2.23 Whilst there has been a restructure within Operations in 2021, we note that different processes at varying levels of maturity continue to operate at a local level in terms of risk management obligations, and identification and assessment of risks.
- 2.24 We were informed that emerging risks would be identified by an individual who would typically be the risk owner, who would add the details of the risk to the local

risk register / Datix as appropriate. A risk assessment is not completed, contrary to the Guidelines, as per para 2.20. See **Matter Arising 2**.

- 2.25 The risks are managed by risk owners that hold responsibility for escalating risks to the Senior Operations Team (SOT) as relevant. SOT supports the Senior Leadership Team (SLT) in the day-to-day leadership and management of the Operations Directorate.
- 2.26 Whilst the risk assessment forms were not completed, this process is being undertaken to an extent via the risk assessment section within Datix (which requires details including risk description / risk owner / RAG rating / score etc.) for four of the eight local risk registers: Integrated Care, Emergency Medical Services (EMS) Co-Ordination, Ambulance Care and Emergency Planning Risk and Resilience.
- 2.27 We are advised that completion of a risk assessment form would not be necessary for local or directorate risks. It was suggested that the risk be input straight onto Datix to avoid duplication. However, this is not confirmed at the Guidelines (see para 2.20). Furthermore, this deviation from practice may become problematic for those risk registers held outside of Datix where the information is less consistent and complete (see para 2.28).
- 2.28 A further four local risk registers are in place for EMS Response, covering the localities. These are held within separate Excel spreadsheets outside of Datix (See para 2.41). At our 2021/22 report we recommended that *'the Trust consider the issues identified above regarding risk management occurring outside of Datix and develop guidance to support the escalation criteria and processes which can be implemented across the organisation'*. Review of the internal audit recommendation tracker confirms that such was closed given the Guidelines, required, had been developed. However, risk registers are still held outside of Datix but we do acknowledge that the availability of resourcing, within the Risk team, to support the use of recording local and directorate risks is limited. See **Matter Arising 3**.

Directorate Risks - Clinical

- 2.29 We understand that emerging risks would be identified by a Lead (usually a clinician) / Manager / Project Manager. They would become the risk owner and bring to the attention of the Business Manager, who manages the Clinical Directorate Risk Register on Datix. A meeting will then be held between the Business Manager and the risk owner to evaluate and assess the risk.
- 2.30 Review of the current open risks for this directorate (at the date of fieldwork, 12 directorate and three local) noted that, contrary to the requirements of the Guidelines, no risk assessment forms had been completed. See **Matter Arising 2**. Similarly to the process outlined at para 2.26 above, reliance is instead placed on the risk assessment section of Datix to assess, evaluate and complete risk details.
- 2.31 All Clinical risks were captured on Datix for ongoing monitoring and management at both local and directorate level. We note that Datix entries require updating to align with the information at the risk reports, which outline details of 'open'

directorate and local level risks – see para 2.51 and **Matter Arising 4**. We also noted that the volume of risks within this directorate was manageable, with deep dive reviews focusing on three risks being undertaken monthly at the Clinical Directorate Business Meetings (for further details, refer to **audit objective 3**).

Conclusion:

2.32 Although the Trust risk management process is well established, inconsistencies were noted in the application of the Guidelines in relation to the completion of risk assessment forms for local and directorate risks and the recording and scoring of these on Datix. However, we do note that there are appropriate mitigating actions in place, including the capture of risks at local risk registers. Accordingly, we have assessed a **reasonable** level of assurance for this objective.

Objective 3: There is appropriate management and evaluation of corporate and directorate level risks identified (e.g. risk score, mitigating actions, target dates, responsible owners, escalation / de-escalation and impact on strategic objectives).

2.33 As noted in 2.13 above, there are 3 Tiers at which risks may be identified, managed, controlled, and monitored. Risks within the Datix Risk Registers are categorised (type) and managed as below:



Corporate/Principal Risks

2.34 The Trust's principal and strategic risks are set out in its CRR. Entries are assigned a lead Executive for ownership, and each is also assigned to a specific Committee for oversight and assurance.

2.35 Corporate/principal risks are monitored and reviewed at the monthly ADLT (for risks that should potentially be escalated to the CRR) and ELT meetings (to monitor

and manage risks on the CRR), ahead of presentation to the Board and Committee structures. Frequency of review varies in line with scores applied to risks, with higher scoring risks subjected to review more frequently, including deep dives where applicable, and in accordance with the risk review schedule.

- 2.36 Discussions around risk score (including changes to the score), mitigating actions, target dates, risk owners, potential for escalation or de-escalation and impact on strategic objectives are discussed at these meetings, with updates clearly highlighted.
- 2.37 Any issues discussed at ELT are fed back to the ADLT group to ensure a complete audit trail. ELT ultimately determine if a risk should be included on the CRR. It is also the deciding body should a risk need to be de-escalated to the directorate risk register.

Directorate and Local Risks

- 2.38 Directorates are responsible for managing both their directorate and local risks and escalating to the Head of Risk / Deputy Board Secretary for inclusion on the CRR as per para 2.17.
- 2.39 We were informed that risks are considered for escalation when it is known it spans several directorates or is a high-level risk, scoring 12 and above. The Business Manager or Risk Owner escalates these risks to the Head of Risk / Deputy Board Secretary, who also intends to review the top Directorate risks on a quarterly basis although we note that capacity has prevented the achievement of this more recently.

Operations Risk Register

- 2.40 There are no 'open' or 'active' risks within the Directorate risk register at present (see 2.22). However, Datix requires updating to reflect this position noting that several outdated directorate level risks were recorded as 'open' at the time of audit. See **Matter Arising 4**.
- 2.41 Currently there are eight local risk registers, four of which (those covering the localities) are being maintained in individual excel spreadsheets rather than centrally within Datix, as reported in our 2021/22 report. We found that these risk registers did not mirror the information that would be included on Datix (e.g. they did not have review or target dates to facilitate regular review, including ensuring that the mitigating actions are up to date). See **Matter Arising 3**.
- 2.42 In addition, the information held on Datix does not accurately capture the latest position in relation to risks, reflecting changes made by the relevant risk owners. For example, the table in **Appendix B** highlights that a significant number of risks had missed their target and review dates. However, we acknowledge that the review date field on Datix is not updated automatically post a risk review having taken place. We were also unable to confirm that risks were being reviewed in line with required frequencies. Accordingly, oversight by Senior Leaders may be difficult. See **Matter Arising 3**.

-
- 2.43 We acknowledge that Operations is a complex area noting it covers numerous territories and functional areas. Historically individual areas have undertaken risk management arrangements in isolation. However, since the Operations Governance structure has been established, monthly, structured Business Management Team meetings are taking place, to facilitate appropriate review and escalation of local level risks in a consistent manner. See **objective 4** for further details on monitoring and escalation of risks.
- 2.44 We note that the Directorate is planning a large data cleansing exercise of all local level risks at SOT (targeted end May 2024) to gain assurance that risks have been accurately identified, are still relevant and to eliminate duplicate risks. Datix will then be updated accordingly, allowing for risks to be monitored centrally. Senior leaders will also gain access to emerging risks locally, should the need arise. We are advised that it will also be determined whether the eight local risk registers could be consolidated into one register.
- 2.45 Noting that the information on Datix and the local risk registers was not up to date and recognising that the detail captured at **Appendix B** was not readily available, we had to seek further clarification to confirm the total number of risks and their status. It would therefore be beneficial to develop summary risk reports / enhance the level of information presented within existing reports at local and directorate level, similar to the format presented at Board and Committees. See **Matter Arising 5**. We are advised that this level of reporting is planned to follow the cleansing exercise at the end of May 2024.
- 2.46 Noting that risk assessment forms have not been used consistently, and noting that completion of information on Datix may be inconsistent by users, there may be some training needs which need to be considered within the Directorate. See **Matter Arising 2**.
- Clinical Risk Register
- 2.47 As noted at para 2.29, at the date of fieldwork, risk assessment forms were not completed for directorate or local risks within the Clinical Directorate. See **Matter Arising 2**. However, upon identification of directorate and local risks, relevant information is uploaded directly onto Datix.
- 2.48 As per para 2.43, review of the risk register on Datix demonstrated that the information held on the system was outdated. Similarly to the Operations Directorate, a significant number of risks appear to have missed their target and review dates, and we cannot confirm that other information such as mitigating actions does not require further review - see **Appendix B** and **Matter Arising 4**.
- 2.49 We were also unable to confirm that risks were being reviewed in line with required frequencies. Three of the twelve risks on the Directorate risk register had a high score which should be reviewed monthly, and seven of the risks with moderate scores should be reviewed quarterly, in line with the Guidelines. (Lower scoring risks may be reviewed bi-annually). However, it was difficult to gain assurances that this was completed from the information on Datix and the action and decision logs from the business meetings. See **Matter Arising 4**.
-

-
- 2.50 Whilst we recognise that risks are regularly reviewed, discussed and evaluated at the monthly Clinical Directorate Business meetings (see **objective 4** below for further details on monitoring and escalation of risks), there is a need for Datix to be updated to reflect the discussions held. See **Matter Arising 4**.
- 2.51 Similarly to 2.45 above, we considered it would be beneficial to enhance the summary risk report that has been developed by the Directorate (see **objective 4** below). See **Matter Arising 5**.
- 2.52 We also recognise the importance of the ongoing work to define the risk appetite statements is key to address these areas moving forwards.

Conclusion:

- 2.53 Review of Datix noted that there is demonstrable, active management of risks at the corporate level. There are issues evidencing the management of risks at a directorate level, with Datix not being updated to reflect reviews undertaken. However, recognising that risk activity is regularly discussed at directorate and local levels, and there are plans in place to review the arrangements supporting the consistency and completeness of risks through a cleansing exercise, we assign this objective **reasonable** assurance.

Objective 4: Risks are actively monitored and scrutinised at an appropriate level within the Directorates.

- 2.54 Local and directorate level risks are assigned a lead for ownership and the risk is assigned to a relevant Group (Business Management Team / SOT) for oversight and assurance.

