Bundle Audit, Risk and Assurance Committee (Open) 6 March 2025

Agenda attachments

ITEM 00 Agenda 6 March 2025

0 09:30 - OPENING ITEMS

1 Chair's Welcome, Apols and Quorum

2 Declarations of Interest

ITEM 02 Board Member register of Interests 8 January 2025

3 Minutes of the Last Meeting: 21 November 2024

3.1 Chairs Action Ratification (Approval of All-Wales Over Payments Procedure

ITEM 03 2024-11-21 Draft ARAC OPEN Minutes

ITEM 03.1 Ratification of ARAC Chairs Action - All-Wales Over Payments Procedure

ITEM 03.1a Ratification of ARAC Chairs Action Annex 1 - All-Wales Over Payments Procedure

ITEM 03.1b Ratification of ARAC Chairs Action Annex 2 -Gweithdrefn ar gyfer Adennill Gordaliadau

4 Action Log & Matters Arising:

4.2 Committee AAA Report

ITEM 04.1 Action Log

ITEM 04.2 Audit Committee AAA Report November 2024

4.1 FOR APPROVAL, ASSURANCE AND DISCUSSION

5 09:35 - 2024/25 Committee Effectiveness Review

ITEM 05 Effectiveness Review SBAR ARAC 6 March 2025

ITEM 05.1 Annex 1 WAST Board Committee Remits

ITEM 05.2 Annex 2 NAO Questionnaire ARAC 2024-25 Effectiveness Review Committee Version

ITEM 05.3 Annex 3 ARAC Terms of Reference 2024-25 - Approved by Trust Board 30052024 1

ITEM 05.4 Annex 4 Cycle of Business 2024-25

ITEM 05.4a Annex 4 Cycle of Business Notes

ITEM 05.5 Annex 5 Draft ARAC Annual Report 2024-25

6 10:05 - Internal Audit Items

6.1 Internal Audit Progress Report
6.2 Internal Audit Reports:
6.2.1 Vehicle Accident Management (Lee Brooks)
6.2.2 Exposure to Fumes (Liam Williams)
6.2.3 Patient Experience and Community Involvement (Liam Williams)
6.2.4 Rollout of Penthrox (Andy Swinburn)
6.2.5 111 Digital Operations (Jonny Sammut)
6.2.6 Energy Management (Chris Turley)

ITEM 06.1 WAST_2425_Internal Audit Progress Report_March 25_Final

ITEM 06.2.1 WAST_2425-04_Vehicle Accident Management_Final Report_Trust Issue

ITEM 06.2.2 WAST-2425-07 Exposure to Fumes_Final Internal Audit Report_Trust Issue

ITEM 06.2.3 WAST-2425-08-Patient Experience & Community Involvement Final Internal Audit Report

ITEM 06.2.4 WAST_2425-09_Rollout of Penthrox_Final Internal Audit Report

ITEM 06.2.5 WAST_2425-14_111 Digital Operations_Final Internal Audit Report

ITEM 06.2.6 WAST_2425-20_Energy Management_ Final Audit Report

7 10:50 - 2025/26 Internal Audit Plan

ITEM 07 WAST_2025-26_Draft Internal Audit Plan_for ARAC

7.1 11:00 - Comfort Break

8 11:15 - Audit Wales Items

8.1 Annual Audit Report 2024/25 (Assurance)
8.2 Outline Audit Plan 2025/26 (Approval)
8.3 Audit Wales Quality Governance Follow-up Report (Assurance)

ITEM 08.1 WAST Annual Audit Report 2024 FINAL

ITEM 08.2 2025 Outline Audit Plan WAST final

ITEM 08.3 Quality Governance Follow Up Report FINAL

9 11:45 - Risk Management and Board Assurance Framework
- ITEM 09 Executive Summary Risk Management Report ARAC 060325

10 12:05 - Audit Tracker 2.0 - December 2024 (Q3)
- ITEM 10 SBAR Audit Tracker to Committees - 24-25 Q3 Reporting (October-December 2024) - ARAC (Open Session)
- ITEM 10.1 Internal Audit ARAC Only up to 2023-24
- ITEM 10.2 Internal Audit up to 2023-24 All
- ITEM 10.3 Internal Audit 2024-25 All
- ITEM 10.4 AW HIW up to 2023-24

11 12:25 - 2024/25 Annual Accounts Report
- ITEM 11 2024-25 Annual Accounts Report for ARAC March 2025

12 12:40 - 2024/25 Annual Filings Schedule
- ITEM 12 2024-25 Annual Filings Schedule for ARAC March 2025

12.1 12:50 - Lunch Break

13 13:30 - Integrated Governance Programme: The Dynamic Integrated system of Governance and Oversight
- ITEM 13 Integrated Governance Programme Report ARAC 060325
- ITEM 13.1 Annex 1a - Assurance Arm
- ITEM 13.2 Annex 1b - Advisory Arm
- ITEM 13.3 Annex 1c - Organisational Governance Arm
- ITEM 13.4 Annex 1d - Strategic Development and Delivery Arm
- ITEM 13.5 Annex 1e - Directorate Governance Arm
- ITEM 13.6 Annex 2 - Organisational Governance Tiering Principles
- ITEM 13.7 Integrated Governance Mapping Key

14 13:45 - Policy Report
- ITEM 14 Executive Summary Policy Report - ARAC 060325

15 13:50 - Quest Committee Highlight Report: Clinical Audit Plan 2025/26 (assurance from QuEST to ARAC)
- ITEM 15 Quest Committee Highlight Report to ARAC re Clinical Audit Plan - March 2025

16 13:55 - Losses and Special Payments - Payments for the Period from 1 April 2024 to 31 January 2025
- ITEM 16 Executive Summary SBAR Losses and Special Payments (003)
- ITEM 16.1 Annex 1 - Losses Special and Payments 2024-25

17 14:00 - Committee Induction
- ITEM 17 Committee Induction
- ITEM 17a Annex 1 Committee Induction Template

18 14:05 - Amendments to Standing Orders and SoRD and Standing Orders Non-compliance Report
- ITEM 18 2025 Standing Order Amendments and Non-compliance Report
- ITEM 18a Annex 1 WAST Standing Orders - Schedule 1 Scheme of Reservation and Delegation of Powers v.9 for ARAC 06032025

19 14:10 - All Wales Audit Committee Chairs meeting held on 10 December 2024 - Update

19.1 CONSENT ITEMS

20 Committee Priorities & Cycle Monitoring Report
- ITEM 20 Audit Committee Priorities and Cycle Monitoring Report - March 2025
- ITEM 20.1 Cycle of Business Monitoring Report - March 2025
- ITEM 20.1a Cycle of Business Notes

21 Impact Assessments
- ITEM 21 Impact Assessments Signposting - Consent Item
- ITEM 21a Annex 1 Impact Assessments Signposting Document
- ITEM 21b Annex 2 Impact Assessments Flowchart

21.1 14:15 - CLOSING ITEMS

22 Reflections and Summary of Decisions/Actions

23 Any Other Business

24 Date & Time of the Next Meeting: 1 May 2025

Length of Meeting:	04:55	Agenda Status:	[OPEN] AUDIT, RISK AND ASSURANCE COMMITTEE - 6 MARCH 2025					Deadline for Papers:	25 February 2025
Time	**Mins allotted**	**Agendum**	**Title**	**Format**	**Item for**	**Item requested by**	**Paper prepared by**	**Item presented by**	**Colleagues to cc**
			OPENING ITEMS						
		1	Chair's Welcome, Apols and Quorum	Verbal	Information	Standing	n/a	Chair	n/a
		2	Declarations of Interest	Verbal	To State Conflicts	Standing	n/a	Chair	n/a
09:30	00:05	3	Minutes of the Last Meeting: 21 November 2024 3.1 Chairs Action Ratification (Approval of All-Wales Over Payments Procedure)	Paper	Approval	Standing	n/a	Chair	n/a
		4	Action Log & Matters Arising: 4.1 Action Log 4.2 Committee AAA Report - November 2024	Paper	Discussion	Standing	n/a	Chair	n/a
			FOR APPROVAL, ASSURANCE AND DISCUSSION						
09:35	00:30	5	2024/25 Committee Effectiveness Review	Paper	Assurance	CoB	CorGov	Trish Mills	Trish Mills, Alex Payne
10:05	00:45	6	6.1 Internal Audit Progress Report 6.2 Internal Audit Reports: 6.2.1 Vehicle Accident Management (Lee Brooks) 6.2.2 Exposure to Fumes (Liam Williams) 6.2.3 Patient Experience and Community Involvement (Liam Williams) 6.2.4 Rollout of Penthrox (Andy Swinburn) 6.2.5 111 Digital Operations (Jonny Sammut) 6.2.6 Energy Management (Chris Turley)	Paper	Assurance	CoB	Internal Audit	Osian Lloyd	Felicity Quance
10:50	00:10	7	2025/26 Internal Audit Plan (inc. Internal Audit Mandate and Charter)	Paper	Approval	CoB	Internal Audit	Osian Lloyd	Felicity Quance
11:00	00:15		COMFORT BREAK						
11:15	00:30	8	Audit Wales Items:- 8.1 Annual Audit Report 2024/25 8.2 Outline Audit Plan 2025/26 8.3 Audit Wales Quality Governance Follow-up Report	Paper	Assurance Approval Assurance	CoB	External Audit	Fflur Jones	n/a
11:45	00:20	9	Risk Management Report	Paper	Assurance	CoB	CorGov	Julie Boalch	n/a
12:05	00:20	10	Audit Tracker 2.0 - December 2024 (Q3)	Paper	Assurance	CoB	CorGov	Trish Mills	Lisa Trounce
12:25	00:15	11	2024/25 Annual Accounts Report	Paper	Assurance	CoB	FinCor	Ed Roberts	Edward Roberts, Jessica Price
12:40	00:10	12	2024/25 Annual Filings Schedule	Paper	Approval	CoB	CorGov	Alex Payne	Trish Mills, Lisa Trounce, Alex Payne
12:50	00:40		LUNCH BREAK						
13:30	00:15	13	Integrated Governance Programme: The Dynamic Integrated System of Governance and Oversight	Paper	Assurance	Ad Hoc	CorGov	Trish Mills	Julie Boalch, Alex Payne
13:45	00:05	14	Policy Report (and any policies for approval/adoption)	Paper	Assurance	CoB	CorGov	Lisa Trounce	Trish Mills, Lisa Trounce
13:50	00:05	15	Quest Committee Highlight Report: Clinical Audit Plan 2025/26 (assurance from QuEST to ARAC)	Paper	Assurance	CoB	CorGov	Trish Mills (in lieu of Bethan Evans)	Alex Payne
13:55	00:05	16	Losses and Special Payments - Payments for the Period from 1 April 2024 to 31 January 2025	Paper	Assurance	CoB	FinCor	Ed Roberts	Edward Roberts
14:00	00:05	17	Committee Induction	Paper	Assurance	Ad Hoc	CorGov	Alex Payne	Trish Mills, Alex Payne
14:05	00:05	18	Amendments to Standing Orders and Standing Orders Non-compliance Report	Paper	Endorsement	Ad Hoc	CorGov	Trish Mills	Alex Payne
14:10	00:05	19	All Wales Audit Committee Chairs meeting held on 10 December 2024 - Update	Paper	Discussion	Ad Hoc	CorGov	Chair	n/a
			CONSENT ITEMS						
14:15	00:00	20	Committee Priorities & Cycle Monitoring Report	Paper	Information	CoB	CorGov	Trish Mills	Alex Payne
		21	Impact Assessments	Paper	Information	Forward Planner	CorGov	Trish Mills	Alex Payne
			CLOSING ITEMS						
		22	Reflections and Summary of Decisions/Actions	Verbal	Discussion	Standing	n/a	Chair	n/a
14:15	00:10	23	Any Other Business	Verbal	Discussion	Standing	n/a	Chair	n/a
		24	Date & Time of the Next Meeting: 1 May 2025	Verbal	Information	Standing	n/a	Chair	n/a

14:25	**04:55**	**CLOSE**

LEAD PRESENTERS

Name	Position
Julie Boalch	Assistant Director of Governance and Risk
Peter Curran	Non-Executive Director and Committee Chair
Fflur Jones	Audit Wales
Osian Lloyd	Head of Internal Audit
Rachel Marsh	Executive Director of Strategy, Planning and Performance
Trish Mills	Director of Corporate Governance/Board Secretary
Alex Payne	Corporate Governance Manager
Ed Roberts	Interim Deputy Director of Finance
Lisa Trounce	Head of Compliance and Assurance