Operations Directorate

- 2.55 Individual risks are discussed at the weekly SOT and SLT meetings and Alert, Advise, Assure (AAA) highlight reports are issued following the formal meetings.
- 2.56 The Directorate risk register is included at the weekly SOT meetings. However, we note that at the time of audit, there are no 'open' risks at this level currently (since October and November 2023 - although Datix requires updating to reflect this position).
- 2.57 Corporate risks relating to the Operations Directorate are also reviewed at the weekly SLT meetings. The SOT supports the directorate's SLT and has the role of reviewing the Directorate risk register and relevant risks held on the CRR (including controls and mitigating actions), escalating to SLT as required. Membership of SOT includes heads of service alongside resourcing, finance, quality improvement, clinical lead and the Operations Directorate Business Managers.
- 2.58 Operations is an agenda item at ADLT. An AAA highlight report is also prepared for discussion beyond the Directorate at ELT, to consider the escalation of risks for inclusion at the CRR. Recent examples of the escalation process in operation can be evidenced via two new risks in development relating to the governance around the volunteers in the volunteering sector, and staff retention within EMS

Coordination (and the ability to put sufficient capacity in call handling environments in particular).

- 2.59 As per para 2.41, there are currently eight local risk registers in place, which are reviewed at the monthly Business Management Team meeting led by the Business Manager (Operations).
- 2.60 An AAA Highlight report is published following each Business Management Team meeting. Where a risk scores sufficiently highly it is the risk owners' responsibility through the Business Management Team Meeting structure to highlight this. All risks requiring review for escalation, would feature in the AAA Report for onward consideration by the SOT.
- 2.61 Further to 2.45 above, we consider the development of a risk report summarising the risks held within each local risk register, capturing further details and status updates, similar to the format presented at Board and Committees, would enhance monitoring arrangements at this level. See **Matter Arising 5**. We are advised that this level of reporting is planned to follow the cleansing exercise at the end of May 2024.

Clinical Directorate

- 2.62 The Directorate risk register includes corporate, directorate and local risks, held centrally on Datix.
- 2.63 Local and directorate risks are discussed at the monthly Clinical Directorate Business meetings, and noted in the action / decision logs, with deep dives being undertaken on three risks per meeting (usually prioritised by longest outstanding risks, or those with highest priority) to ensure effective monitoring of the risks.
- 2.64 Action / decision logs and Summary Risk Management Reports support the operation of the Business meetings (which are not formally minuted). These capture discussions on risk and include recommendations for risks that may require escalating / deescalating.
- 2.65 A summary risk report is then provided which includes updates such as closed, transferred or escalated risks for ongoing monitoring within the Clinical Directorate.
- 2.66 Recent examples of the process in operation can be evidenced via the May 2024 Summary Risk Management Report, where it was noted that the team discussed risks 581 (Delivery of Clinical Directorate BAU) and 535 (Deterioration in Clinical Indicator Performance following transition from Digital Pen to Electronic Patient Clinical Record (EPCR)).
- 2.67 Similarly to para 2.61, we have recommended enhancements to the summary report to better evidence risk review activity. See **Matter Arising 5**.

Conclusion:

- 2.68 Risks are actively monitored and scrutinised at an appropriate level within the directorates reviewed, however we have identified risks and associated mitigating actions that appear overdue for review and have passed their target dates. The recording of some local risks within the Operations Directorate outside of Datix

could prevent effective oversight, but we note that plans are in place to review such and record appropriately. The development of a summary highlight report for directorate and local level risks, similar to the format currently presented at Board and Committee level, would enhance and better evidence risk review activity. Accordingly, we assign this objective **reasonable** assurance.

Appendix A: Management Action Plan

Matter Arising 1: Impact of risks on the achievement of strategic and directorate objectives and priorities (Design)		Impact
<p>As outlined in the Risk Management Guidelines a range of techniques can be used to identify risk, and this might include specific methods advised or delivered by the risk management and compliance functions.</p> <p>The Guidelines further state that <i>'the main purpose of a risk assessment is to prioritise the organisation's most important risks. Risks should be assessed on the likelihood of the risk materialising and impact / consequence of its occurrence on Trust objectives. Controls and assurances in place to manage / mitigate the risk should also be considered.'</i></p> <p>Review of the risk assessment forms developed by the Trust, that facilitate the <i>'if, then resulting in'</i> format, identified that they could be enhanced to capture the objectives and priorities that are impacted.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> Lack of consideration of potential impact on strategic and directorate objectives and priorities, which may jeopardise their achievement.
Recommendations		Priority
1.1	The Trust should consider amending the risk assessment form to capture the strategic and directorate objectives and priorities impacted by each risk.	Medium
Agreed Management Action		Target Date
1.1	<p>The RAF and BAF already have sections to capture the strategic objectives, however there was a timing issue with the new IMTP to facilitate the inclusion of such. These will be included going forward.</p> <p>At this stage of the risk management maturity at the Trust we will not include the directorate objectives and priorities impacted by each risk but is something we can look to do when we have an appropriate electronic risk management system.</p>	30 August 2024
		Responsible Officer
		Head of Risk

Matter Arising 2: Completion of risk assessments at directorate and service level (Operation)		Impact	
<p>Our audit identified that the risk assessment form developed by the Trust is not being completed for directorate and service level risks.</p> <p>The Risk Management Guidelines state <i>each Directorate needs to identify operational and strategic risks through the completion of risk assessments and for ensuring that risk assessments are completed on an ongoing basis.</i></p> <p>Whilst reliance is placed on this process being undertaken, in some instances, via the risk assessment section within the Datix system (which requires details including risk description / risk owner / RAG rating / score etc.), the system does not capture the full level of detail required.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> Inconsistent approach to assessment of risks. 	
Recommendations		Priority	
2.1	Risk assessment forms should be completed for all risks.	Medium	
2.2	User / training requirements needed to support managers / risk owners through this transition should be considered to ensure that individuals feel competent to complete risk assessment forms and upload the information onto Datix.	Medium	
Agreed Management Action		Target Date	Responsible Officer
2.1	It may be that risk assessment forms do not need to be completed for all risks if they are developed directly on Datix. However, a siren notice will be issued to remind colleagues of the correct templates to use, support available and direct them to the risk management framework; and the narrative included in the Risk Management Guidelines will be updated accordingly too.	30 August 2024	Head of Risk

2.2	Resourcing for the risk team is limited at this time, therefore the full programme of training and education will be in line with the risk transformation programme. However, the Corporate Governance Directorate will develop a virtual roadshow to senior directorate meetings and ADLT to provide information and signposting on risk management (as well as audit, policy, FOIs etc).	31 March 2025	Head of Risk
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Matter Arising 3: Risk register records maintained outside Datix (Operation)		Impact
<p>Four local risk registers are in place for EMS Response, covering the localities. These are held within separate Excel spreadsheets outside of Datix. At our 2021/22 report we recommended that 'the Trust consider the issues identified above regarding risk management occurring outside of Datix and develop guidance to support the escalation criteria and processes which can be implemented across the organisation'. Review of the internal audit recommendation tracker confirms that such was closed given the Guidelines, required, had been developed. However, risk registers are still held outside of Datix but we do acknowledge that the availability of resourcing, within the Risk team, to support the use of recording risks is limited.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> Inconsistent monitoring, management, and escalation of risks within the Trust.
Recommendations		Priority
3.1	All risks should be uploaded and managed on Datix.	Medium
Agreed Management Action		Target Date
3.1	<p>Datix is not currently fit for purpose. Therefore, agreeing that all risks should be uploaded and managed on Datix is not possible at this time.</p> <p>What is accepted is that there should be an agreed approach within local and directorate risk registers i.e. either all on Datix and managed there with appropriate reporting, or outside of Datix with an audit trail of identification, development, review, escalation, and closure.</p> <p>Resourcing in the risk team currently is challenging and it is therefore impossible in a timely way to agree to this recommendation. Propose that the MA related to the EMS local risk register is dealt with in action 4.1 with SOT and that the recommendation that all risks are uploaded and managed on Datix is deferred until such time as a way forward is agreed on whether changes will be made to Datix on an All-Wales basis, or whether Health Boards and Trusts will be procuring their own solutions.</p>	31 January 2025
		Responsible Officer
		Head of Risk

Matter Arising 4: Evidencing risk review activity undertaken at the directorate and service level (Operation)	Impact
<p>There are no 'open' or 'active' risks within the Operations Directorate risk register at present. A review of the Directorate risk register identified that at the time of audit, Datix required updating to reflect this position noting that several outdated directorate level risks were recorded as 'open' which is an audit trail issue.</p> <p>Currently there are eight local risk registers in the Operations Directorate. However, the information held was not accurate and required updating. A significant number of risks had missed their target and review dates. In summary (see Appendix B):</p> <ul style="list-style-type: none"> • A total of 55 risks were included on the Emergency Plan Risk and Resilience, 111 (Integrated Care), EMS Co-Ordination and Ambulance Care local risk registers: <ul style="list-style-type: none"> ○ 47 of 55 risks were noted as past their target date; and ○ 46 of 55 risks were noted as past their 'next review date'. • A total of 38 risks were included on the EMS Response locality risk registers. No target or review dates were included for these risks. <p>A review of the Clinical Directorate and local risk register on Datix also identified that the information held was outdated. In summary (see Appendix B):</p> <ul style="list-style-type: none"> • A total of 12 risks were open on the Directorate Risk Register: <ul style="list-style-type: none"> ○ 9 of 12 risks were noted as past their target date; and • 12 of 12 risks were noted as past their 'next review date'. A total of 3 risks were currently open on the Local Risk Register: <p>We were also unable to confirm that risks and associated mitigating actions are being reviewed in line with required frequencies. Whilst we recognise that risks are regularly reviewed, discussed and evaluated at the monthly Business meetings, there is a need for Datix to be updated to reflect the discussions held.</p>	<p>Potential risk of:</p> <ul style="list-style-type: none"> • Inconsistent monitoring, management, and escalation of risks within the Trust.

Recommendation		Priority
4.1	We recommend the Trust consider arrangements to support the consistency and monitor the completeness of directorate registers.	Medium
Agreed Management Action		Responsible Officer
4.1	<p>The risk team will work with the clinical and operations team with respect to the risks set out here particularly and either develop a plan to manage these risks externally to Datix but with an appropriate audit trail whilst an electronic risk management system is procured, or to use Datix for the capture of the operations and clinical risks with appropriate and user-friendly reporting for their purposes. This will be evidenced by a record of this being agreed by SOT and the appropriate clinical directorate meeting.</p> <p>The data cleansing exercise to be undertaken by the Operations Directorate, as referenced at para 2.45, will also assist in managing the accuracy of the risk register.</p>	<p>Target Date: 31 October 2024</p> <p>Responsible Officer: Head of Risk</p>

Matter Arising 5: Directorate and service level risk reporting (Design)		Impact	
<p>Noting that the information on Datix and the local risk registers are not kept up to date and recognising that the detail captured at Appendix B is not readily available, we had to seek further clarification to confirm the total number of risks and their status. It would therefore be beneficial to develop summary risk reports at service and directorate level, similar to the format presented at Board and Committees, to improve and enhance monitoring arrangements at this level. The report could capture changes to the risk (e.g. description / score / escalation / mitigating actions etc.) as well as an update of those risks that are past their target and review dates.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> Inconsistent monitoring, management, and escalation of risks within the Trust. 	
Recommendation		Priority	
5.1	<p>A summary risk report, similar to the format presented at Trust Board and Committees, should be developed and reported at directorate and service level.</p>	<p>Medium</p>	
Agreed Management Action		Target Date	Responsible Officer
5.1	<ol style="list-style-type: none"> It is accepted that an appropriate overarching risk report is beneficial for local and directorate risks, however the risk team will look at what reporting can be drawn from Datix currently, noting the limitations it has. This management action is closely aligned to the work that the team will do for action 4.1. Operations are developing a dashboard to be reported to SOT which highlights the total number of risks, how many risks at each level, review compliance (% in-date and overdue), and requesting all risks be reviewed so that any no longer relevant can be closed or replaced as appropriate, and up-to-date mitigation (controls and treatments) are recorded for any which are still applicable and need to remain open. 	31 October 2024	<ol style="list-style-type: none"> Head of Risk Deputy Business Manager

Appendix B: Local and Directorate Risk Totals

	Name of Risk Register	Format	No. of Open Risks	No. of Risk Assessments Completed	No. of High Risks	No. of Medium Risks	No. of Low / Very Low Risks	No. past Review Dates	No. past Target Dates
Operations Directorate									
1	*Directorate Risk Register	Datix	0	0/0	0/0	0/0	0/0	0/0	0/0
2	Emergency Plan Risk and Resilience	Datix	21	0/21	0/21	6/21	15/21	21/21	21/21
3	111 (Integrated Care)	Datix	13	0/13	1/13	8/13	4/13	8/13	6/13
4	EMS Co-Ordination	Datix	9	0/9	1/9	5/9	3/9	5/9	8/9
5	Ambulance Care	Datix	12	0/12	0/12	9/12	3/12	12/12	12/12
6	Ems Response - BCU	Excel	19	0/20	5/20	12/20	3/20	No review date recorded	No target date recorded
7	EMS Response - South Central	Excel	7	0/7	2/7	5/7	0/7	No review date recorded	No target date recorded

	Name of Risk Register	Format	No. of Open Risks	No. of Risk Assessments Completed	No. of High Risks	No. of Medium Risks	No. of Low / Very Low Risks	No. past Review Dates	No. past Target Dates
8	EMS Response - Central	Excel	5	0/5	1/5	3/5	1/5	No review date recorded	No target date recorded
9	EMS Response – South East	Excel	7	0/7	2/7	5/7	0/7	No review date recorded	No target date recorded
Clinical Directorate									
1	Directorate Risk Register	Datix	12	0/12	2/12	7/12	3/12	12/12	9/12
2	Local Risk Register	Datix	3	0/3	0/3	1/3	2/3	3/3	3/3




*There are currently no ‘active’ risks on the Operations Directorate Risk Register.

Note - One of the Clinical (Paramedicine) risks had no rating as it was decided that this risk should be escalated to the Corporate Risk Register (Emerging Risk Advanced Paramedic Practitioner).

Appendix C: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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



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CYMRU
NHS
WALES

Partneriaeth
Cydwasaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services
Partnership
Audit and Assurance Services

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership](#)



AGENDA ITEM No	09
OPEN or CLOSED	OPEN
No of ANNEXES	2

AUDIT TRACKER 2.0 – JUNE 2024 (Q1)

MEETING	Audit, Risk and Assurance Committee
DATE	12 September 2024
EXECUTIVE	Trish Mills, Director of Corporate Governance/Board Secretary
AUTHOR	Trish Mills, Director of Corporate Governance/Board Secretary Alex Payne, Corporate Governance Manager
CONTACT	trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. This paper provides the Audit, Risk and Assurance Committee (ARAC) 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 good engagement with Directorates on the revised Tracker 2.0 for quarter one, with the result that of the total of 144 internal audit actions on the Tracker, 36 have been closed in quarter. This is a closure figure of 25% of all internal audit actions. Progress has been particularly good with actions assigned to the Quality, Safety and Patient Experience Committee.
3. Of the total internal audit actions, 45 of the 144 actions have been given proposed revised dates in Quarter (31% of the total) and there are five actions on their third revised date (3%). This latter figure includes one action – reference 567 – which is on its third revised date and is yet to be completed. There is further detail on this action in the paper.
4. Of the total external audit actions eight of the 22 have been closed in quarter (36%); seven (31%) have been given a proposed date in quarter, and one action is on its third revised date (reference 106a).
5. Of the six internal audit actions where the ARAC is the owning Committee, none of the actions have been closed in quarter. Of these, four have been given revised dates in quarter; none are on a third revised date.



6. Of those external audit actions where the ARAC is the owning Committee, one of the three actions has been closed in quarter (33%). The remaining two actions – which relate to the 2023 Structured Assessment – have been given revised dates in quarter.
7. 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

8. 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, closed off in quarter or clarity provided on dates which have moved and rationale;
 - (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: -
 - o Internal Audit: Volunteer Governance (noting this was discussed at the People and Culture Committee on 30 August 2024);
 - o Internal Audit: Disciplinary Case Management (noting this was discussed at the People and Culture Committee on 30 August 2024);
 - o Internal Audit: Risk Management.

KEY ISSUES/IMPLICATIONS

As set out above.

REPORT APPROVAL ROUTE

Tracker presented to ADLT at a meeting in July 2024.

REPORT APPENDICIES

Annex 1 – Tracker 2.0 –April - June 2024 for Committee Reporting – ARAC Actions
Annex 2 - Tracker 2.0 –April - June 2024 for Committee Reporting – Full Tracker



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

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

9. 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

10. In September 2023 the Audit Committee approved the Audit Process and Reporting Handbook. The Handbook has been further revised since this date to include Audit Wales content.
11. The Handbook includes roles and responsibilities for the various stakeholders including:
 - The Assistant Directors Leadership Team (ADLT) as the forum to agree closure of actions, taking a check and challenge role on the Tracker.
 - Different reporting for the Audit Committee and Executive Leadership Team (ELT) to that provided to Committees, with the latter focused more on individual audits, progress and impact, and Audit Committee and ELT on the broader audit framework, progress, and exposure. This will start when Tracker 3.0 is developed which will draw the agreed reporting from the tracker via Power BI.
 - The introduction of a point of contact in Directorates for audits. This person(s) steers the audit with the Director and Assistant Directors/Deputies, ensuring internal audits feature on the directorate agenda monthly, they update the Tracker, and escalate issues as appropriate.
12. 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.

ASSESSMENT

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

14. 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.
15. 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**.
16. It is noted that 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.

Internal Audit: - Full Tracker Review

17. There has been good engagement with Directorates on the revised Tracker 2.0 for quarter one, with the result that of the total of 144 internal audit actions on the Tracker, 36 have been closed in quarter. This is a closure figure of 25% of all internal audit actions. Progress has been particularly good with actions assigned to the Quality, Safety and Patient Experience Committee.
18. Of the total internal audit actions, 45 of the 144 actions have been given proposed revised dates in Quarter (31% of the total) and there are five actions on their third revised date (3%). These actions are 645 and 646 (Savings and Efficiencies audit), which will be completed in Q3 24/25; action 654 (Records Management audit), which will be completed in Q2 24/25, and action 613 (Senior Paramedic Role), which will be completed in Q2 24/25. This latter figure includes one action – action reference 567 – which is on its third revised date and is yet to be completed.

Action 567 - Operations (HART Internal Audit)

19. Action 567, 'The Trust should undertake a self-assessment against the NARU key lines of enquiry review document. This could support any future "critical friend" review undertaken', is on its third revised date and is yet to be completed. The self-assessment has been completed; however, the Operations Directorate senior leadership wish to seek a peer review of the self-assessment before finalisation, to be assured of its accuracy.

20. Colleagues in the Operations Directorate are in the process of organising the peer review requested by the Operations Senior Leadership Team (SLT). When this peer review has been completed the self-assessment will return to the Operations SLT for assurance. Judith Bryce, Assistant Director of Operations, National Operations & Support, will provide additional context for Committee as its meeting on the 12 September 2024.

Internal Audit: – ARAC Actions

21. The internal audit recommendations within the purview of ARAC relate to the Risk Management, Standards of Business Conduct, and Follow Up audits. Of the six internal audit actions where the ARAC is the owning Committee, none of the actions have been closed in quarter. Of these, four have been given revised dates in quarter; none are on a third revised date. These actions can be viewed in Annex 1.

22. Actions 545, 547 and 549 relate to the Standards of Business Conduct audit and were given a revised date of completion in Q2. The decision-makers Register of Interests has been developed, shared with line managers and will be published in the coming weeks; these actions have now been met.

23. Action 596 which relates to the Risk Management audit has a revised date of March 2025 in line with the Risk Management report, which is on the agenda for consideration at this meeting. Actions 598 (Risk Management) and 706 (Follow Up audit), are not yet due.

External Audit: - Full Tracker Review

24. Of the total external audit actions eight of the 22 have been closed in quarter (36%); seven (31%) have been given a proposed date in quarter, and one action is on its third revised date (reference 106a).

External Audit: – ARAC Actions

25. Of those external audit actions where the ARAC is the owning Committee, one of the three actions has been closed in quarter (33%). The remaining two actions – which relate to the 2023 Structured Assessment – have been given revised dates in quarter and will be picked up in discussions taking place currently on the 2024 Structured Assessment and in the now finalised Savings Efficiencies audit.

Management and Development of the Tracker

26. 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 some traction with these, and discussions will continue into Quarter one with a view to closing down or revising as many as possible.
27. With respect to the Committee's responsibility to scrutinise the impact of actions, in November the Committee agreed that the most effective way to improve the scrutiny of the impact of actions was by identifying actions within audits as audit reports are reviewed by the Committee, going forward.
28. The current version of the tracker is now open for Directorate review for actions due in July to September. These updates will then be reported to the Committee at its meeting in November 2024. The team will work with Directorate contacts to ensure a smooth transition between Tracker 2.0 and 3.0.
29. The team continues to work on the development of the SharePoint solution for Tracker 3.0. The Team is working to implement Tracker 3.0 from Q3 onwards (with initial reporting being seen in Q4). Due to technical restrictions, it has been agreed that the current Excel Tracker will include for 2023/24 and that Tracker 3.0 will include actions from 2024/25 onwards.
30. 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 have regular check-in meetings to discuss issues and provide support. The Corporate Governance Team will work closely with the points of contact as the SharePoint Tracker 3.0 development continues.