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended	Left Trust
BEAUMONT-WOOD, Rhiannon	**Non-Executive Director** * Member of the Remuneration Committee * Member of the the Audit, Risk and Assurance Committee * Member of the Quality, Patient Experience and Safety Committee	Dorset Integrated Care Board (NHS Dorset), Non-Executive Director	Financial Interest	May 2023		
		Nursing and Midwifery Council (NMC), Designated Council Member for Wales	Financial Interest	June 2024		
		RBW Executive and Professional Coaching Ltd, Company Director (Company No 14938585) and Shareholder	Financial Interest	June 2023		
		Currently on coaching framework with Health Education and Improvement Wales	Financial Interest	June 2024		
		Registered Nurse (NMC)	Non-Financial Professional	January 1995		
		Registered Specialist Community Public Health Nurse	Non-Financial Professional	September 1996		
		Member of the Royal College of Nursing	Non-Financial Professional	2007		
BEESLEE, Jayne	**Non-Executive Director** * Chair of the Finance and Performance Committee * Member of the Remuneration Committee * Member of the Academic Partnership Committee	Employment for interim assignments via Public Sector Resourcing (an agency) regarding the review of major UK government programmes (remunerated net of tax via an Umbrella Company – Danbro Employment Umbrella Ltd)	Financial Interest	01 October 2023		
		Member Representative on the UK Civil Service Pension Board	Non-Financial Personal	01 October 2019		
		Governor on the Finance & General Purposes Committee of Cardiff and Vale Further Education College	Non-Financial Personal	01 February 2024		
		Fellow Chartered Institute of Personnel & Development	Non-Financial Personal	01 April 2006		
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, Risk and Assurance Committee * Chair of the Charity 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	31 October 2024	
		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		
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		
EVANS, Bethan	**Non-Executive Director** * Chair of Quality, Patient Experience & Safety Committee * Member of Finance & Performance Committee * Member of People & Culture Committee * Member of Remuneration Committee	Managing Director (Employed) at My Choice Healthcare Limited.	Any Other Interest	01 June 2019		
		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 (Barqoed) 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		
		[Previously called Homes of Excellence Healthcare Limited, Company name changed 12.08.2022 - #12513139]	*Directorships*	*12 March 2020*		
		Company Director – Hawthorn Court Property Limited	Directorships	27 April 2022		
		[Previously called My Choice Healthcare (Three) Limited, Company name changed 12.08.2022 - #13371375]	*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 – Glyncornel 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		
HUTCHINGS, Hayley	**Non-Executive Director** * Member of the Remuneration Committee * Member of the Academic Partnership Committee * Member of the People and Culture Committee	Employed at Swansea University, Professor of Health Services Research	Financial Interest	17 June 1995		
HITCHON, Estelle	**Director of Partnerships and Engagement**	Member of Academi Wales Expert Panel	Position in Charity or Voluntary Organisation	15 July 2024		

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 the People and Culture Committee * Member of the Charity 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		
		Chairperson – Association of Ambulance Chief Executives (AACE)	Non-Financial Professional	September 2024		
		Company Director of the Association of Ambulance Chief Executives (AACE), Co No. (07761209)	Directorships	September 2024		
		Officer of the Order of St John	Any Other Interest	January 2024		
		Member of the Order of St John	Any Other Interest	2009	2024	
KNEESHAW, Carl	**Director of People**	Chartered Fellow of Chartered Institute of Personnel and Development	Personal or Departmental Sponsorship	April 2020		
		Fellow of Institute of Leadership	Personal or Departmental Sponsorship	October 2020		
		Safeguarding Lead for local outreach charity, Brunstad Christian Church – Huntworth, Bridgwater, Somerset	Position in Charity or Voluntary Organisation	September 2018		
LEWIS, Angela	**Director of Culture Change**	Nil Declaration				
MARSH, Rachel	**Executive Director of Strategy, Planning and Performance**	Nil Declaration				
MILLS, Patricia (Trish)	**Director of Corporate Governance/ 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		
SWINBURN, Andrew (Andy)	**Executive Director of Paramedicine**	Strategic Advisor to College of Paramedics	Any Other Interest	01 January 2020		
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	05 November 2024	
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		

WELSH AMBULANCE SERVICES UNIVERSITY NHS TRUST

MINUTES OF THE OPEN MEETING OF THE AUDIT, RISK AND ASSURANCE COMMITTEE OF THE WELSH AMBULANCE SERVICES UNIVERSITY NHS TRUST HELD ON THURSDAY 21 NOVEMBER 2024 IN CARDIFF MRD AND VIA TEAMS

Meeting Commenced at 09:30

PRESENT:

Peter Curran	Non-Executive Director and Committee Chair
Bethan Evans	Non-Executive Director (Attended just for this meeting)
Ceri Jackson	Non-Executive Director and Vice Chair of the Trust Board

IN ATTENDANCE:

Hugh Bennett	Assistant Director Commissioning and Performance
Julie Boalch	Assistant Director of Corporate Governance and Risk
Lee Brooks	Executive Director of Operations (left at 10:00)
Christian Fox	Trade Union Partner
Fflur Jones	Audit Wales
Osian Lloyd	Head of Internal Audit, NWSSP (Joined at 10:15)
Martyn Lewis	Internal Audit
Trish Mills	Director of Corporate Governance/Board Secretary
Carl Kneeshaw	Director of People
Steve Owen	Corporate Governance Officer
Alex Payne	Corporate Governance Manager
Jessica Price	Head of Financial Accounting
Felicity Quance	Internal Audit (Joined at 10:05)
Jonathan Sweet	Assistant Director of Operations
Andy Swinburn	Executive Director of Paramedicine (Joined at 11:25, left at 11:40)
Chris Turley	Executive Director of Finance and Corporate Resources
Jonny Sammut	Director of Digital Services (Left at 11:50)
Jonathan Turnbull-Ross	Assistant Director of Quality Governance
Damon Turner	Trade Union Partner (Left at 10:00)
Carl Window	Local Counter Fraud Manager

OBSERVER

Lisa Trounce	Head of Compliance and Assurance

DRAFT

APOLOGIES:

Rhiannon Beaumont-Wood	Non-Executive Director
Judith Bryce	Assistant Director of Operations
Liam Williams	Executive Director of Quality and Nursing

53/24 PROCEDURAL MATTERS

The Chair welcomed all to the meeting noting the apologies of Rhiannon Beaumont-Wood, Judith Bryce and Liam Wiliams.

Minutes:

The Minutes of the Audit, Risk and Assurance Committee (ARAC) meeting held on 12 September 2024 were approved.

Action Log:

Action 42/24: Internal Audit reviews: *Disciplinary Case Management Compassionate Practices. The need for a clearer explanation and context of the underlying reasons that contributed to this Limited Assurance was requested.* Following advice from the Board Secretary, the Chair of ARAC has confirmed that no further context or follow up was required on the actions generated from the 'Disciplinary Case Management' internal audit, as the matters arising were accepted and have corresponding actions. It was acknowledged that good progress has been made on compassionate practices however there was still an improvement to be made. Given all these actions were due to be implemented by the end of September 2024, it will be for the ARAC to monitor the progress against the actions and the extent to which they have been completed via receipt of the Audit Tracker. It was agreed this action would be closed.

Action 43/24: Audit Wales Reports: *In terms of the digital deep dive scheduled for 2024/25 and whether this was being cross correlated across Wales, further information was requested regarding how this information was fed into National Frameworks.* The review will be undertaken at each body across Wales to assess how well bodies understand current and future digital and data risks, challenges and opportunities, how they are planning to mitigate these challenges and risks and how they are delivering and monitoring their digital plans. The review will also seek to understand the role of Welsh Government and DHCW in the management of digital services across Wales, particularly within the DHCW-specific report. Audit Wales will share the project brief with committee members in due course. It was agreed this action would be closed.

DRAFT

Action 47/24: Quality and Performance Management Framework (QPMF): *Further information was requested on the three actions in respect of the Trust level work programme that were beyond the Trust's control that were currently paused*. Hugh Bennett explained there were three items currently paused in respect of the Trust level work programme that were beyond the Trust's control; the Commissioning forward plan, the JCC was still forming so it was difficult to work out timelines on this, once JCC becomes more settled this will be actioned. The Strategic Transformation Board dashboard, this has been paused but the methodology of framing this has just been agreed and will be undertaken at the Clinical Model Transformation Programme Board on 11 December. The third one was around staff strategies and plans, and which there was now a forward plan. It was agreed to close this action.

Declarations of Interest:
No other declarations of interest were added to those already on the register.

RESOLVED: The Committee:

(1) Noted the apologies of Rhiannon Beaumont-Wood. Judith Bryce and Liam Wiliams.

(2) Approved the Minutes of 12 September 2024.

(3) Noted there were no further declarations of interests recorded other than those listed on the Register of Interests.

54/24 CHAIR'S REPORT ON CONTINUOUS COMMITTEE EFFECTIVENESS

In terms of this year's Committee effectiveness review, the Chair emphasised a continuous approach to addressing areas that did not score well in the previous year's review. The Committee was transitioning to a continuous effectiveness review approach instead of an annual review. He stressed the importance of ongoing feedback from all members and staff to improve the Committee's effectiveness.

The Committee further discussed the questionnaire for identifying best practices but noted the need for a hybrid approach, combining collective views and focusing on qualitative questions. They felt the current questionnaire/approach was not fit for purpose and advocated for a streamlined approach.

RESOLVED: The update was noted.

DRAFT

55/24 RESOURCING POLICY (LIMITED ASSURANCE) – INTERNAL AUDIT

The Resourcing Policy Internal Audit was received at this stage of the agenda due to other commitments of the Executive Director of Operations.

Lee Brooks explained that the internal audit for the resourcing policy, which resulted in a limited assurance opinion, had been anticipated. He stressed that the audit had been initiated with the understanding that there were areas that required improvement. He added that the limited assurance outcome was not a surprise and viewed it as an opportunity to create the impetus for necessary progress in those areas requiring improvement going forward.

Jonathan Sweet discussed the outcomes of the resourcing policy internal audit, highlighting several key points:

The current policy was more of a procedure document and does not translate well across all functional areas of operations. It was very EMS response-focused and does not meet the needs of a modern service.

The management team has acknowledged the recommendations, and progress has already been made in some areas, such as process mapping of local arrangements and working time breach reporting.

Discussions have started with the senior operations team to develop departmental standard operating procedures and review the resourcing policy to make it fit for a modern service.

The Team recognised the complexity of the task and the need for significant consultation and engagement with staff and Trade Union partners. Overall, the Team was committed to addressing the recommendations and improving the resourcing policy to better meet the needs of the service.

Damon Turner queried how the scope of the audit was determined and asked why overruns were not included. Lee Brooks explained that the scope of the audit was determined through a standard approach involving himself and Judith Bryce. The audit focused on the resource policy, and since overruns were not a matter for the resource policy, they were not included. However, Time off In Lieu (TOIL) was included because it was a feature of resource management.

On the matter of Trade Union (TU) consultation, Lee Brooks commented that that for future audits, especially those closely related to staff, it would be beneficial to involve TUs in setting the audit agenda.

DRAFT

Ceri Jackson asked a specific question about the management action plan, particularly focusing on the working time breaches and whether these breaches should be reported to the Executive Leadership Team (ELT). Lee Brooks suggested that the oversight and assurance reporting on working time breaches should be strengthened and proposed that this reporting should go through the Senior Operations Team (SOT) and then be provided to the Senior Leadership Team (SLT).

RESOLVED: The Committee received the Resourcing Policy Internal Audit Report.

56/24 AUDIT WALES REPORTS

Fflur Jones provided an update on the financial audit and performance audit work. She mentioned that the accounts were completed, and the charitable funds work was due to begin shortly, with no issues reported so far.

She also highlighted the deep dive into financial efficiencies and the Structured Assessment, which were both on the agenda. Upcoming work included the follow-up Review of Quality Governance arrangements and the review of unscheduled care, both of which neared completion.

Additionally, she mentioned the Deep Dive on Digital Systems review, with the scope to be finalised and shared with the Committee in due course. Fflur Jones agreed to send an email between meetings to keep the Committee updated on the timeline for the deep dive on digital systems.

In terms of the follow up Review of Quality Governance Audit follow up audit, the Committee inquired whether there was anything specific to alert the committee to, given that the review was almost ready. Fflur Jones responded that the follow-up review of quality governance was nearly finalised. She noted that while there had been progress on each recommendation, some were not fully completed, and further arrangements could be strengthened. Specifically, out of eight recommendations, three were considered complete, one was superseded, and four were in progress.