Impact of Closed Management Actions

31. 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.

RECOMMENDATION

32. 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, closed off in quarter or clarity provided on dates which have moved and rationale;
- (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:
 - Internal Audit: Volunteer Governance (noting this was discussed at the People and Culture Committee on 30 August 2024);
 - Internal Audit: Disciplinary Case Management (noting this was discussed at the People and Culture Committee on 30 August 2024);
 - Internal Audit: Risk Management.

Points of Contact, Directors and Owners of Audit Actions - Do Not Amend Any Column With a Red Header
When proposing a revised 1st, 2nd or 3rd date, include the rationale for the movement and any progress on the action to date
ALL FINAL INTERNAL AUDIT REPORTS CAN BE FOUND ON THE CORPORATE GOVERNANCE SIREN PAGE

Trust Ref. No.	Year / Audit Plan	Committee assigned to	Report Title	Assurance Rating	Responsible Officer	Director	Priority Level	Ref. 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 include here: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. Please add most recent update first
545	22/23	Audit	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	Aug-24		Open	050724: The Trust decision-makers are a known cohort and the collection of interests for these decision-makers has been sought. The Register is in the process of being built and will be finalised over the coming month. Revised date of August 2024 added in Q1 24/25 (which is now the 2nd revised date). This will close when the August Register is published. Last updated: 11/07/23 Declarations for the decision makers listed in the policy will commence from March 2024 so as not to duplicate efforts given declarations were sought from ADLT in March 2023 as part of the annual review.
547	22/23	Audit	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	Aug-24		Open	050724: The follow up of decision-makers declarations and escalations to Directors where not received is ongoing. Decision-makers process document developed and will ensure integration within the Trust's induction processes. Revised date of August 2024 added in Q1 24/25 (which is now the 2nd revised date). This will close when the August Register is published. Last updated: 11/07/23 There will be a known cohort to enable the tracking any outstanding declarations. The PADR form now has a prompt for the line manager to ensure staff have completed their declarations.
549	22/23	Audit	Standards of Business Conduct: Declarations	Limited	Trish Mills	Trish Mills	High		5.1 The Trust should look to implement a centrally maintained register which includes the DOIs of all 'high risk' staff and decision makers, not limiting the register exclusively to Board members.		See 4.1 and 4.2 management responses above	Jun-23		Jul-23	Aug-24		Open	050724: (AP) Propose closure when the August Register is published. 030624: Action reopened in Q1 24/25 in response to the completion of the 23/24 Follow Up Internal Audit report. IA stated in their report: "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". Last updated: 11/07/23 The Board and EMT declarations are now centrally held. Additionally, decision makers included in the Policy will be held centrally going forward. This was closed down in July 2023 therefore and reported as such in Q3.
596	22/23	Audit	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 Met	Mar-2025			Open	050724: This activity is aligned to the IMTP delivery and will be completed by end of Q4. Revised date of March 2025 added in Q1 24/25. 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	Audit	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	110724: (JB): The Risk Officer will design a feedback form/s for colleagues to complete following training to capture their views. This will likely be level 2 training and can also be issued when directorate sessions are held or specific staff groups are trained, for example a new cohort of DOMs. Once this is complete the action can be closed. July 2024 Update: The risk management training for level one and two has been included 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.
706	23/24	Audit	Follow Up Audit 23/24	Reasonable	Carl Window	Trish Mills	Medium	1.1	The Trust should consider the inclusion of recommendations from other assurance providers within the enhanced tracker system.	1.1	This recommendation is accepted. 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.	Aug-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 HW Report	Year	Committee Assigned to	Report Title	Responsible Officer	Director	Priority Level	Ref. No. in Audit	Recommendation	Response Date in Audit	Management Response	Agreed Date/Next 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 include here: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. Please add most recent update first.	Closed Status
147	Audit Wales	22/23	Audit	Structured Assessment 2023	Alex Crawford	Rachel Marsh	High	3	Clarity of IMTP objectives/actions 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	Met				100724: Closure accepted and status updated. 100724: Update from SPP: The final IMTP for 24-27 is evidence of completion of this action. For each section of the plan we have included "what good looks like" statements and measures, alongside a set of delivery milestones that are SMART. The documents is available here: https://ambulance.nhs.wales/files/publications/strategies-and-plans/wast-imp-2024.pdf/ . Propose for closure.	Closed in Quarter
148	Audit Wales	22/23	Audit	Structured Assessment 2023	Alex Crawford	Rachel Marsh	High	4	Oversight of IMTP delivery 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	Not Met	Sep-24		100724: Revised date of September 2024 added in Q1 24/25. 100724: Update from SPP: Benefits realisation plans are being developed for the re-structured programme arrangements to deliver the Clinical Model Transformation and the Planning Team is working with Performance Team to align the 'what good looks like' measures set out in the IMTP to the deliverables. This action will be closed when this is reported to the Board in September 2024, as the end of Q2 24/25. Revised date of September 2024 proposed.	Open	
149	Audit Wales	22/23	Audit	Structured Assessment 2023	Chris Turley	Chris Turley	High	5	Oversight of Savings plans 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. Whilst 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. Recognising the current and future climate for the public sector and the NHS specifically, the organisation has mitigated 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. 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	Jul-24	080724: Revised date of July 2024 added in Q1 24/25 on advice from Jason Collins. Detail to be included in July Trust Board report (and then onwards with reporting), at which point the action will be closed. 170424: Update from Havin: 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 CGO once it has been produced at the end of May. Date extended in quarter 4 to May 2024.	Open	

Status:

Open - action not complete

Closed - action complete (normally filtered out)

Closure proposed - action complete and evidence reviewed/known

Closure proposed (pending evidence) - action complete and evidence awaited

Closed in Quarter - selected post ADLT when 'closure proposed' agreed. This provides Committee with overview of actions closed in quarter.

Internal Audit will review 'closed in quarter' as part of Committee papers



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AGENDA ITEM No	10
OPEN or CLOSED	Open
No of ANNEXES ATTACHED	N/A

TRUST POLICY REPORT

MEETING	Audit, Risk and Assurance Committee
DATE	12 September 2024
EXECUTIVE	Trish Mills, Director of Corporate Governance / Board Secretary
AUTHOR	Julie Boalch, Assistant Director of Corporate Governance & Risk
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, 45% of Trust policies that were identified as a priority for review are now within their review date.
4. It is expected that 52% of all Trust Policies will be within their review date after the next round of approvals in October and November 2024. This is an improvement on 14% overall reported in July 2023 at the time the prioritisation exercise was undertaken. This figure does not include those policies developed by NHS Wales or the NHS Employers Unit which are adopted by the Trust.
5. The work plans are progressing well, with significant levels of activity taking place to refresh existing policies and develop new ones and 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.
6. A review of the policy prioritisation list will take place at the ELT on 25 September 2024 to consider those policies that are yet to be reviewed and determine whether these remain a priority given the context that the Trust is operating within acknowledging that several work streams will have moved on since the initial prioritisation exercise was undertaken in 2023.
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: Members are asked to Note the update.

KEY ISSUES/IMPLICATIONS

8. The key issues are set out in the Executive Summary above.

REPORT APPROVAL ROUTE

9. 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

QUALITY AND PERFORMANCE MANAGEMENT STEERING GROUP

TERMS OF REFERENCE AND OPERATING ARRANGEMENTS APPROVED BY EXECUTIVE LEADERSHIP TEAM ON 22 MAY 2024

1. PURPOSE

- 1.1. The Quality & Performance Management Steering Group (the Group) is established by the Executive Leadership Team (ELT) to implement, oversee and steer the ongoing development of the WAST Quality & Performance Management Framework (the Framework).
- 1.2. This Framework, the first version of which was approved by the Trust Board in March 2022, sets out the Trust's approach to quality and performance management through a set of Organisational Requirements, which incorporate how the Trust will comply with the quality and performance regulatory requirements. These include the Health and Social Care (Quality and Engagement) Act 2020, the NHS Wales Performance Framework, requirements of our commissioners and other key national requirements
- 1.3. The ELT is responsible for monitoring performance against KPIs and objectives set by the Board and ELT and for satisfying itself on the integrity of management information, ensuring there is an effective system of governance and internal control and integration, connection and liaison between services and directorates.
- 1.4. From a Board perspective, the Finance & Performance Committee oversees performance against targets and the effectiveness of the Framework; the Quality, Patient Experience and Safety Committee oversees the duty of quality; and the Audit, Risk and Assurance Committee has oversight of the implementation of the Framework.
- 1.5. The Framework aims to enhance organisational performance, align individual and directorate goals with strategic objectives, and promote a culture of continuous improvement while maintaining a strong emphasis on quality. The Group's primary responsibility is to ensure the effective design, implementation, and monitoring of the Framework with a focus on quality standards.

- 1.6. The Framework will be formally revised every three years and kept under review during this time. In 2023 the Framework was reviewed to ensure the duty of quality - as set out in the Health and Social Care (Quality and Engagement) Act 2020 - was appropriately reflected and embedded in the Framework.
- 1.7. The Group shall work diligently to enhance the organisation's performance management practices while ensuring the highest quality standards are maintained and improved. In so doing it will aid the delivery of appropriate patient safety, patient experience and staff well-being.
- 1.8. The Group recognises that there are a number of other forums within WAST that deal with related issues, particularly the implementation more widely of the duty of quality and the duty of candour. It is not the intention of this Group to duplicate that work and its members will be conscious of this as they fulfil their duties and as those various forums become clearer.

2. REMIT

It is impossible to be prescriptive on all matters the Group will discuss, monitor, and review, and there will from time to time be matters before the Group which do not fall within the items listed below, but which align to the Group's purpose and allow it to be agile in its ways of working. Ultimate authority on issues before the Group will be for the Chair.

The Group is established to:

- 2.1. Develop a work programme for the implementation of the Framework that includes the Framework's Organisation Requirements related to:
- (a) Setting aspirational and stretching objectives;
 - (b) Balanced and coherent measures and targets;
 - (c) Ownership and accountability;
 - (d) Assurance and review mechanisms; and
 - (e) Support to individuals and teams.

- 2.2. Establish guidelines and processes for setting 'floor to Board' quality and performance goals, recommending performance appraisal methods, tools and frequency aligned to the Framework and which take account of the impact on quality.
- 2.3. Define key performance indicators (KPIs) and metrics that measure progress towards organisational goals with a specific focus on quality-related outcomes.
- 2.4. Ensure the quality and integrity of performance indicators in conjunction with the wider governance arrangements for informatics and information governance.
- 2.5. Provide clarity and, where necessary, develop, the meeting structures, roles and responsibilities and associated governance required to evaluate performance and recommend corrective actions.
- 2.6. Ensure fairness, transparency, and equity in the performance evaluation process, especially in relation to quality impact assessments
- 2.7. Provide guidance and training to managers and employees on performance management best practices, emphasising quality.
- 2.8. Monitor and assess the effectiveness of the Framework, particularly its impact on maintaining and enhancing quality standards;
- 2.9. Undertake a formal review of the Framework every three years, noting that continuous improvements will be identified and prioritised to the Framework within that period based on stakeholder feedback, and manage the delivery of these.
- 2.10. Ensure the implementation and continuous improvement of the Framework is communicated to the Trust on a regular basis.

3. AUTHORITY

- 3.1. The Group shall develop and present recommendations to the ELT for approval regarding changes, improvements, or modifications to the Framework.
- 3.2. The Group may determine that certain elements of its remit shall be exercised by Sub-Groups. Sub-Groups will report to the Group on a regular basis through a AAA (alert, advise, assure) report, highlighting matters for escalation.

4. MEMBERSHIP

4.1. Membership shall include:

- Executive Director of Strategy, Planning and Performance (Chair)
- Executive Director of Quality and Nursing (Deputy Chair)
- Director of Corporate Governance/Board Secretary
- Assistant Director Commissioning and Performance (Group Secretary)
- Assistant Director Quality and Governance
- Assistant Director Planning and Transformation
- Assistant Director Data & Analytics
- Assistant Director Operations Resourcing & EMS Co-ordination
- Head of Risk Management/Deputy Board Secretary
- Head of Quality Assurance
- Commissioning & Performance Manager
- Head of Patient Safety & Learning
- Senior Quality Governance Lead
- TU Partner

4.2. The Chair shall:

- Facilitate Group meetings. Where the Chair is unavailable the Deputy Chair will Chair the meeting.
- Ensure the Group operates efficiently and effectively.
- Report to ELT on progress and any escalations via the AAA report.

4.3. The Group Secretary shall

- Schedule and coordinate meeting logistics including invitations to members and Microsoft Teams links;
- Collaborate with the Chair to develop the agenda;
- Call for, collate and distribute meeting papers;
- Serve as a point of contact for members;
- Draft the AAA report (note, no minutes of this meeting are required);
- Maintain an actions and decision log in addition to the AAA, ensuring that all actions are updated ahead of meetings;
- Track action items assigned during meetings and ensure responsible parties complete them within specified timelines;

- Maintain an up to date repository of the terms of reference, actions and decisions log, and meeting papers which are accessible to all members.

4.4. Members may send deputies in their absence who will act with their full authority. Such deputies must be notified to the Chair in advance of the meeting. The Chair will appoint another member to chair meetings when they are absent.

4.5. Invitations may be extended to others to attend all or part of a meeting both from within or outside the organisation to assist with its discussions on any particular matter.

5. OPERATING ARRANGEMENTS

5.1. Meetings of the Group are internal to the management and executive governance structure at WAST are not open for the public.

Quorum

5.2. The Chair or Deputy Chair and at least 3 member members must be present to achieve a quorum.

Frequency

5.3. Meetings of the Group will be held monthly or as otherwise directed by the Chief Executive Officer.

Agenda and Papers

5.4. Papers will be available to members three working days before a meeting and shall be received by the Group's Secretary four working days before a meeting.

Duration

5.5. The Group is enduring in nature until such time as it is disbanded by the ELT.

6. REPORTING

- 6.1. The Group is established by the Executive Leadership Group (ELT) and will report into the ELT after each meeting by way of a AAA report presented by the Chair of the Group.
- 6.2. The AAA report will provide information on an alert, advise, assure basis and be clear what is required of ELT where any escalations are made in the alert section.
- 6.3. The Audit, Risk and Compliance Committee will receive regular reporting on the implementation of the Framework by the Executive Director of Strategy, Planning and Performance.

7. REVIEW

- 7.1. These terms of reference and operating arrangements shall be reviewed at least annually but more frequently if required.

8. VERSION CONTROL TABLE

Version Number	Change	Author/ Reviewer/ Approver	Date
1.0	Terms of Reference approved	Trust Board	March 2022
2.0	DRAFT Revision to Terms of Reference included wholesale changes	QPMF Steering Group	October 2023
3.0	Terms of Reference approved	QPMF Steering Group	2 November 2023
4.0	Terms of Reference approved	ELT	22 May 2024



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AGENDA ITEM No	11
OPEN or CLOSED	OPEN
No of ANNEXES ATTACHED	1

Quality & Performance Management Framework Update
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MEETING	Audit, Risk and Assurance Committee
DATE	17 September 2024
EXECUTIVE	Rachel Marsh – Executive Director of Strategy, Planning & Performance
AUTHOR	Hugh Bennett – Assistant Director of Commissioning and Performance
CONTACT	Hugh.bennett2@wales.nhs.uk

EXECUTIVE SUMMARY

1. Trust Board approved a Quality & Performance Management Framework (the framework) in March 2022. The Framework has five building blocks and within each building block “organisational requirements” that set out the standards that the Trust expects for quality and performance management across the Trust. There are 24 organisational requirements. The Framework reflects the Health and Social Care (Quality and Engagement) (Wales) Act and forms part of the wider Trust response to the duty of quality.

2. The Trust’s Structured Assessment has already noted that the good arrangements in place for quality and performance management, but an on-going internal audit will give further depth to this assessment. Delivery of the Framework is supported by the Quality & Performance Framework Steering Group, which meets monthly, is chaired by the Executive Director of Strategy, Planning & Performance (with the Director of Corporate Governance and Executive Director of Quality & Nursing also members of the group).

3. The Steering Group has undertaken a corporate level self-assessment against the 24 organisational requirements and has developed a programme of work based on this self-assessment. The overall assessment is that the Trust has strong arrangements for quality & performance at the corporate level, but there is more variation at a directorate/service level (there is some very good

practice), whilst at an individual staff level, the vast majority of staff receive an appraisal.

4. The main mechanism for reducing variation and ensuring consistency of practice is Q&PMF Self-Assessments, undertaken at a directorate or service level, depending on the size.
5. The pathfinder Q&PMF self-assessment (proof of concept) has been successfully completed by the Resource Service, with positive feedback and a work programme for Resource. The remainder of 2024/25 will see the completion of another four self-assessments across the Trust.
6. There are 18 actions on the Trust level work programme, with current status as follows:-
 - 2 completed;
 - 8 on-target;
 - 3 paused (for example, due to issues beyond the Trust's control);
 - 1 not started (a 2024/25 action); and
 - 4 focused required.
7. The Q&PMF Steering Group terms of reference was updated and approved by ELT in May 2024 and is attached for approval by Committee.

RECOMMENDATIONS: The Committee is asked to: -

- (1) NOTE that the Trust has a Quality & Performance Management Framework.**
- (2) NOTE the updated terms of reference for the Quality & Performance Management Steering Group as approved in May 2024 ELT (see Appendix 1)**
- (3) NOTE that ELT has considered an organisational self-assessment undertaken by the Quality & Performance Management Steering Group against the organisational requirements and the resultant Quality & Performance Management Steering Group's work plan.**
- (4) NOTE the progress made on the work programme.**
- (5) CONSIDER whether the Framework, Q&PMF Steering Group, its ToR, the completion of an organisational level self-assessment against the**

Framework, a work programme and the performance management of the framework, give sufficient assurance.

REPORT APPROVAL ROUTE

Date	Meeting
05 September 2024	Executive Director Strategy, Planning & Performance
12 September 2024	Audit, Risk and Assurance Committee

REPORT APPENDICES

Appendix 1 – Q&PMF Steering Group Terms of Reference.

REPORT CHECKLIST

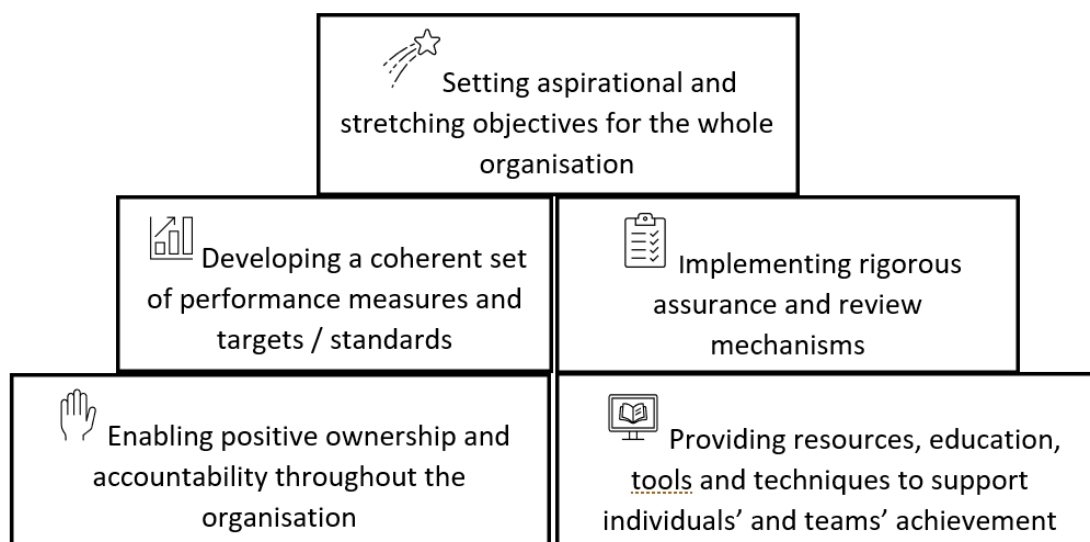
Confirm that the issues below have been considered and addressed		Confirm that the issues below have been considered and addressed	
EQIA (Inc. Welsh language)	x	Financial Implications	x
Environmental/Sustainability	x	Legal Implications	x
Estate	x	Patient Safety/Safeguarding	x
Ethical Matters	x	Risks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

SITUATION

1. The Trust had a Board approved Planning & Performance Management Framework in 2016, which it replaced with the new Quality & Performance Management Framework (the Framework) in March 2022.
2. The report provides Audit Committee with a progress update on delivering the new Framework.