Ceri Jackson asked for assurance that the timeline for the filing of the charity accounts by the end of January would be met, having expressed concern about compliance issues. Fflur Jones gave assurance that the financial audit team has been engaging with Chris Turley and his team to discuss the timelines and that no issues have been reported. She was therefore confident that Audit Wales would meet the required timelines. Chris Turley confirmed that the timelines for the Independent Examination of the charity accounts had been discussed with Audit Wales colleagues. He assured the Committee that both sides were aligned to meet the filing deadline of 31 January 2025, with the Charity Committee meeting planned for mid-January to receive the accounts.

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Review of Cost Savings Arrangements

Fflur Jones presented the report noting that the review had been very positive, adding that the Trust has a good understanding of its cost drivers and has identified all its savings for the year, which was an improvement from the previous year. The Trust recognised areas for improvement, such as increasing recurrent savings. There were some discrepancies in reported figures, but these have been clarified. The Trust regularly reviews risks and reports savings performance to the Board and the Finance and Performance Committee.

Chris Turley welcomed the report, stating that it did not present any unexpected findings. He mentioned that one recommendation had already been addressed and another was detailed in a previous gateway review. He added that the Trust was delivering more on recurrent savings than initially planned, which should help boost the percentage of recurrent savings in the future.

Structured Assessment

Fflur Jones presented the report and highlighted the following areas of note for the Committee's attention:

The Trust has maintained an excellent track record for developing Integrated Medium Term Plans (IMTP) that met Welsh Government approval and financial duties. There were strong arrangements in place for developing other plans, including the Strategic Quality Plan and the Digital Plan.

The Board and committees operated effectively with high levels of transparency and a full complement of members. There was significant ongoing work to strengthen areas such as the Board Assurance Framework, audit tracking, and quality management.

There was regular oversight of financial spending and savings performance, with good levels of scrutiny and challenge from Board Members.

Trish Mills acknowledged the positive report and confirmed that the Trust was already addressing the recommendations.

The Committee congratulated all those involved with the continuous improvement of the work being undertaken.

RESOLVED: The Audit Wales update report and the review of cost savings arrangements and Structured Assessment reports were received.

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57/24 INTERNAL AUDIT PROGRESS REPORT AND INTERNAL AUDIT REPORTS

Osian Lloyd provided his Internal Audit Progress report update:

The audit plan was on track with no concerns raised about the delivery of the plan so far, with some audits scheduled towards the end of the year. Four reports have been finalised, including the Patient Experience Community Involvement report, which had been completed and will be presented to the Committee at its meeting in March.

There are new global internal audit standards which will become effective from 1 April 2025. Preparatory work has been undertaken to understand the impact and ensure appropriate application of the revised standards, going forward. No significant changes to the audit approach were anticipated; but there may be a need for more evidence on the implementation of agreed management actions.

The indicator for management's response to audit recommendations was currently showing as red, indicating a deterioration from the previous status.

Trish Mills advised the Committee that she and Osian Lloyd met monthly to review each item on the audit plan, ensuring close monitoring of progress. Recent delays in management responses were attributed to several factors, including a series of Committee meetings and multiple Audit Wales reports arriving simultaneously. Trish agreed to emphasise the need for timely responses and will take this issue back to the Executive Leadership Team and similarly with the Assistant Directors Leadership Team.

Internal Audit Reports

Integrated Quality and Performance Management Framework (QPMF) (Reasonable Assurance): Felicity Quance explained that the purpose of the audit was to assess the adequacy and effectiveness of the Trust's governance and operational management of quality and performance.

Felicity added that discussions were held with Audit Wales to understand themes from their recent Follow-Up Review of Quality Governance arrangements, to ensure comprehensive coverage.

The audit concluded with a reasonable assurance rating, identifying three high-rated and five medium-rated recommendations. These included reviewing the communication plan for the quality and performance management framework to ensure actions were clear, defined, and achievable and to review the governance structure to ensure sufficient oversight of the framework.

Trish Mills commented that one of the priorities for the Committee was to monitor and oversee the implementation of the QPMF. She suggested transferring the oversight of the

QMPF and its ongoing effectiveness to the Finance and Performance Committee (FPC), in line with FPC's Terms of Reference. The ARAC will instead receive periodic updates on the effectiveness of the QPMF from the Finance and Performance Committee going forward, by way of assurance – through the FPC's Annual Report

Overtime Controls (Reasonable Assurance): Felicity Quance advised that the audit aimed to provide assurance on the adequacy of processes in place to control and monitor overtime allocation in line with the Trust's financial savings plan.

The audit covered planned overtime but did not include unplanned overtime such as overruns due to patient handovers.

Two matters arising led to three medium-priority recommendations with a conclusion that the audit was a reasonable assurance rating.

The Trust's overall overtime usage remained within the allocated budget, however there was scope to better demonstrate the linkage between the review of hours and the rationale for amendments in overtime allocation.

The testing of overtime payments matching timesheets and payroll returns revealed no issues, but the process was manual and time-consuming, requiring significant development for automation going forward.

The management have accepted the findings and have provided responses to address and take forward the recommendations.

Jonathan Sweet welcomed the review and acknowledged the interdependencies with the resourcing policy. He advised that work was already progressing on the management actions required, particularly in formalising the mechanism to capture changes in overtime allocation. There will be subsequent reporting to the senior operations team and the senior leadership team, including an assessment of variations and a robust rationale for any changes in the local approach. The introduction of the electronic timesheet was a priority, and it will be featured in the next IMTP for the following year.

Christian Fox referred to objective 2.18 in the report which reflected the workforce as being EMT Band 4, it was agreed this required changing to state EMT Band 5 and it was asked for this to be updated to reflect the change. Jonathan Sweet noted this comment and will ensure it is updated.

Data Quality (Reasonable Assurance): In presenting the report, Martyn Lewis acknowledged that the Trust was making timely progress in developing a data quality culture, supported by a strategy and commitment to enhancing data quality.

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There were some underpinning policies within the data quality policy which were out of date and required updating. Policies were not published on the website, and this was an organisational decision.

There was no specific training for data quality, though it was included in the Information Governance (IG) training. It was noted that compliance with IG training had fallen below 75%, which may hinder achieving a full data quality culture.

There were many data silos within the Trust, and work was ongoing to develop an information asset register to ensure asset owners were fully up to date.
Data quality was reported to the IG steering group, but discussion on data quality has been limited, there have been no data quality metrics or Key Performance Indicators (KPI) developed to provide a clear status of data quality.

Jonny Sammut thanked the audit team for their work on the review and acknowledged the progress made despite limited resources.

In response to the two high-level recommendations regarding the requirement for additional resources recruitment for these positions was underway, with around 20 applicants for the Data Quality Manager and 40 for the Data Quality Analyst.

In terms of the Information Asset Register training was scheduled for information asset owners to ensure data quality at the source and to identify and flag risks.

The team will review where data silos exist within the Trust and provide recommendations to the Executive and Committee going forward.

The issue of public website policies was a corporate stance, with plans to review this in 2025-2026.

Resourcing Policy (Limited Assurance): The Committee noted this item had been discussed earlier in the meeting. Felicity Quance highlighted that Lee Brooks requested the audit due to the policy not being updated for 10 years. The audit did not include an assessment of the adequacy of rosters, the method for uploading rosters, or testing information on the global rostering system or shift track.

Discussions with locality managers and staff were not included; the focus was on corporate arrangements and regional resourcing teams' management.

Local arrangements varied and were not formally defined or quantified, requiring the development of standard operating procedures for clarity.

Systems were in place to capture key requirements like annual leave, sickness, TOIL, and Trade Union time, but there was a lack of review and reporting on working time breaches.

The process for TOIL needed further clarity due to ambiguous policy language.

There was no reconciliation of sick leave between the Trust's Global Rostering System (GRS) and the Electronic Staff Record (ESR), with limitations in system interconnectivity being addressed.

Inconsistent processes were applied across Wales, with work in early stages to map and consolidate these processes for fairness and effectiveness.

Reporting on outside resource authorisations needed enhancement, with no reason codes currently included in GRS for management information.

Jonathan Sweet agreed with the limited assurance outcome of the audit, acknowledging that the current resourcing policy was more of a procedure than a policy document and did not translate well across all functional areas of operations. Management has acknowledged the recommendations, and progress has already been made in some areas, such as process mapping of local arrangements and reporting mechanisms for working time breaches. Significant consultation and engagement with staff and Trade Union partners will be required to develop departmental standard operating procedures and review the resourcing policy and TOIL process. The work will involve the wider directorate, senior operations team, and senior leadership team to ensure appropriate resourcing and delivery.

RESOLVED: The Internal Audit Progress report and the Internal Integrated Quality and Performance Management Framework, Overtime Controls, Data Quality and Resourcing Policy Audit Reports were received.

58/24 RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK

Julie Boalch provided an update on the Risk Transformation Programme, highlighting the progress made and the next steps, including the development of the new Strategic Board Assurance Framework (BAF) and Risk Appetite Statements. She added there was potential to use a digital solution to support this work. Julie Boalch also added that she could bring a more detailed programme update, including timelines, to the next meeting. It was further recognised that the Trust has commissioned additional external support to assist with developing risk appetite statements and conducting workshops. The first workshop, planned for December, will focus on training and understanding risk appetite, while the second workshop in February will develop the Trust's risk appetites against strategic objectives. Julie Boalch added that she would collaborate closely with colleagues to ensure that the dates of the workshops will have full participation.

Julie Boalch provided updates on the principal risks and noted that some scores have been reduced due to positive engagement and mitigations. Specifically, 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*) was reduced from 20 to 15, and risk 163 (*Maintaining Effective & Strong Trade Union Partnerships*) was reduced from 16 to 12. Both risks will remain on the Corporate Risk Register for ongoing monitoring and mitigation.

Trish Mills noted that the Committee should own the monitoring and oversight of the strategic BAF carefully. She stressed the importance of not rushing into a strategic BAF before working out both the line of sight and the digital solution.

RESOLVED: Members considered and discussed the contents of the report and:

(1) Noted the progress of the Risk Management Transformation Programme: specifically, the development of risk appetite statements and strategic Board Assurance Framework.
(2) Noted the next steps in relation to a digital risk management solution.
(3) Noted the ongoing repositioning of Risks 223 and 224.
(4) Noted the reduction in score for Risk 163 from 16 (4x4) 12 (3x4) and Risk 594 from 20 (4x5) to 15 (3x5). Both risks will remain on the Corporate Risk Registers for ongoing management.
(5) Received assurance on the review and attention to the principal risks, including their review at ADLT, ELT and at relevant Committees.
(6) Noted the ratings and mitigating actions for each principal risk.

59/24 AUDIT TRACKER

Trish Mills updated the with the current position with respect to management actions for audits within the purview of the Audit, Risk and Assurance Committee (ARAC), in addition to the wider progress in Quarter two 2024/25.

There has been exceptionally good engagement with Directorates on the revised Tracker 2.0 for quarter two, with the result that of the total of 115 internal audit actions on the Tracker, 43 have been closed in quarter. This was a closure figure of 37% of all internal audit actions (25% in the previous quarter). Progress has been particularly good with actions assigned to the Finance and Performance Committee.

Of the total internal audit actions, 33 of the 115 actions have been given proposed revised dates in quarter, which was 29% of the total (31% in the previous quarter). There was narrative included in the report regarding the closure of action 470 from the 'Asset Management RAM System' internal audit.

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In terms of the external audit actions where the ARAC was the owning Committee, both outstanding actions have been closed in quarter (100%). These actions were from the 2023 Structured Assessment and related to oversight of the IMTP delivery and oversight of the Trust savings plan.

The following Internal Audit reports and the relevant actions were given updates on by the responsible Director as follows:

Andy Swinburn:

Pain Management Internal Audit

Action 604 (The Trust should ensure all Patient Group Directions (PGD)s follow the Medicines Management policy, with a review undertaken every three years as a minimum). Andy Swinburn mentioned that the Trust now has its own pharmacist. who has started working on this issue. The delay was due to reliance on external bodies for approvals, but now the Trust has control over the process.

Senior Paramedic Role Internal Audit

Action 612 (A training plan and expected timeline for the required clinical skill enhancements should be established) Training has been completed for 59 staff members, with only four remaining, who were new recruits, and these will be completed shortly.

Action 613 (The terms of reference should be reviewed to: Include a defined pathway for escalation of issues; Update membership to ensure representation from each locality; and Define quoracy). Adjustments have been made to the terms of reference, and they will be coming back through the Senior Operations Team (SOT) for approval.

Action 614 (The Trust should undertake a lessons learned exercise on the development and evolution of the SP role.) There has been minimal movement against this due to capacity issues and it was agreed that the date of completion be extended.