BACKGROUND

3. The Trust has made enormous strides in improving its approach to quality and performance management since it was in enhanced monitoring in 2015 and 2016.
4. The Framework is about providing a mechanism for further improvement, rather than addressing fundamental weakness.
5. The framework has five “building blocks”:-



6. Each “building block” is supported by “organisational requirements” (24 of them) that set out the Trust’s standards, for example:-

Balanced & Coherent Measures and Targets

OR10	The Trust will develop appropriate measures at every level of the organisation, aligned to plans that demonstrate progress in achieving long term ambitions and objectives.
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OR11	The measures will be proportionate and balanced reflecting the quality of services to our patients, our people, finance & value and partnership & system contribution.
OR12	In reviewing progress against quantitative measures, consideration will be given to progress over time , and information will be simply presented to ensure that it is clearly understood.
OR13	Everyone in the Trust should have easy access to information on the measures relevant to their role, empowering quality and performance management in their job.
OR14	Everyone in the Trust should have access to and be aware of the corporate level measures and metrics to understand the progress that is being made.
OR15	All reports setting out progress against these measures will be quality assured in terms of the data, with clarity provided on data definitions.

7. The Framework was approved at March 2022 Trust Board and will be due for formal review in March 2025. The Trust established a Quality & Performance Management Steering Group to oversee the further development of the Framework.

ASSESSMENT

8. The Trust has continued to respond to the changing landscape of quality and performance management. The Trust has recently introduced new reports to meet the requirements of 111 commissioning and the Trust is now also subject to bi-monthly Integrated Quality, Planning & Delivery (IQPD) meetings with Welsh Government. There is also now a significant body of quality and performance management work going on around the evolving clinical response model.
9. The Health and Social Care (Quality and Engagement) (Wales) Act became law on 1 April 2023. The Quality & Performance Management Framework's Steering Group has updated its terms of reference to reflect this Act (see Appendix 1).

10. A key part of the Framework is that the Trust should self-assess itself against the Organisational Requirements. The Quality & Performance Management Steering Group is doing this at two levels:-

- i. Organisational level self-assessment; and
- ii. Service level assessments.

11. The organisational level self-assessment has been completed and reported to ELT. The areas for improvement identified have been converted into an organisational level Q&PMF Work Programme with 18 actions. Areas for improvement include:-

- i. Improving the PADR rate to the Welsh Government target level of 85%;
- ii. Introducing a commissioning forward plan, to help drive the Trust's strategic ambition at commissioning meetings;
- iii. Directorate balanced scorecards;
- iv. Completion of service review pathfinders i.e. EMSC and Resource function review against the organisational requirements and further roll out based on the experience of the pathfinders;
- v. Converting the Monthly Integrated Quality & Performance Report (MIQPR) to Power BI and making it "Always On" (or always available) to every member of staff;
- vi. Ensuring regular review of the 111 and EASC commissioning intentions at STB, (currently intermittent); and
- vii. Quality & Performance Management Training for managers (2025/26 action).

12. Development capacity to take forward the work programme has been an issue, but this is easing with the QSPE Directorate having recruited to a number of new posts and SP&P also recruiting to a key post, however, this is an internal movement, so there is a need to backfill. The current status of the 18 actions in the organisational level work programme is as follows:-

- 2 completed;
- 8 on-target;

- 3 paused (for example, due to issues beyond the Trust's control);
- 1 not started (a 2025/26 action); and
- 4 focus required.

13. For the four actions that require focus:-

Action	Status	Corrective Action
PADR rate (85%)	Jul-24 76.76%	P&C Directorate undertaking work to pin-point areas of the Trust that are below target.
House Style for Strategies & Plans	To be developed as the current planning cycle	Executive Director of SP&P's position is that this is not a high priority, but a style will develop at SP&P work with directorates on plans via the forward plan (see next item).
Forward Plan for strategies & plans	To be delivered by 31 Jul-24	The forward look is largely complete, and it is acknowledged that this is a live, dynamic document as strategies and plans are reviewed and updated at different times. This should be a standing item quarterly on QPMF Steering Group agenda to keep the forward look up to date.
Q&PMF Self-Assessment Pathfinders	One complete, one outstanding.	Second expected in Sep-24. A further three expected by year end.

RECOMMENDATIONS: The Committee is asked to: -

- (1) NOTE that the Trust has a Quality & Performance Management Framework.**
- (2) NOTE the updated terms of reference for the Quality & Performance Management Steering Group as approved in May 2024 ELT (see Appendix 1).**
- (3) NOTE that ELT has considered an organisational self-assessment undertaken by the Quality & Performance Management Steering Group against the organisational requirements and the resultant Quality & Performance Management Steering Group's work plan.**
- (4) NOTE the progress made on the work programme.**
- (5) CONSIDER whether the Framework, Q&PMF Steering Group, its ToR, the completion of an organisational level self-assessment against the Framework, a work programme and the performance management of the framework, give sufficient assurance.**



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AGENDA ITEM No	12
OPEN or CLOSED	Open
No of ANNEXES	0

Assurance to ARAC on Speaking Up Safely Arrangements at WAST

MEETING	Audit, Risk and Assurance Committee
DATE	12 September 2024
EXECUTIVE	Ceri Jackson, Vice Chair of Trust Board, Chair of People and Culture Committee
AUTHOR	Trish Mills, Director of Corporate Governance/Board Secretary
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. The National Audit Office Effectiveness Tool requires that the Audit, Risk and Assurance Committee ensures the organisation operates appropriate and effective whistleblowing practices, and this is regularly considered by ARAC.
2. The People and Culture Committee has the following mandate in its terms of reference which were approved by the Trust Board in May 2024:

Receive assurance that arrangements are in place to allow staff to raise concerns in confidence, and that those processes allow any such concerns to be investigated proportionately and independently and that the learning from such concerns is considered and applied
3. As Chair of the People and Culture Committee and Non-Executive Director Champion for Raising Concerns, I provide the following assurance.
4. The All-Wales Speaking Up Safely Framework was adopted by the People and Culture Committee in November 2023 and ratified by the Trust Board at its November meeting. A self-assessment against the framework as requested by Welsh Government was completed in 2023.



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5. The Speaking Up Safely Lead Guardian, Lizzie O'Shea, joined the Trust in 2024 and together with our other Speaking Up Safely Guardian, Catherine Goodwin, will further develop this important function.
6. Anybody within the Trust can speak with a Speaking Up Safely Guardian in a completely confidential way. Guardians provide a valuable service that help improve patient safety, the safety of our people and working relations, whilst supporting wellbeing. People may want to speak with a Guardian about patient safety concerns, bullying and harassment or the safety of our people as well as many other things.
7. Whilst Guardians advocate that a conversation is had first with a staff members' line manager, if this is not possible for any reason, the Guardians are there to listen and support offering safe and confidential spaces to talk through concerns. This can be done via Teams, phone, email, face to face or anonymously on the Work in Confidence (WiC) platform.
8. The WiC platform protects the identify of a staff member when using the system, with all sensitive information, including messages being encrypted. These are encrypted before being stored on the WiC servers and WAST does not have access to them.
9. The Guardians meet quarterly with myself, the Chief Executive, and Director of People and Culture to provide feedback on themes, areas of concern and to identify areas for improvement.
10. The People and Culture Directorate will develop reporting on Speaking Up Safely through 2024/25 as the Speaking Up Safely Guardians embed in the Trust. In the meantime, the cultural themes and trends and other key metrics monitored at the People and Culture Committee captures some of this reporting.
11. It is anticipated that with the change in portfolios with the Director of Culture and the Director of People from Q3 2024/25, the Committee will have more of a focus on Speaking Up Safely reporting to that forum, and to the Board, for 2025/26.
12. The People and Culture Committee heard at their August 2024 meeting that instance of reporting, the number of disciplinary cases and Employment Tribunal cases are rising. This was anticipated when the Speaking Up Safely



programme was launched, and the Committee welcomes this as a positive sign that our people feel safe to report issues. The Committee will of course keep an eye on this over the coming twelve months.

13. There is an internal audit on Speaking Up Safely taking place in Quarter 4 of 2024/25 and the brief for that audit has been agreed.

RECOMMENDATION: The Committee is requested to receive assurance on the arrangements for Speaking Up Safely at WAST and note that the People and Culture Committee will continue its oversight of this area, reporting annually to ARAC.

KEY ISSUES/IMPLICATIONS

No issues to raise.

REPORT APPROVAL ROUTE

Not applicable.

REPORT APPENDICES

Not applicable

REPORT CHECKLIST

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



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AGENDA ITEM No	13
OPEN or CLOSED	Open
No of ANNEXES ATTACHED	1

**LOSSES AND SPECIAL PAYMENTS - PAYMENTS FOR THE PERIOD FROM
1ST APRIL 2024 TO 31ST JULY 2024**

MEETING	Audit, Risk and Assurance Committee
DATE	12 th September 2024
EXECUTIVE	Director of Finance and Corporate Resources
AUTHOR	Jessica Price, Head of Financial Accounting
CONTACT	Chris Turley Chris.Turley2@wales.nhs.uk

EXECUTIVE SUMMARY
In accordance with SFI's this report presents to the Committee details of Losses and Special Payments made during the four months from 1 st April 2024 to 31 st July 2024 (Annex 1)

KEY ISSUES/IMPLICATIONS
Total net Losses and Special Payments made were as follows: - <ul style="list-style-type: none"> • period 1st April 2024 to 31st July 2024 -£0.341m

REPORT APPROVAL ROUTE
Audit Committee 12 th September 2024 – no action required for information under SFI's only

REPORT APPENDICES
Annex 1 – Summary and details of payments made for the four months to 31 st July 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 31st JULY 2024**

SITUATION

1. In accordance with SFI's all losses and special payments made are to be reported to the Audit Committee on a regular basis.

BACKGROUND

2. This report presents to the Committee details of Losses and Special Payments made during the four months from 1st April 2024 to 31st July 2024 (**Annex 1**)

ASSESSMENT

3. Total net Losses and Special Payments made during the period 1st April 2024 to 31st July 2024 amounted to -£0.341 million.
4. This relates to actual payments made less reimbursements received from the Welsh Risk Pool and does not relate to any adjustments made to the provision. During the four months to 31st July 2024 reimbursements received exceeded payments made by £0.341m.
5. During June you will note the Welsh Risk Pool reimbursements amounted to £0.975m. The vast majority of which relates to the reimbursement of 1 medical negligence case against the Trust for incorrect medical diagnosis.

6. During July you will note the Damages costs amounted to £0.377m of which £0.282m relates to 1 medical negligence case against the Trust in relation to the handling and treatment of a patient.