IM&T Infrastructure Internal Audit

Jonny Sammut addressed actions 624 (The process for clearing all PRTG/system alerts should be formalised and documented) and 625 (Switches should be identified within the asset register), explaining that the delays were due to prioritising the CAS implementation and upgrades to the 999 telephony suite. The new helpdesk IT software, House on the Hill, was now in place, and the team was working on its configuration. He was confident that they will meet the revised date for these actions.

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Records Management Internal Audit

In terms of action 657 (Records should be moved into the new storage area). Jonny Sammut explained that the data quality team was currently only 0.4 Full Time Equivalent, but two new positions have been advertised (Data Quality Manager and Data Quality Analyst) and received a good number of applicants. This will help address the high-level recommendations around the information asset register and data quality improvement.

111 Commissioning Final Advisory Report

In respect of action 643 (The Trust should obtain written confirmation of the escalation process to be followed within the current governance structure). Hugh Bennett mentioned that the escalation arrangements with the Commissioners were well-established and have been agreed upon. A letter has been drafted and was currently awaiting Rachel Marsh's signature for closure.

The Committee were assured that actions on their third revised date were being actively managed and were expected to be completed by the revised deadlines. Members acknowledged the updates and assurances on the progress of specific actions, with the Directors explaining the reasons for delays and the steps being taken to ensure completion by the revised dates.

RESOLVED: The Committee:

(1) Received assurance that the management actions for the audits within the purview of this Committee and overall were being effectively and appropriately managed, closed off in quarter or clarity provided on dates which have moved and rationale. It was noted that the actions against the Cyber-Security and Technical Resilience internal audit will be received in closed session.

(2) Received and review any Internal Audits and Audit Wales reviews within their remit where relevant. For this meeting these were the following internal and external audits. It was noted that the internal audits a-c were received by the Finance and Performance Committee on the 19 November 2024:

Internal Audits

a) Quality and Performance Management Framework (Reasonable)
b) Data Quality (Reasonable)
c) Overtime Controls (Reasonable)
d) Resourcing Policy (Limited)

External Audits

e) Structured Assessment 2024
f) Review of Cost Savings Arrangements.

60/24 POLICY REPORT

Julie Boalch provided an update on the Policy Report, highlighting significant progress over the last 16 months. The percentage of policies within their review date has increased from 14% to 46%. She noted that out of 47 policies identified as priorities for review in the 2023-2024 and 2024-2025 work programmes, only 12 have been reprioritised to the 2025-2026 work programme. Julie acknowledged the collaborative effort across the Trust to achieve this progress.

Julie Boalch explained that the 42 policies identified for the 2025-2026 work program have been assigned priority numbers from 1 to 10. Policies with priority numbers 1 to 3 were considered high priority and were expected to be completed next year. She also mentioned that while the focus will be on these high-priority policies, additional policies may be reviewed depending on activity and changes in legislation or practice.

The All Wales Recovery of Overpayments Policy (English Version) was erroneously omitted from the papers; this would be circulated separately by the Corporate Governance team to Members as a Chair's action for approval, to avoid any delay in its adoption.

RESOLVED: The Committee

(1) Considered the progress to bring the Trust's Policies up to date and endorsed the future work plans for the remainder of this work.

(2) The All Wales Recovery of Overpayments Policy (English Version) would be circulated separately to Members as a Chair's Action for approval.

61/24 NEAR MISS AND LOW HARM INTELLIGENCE REPORT

Bethan Evans, Chair of the Quality, Patient Experience and Safety Committee (QuEST) provided an overview of the near miss and low harm intelligence report, emphasising its importance for the Trust. It should be noted that the QuEST Committee received an update at their meeting on 5 November 2024. Bethan Evans highlighted the following key points for the Committee's attention:

The report covered near misses and low harm incidents recorded from September 2022 to September 2024.

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The QuEST Committee agreed to include future reporting and analysis of all near misses and low harm incidents within the Putting Things Right (PTR) report.

The analysis showed a high volume of grade one and grade two complaints, many of which were assessed as near miss opportunities for learning.

The main causes of these incidents were handover delays and immediate release requests being declined. Recent improvement work on the use and scope of the Datix Cymru Incident Module by the Quality Governance and Assurance Team have reduced this type of trigger-reporting and will enable more effective analysis of incidents in future.

The QuEST Committee recognised the value of near misses for moving from a reactive to a proactive approach to patient safety.

The QuEST Committee will continue to monitor and analyse lower-graded incidents, especially as the clinical model transformation program progresses.

The ongoing scrutiny and analysis will be reported through the AAA report to the Trust board after each meeting.

The Chair asked about the Executive ownership and accountability for this area. Bethan Evans confirmed that the Quality and Nursing Directorate owned this responsibility, and there has been recent investment in the Putting Things Right (PTR) team to address resource challenges. She also mentioned that Claire Appleton, operating at assistant director level, oversaw the PTR agenda.

That the Committee:

(1) Approved the future reporting of near misses being included in the quarterly Putting Things Right Report to Committee.

(2) Received assurance that the Chair of the QuEST Committee would provide assurance to the Audit, Risk and Assurance Committee on the future approach.

62/24 LOSSES AND SPECIAL PAYMENTS – 1 June to 30 September 2024

Chris Turley advised that this report presented to the Committee gave details of Losses and Special Payments made during the four months from 1 June to 30 September 2024. The losses and special payments made during this period amounted to £186K net repayments

RESOLVED: The Losses and Special Payments Report for the period 1 June to 30 September 2024 as received.

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63/24 COMMITTEE HIGHLIGHT REPORT (NO ALERTS FROM SEPTEMBER 2024)

No further comments were made to the report.

RESOLVED: The update was noted.

64/24 CYCLE OF BUSINESS MONITORING REPORT AND COMMITTEE PRIORITIES

Trish Mills added there were no matters to escalate to ARAC from the Cycle of Business.

RESOLVED: The Committee.

(1) Confirmed its assurance on the implementation of the Quality and Performance Management Framework (QPMF) within the Trust (agreed earlier in the meeting Item 57/24), noting ongoing work which will continue to evolve. This will allow for the oversight of the QPMF and its effectiveness to move to the Finance and Performance Committee;

(2) Noted the update on the Cycle of Business Monitoring Report for the Committee.

65/24 REFLECTIONS AND SUMMARY OF ACTIONS

Hybrid Meeting Success: The hybrid meeting format was deemed successful, with positive feedback on the room configuration and the effectiveness of minimising chat to maintain engagement.

Focus on Third Revised Dates: Ceri Jackson highlighted the importance of focusing on third revised dates for action items, which allowed for detailed discussions and ensured effective tracking of actions.

Acknowledgment of Efforts: The Chair acknowledged the hard work of the directors and the team in managing the audit tracker and ensuring actions were addressed. He emphasised the importance of directors' involvement in providing updates and explanations for action items.

Overall Satisfaction: Participants expressed satisfaction with the meeting's structure and the progress made on various agenda items.

Meeting concluded at 12:20

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

AGENDA ITEM No	**3.1**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**1**

Audit, Risk and Assurance Committee: Ratification of Chair's Action

MEETING	Audit, Risk and Assurance Committee (ARAC)
DATE	06 March 2025
EXECUTIVE	Trish Mills, Director of Corporate Governance/Board Secretary
AUTHOR	Alex Payne, Corporate Governance Manager
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. There was a matter of business which required decision by the Committee, which was dealt with via Chair's Action in November 2024, due to the omission of the document from the agenda pack at its meeting in November 2024.

2. The request was for the adoption of the All-Wales Procedure for the Recovery of Overpayments. It was noted that the procedure was endorsed by the Policy Group prior to receipt by the Audit, Risk and Assurance Committee (ARAC).

3. The request was issued by email on the 21 November 2024 and the decision to adopt the procedure was made on the 02 December 2024 following the required committee engagement. No issues or questions were raised.

RECOMMENDATION:

4. **The Committee is asked to RATIFY the decision made by Chair's Action to adopt the All-Wales Procedure for the Recovery of Overpayments on the 02 December 2024.**

KEY ISSUES/IMPLICATIONS

Not applicable.

REPORT APPROVAL ROUTE
Not applicable.

REPORT APPENDICES
Annex 1: All-Wales Over Payments Procedure (English) Annex 2: All-Wales Over Payments Procedure (Welsh)

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

PROCEDURE FOR THE RECOVERY OF OVERPAYMENTS – Salary & Expenses

Procedure Status: FINAL APPROVED
Procedure Issued: September 2024
Implementation Date: October 2024
Review Date: October 2027

Procedure for the Recovery of Overpayments

Index

1. Introduction
2. Procedure Statement
3. Aims
4. Equality
5. Objectives
6. Scope
7. Overpayment Recovery Process
8. Dispute Resolution
9. Training and Awareness
10. Information Governance

Appendix A - Roles & Responsibilities

Appendix B – Reasons overpayments occur

Appendix C – Adjustment to Salary Letter

Appendix D – Income & Expenditure Template

Appendix E - Overpayments Process Map

Appendix F – Overpayment Letter 1

Appendix G – Overpayment Letter 2

Appendix H – Overpayment Letter to Line Manager

Appendix I – Salary Deduction Authorisation

Appendix J – Counter Fraud Assessment form

1. Introduction

This Procedure has been written to bring a unified approach in how an overpayment should be handled across NHS Wales. This All-Wales procedure will replace any existing local processes to ensure consistency by NHS Wales Shared Services Partnership Payroll Services and NHS Wales Organisations upon the identification of an overpayment.

An overpayment is defined as any monies incorrectly paid to a current or former employee or worker through the payroll system.

2. Procedure Statement

Everyone involved in the application of the procedure will be treated with respect and dignity throughout the process.

It is recognised that overpayments are not usually the fault of the employee or worker, and this procedure seeks to support those who have been overpaid to have the overpayment recovered in a fair and reasonable manner.

Overpayments primarily arise from a "mistake of fact" (where a payment was inconsistent with the facts e.g. due to clerical, computer input or procedural error). NHS Wales Organisations have a legal right to recover any overpayments which have arisen from a mistake of fact.

NHS Wales Organisations must pursue the recovery of all overpayments regardless of fault. NHS overpayments come out of public funds and therefore NHS Wales Organisations have an obligation to recover them although this must be done in a fair and reasonable way.

Consideration will be given to individual needs and financial circumstances.

3. Aims

This procedure aims to standardise the recovery of overpayments to ensure consistency across NHS Wales.

It also aims to ensure all overpayments are recovered efficiently and as quickly as possible without imposing hardship and to ensure that employees, ex-employees, workers and ex-workers are treated fairly and consistently without any needless stress or worry.

4. Equality

NHS Wales aims to provide a safe environment free from discrimination and a place where all individuals are treated fairly, with dignity and appropriately to their need. It is recognised that equality impacts on all aspects of day-to-day operations and all policies and procedures have an Equality Integrated Impact Assessment (EqIIA) undertaken and Welsh Language Impact Assessment undertaken.

We will ensure that we deliver this procedure in line with the requirements of the Welsh Language Standards, specifically:

- Making our service available in Welsh that is equal to the English language service that we provide by:
  - Providing Welsh language correspondence to staff through the medium of Welsh without staff having to request this.
  - Provide any communication about this procedure through the medium of Welsh without staff having to request communications from us through the medium of Welsh.
  - Provide a telephone service through the medium of Welsh that is equivalent and equal to the English language service that we provide.
  - Make available all documents and forms in relation to this procedure and its delivery available through the medium of Welsh without hesitation or delay.
  - Ensure that information about this procedure is available on our intranet pages and webpages are available to NHS Staff.
  - Any social media posts relating to this procedure will be made available through the medium of Welsh at the same time as English medium posts are available.

5. Objectives

The objectives of this procedure are to ensure:

- An equitable process for the recovery of overpayments while allowing the personal financial circumstances of those who have been overpaid to be considered.
- The recovery of the overpayment should be affordable and sustainable.
- The responsibilities of those who may be involved in the process are made clear - Appendix A.
- The potential reasons for overpayments are explained - Appendix B.
- The reduction in the frequency of overpayments through using information found in this procedure to educate and improve.

6. Scope

This procedure will apply to employees, ex-employees, workers and ex-workers of NHS Wales Organisations and covers both manual and electronic systems utilised across NHS Wales.

Where NHS Organisations have rolled out Manager Self-Service (MSS) in the Electronic Staff Record (ESR), the Line Manager should utilise MSS to update employees' assignments. If MSS is not fully rolled out, information should be communicated to Payroll Services using the forms/Staff Movement Advice (SMA) available under Useful Documents through the Organisations page on the link below.

This link also details Payroll Services contact information: Payroll Services (sharepoint.com)

7. Overpayment Recovery Process

Automatic Recovery

There may be circumstances where an overpayment could be automatically recovered from future salary payments.

This will only happen if the following applies:

- The overpayment was a result of late notification of changes i.e. a change of hours, termination of employment, sickness, pension or other absence **and**
- The change or termination of employment should have been actioned less than one month before notification was received by Payroll Services **and**
- The deduction will not amount to more than a 30% reduction in gross monthly pay.

If all these criteria are met, the overpaid salary will automatically be recovered over a maximum 3-month period. Gross monthly pay overpayments of 0-10% will be recovered over 1 month, 10-20% over 2 months and 20-30% over 3 months.

If an automatic deduction is to happen, Payroll Services will inform the individual before pay day by sending an **Adjustment to Salary Letter** (Appendix C). The letter will detail the intended recovery values per month. This is intended to provide an affordable and sustainable recovery option. Tools to help you work out what is affordable can be found at Appendix D.

If the proposed overpayment recovery timescale is not affordable, NWSSP Payroll Services can be contacted via the contact information provided on the letter. If recovery cannot be agreed over the 3-month period, the overpayment will be referred to the All Wales Overpayments Team to progress the standard recovery procedure outlined below.

If the individual terminates their employment before the overpayment is repaid in full, payroll will contact the individual with a view to recovering the outstanding amount from the final salary.

Standard Recovery

Where an overpayment is a larger sum of money and/or has occurred over a longer time period, so the criteria for automatic recovery are not met, the standard recovery process will be as follows.

This is also set out in a flow chart at Appendix E.

1. Payroll Services will send **Overpayment Letter 1** (Appendix F) to the individual who has been overpaid as soon as they are made aware of a potential overpayment.
   The letter will provide notice that a potential overpayment has occurred, detail the reason for the suspected overpayment and the period it relates to (if known). It will reference the follow up letter (**Overpayment Letter 2** – Appendix G) that will be sent with the detailed overpayment calculation once confirmed.
2. Payroll Services will send an email with an attached letter to the individuals Line Manager informing them of the potential overpayment (Appendix H). This may include an MS Forms link to provide details or reasons for why and how the overpayment may have occurred and a video link explaining how to reduce overpayments in future.

3. Once the overpayment has been calculated, Payroll Services will issue **Overpayment Letter 2** to the individual and their Line Manager detailing the overpayment calculation (Appendix G). The Finance Department from their Organisation will be copied into this letter.

(a) Where the individual remains in post within the Organisation:

Overpayment Letter 2 will show the calculation of the overpayment and the full value. The letter will explain that the overpayment will need to be recovered in full and the ways this can be done.

We aim to recover any overpayments over the same time frame as the overpayment occurred e.g. if you were overpaid for 3 months, this should be recovered over 3 months. There is also the option to repay the overpayment as a lump sum or to discuss the arrangement of a more affordable monthly recovery option.

Any requests to recover the overpayment in excess of 12 months will need to be agreed by the Director of Finance and/or Director of Workforce/People for that Organisation or their nominated deputies. Any requests will be reviewed with consideration of how and when the overpayment occurred and the individual's financial circumstances.

There can also be the consideration of alternative options such as undertaking additional hours to pay back the sums owed.

Overpayment recoveries should be made via salary unless you choose to repay in full separately or agree to set up a standing order.

Overpayment Letter 2 will mention that an invoice will be sent shortly, and this will include information on who you can contact to agree the recovery of the overpayment.

The Finance Department for your Organisation will receive a copy of this letter so that the invoice can be sent. They will note that you are a current employee or worker who may have recoveries made via salary deductions.

A copy of the salary deduction request proforma is included in Appendix I to be completed if requested.

Tools to help you work out what is affordable can be found at Appendix D.

(b) Where the individual is no longer working for the Organisation:

Overpayment Letter 2 will show the calculation of the overpayment and the full value. The letter will explain that the overpayment will need to be recovered in full and the ways this can be done.

The letter will mention that an invoice will be sent shortly, and this will include information on who you can contact to agree the recovery of the overpayment.

The Finance Department for your Organisation will receive a copy of this letter so that the invoice can be sent. As the individual is no longer an employee or worker for the Organisation, recovery via salary is not possible so payments can be made by Standing Order, Bank Transfer, Cheque or Debit/Credit Card (where Organisations have this facility).

We aim to recover any overpayments over the same time frame as the overpayment occurred e.g. if you were overpaid for 3 months, this should be recovered over 3 months. There is also the

option to repay the overpayment as a lump sum or to discuss the arrangement of a more affordable monthly recovery option.

Longer recovery periods **may** be possible but will need to be agreed by the Director of Finance and/or Director of Workforce/People for that Organisation or their nominated deputies.

Tools to help you work out what is affordable can be found at Appendix D.

The Finance Department reserves the right to progress debt collection procedures through a debt collection agency once local Organisation procedures and attempts to collect the outstanding debt have been exhausted.

Counter Fraud

There may be occasions where an overpayment needs to be assessed by Counter Fraud Services.

An initial high-level assessment by Counter Fraud Services will be requested only if **all three** of the criteria below are met which indicate there may be evidence to suggest fraud may have occurred:

1. The individual has not notified the Organisation/Line Manager/Payroll Services of the overpayment; **and**

2. The overpayment has occurred for more than 3 months; **and**

3. The overpayment value is estimated at more than £5,000

If all three criteria are met, Payroll Services will send a notification to the relevant Local Counter Fraud team using the review form in Appendix J.

Local Counter Fraud teams will make an initial assessment and advise within 5 working days if an investigation is required, or if the overpayment recovery can continue with the usual recovery procedure. If no response is received from the Local Counter Fraud team within 5 working days, Payroll Services will request final confirmation to continue with recovery of the overpayment in line with this procedure and as shown in Appendix E.

Any overpayments under initial assessment by Local Counter Fraud teams are included under the Counter Fraud section of the overpayments dashboard. Senior Workforce/People and Finance colleagues within Organisations have access to this dashboard to monitor assessments being undertaken.

If Counter Fraud Services identify that further investigation is required, the overpayment recovery will be placed on hold by Payroll Services until further advice is received from the Local Counter Fraud team.

Prior to further investigations commencing, the Local Counter Fraud team will follow local Organisation procedure for informing the Director of Workforce/People and/or Director of Finance of the details of the case to be investigated. This may include obtaining any agreement to further investigation if required locally by Organisations. In the event of any local disagreement on the correct course of action, the Local Counter Fraud team will seek advice from the national NHS Counter Fraud Service Wales.

To ensure any potential criminal investigations are not compromised, it is important that no contact is made with the individual who has been overpaid until the Local Counter Fraud team has confirmed they do not need to investigate the matter further.

8. Dispute Resolution

Where an individual refuses to consent to the recovery of the overpayment and where discussions have been exhausted, the overpayment should be referred to the Director of Workforce/People and/or Director of Finance or their nominated deputies for the Organisation with the aim of reaching an agreement for the recovery of the overpayment, taking into account the individual's personal circumstances.

A meeting should be arranged between the individual who has been overpaid and the Director of Workforce/People and/or Director of Finance or their deputies. The individual has the right to be accompanied by either a Trade Union representative or a workplace colleague.

Members of the Finance team or Payroll Services along with the Line Manager or Budget Holder may also be requested to attend this meeting where it would be helpful. The proposed outcome of the meeting may require approval by the Director of Finance or other authorised budget holder if they are not present at the meeting.

Where an individual feels they have been treated unfairly, they are encouraged to use the Respect and Resolution policy. No further action should be taken on recovery during any dispute resolution process including a complaint under the Respect and Resolution process.

If you have left NHS Wales employment and have been unable to reach an agreement, you may be able to get support through:
Acas | Making working life better for everyone in Britain or
Work - Home (citizensadvice.org.uk)
Or your Trade Union if you are still a member (if you pay through your salary, you can switch to Direct Debit to maintain membership).

It is important to remember that there is a legal right for NHS Organisations to recover any overpayment. NHS Organisations reserve the right to engage a debt collection agency should it be required.

9. Training and Awareness

NHS Organisations should make employees or workers and managers aware of this procedure on commencement. A copy of the procedure should be available on the NHS Organisation's Intranet Site and referenced in any induction and/or new manager training.

Overpayments can be minimised if everyone does their part. Managers can ask for guidance on how to ensure prompt and accurate updates of employment information including new starters, changes, terminations, and employee or worker absence should they require.

Delayed submission of payroll documentation or Manager Self-Service updates can cause significant inconvenience and anxiety for staff and unnecessary additional administration for

NWSSP Payroll Services. It can also lead to complexities for those affected in respect of tax and universal credit issues.

The roles and responsibilities of all parties detailed in this procedure are outlined in Appendix A.

10. Information Governance

Any personal data utilised within the application of this procedure will be processed in accordance with the relevant UK General Data Protection (UK GDPR) and records management strategic frameworks and policies.

APPENDIX A

Key responsibilities in respect of the overpayments process can be summarised as:

NHS Wales Shared Services Partnership Payroll Services will: -

- Pay staff correctly and on time in accordance with employee/worker data held on ESR at the point of payrolls being run.
- Make an itemised payslip available to the employee/worker. This will be an electronic payslip where MyESR (Employee Self Service) is in use.
- Inform relevant staff regarding cut-off dates for submission of Electronic Paperwork for example starters, changes, terminations, and variable pay data Payroll Services (sharepoint.com).
- Correct identified errors.
- Undertake an assessment of overpayments against the criteria to establish if a review by Local Counter Fraud Services is required
- Rectify any identified overpayment in line with this procedure for the recovery of overpayments of salary. This will include writing to the employees/ex-employees/workers/ex-workers, providing them with a detailed explanation of the overpayment.
- Inform the Line Manager that an overpayment has occurred and issue a MS Forms link for them to complete an overpayment report, which will request detail on why the overpayment has occurred and what remedial action has been taken to prevent future reoccurrence.
- Maintain a register of overpayments to share monthly/bi-monthly with nominated representatives from each Organisation. NWSSP will inform the NHS Organisation of overpayments, the reasons for them and if there is a recurrence of the manager not complying with processes and procedures relating to employee/worker data.
- Review the register of overpayments with NHS Organisations in the regular Payroll Customer Relationship Manager meetings
- Liaise with local trade union representatives where appropriate.
- Deduct monies from the employees'/workers salary in line with the agreed recovery period where appropriate.
- Upon termination, deduct any outstanding overpayments, overtaken annual leave, including salary sacrifice arrangements from the final salary where possible.
- Deal with overpayment matters with compassion and understanding, noting that in the vast majority of cases the employee/worker is not at fault
- For a limited time after termination of employment, ensure ex-employees/ex-workers have access to their payslips, P60s and P45s via a Leavers Dashboard.

- Liaise with HMRC and/or NHS Pensions if an overpayment is likely to affect tax or pension.

- Implement this procedure through the medium of Welsh in line with the Welsh Language Standards.

Employee/Ex-employee/Worker/Ex-worker Responsibility:-

Employees/Ex-employees/Workers/Ex-workers must:

- Verify basic pay, contracted hours and other regular payments included in their payslip to ensure they are in line with their contract.

- Where applicable, and possible, verify variable hours are correct on e-roster systems before rosters are finalised.

- Raise any payslip queries with their Line Manager in the first instance. This may be in respect of incorrect contracted salary, hours, regular payments, incorrect receipt of variable hours or receipt of any unexpected monies.

- Seek clarification from Payroll Services if their Line Manager cannot resolve any queries on their payslip.

- Immediately inform Payroll Services if an overpayment is identified so that recovery can begin. Any employee, ex-employee, worker or ex-worker that knowingly or willingly fails to advise Payroll Services of an overpayment may be subject to referral to the Local Counter Fraud team and if necessary the Police.

- Agree terms of recovery and ensure full recovery of any overpayments.

- Be aware of payroll cut-off dates to know when to reasonably expect payment of travel, subsistence claims, shifts on e-roster systems or variable pay elements.

- Submit expense claims and additional hours worked claims for payment within 3 months. Please note that any claims older than 3 months will not be processed for payment unless circumstances prevented the submission of the claim in time.

- Ensure the NHS Organisation is aware of any change of address and contact details to be updated via MyESR (Employee Self Service).

- Access support and advice from trade union representatives where applicable.

Line Managers:

Line Managers must notify Payroll Services of any pay impacting changes as soon as they become aware of them and their responsibilities include:

- To complete the employee change notifications and submit to Payroll Services prior to employees/workers commencing new position/hours/base.