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

Welsh Ambulance Services University NHS Trust
Losses and Special Payments

Annex 1

Summary of payments for the 4 month to 31 July 2024:

	£
April 2024	44,627.36
May 2024	23,895.81
June 2024	- 901,844.23
July 2024	492,152.45
August 2024	-
September 2024	-
October 2024	-
November 2024	-
December 2024	-
January 2025	-
February 2025	-
March 2025	-
	<u><u>-£341,168.61</u></u>

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	9,266.80	26,000.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	£35,266.80
Counsel fees	10,137.50	7,366.66	6,846.66	-1,100.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	£23,250.82
CRU	0.00	0.00	833.00	1,335.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	£2,168.00
Damages	22,500.00	0.00	-36,079.00	376,710.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	£363,131.00
Defence Costs	45.92	967.74	14,442.55	25,512.80	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	£40,969.01
Expert Witness	398.91	1,500.00	3,233.57	390.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	£5,522.48
Vehicle Repairs	11,545.03	13,521.41	73,806.43	30,444.65	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	£129,317.52
WRP Refund	0.00	0.00	-975,394.24	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-£975,394.24
Property Repairs	0.00	540.00	1,200.00	32,860.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	£34,600.00
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	£23,895.81	-£901,844.23	£492,152.45	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	-£341,168.61

Welsh Ambulance Services University NHS Trust
Losses and Special Payments

Key
 MN Medical Negligence
 PI Personal Injury
 DP Damage To Property

Summary of payments for the four months to 31 July 2024:

	£	
DP cases <£1000	9,844.72	28 CASES
PI cases < £1,000	3,609.00	6 CASES
Redress cases <£1000	650.00	1 CASE
24RT4MN0012	14.35	
23RT4MN0004	66.00	
23RT4MN0011	390.00	
18RT4MN0012	437.50	
22RT4MN0002	750.00	
18RT4MN0016	1,000.00	
24RT4MN0011	1,500.00	
22RT4MN0016	1,629.67	
21RT4MN0009	2,200.00	
25RT4MN0016	2,820.00	
22RT4MN0011	40,000.00	
24RT4MN0009	50,000.00	
20RT4MN0018	80,067.89	
22RT4MN0001	101,357.91	
25RT4EG0003	1,000.00	
25RT4EG0006	1,000.00	
25RT4EG0008	1,000.00	
25RT4EG0013	1,000.00	
25RT4EG0014	1,000.00	
24RT4DP0034	1,067.66	
25RT4EG0002	1,100.00	
25RT4DP0001	1,138.42	
22RT4DP0085	1,200.00	
25RT4DP0043	1,247.20	
25RT4EG0019	1,250.00	
25RT4DP0049	1,300.00	
24RT4DP0068	1,366.97	
24RT4GN0020	1,375.00	
25RT4EG0009	1,400.00	
24RT4DP0017	1,500.00	
25RT4EG0017	1,500.00	
25RT4EG0018	1,500.00	
25RT4DP0050	1,560.43	
24RT4GN0019	1,600.00	
25RT4DP0035	1,622.58	
25RT4DP0051	1,626.30	
25RT4DP0034	1,837.08	
25RT4DP0063	1,922.30	
19RT4PI0032	2,000.00	
25RT4DP0036	2,287.04	
25RT4DP0004	2,770.56	
25RT4DP0059	2,969.88	
25RT4DP0055	3,000.00	
25RT4DP0023	3,160.49	
25RT4DP0007	3,358.60	
25RT4DP0039	3,573.10	
22RT4GN0005	3,800.00	
23RT4GN0022	4,100.00	
19RT4PI0037	4,360.00	
25RT4DP0052	4,886.26	
25RT4EG0004	5,500.00	
22RT4PI0046	5,951.85	
25RT4DP0022	6,058.55	
25RT4DP0024	6,104.85	
25RT4DP0054	6,189.54	
25RT4DP0053	6,524.78	
25RT4DP0021	7,576.41	
25RT4DP0060	7,925.65	
24RT4EG0028	8,080.32	
25RT4DP0038	9,505.54	
19RT4PI0009	14,562.80	
22RT4PI0022	23,400.00	
25RT4DP0057	31,560.00	
21RT4PI0006	36,250.00	
25RT4DP0037	38,818.43	
23RT4PI0035	54,000.00	
22RT4PI0019	- 2,500.00	Overpayment
21RT4PI0035	- 743.00	WRP Refund
23RT4GN0036	- 5,000.00	WRP Refund
20RT4MN0019	- 76,776.28	WRP Refund
20RT4MN0011	- 892,874.96	WRP Refund
Total	- 341,168.61	

Welsh Ambulance Services University NHS Trust
May-24

Case Reference	Details	Amount (£)
19RT4PI0037	Counsel fees	2,300.00
22RT4PI0003	Counsel fees	500.00
22RT4PI0022	Counsel fees	900.00
22RT4PI0046	Defence Costs	16.35
20RT4MN0018	Expert Witness	1,500.00
20RT4MN0018	Counsel fees	1,066.66
25RT4DP0019	Defence Costs	41.90
25RT4EG0006	Counsel fees	1,000.00
25RT4EG0005	Defence Costs	79.17
24RT4EG0028	Defence Costs	80.32
25RT4DP0020	Vehicle Repairs	889.71
25RT4DP0022	Vehicle Repairs	1,000.00
25RT4DP0023	Vehicle Repairs	51.43
25RT4EG0007	Defence Costs	750.00
25RT4DP0024	Vehicle Repairs	6,104.85
25RT4DP0023	Vehicle Repairs	3,109.06
25RT4DP0025	Vehicle Repairs	342.39
24RT4DP0068	Vehicle Repairs	1,366.97
25RT4DP0026	Vehicle Repairs	657.00
25RT4DP0027	Property Repairs	540.00
25RT4DP0012	Vehicle Repairs	- 786.35
25RT4DP0032	Vehicle Repairs	- 267.97
25RT4DP0031	Vehicle Repairs	- 5,007.44
24RT4DP0035	Vehicle Repairs	- 872.52
25RT4DP0030	Vehicle Repairs	- 155.44
25RT4DP0029	Vehicle Repairs	- 2,061.77
25RT4DP0028	Vehicle Repairs	- 1,828.58
25RT4DP0012	Vehicle Repairs	786.35
25RT4DP0032	Vehicle Repairs	267.97
25RT4DP0031	Vehicle Repairs	5,007.44
24RT4DP0035	Vehicle Repairs	872.52
25RT4DP0030	Vehicle Repairs	155.44
25RT4DP0029	Vehicle Repairs	2,061.77
25RT4DP0028	Vehicle Repairs	1,828.58
23RT4GN0022	Counsel fees	1,600.00
Totals		23,895.81

Welsh Ambulance Services University NHS Trust
Jun-24

Case Reference	Details	Amount (£)
19RT4PI0037	Counsel fees	400.00
21RT4PI0006	Counsel fees	750.00
22RT4PI0046	Defence Costs	1,518.00
24RT4PI0045	Counsel fees	500.00
18RT4MN0016	Counsel fees	1,000.00
20RT4MN0018	Counsel fees	923.66
20RT4MN0018	Counsel fees	- 1,052.00
20RT4MN0018	Expert Witness	1,170.00
20RT4MN0018	Counsel fees	190.00
20RT4MN0018	Counsel fees	- 190.00
20RT4MN0018	Expert Witness	63.57
20RT4MN0018	Expert Witness	500.00
21RT4MN0009	Counsel fees	1,520.00
21RT4MN0009	Counsel fees	680.00
22RT4MN0002	Counsel fees	750.00
24RT4MN0011	Expert Witness	1,500.00
24RT4MN0012	Defence Costs	14.35
25RT4DP0042	Vehicle Repairs	42.86
25RT4EG0012	Defence Costs	51.66
25RT4EG0011	Defence Costs	120.54
25RT4DP0038	Vehicle Repairs	223.53
25RT4EG0010	Defence Costs	275.00
25RT4DP0041	Vehicle Repairs	450.00
25RT4DP0022	Vehicle Repairs	576.80
24RT4DP0012	Vehicle Repairs	657.02
25RT4DP0040	Vehicle Repairs	877.14
25RT4EG0008	Defence Costs	1,000.00
25RT4EG0013	Defence Costs	1,000.00
25RT4EG0014	Defence Costs	1,000.00
24RT4DP0034	Vehicle Repairs	1,067.66
22RT4DP0085	Property Repairs	1,200.00
25RT4DP0043	Vehicle Repairs	1,247.20
25RT4EG0009	Defence Costs	1,400.00
24RT4DP0017	Vehicle Repairs	1,500.00
25RT4DP0035	Vehicle Repairs	1,622.58
25RT4DP0038	Vehicle Repairs	1,706.59
25RT4DP0034	Vehicle Repairs	1,837.08
25RT4DP0007	Vehicle Repairs	2,116.92
25RT4DP0036	Vehicle Repairs	2,287.04
25RT4DP0021	Vehicle Repairs	2,981.16
25RT4DP0039	Vehicle Repairs	3,573.10
25RT4DP0022	Vehicle Repairs	4,481.75
25RT4DP0038	Vehicle Repairs	7,575.42
24RT4EG0028	Defence Costs	8,000.00
25RT4DP0037	Vehicle Repairs	11,388.50
25RT4DP0037	Vehicle Repairs	27,429.93
25RT4DP0011	Vehicle Repairs	- 233.34
25RT4DP0044	Property Repairs	- 640.50
25RT4DP0045	Vehicle Repairs	- 190.65
25RT4DP0048	Vehicle Repairs	- 1,950.34
25RT4DP0047	Vehicle Repairs	- 20,737.44
25RT4DP0046	Vehicle Repairs	- 12,837.39
25RT4DP0044	Property Repairs	640.50
25RT4DP0045	Vehicle Repairs	190.65
25RT4DP0048	Vehicle Repairs	1,950.34
25RT4DP0047	Vehicle Repairs	20,737.44
25RT4DP0046	Vehicle Repairs	12,837.39
21RT4PI0035	WRP Refund	- 743.00
20RT4MN0011	WRP Refund	- 892,874.96
20RT4MN0019	WRP Refund	- 76,776.28
23RT4GN0036	WRP Refund	- 5,000.00
19RT4PI0009	Damages	7,296.00
19RT4PI0009	Claimants Solicitor Costs	7,266.80
19RT4PI0032	Claimants Solicitor Costs	2,000.00
22RT4PI0022	Damages	22,500.00
20RT4MN0018	Damages	75,000.00
20RT4MN0018	CRU	833.00
22RT4MN0001	Damages	- 180,875.00
22RT4MN0011	Damages	40,000.00
24RT4GN0020	Counsel fees	1,375.00
22RT4DP0013	Vehicle Repairs	397.49
20RT4MN0018	Defence Costs	63.00
Totals		- 901,844.23