- To complete the employee termination process at the point of the employees/workers resignation.

- For employees/workers accessing NHS Pension - in line with NHS Organisations Retirement Policy a termination form must be completed a minimum of 4 months prior to termination.

- To resolve any initial queries received from employees/workers regarding variable hours paid in month or receipt of unexpected payments, advising them they must report any suspected overpayments to Payroll Services without delay.

- To open and close employee/worker sickness absence on their ESR record at the point of notification.

- To notify Payroll Services of any unpaid leave.

- To submit authorised notification of Maternity/Paternity/Adoption/Career Break. Application forms for payment under these policies must be completed and submitted to Payroll Services prior to the date the employee/worker commences the period of leave.

- To verify an employee's/worker's contract details via Manager Self Service and monthly budgets and advise Payroll Services immediately where an employee's/worker's contractual details are incorrect.

- To ensure the employee/worker rotas (where applicable) are correct in accordance with E-roster systems. Discrepancies should immediately be brought to the attention to Organisational E-Systems Teams.

- To ensure payroll workbooks (where applicable) are completed accurately in accordance with the employees/workers working pattern.

- Support individuals who have received an overpayment.

The Workforce/People Department will: -

- Act as a link between NWSSP Payroll Services, the Line Manager, the Finance team and the employee/worker where required.

- Ensure that managers are aware of their requirements to submit payroll data including employee/worker change notifications, termination notifications and e-rostering data in line with published payroll submission deadlines.

- Ensure that managers are aware of the potential for overpayments and their requirement to see that such instances are kept to a minimum.

- Ensure that managers are aware of the Recovery of Overpayments Procedure through the inclusion on induction and Manager training programmes.

- Review overpayment data on a regular basis to identify key themes and any areas where overpayments are a regular occurrence bringing it to the attention of the respective Managers to escalate.

- In conjunction with Senior Finance staff, review and jointly agree any hardship applications with regard to extended recovery periods.

- Ensure individuals who are subject to the overpayment process are treated fairly and compassionately.

Finance/Accounts Receivable Teams will: -

- Be responsible for issuing invoices to individuals to recover overpayments.

- Agree recovery terms in line with this procedure.

- Progress debt collection procedures where recovery of overpayments is not forthcoming.

Local Counter Fraud Teams will: -

- Undertake an initial assessment of any overpayments referred to them by NWSSP Payroll Services that meet the three referral criteria

- Respond to any referrals within 5 working days and confirm to Payroll Services whether normal recovery proceedings can commence or if further investigation is required.

APPENDIX B

Reasons for Overpayments

It is important that all information relating to appointments, changes and terminations are completed promptly and accurately by the Line Manager. Notifications/Staff Movement Advice (SMA) must be submitted to NWSSP Payroll Services or updated on ESR via Manager Self-Serve (MSS) immediately after they have been agreed.

Please note that:

- Employees or workers will continue to be paid according to the details held in ESR until Payroll Services are instructed to do otherwise (i.e. via change form or termination form)
- For changes to be reflected in the next monthly salary, any changes must be notified to Payroll Services by the last day of the current month (i.e. changes to be reflected in the April salary must be notified to Payroll Services by 31st March).
- monthly salary payments cover the period to the end of the month and not only up to the pay date.
- If an employee or worker self-declares an overpayment of salary, with their agreement in writing, Payroll Services will look to suspend the relevant overpaid element of their pay to prevent any further overpayments occurring while the issue is investigated and relevant documentation is requested.

Prevention of an overpayment occurring is paramount.

NHS Wales Organisations must ensure that managers are adhering to policies and procedures that minimise the potential for overpayments.

The most frequent reasons for overpayments are: -

- Late Termination Notification – A termination form, Staff Movement Advice or update via Manager Self-Serve must be actioned as soon as it is known that an employee or worker is leaving their post, i.e. at the point of resignation, end of contract or on dismissal. Consideration must be given to whether the employee or worker has taken the correct amount of annual leave. If they have taken more leave than they have accrued, they can either work additional hours to repay the time, or they can repay the money. If they are owed annual leave, they may be able take the leave off the notice period or can be paid instead if required.
  It is important that the termination form is submitted to NWSSP Payroll Services as swiftly as possible in case a deduction needs to be made from the final salary payment.
- Late and inaccurate update of employee or worker contractual hours – as soon as the new hours are agreed, the information should be passed on via Manager Self-Serve or an employee change form. This should be prior to the date that the employee or worker begins working the new hours.
- Late and inaccurate update of an employee or worker absence (sickness, maternity, unpaid leave etc) – absences should be reported via ESR Manager Self-Serve or submission of forms to payroll as soon as possible and monitored for the duration.

Managers must ensure that the absence is closed as soon as the individual reports as fit for work.
Payroll Services will (on behalf of NHS Organisations) pay 'average sick pay' based on open sickness absence periods. If the absence is not closed, this may lead to inaccuracies.

- Late or inaccurate reporting of enhancements, overtime, on call, start date, salary, banding etc – the manager or supervisor should submit information, changes or variable pay promptly and with enough time for it to be processed by Payroll Services.
- System errors - while these errors do not happen often, once a system error is discovered, action should be taken as soon as possible in order to minimise incorrect payments. These can include ESR, E-roster and E-Expenses.

Where NHS Organisations have rolled out Manager Self-Service (MSS) in the Electronic Staff Record (ESR), the Line Manager should utilise MSS to update employees' assignments. If MSS is not fully rolled out, information should be communicated to Payroll Services using the forms/Staff Movement Advice (SMA) available under Useful Documents through the Organisations page on the link below.

This link also details Payroll Services contact information: Payroll Services (sharepoint.com)

NWSSP Payroll Services will endeavour to keep errors to a minimum, however human error can occur due to inaccurate calculation or misinterpretation of information.

APPENDIX C – ADJUSTMENT TO SALARY LETTER

NWSSP All Wales Overpayment Team
NWSSP Payroll Services
4th Floor
Companies House
Crown Way
Cardiff
CF14 3UB

Private and Confidential

Name
Address 1
Address 2
Address 3
Post Code

Our Ref: JEC/Assignment number
Tel: 02921 500100

Email: NWSSP.AllWalesoverpayments@wales.nhs.uk

Date:

RE: Overpayment of Salary

Dear

We are writing to let you know that we have discovered an overpayment of your salary and/or expenses.

The amount overpaid is **£XXX** and occurred due to the late submission of information to NWSSP Payroll Services relating to a change to your pay that should have been made within the last month.

The All-Wales Procedure for the Recovery of Overpayments classes such an overpayment as an 'Adjustment to Salary' and allows the automatic recovery of overpayments of up to 30% of salary, with 0-10% recoverable in one month, 10-20% over two months and 20-30% over three months. Your overpayment was **X%** of your salary so will be recovered over **X** months.

If you would like further details of the overpayment or feel the planned automatic recovery is not affordable, please contact us on 02921 500100 quoting the reference number above. The team is happy to help and support both employees and managers.

If you would like more information on how the recovery of overpayments are handled, please read the All-Wales Procedure for the Recovery of Overpayments which can be found on the NWSSP Payroll Services sharepoint site link Payroll Services (sharepoint.com)

Yours sincerely,

Insert OP Team Leader Name
All Wales Overpayment Team
NWSSP Employment Services

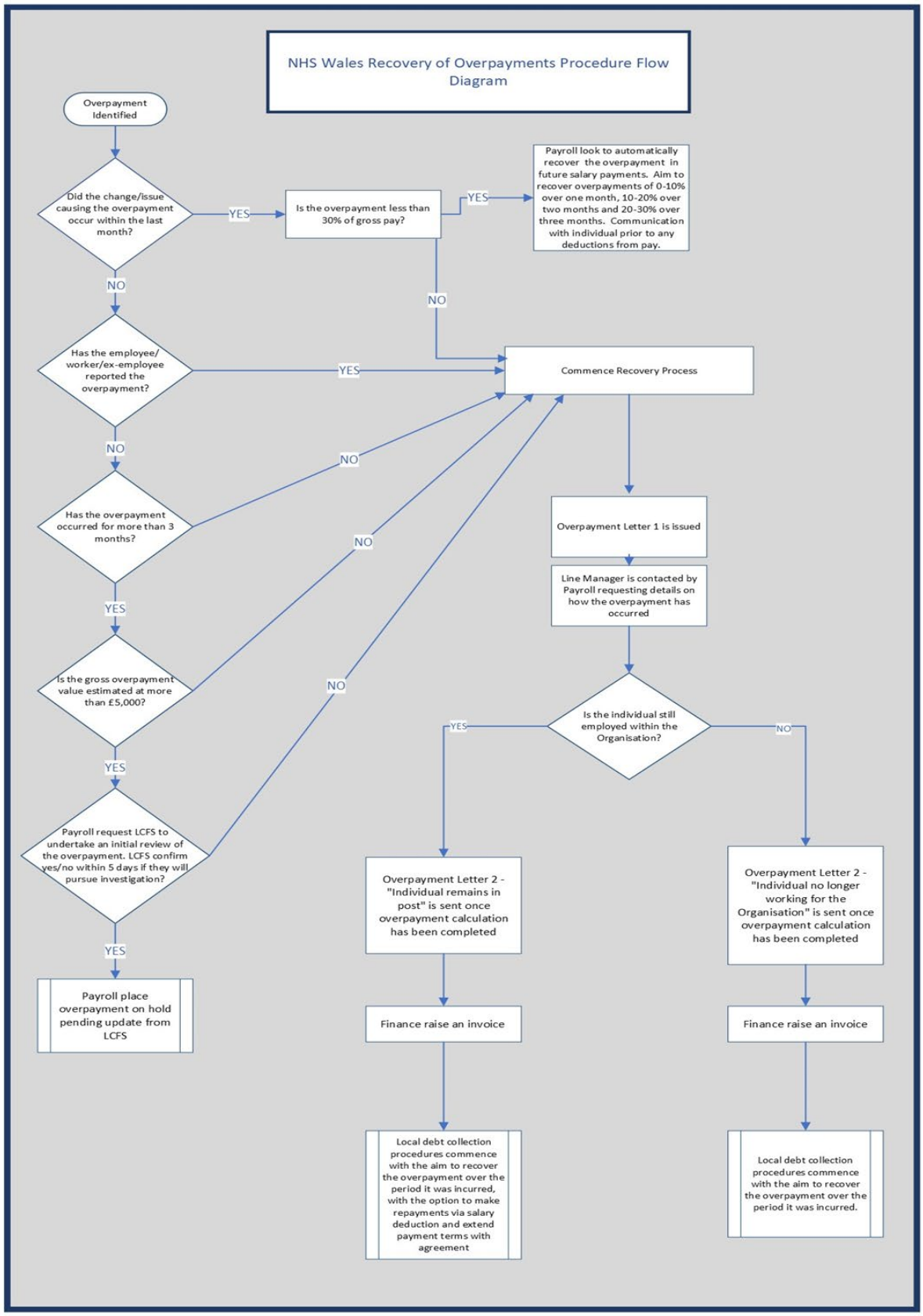
APPENDIX D – INCOME & EXPENDITURE TEMPLATE

Income%20and%20
Expenditure%20Sum

Tools and calculators | MoneyHelper

If you find yourself in financial hardship, there may be help or debt advice available from your Trade Union.
You can also check if you may be eligible for any benefits here:
Tackling Financial Insecurity Together | Turn2us
Debt advice from reputable sources Get free debt advice - GOV.UK (www.gov.uk)

APPENDIX E – OVERPAYMENTS PROCESS DIAGRAM



APPENDIX F – OVERPAYMENT LETTER 1

NWSSP All Wales Overpayment Team
NWSSP Payroll Services
4th Floor
Companies House
Crown Way
Cardiff
CF14 3UB

Private and Confidential

Name
Address 1
Address 2
Address 3
Post Code

Our Ref: JEC/Assignment number
Tel: 029 21 500055

Email: NWSSP.AllWalesoverpayments@wales.nhs.uk

Date:

RE: Notification of Potential Overpayment of Salary

Dear

We are writing to let you know that we have discovered a potential error that may have resulted in an overpayment of your salary and/or expenses.

The potential error was a result of ******Insert reason here******.

The payroll team are currently looking into this and will be in touch soon to confirm the overpayment, show a detailed calculation of the amount and give details of how this can be recovered.

We have also contacted your manager to advise them of the potential overpayment so they may provide any additional information which could help clarify the overpayment calculation.

You do not need to do anything at this time, but should you want to contact the **Overpayments team you can reach them on 02921 500055 quoting the reference number above [JEC/Assignment].** The team is happy to help and support both employees and managers.

Please be aware, until the calculations are complete NWSSP Payroll Services will not be able to provide you with any overpayment figures, therefore, please allow time for these to be completed before contacting us.

If you would like more information on how the recovery of overpayments are handled, please read the All-Wales Procedure for the Recovery of Overpayments which can be found on the NWSSP Payroll Services sharepoint site link Payroll Services (sharepoint.com). You can access support and advice from Trade Union representatives where applicable.

Yours sincerely,

Insert OP Team Leader Name
All Wales Overpayment Team
NWSSP Employment Services

NWSSP Payroll Services
4th Floor
Companies House
Crown Way
Cardiff
CF14 3UB

Private and Confidential

APPENDIX G - OVERPAYMENT LETTER 2

Individual remains in post

Our Ref: JEC/Assignment
Department: NWSSP Payroll Services for All Wales Overpayments
Tel: 029 21 500055

Email: NWSSP.AllWalesoverpayments@wales.nhs.uk

Date:

RE: Overpayment of Salary

Dear

Following on from our previous letter dated ** [insert date] ** we can now give more details of your overpayment. Please accept our sincere apologies for this overpayment and any upset or inconvenience it may cause you.

The overpayment is calculated as follows: -

Period of Overpayment:	
Reason for Overpayment:	

Gross Overpayment:		**£**
Less		
	Pension:	£
	PAYE:	£
	National Insurance Contributions:	£
	Student Loan:	£
Net Overpayment Due:		**£**

An invoice will be sent to you directly from your previous organisation's Finance Department so they can begin to recover this overpayment.

Contact details of the Finance Department will be shown on the invoice should you have any queries on how to make payment. As you are no longer employed by your previous Organisation the options to repay will be either by bank transfer, standing order, cheque or debit/credit card if the facility is available within the Organisation.

You can arrange an affordable monthly recovery option or choose to repay the amount in full in one payment. Ideally, the recovery of the overpayment should occur over the same time period in which the overpayment occurred. Should you wish to discuss a different recovery time frame please contact the Finance Department.

If you have any queries in relation to the calculation of the overpayment please do not hesitate to contact the NWSSP All Wales Overpayments Team by emailing NWSSP.AllWalesOverpayments@wales.nhs.uk, or contact them on **02921 500055 quoting the reference number above [JEC/assignment number]**. The team are happy to help and support both employees and managers.

We do understand that overpayments are regrettable and may cause anxiety, so we aim to answer all queries swiftly to minimise any upset or distress.

NWSSP Payroll Services
4th Floor
Companies House
Crown Way
Cardiff
CF14 3UB

Individual no longer working for the Organisation

Private and Confidential

Our Ref: JEC/Assignment
Department: NWSSP Payroll Services for All Wales Overpayments
Tel: 029 21 500055

Email: NWSSP.AllWalesoverpayments@wales.nhs.uk

Date:

RE: Overpayment of Salary

Dear

Following on from our previous letter dated ** [insert date] ** we can now give more details of your overpayment.

Please accept our sincere apologies for this overpayment and any upset or inconvenience it may cause you.

The overpayment is calculated as follows: -

Period of Overpayment:	
Reason for Overpayment:	

Gross Overpayment:	**£**
Less	
Pension:	£
PAYE:	£
National Insurance Contributions:	£
Student Loan:	£
Net Overpayment Due:	**£**

An invoice will be sent to you directly from your organisation's Finance Department so they can begin to recover this overpayment. Contact details for the Finance Department will be shown on the invoice should you have any queries. As you are still employed by your Organisation recovery of the overpayment is possible through monthly salary deductions.

You can arrange an affordable monthly recovery option or choose to repay the amount in full in one payment. Ideally, the recovery of the overpayment should occur over the same time period in which the overpayment occurred. Should you wish to discuss a different recovery time frame please contact the Finance Department.

If you have any queries in relation to the calculation of the overpayment please do not hesitate to contact the NWSSP All Wales Overpayments Team by emailing NWSSP.AllWalesOverpayments@wales.nhs.uk, or contact them on **02921 500055 quoting the reference number above [JEC/assignment number]**. The team are happy to help and support both employees and managers.

We do understand that overpayments are regrettable and may cause anxiety, so we aim to answer all queries swiftly to minimise any upset or distress.

Recovery of overpayments will be made in line with the All-Wales Procedure for the Recovery of Overpayments which can be found on the NWSSP Payroll Services sharepoint site: Payroll Services (sharepoint.com). The Procedure also includes a budgeting tool to help you work out what you can afford to pay at Appendix H. You can also access support and advice from Trade Union representatives where applicable.

Yours sincerely

Insert OP Team Leader Name
All Wales Overpayment Team
NWSSP Employment Services

NWSSP Payroll Services
4th Floor
Companies House
Crown Way
Cardiff
CF14 3UB

Recovery of overpayments will be made in line with the All-Wales Procedure for the Recovery of Overpayments, a copy of which can be provided if requested.

The Procedure also includes a budgeting tool to help you work out what you can afford to pay at Appendix H. You can also access support and advice from Trade Union representatives where applicable.

Yours sincerely

Insert OP Team Leader Name
All Wales Overpayment Team
NWSSP Employment Services

NWSSP Payroll Services for All Wales Overpayments
4th Floor
Companies House
Crown Way
Cardiff
CF14 3UB

APPENDIX H – LINE MANAGER LETTER

Private and Confidential

Our Ref: JEC/Assignment Number
Department: NWSSP Payroll Services for All Wales Overpayments
Tel: 029 21 500055

Email: NWSSP.AllWalesOverpayments@wales.nhs.uk

Date:

RE: Overpayment of Salary

Dear Manager

We are writing to let you know that a potential overpayment of salary has occurred for a member of staff that you line manage.

Details of the potential overpayment of salary are noted below:

Employee Name:
Assignment Number:
Period of Overpayment:
Reason for Overpayment:

Next Steps…

Once the overpayment has been verified and processed in ESR, both you and the employee will receive a further letter which will confirm the overpayment and show a detailed calculation of the amount. It may take up to 14 days from the date of this letter.

The employee will then be issued with an invoice from your Organisation's Finance Team with instructions on how recovery of the overpayment can be made.

As the manager of the individual who has been overpaid, please could you discuss the overpayment with them and ensure they understand the need to repay the overpaid funds and that all overpayments are recoverable regardless of fault.

The employee will need to be made aware that if they do not repay the overpayment, the Organisation has the right to engage a debt collection agency or take legal action in order to recover the debt.

Please be supportive of your employee and draw their attention to the tools at Appendix D of the Procedure mentioned below if they need help to work out what is affordable.

For full details of how the overpayment will be treated, please refer to the All-Wales Procedure for the Recovery of Overpayments which can be found on the NWSSP Payroll Services SharePoint site: Payroll Services (sharepoint.com)

You will also be sent an Overpayment notification form to complete electronically. The information gathered will support your Organisation to monitor overpayments, understand how they occurred and what measures have been put in place to avoid future overpayments.

If there are any questions about the overpayment, please contact the **Overpayments Team on 02921 500055 quoting the reference number above [JEC/assignment].** The team are there to help and support employees and managers.

Yours sincerely

Insert OP Team Leader Name
All Wales Overpayment Team
NWSSP Employment Services

APPENDIX I – SALARY OVERPAYMENT DEDUCTION

Deduction direct from Salary Payment – Authorisation Form

Name:	
Assignment Number:	
Health Board/Trust/SHA:	
Department:	

I authorise NHS Wales Shared Services Partnership Payroll Services to deduct the sum of £ _____ direct from my Salary each month.

I understand that this will be deducted as a Net payment and that this deduction will continue until the overpayment £ _____ has been repaid in full.

I give my full consent for this deduction.

If my employment comes to an end, I agree that I will contact the Finance department to discuss options to either recover the outstanding balance of the overpayment from my final pay or agree how payment of the outstanding balance will be made.

Signed _____

Print Name _____ Date: _____

Once completed, please email to [Organisations to insert their accounts receivable teams email].
Finance Teams to note recovery of the overpayment is being made in instalments via salary deduction and then forward this deduction authorisation form to NWSSP.AllWalesOverpayments@wales.nhs.uk for Payroll services to action

APPENDIX J – COUNTER FRAUD INITIAL ASSESSMENT - INFORMATION REQUIRED

Individuals Name		
Pay Group / Pay Number		
NHS Organisation		
Job Title		
Pay Grade /Hours **Full/Time Part time**	Grade	Hours
Workplace / Location		
Value of Overpayment Please attach O/P Breakdown	**Gross**	**Net**
Period of Overpayment	**Date From**	**Date to**
Reason for overpayment		
Dept / Manager contact name and details		
Payroll Services Contact details		
Salary Overpayment contact details		
Please confirm what checks have been made to verify whether the individual has contacted Payroll Services		**Checks made by:** **Date:**
FURTHER DETAILS OF INDIVIDUAL:		
Address		
Date of Birth		
NI Number		
Bank A/C details		
Form Completed by:	**Date:**	
Please add any further details which may assist the Local Counter Fraud Team with their review: **Please do not contact individuals without consulting your Local Counter Fraud Service team.** **Please report any further contact to or from the individual to the Local Counter Fraud team immediately.**		

GWEITHDREFN AR GYFER ADENNILL GORDALIADAU - Cyflogau a Threuliau

Statws y Weithdrefn: TERFYNOL - WEDI'I CHYMERADWYO
Dyddiad Cyhoeddi'r Weithdrefn: Medi 2024
Dyddiad Gweithredu: Hydref 2024
Dyddiad Adolygu: Hydref 2027

Gweithdrefn ar gyfer Adennill Gordaliadau

Mynegai

1. Cyflwyniad
2. Datganiad Gweithdrefn
3. Nodau
4. Cydraddoldeb
5. Amcanion
6. Cwmpas
7. Proses Adennill Gordaliadau
8. Datrys Anghydfod
9. Hyfforddiant ac Ymwybyddiaeth
10. Llywodraethu Gwybodaeth

Atodiad A - Rolau a Chyfrifoldebau

Atodiad B – Y rhesymau pam mae gordaliadau yn digwydd

Atodiad C – Llythyr Addasiad Cyflog

Atodiad D – Templed Incwm a Gwariant

Atodiad E - Map Proses Gordaliadau

Atodiad F – Llythyr Gordaliad 1

Atodiad G – Llythyr Gordaliad 2

Atodiad H – Llythyr Gordaliad i'w anfon at y Rheolwr Llinell

Atodiad I – Awdurdodi Didyniad Cyflog

Atodiad J – Ffurflen Asesu Atal Twyll

1. Cyflwyniad

Ysgrifennwyd y Weithdrefn hon i sicrhau dull unedig o ran sut y dylid ymdrin â gordaliadau ar draws GIG Cymru. Bydd y weithdrefn Cymru gyfan hon yn disodli unrhyw brosesau lleol presennol er mwyn sicrhau cysondeb rhwng Gwasanaethau'r Gyflogres Partneriaeth Cydwasanaethau GIG Cymru (PCGC) a Sefydliadau GIG Cymru pan fo gordaliad yn dod i'r amlwg.

Diffinnir gordaliad fel unrhyw arian a dalwyd ar gam i gyflogai presennol neu cyn-gyflogai drwy'r system gyflogres.

2. Datganiad Gweithdrefn

Bydd pawb sy'n ymwneud â gweithredu'r weithdrefn yn cael eu trin â pharch ac urddas drwy gydol y broses.

Cydnabyddir nad gweithwyr neu gyflogeion sydd i'w beio fel arfer am ordaliadau. Mae'r weithdrefn hon yn ceisio cefnogi'r rhai sydd wedi cael gordaliad trwy sicrhau bod y gordaliad yn cael ei adennill mewn modd teg a rhesymol.

Mae gordaliadau yn deillio'n bennaf o "gamgymeriad ffeithiol" (pan fo taliad yn anghyson â'r ffeithiau e.e. oherwydd gwall clercyddol, mewnbwn cyfrifiadurol neu wall gweithdrefnol). Mae gan Sefydliadau GIG Cymru hawl gyfreithiol i adennill unrhyw ordaliadau sydd wedi deillio o gamgymeriad ffeithiol.

Rhaid i Sefydliadau GIG Cymru geisio adennill pob gordaliad, waeth pwy sydd ar fai. Daw gordaliadau'r GIG allan o gronfeydd cyhoeddus ac felly mae rhwymedigaeth ar Sefydliadau GIG Cymru i'w hadennill, er bod yn rhaid gwneud hynny mewn ffordd deg a rhesymol.

Bydd anghenion unigol ac amgylchiadau ariannol yn cael eu hystyried.