Welsh Ambulance Services University NHS Trust
Jul-24

Case Reference	Details	Amount (£)
19RT4PI0037	Counsel fees	- 2,300.00
21RT4PI0021	Defence Costs	700.00
22RT4PI0006	Defence Costs	574.00
22RT4PI0046	Defence Costs	3,417.50
22RT4MN0001	Defence Costs	150.00
22RT4MN0016	Defence Costs	1,629.67
23RT4MN0011	Expert Witness	390.00
25RT4MN0016	Counsel fees	1,200.00
25RT4MN0016	Defence Costs	1,620.00
25RT4DP0049	Property Repairs	1,300.00
25RT4EG0015	Defence Costs	45.92
25RT4DP0050	Vehicle Repairs	1,560.43
25RT4DP0051	Vehicle Repairs	1,626.30
25RT4DP0052	Vehicle Repairs	4,886.26
25RT4DP0053	Vehicle Repairs	6,524.78
25RT4DP0054	Vehicle Repairs	6,189.54
25RT4EG0016	Defence Costs	40.18
25RT4DP0055	Vehicle Repairs	3,000.00
25RT4DP0057	Property Repairs	31,560.00
25RT4DP0058	Vehicle Repairs	512.18
25RT4DP0059	Defence Costs	2,969.88
25RT4DP0060	Vehicle Repairs	4,650.00
25RT4DP0060	Defence Costs	3,275.65
25RT4DP0061	Vehicle Repairs	450.00
25RT4EG0017	Defence Costs	1,500.00
25RT4EG0018	Defence Costs	1,500.00
25RT4EG0019	Defence Costs	1,250.00
25RT4EG0020	Defence Costs	650.00
25RT4DP0063	Vehicle Repairs	1,922.30
25RT4DP0064	Defence Costs	70.00
25RT4DP0065	Defence Costs	70.00
25RT4DP0040	Vehicle Repairs	- 877.14
25RT4DP0067	Vehicle Repairs	- 235.50
25RT4DP0067	Vehicle Repairs	235.50
19RT4PI0037	Damages	3,960.00
21RT4PI0006	Damages	19,500.00
21RT4PI0006	Claimants Solicitor Costs	16,000.00
23RT4PI0035	Damages	29,000.00
16RT4PI0068	CRU	647.00
19RT4PI0027	CRU	688.00
22RT4MN0001	Damages	281,750.00
24RT4MN0009	Damages	40,000.00
24RT4MN0009	Claimants Solicitor Costs	10,000.00
22RT4GN0005	Defence Costs	3,800.00
23RT4GN0022	Damages	2,500.00
24RT4GN0019	Defence Costs	1,600.00
24RT4GN0032	Defence Costs	650.00
Totals		492,152.45



Audit Committee Chairs Operating Arrangements

1. INTRODUCTION

The chairs of the Audit Committee Group was established to provide an opportunity for Wales-wide discussions on emerging issues on: governance, risk management, financial controls, cyber security and counter fraud.

2. SCOPE AND DUTIES

The scope and duties of the group will comprise:

- Discussion of common issues arising from internal and external audit reviews.
- Discussion of the highest risks relating to governance, nationally and locally.
- Sharing cultural and thematic challenges and good practice and learning.

Items to be placed on the agenda will be informed by the group's action plan but can come from several sources such as those below but are not limited to:

- Group members.
- Board or trust committees.
- Chair, vice-chair and other members of the boards.
- Directors of Corporate Governance/board secretaries' network or other all-Wales peer groups.
- Audit Wales and Internal Audit.
- NHS Counter Fraud authority.

3. MEMBERSHIP

The membership will comprise chairs of Audit committees across Wales.

Should an NHS body Audit Committee Chair be unable to attend, a representative from the organisations will be identified by the body's Audit Chair.

4. MEETINGS

Hosting

The hosting organisation of the group will rotate every year.

Quorum

At least six members must be present to ensure the quorum.

Chair

The group will nominate a member to chair and this will rotate on a yearly basis.

Secretariat

The Director of Corporate Governance/Board Secretary of the hosting organisation will determine the secretarial and support arrangements for the group.

Frequency of Meetings

Meetings shall be held quarterly. Thematic working groups will be convened as and when required.

Committee Meetings

A standard agenda will be used as the basis for discussion at each meeting. Notes prepared following a meeting shall be circulated to members and retained by the relevant Director of Corporate Governance/Board Secretary as a formal record of the decision making for a period of seven years.

Withdrawal of individuals in attendance

The group 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 on any matter.

5. REVIEW

These operating arrangements shall be reviewed annually.

Last reviewed in July 2024



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AGENDA ITEM No	15
OPEN or CLOSED	Open
No of ANNEXES	1

Committee Priorities & Cycle Monitoring Report

MEETING	Audit, Risk and Assurance Committee
DATE	12 September 2024
EXECUTIVE	Trish Mills, Director of Corporate Governance/Board Secretary
AUTHOR	Trish Mills, Director of Corporate Governance/Board Secretary Alex Payne, Corporate Governance Manager
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY	
<ol style="list-style-type: none"> 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 to the Committee from the Cycle of Business. 2. The Committee is reminded that the priority of oversight of the development of the Quality and Performance Management Framework is reflected in this update, as it has been carried over as a Committee priority for 2024/25. <p>RECOMMENDATION: -</p> <ol style="list-style-type: none"> 3. The Committee is asked to NOTE the update. 	

KEY ISSUES/IMPLICATIONS
No issues to raise.

REPORT APPROVAL ROUTE
Not applicable.



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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



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COMMITTEE PRIORITIES FOR 2024/25 AND CYCLE MONITORING REPORT

SITUATION

4. This report updates the Committee on progress against the priorities it set for 2024/25 and progress against the agreed Cycle of business. There are no matters to escalate to the Committee from the Cycle of Business.
5. The Committee is reminded that the priority of oversight of the development of the Quality and Performance Management Framework is reflected in this update, as it has been carried over as a Committee priority for 2024/25.

BACKGROUND

6. 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.
7. 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.
8. The monitoring report is at Annex 1. The 'pre-agenda setting' key indicates that items in green show where 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.
9. The 'post-agenda setting' key indicates that items in blue were either on the agenda as scheduled or is an *ad hoc* item which was discussed in agenda setting and scheduled. The orange indicates where an item was programmed for receipt but has been deferred to a future meeting.

ASSESSMENT

10. The Committee priorities, and progress against them is as follows:



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Priority	Progress
<ul style="list-style-type: none"> Monitor the development of the Committee specific induction programme. 	<ul style="list-style-type: none"> This work has been added to the Corporate Governance Directorate’s ‘Local Departmental Plan (LDP)’ for progression and will be developed throughout 2024/25. A joint Board and Committee Chairs and Trade Union retrospective induction took place on 12 June A committee member governance overview drop took place in August with another planned for September.
<ul style="list-style-type: none"> Carry-over from 2023/24: Oversight of the development and implementation of the Quality & Performance Management Framework 	<p><u>2024/2025 Update:</u></p> <ul style="list-style-type: none"> Receipt of updates regarding the Quality and Performance Management Framework has been built into the Committee’s Cycle of Business, twice a year (quarter one and quarter three). This business was deferred from quarter one however and has been programmed for receipt in quarter two (the September 2024 meeting) for consideration. <p><u>2023/24 Update:</u></p> <ul style="list-style-type: none"> The Committee received a verbal update regarding the implementation of the Quality and Performance Management Framework at its meeting in November 2023. 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.

11. It is noted that the Cycle of Business Monitoring Report has been adapted to include the extraordinary meeting of the Committee on the 10 July 2024, to receive the 2023/24 Annual Report and Accounts. This has been reflected by the inclusion of a column in between ‘Q1b’ and ‘Q2’ and the business received at that meeting identified.



GIG
CYMRU
NHS
WALES




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





RECOMMENDATION: -

12. The Committee is asked to NOTE the update.

PAPER	PRE or POST C'EE FORUM	FREQUENCY	Q1a	Q1b	10/07	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	Q2: Quality Governance and Urqent & Emergency Care Report to be rec'd.
Losses & Special Payments/Single Tender Waivers											
Quarterly losses 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	Coming from Chair of PCC
Other											
Near Miss Report	QUEST	Annually							TBC	Assurance	Coming from Chair of QuEST
Quality and Performance Management Framework	ELT	Bi-Annually		→					EDSPP	Assurance	Deferred from Q1 and programmed for Q2.
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
 Ad 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. See pages 39 and 40 of Audit Committee Handbook. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/512760/PU1934_Audit_committee_handbook.pdf 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 Audit Committee 25 July 2023 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. 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. 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 - Counter Fraud Policy - Charitable Funds Investment Policy - Standards of Business Conduct - Whistleblowing Policy - Public Sector Payment Policy (All Wales) - Risk Policy - Data Protection Policy - Health & Safety Policy - Information Governance Policy - Information Risk Policy - Information Security Policy
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 (NHS CFA) have entered into a service agreement under section 83 of the Government of Wales Act 2006, to ensure that appropriate provision is in place to tackle all matters connected to Fraud, Bribery and Corruption. It is the role of the LCFS to ensure regular engagement and reporting to senior members surrounding the work completed within this field, with the audit committee being recognised as an appropriate recipient to the status and developments of the service. Service strands of hold to account, prevent and deter, inform and involve, and strategic governance
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: a.there is an effective internal audit function that meets the standards set for the provision of internal audit in the NHS in Wales and provides appropriate independent assurance to the Board and the Accountable Officer through the Committee; b.there is an effective counter fraud service that meets the standards set for the provision of counter fraud in the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Committee and ensure all reported fraud concerns and ongoing investigations are notified to the Committee; c.there are effective arrangements in place to secure active, ongoing assurance from management with regard to their responsibilities and accountabilities, whether directly to the Board and the Accountable Officer or through the work of the Board's committees; d.the work carried out by key sources of external assurance, in particular, but not limited to the Trust's external auditors, is appropriately planned and co-ordinated and that the results of external assurance activity complements and informs (but does not replace) internal assurance activity; e.the work carried out by the whole range of external review bodies is brought to the attention of the Board, and that the organisation is aware of the need to comply with related standards and recommendations of these review bodies, and the risks of failing to comply; f.the systems for financial reporting to the Board, including those of budgetary control, are effective; g.the results of audit and assurance work specific to the Trust, and the implications of the findings of wider audit and assurance activity relevant to the Trust's operations, are appropriately considered and acted upon to secure the ongoing development and improvement of the organisations' governance arrangements; h.progress is monitored against the requirement of the Auditors' Management Letter; i.the Committee receives and reviews key Trust Annual Reports e.g., Trust Annual Report, Infection Control Annual Quality Statement; Annual Governance Statement and make recommendations to the Board for their adoption; and j.the Committee reviews the content of the Corporate Risk Register and obtain assurance that control measures are in place to mitigate all identified risks.