3. Nodau

Nod y weithdrefn hon yw safoni'r broses o adennill gordaliadau er mwyn sicrhau cysondeb ar draws GIG Cymru.

Mae hefyd yn anelu at sicrhau bod pob gordaliad yn cael ei adennill yn effeithlon ac mor gyflym â phosibl heb achosi caledi. Yn ogystal â sicrhau bod cyflogeion, cyn-gyflogeion, gweithwyr a chyn-weithwyr yn cael eu trin yn deg ac yn gyson a heb achosi unrhyw straen neu bryder diangen iddynt.

4. Cydraddoldeb

Nod GIG Cymru yw darparu amgylchedd diogel heb wahaniaethu a man lle caiff pob unigolyn ei drin yn deg, ag urddas ac mewn modd sy'n briodol i'w anghenion. Cydnabyddir bod cydraddoldeb yn effeithio ar bob agwedd ar weithrediadau o ddydd i ddydd. Mae pob polisi a gweithdrefn yn destun Asesiad Integredig o'r Effaith ar Gydraddoldeb (EqIIA) ac Asesiad o'r Effaith ar yr Iaith Gymraeg.

Byddwn yn sicrhau ein bod yn cyflawni'r weithdrefn hon yn unol â gofynion Safonau'r Gymraeg, yn benodol:

- Sicrhau bod ein gwasanaethau sydd ar gael yn Gymraeg yn gyfartal â'r gwasanaethau Saesneg a ddarparwn drwy wneud y canlynol:
  - Darparu gohebiaeth Gymraeg i staff drwy gyfrwng y Gymraeg heb i staff orfod gofyn amdani.
  - Darparu unrhyw gyfathrebiad am y weithdrefn hon trwy gyfrwng y Gymraeg heb i staff orfod gofyn am gyfathrebiadau gennym trwy gyfrwng y Gymraeg.
  - Darparu gwasanaeth ffôn trwy gyfrwng y Gymraeg sy'n gyfartal â'r gwasanaeth Saesneg a ddarparwn.
  - Sicrhau bod yr holl ddogfennau a ffurflenni sy'n ymwneud â'r weithdrefn hon a chyflwyno'r weithdrefn ar gael yn Gymraeg heb oedi.
  - Sicrhau bod gwybodaeth am y weithdrefn hon ar gael ar ein tudalennau mewnrwyd a thudalennau gwe a'u bod ar gael i Staff y GIG.
  - Bydd unrhyw bostiadau cyfryngau cymdeithasol sy'n ymwneud â'r weithdrefn hon ar gael yn Gymraeg ar yr un pryd ag y bydd postiadau cyfrwng Saesneg ar gael.

5. Amcanion

Amcanion y weithdrefn hon yw sicrhau'r canlynol:

- Proses deg ar gyfer adennill gordaliadau tra'n caniatáu ystyried amgylchiadau ariannol personol y rhai sydd wedi cael eu gordalu.
- Dylai adennill y gordaliad fod yn fforddiadwy ac yn gynaliadwy.
- Mae cyfrifoldebau'r rhai a all fod yn rhan o'r broses wedi'u hegluro yn Atodiad A.
- Eglurir y rhesymau posibl dros ordaliadau yn Atodiad B.
- Gostyngiad mewn achosion o ordaliadau trwy ddefnyddio gwybodaeth a geir yn y weithdrefn hon i addysgu a gwella.

6. Cwmpas

Bydd y weithdrefn hon yn berthnasol i gyflogeion, cyn-gyflogeion, gweithwyr a chyn-weithwyr Sefydliadau GIG Cymru. Mae'n cwmpasu systemau llaw ac electronig a ddefnyddir ar draws GIG Cymru.

Pan fo Sefydliadau'r GIG wedi cyflwyno cyfleuster Hunanwasanaeth i Reolwyr (MSS) yn y Cofnod Staff Electronig (ESR), dylai'r Rheolwr Llinell ddefnyddio MSS i ddiweddaru aseiniadau cyflogeion. Os na chaiff y cyfleuster MSS ei gyflwyno'n llawn, dylid rhoi gwybodaeth i Wasanaethau'r Gyflogres gan ddefnyddio'r ffurflenni/Hysbysiad Symud Staff (SMA) sydd ar gael o dan "Dogfennau Defnyddiol" ar dudalen mewnrwyd y Sefydliad trwy'r ddolen isod.

Mae'r ddolen hefyd yn cynnwys manylion cyswllt gwasanaethau'r gyflogres: Gwasanaethau'r Gyflogres (sharepoint.com).

7. Proses Adennill Gordaliad

Adferiad Awtomatig

Efallai y bydd amgylchiadau pan ellid adennill gordaliadau yn awtomatig o daliadau cyflog yn y dyfodol.

Dim ond os yw'r canlynol yn berthnasol y bydd hyn yn digwydd:

- Roedd y gordaliad o ganlyniad i gyflwyno hysbysiad o newidiadau yn hwyr h.y. newid oriau, terfynu cyflogaeth, salwch, absenoldeb arall, neu bensiwn **a**
- Bod y newid neu derfynu cyflogaeth wedi cael ei weithredu llai na mis cyn i Wasanaethau'r Gyflogres gael hysbysiad **a**
- Ni fydd y didyniad yn gyfystyr â gostyngiad o fwy na 30% yn y cyflog misol gros.

Os bodlonir yr holl feini prawf hyn, bydd y cyflog a ordalwyd yn cael ei adennill yn awtomatig dros gyfnod o 3 mis ar y mwyaf. Bydd gordaliadau cyflog misol gros o 0-10% yn cael eu hadennill dros fis, 10-20% dros 2 fis ac 20-30% dros 3 mis.

Os bydd didyniad awtomatig yn digwydd, bydd Gwasanaethau'r Gyflogres yn hysbysu'r unigolyn cyn y diwrnod cyflog drwy anfon **Llythyr Addasiad Cyflog** (Atodiad C). Bydd y llythyr yn rhoi manylion am y symiau a fwriedir eu hadennill bob mis. Bwriad hyn yw darparu opsiwn adennill sy'n fforddiadwy a chynaliadwy. Mae offer i'ch helpu i weithio allan beth sy'n fforddiadwy i'w gweld yn Atodiad D.

Os nad yw'r amserlen arfaethedig ar gyfer adennill y gordaliad yn fforddiadwy, gellir cysylltu â Gwasanaethau Cyflogres PCGC drwy'r manylion cyswllt a ddarperir yn y llythyr. Os na ellir cytuno i adennill y gordaliad dros y cyfnod o 3 mis, bydd y gordaliad yn cael ei gyfeirio at Dîm Gordaliadau Cymru Gyfan i symud ymlaen â'r weithdrefn adennill safonol a amlinellir isod.

Os bydd yr unigolyn yn terfynu ei gyflogaeth cyn i'r gordaliad gael ei ad-dalu'n llawn, bydd gwasanaethau'r gyflogres yn cysylltu â'r unigolyn gyda'r bwriad o adennill y swm sy'n weddill o'r cyflog terfynol.

Proses Adennill Safonol

Pan fo gordaliad yn swm o arian mwy a/neu wedi digwydd dros gyfnod hwy o amser, ac felly nid yw'r meini prawf ar gyfer adennill yn awtomatig yn cael eu bodloni, bydd y broses adennill safonol yn cael ei dilyn fel a ganlyn.

Mae hyn hefyd wedi'i nodi mewn siart llif yn Atodiad E.

1. Bydd gwasanaethau'r gyflogres yn anfon **Llythyr Gordaliad 1** (Atodiad F) at yr unigolyn sydd wedi'i ordalu cyn gynted ag y daw'n ymwybodol o ordaliad posibl.
   Bydd y llythyr yn rhoi hysbysiad bod gordaliad posibl wedi digwydd, yn manylu ar y rheswm dros y gordaliad a amheuir a'r cyfnod y mae'n berthnasol iddo (os yw'n hysbys). Bydd yn cyfeirio at y llythyr dilynol (**Llythyr Gordaliad 2** – Atodiad G) a anfonir gyda chyfrifiad manwl o'r gordaliad unwaith y caiff ei gadarnhau.
2. Bydd gwasanaethau'r gyflogres yn anfon e-bost gyda llythyr ynghlwm at Reolwr Llinell yr unigolyn i roi gwybod iddo am y gordaliad posibl (Atodiad H). Gall hyn gynnwys dolen MS

Forms i roi manylion neu resymau dros pam a sut y gallai'r gordaliad fod wedi digwydd a dolen fideo yn esbonio sut i leihau gordaliadau yn y dyfodol.

3. Unwaith y bydd y gordaliad wedi'i gyfrifo, bydd Gwasanaethau'r Gyflogres yn anfon **Llythyr Gordaliad 2** at yr unigolyn a'i Reolwr Llinell yn manylu ar gyfrifo'r gordaliad (Atodiad G). Bydd Adran Gyllid y Sefydliad dan sylw yn cael copi o'r llythyr hwn.

(a) Os yw'r unigolyn yn parhau yn ei swydd o fewn y Sefydliad:

Bydd **Llythyr Gordaliad 2** yn dangos cyfrifiad y gordaliad a'r gwerth llawn. Bydd y llythyr yn egluro y bydd rhaid adennill y gordaliad yn llawn a sut y gellir gwneud hynny.

Ein nod yw adennill unrhyw ordaliadau dros yr un amserlen â'r gordaliad e.e. os cawsoch eich gordalu am 3 mis, dylid adennill y gordaliad dros 3 mis. Mae opsiwn hefyd i ad-dalu'r gordaliad fel cyfandaliad neu i drafod trefniant adennill misol mwy fforddiadwy.

Bydd angen i'r Cyfarwyddwr Cyllid a/neu Gyfarwyddwr y Gweithlu/Pobl ar gyfer y Sefydliad neu eu dirprwyon enwebedig gytuno i unrhyw geisiadau i adennill y gordaliad dros gyfnod o dros 12 mis. Bydd unrhyw geisiadau yn cael eu hadolygu gan ystyried sut a phryd y digwyddodd y gordaliad ac amgylchiadau ariannol yr unigolyn.

Gellir hefyd ystyried opsiynau eraill megis ymgymryd ag oriau ychwanegol i ad-dalu'r symiau sy'n ddyledus.

Dylid adennill gordaliadau drwy gyflog oni bai eich bod yn dewis ad-dalu'n llawn ar wahân neu'n cytuno i drefnu archeb sefydlog.

Bydd Llythyr Gordaliad 2 yn nodi y bydd anfoneb yn cael ei hanfon yn fuan, a bydd yr anfoneb yn cynnwys gwybodaeth am yr unigolyn y gallwch gysylltu ag ef i gytuno i adennill y gordaliad.

Bydd Adran Gyllid eich Sefydliad yn cael copi o'r llythyr hwn er mwyn gallu anfon anfoneb. Bydd yr adran gyllid yn cadarnhau eich bod yn gyflogai neu'n weithiwr ar hyn y bryd a bod modd adennill arian drwy ddidyniadau cyflog.

Mae copi o'r ffurflen gais i drefnu didyniad cyflog wedi'i chynnwys yn Atodiad I.

Mae offer i'ch helpu i weithio allan beth sy'n fforddiadwy i'w gweld yn Atodiad D.

(b) Os nad yw'r unigolyn yn gweithio i'r Sefydliad mwyach:

Bydd Llythyr Gordaliad 2 yn dangos cyfrifiad y gordaliad a'r gwerth llawn. Bydd y llythyr yn egluro y bydd rhaid adennill y gordaliad yn llawn a sut y gellir gwneud hynny.

Bydd y llythyr yn nodi y bydd anfoneb yn cael ei hanfon yn fuan, a bydd yr anfoneb yn cynnwys gwybodaeth ynglŷn â'r unigolyn y gallwch gysylltu ag ef i gytuno i adennill y gordaliad.

Bydd Adran Gyllid eich Sefydliad yn cael copi o'r llythyr hwn er mwyn gallu anfon anfoneb. Gan nad yw'r unigolyn bellach yn gyflogai neu'n weithiwr i'r Sefydliad, nid yw adennill drwy gyflog yn bosibl. Gellir gwneud taliadau drwy Archeb Sefydlog, Trosglwyddiad Banc, Siec neu Gerdyn Debyd/Credyd (pan fo gan y sefydliad y cyfleuster hwn).

Ein nod yw adennill unrhyw ordaliadau dros yr un amserlen â'r gordaliad e.e. os cawsoch eich gordalu am 3 mis, dylid adennill y gordaliad dros 3 mis. Mae opsiwn hefyd i ad-dalu'r gordaliad fel cyfandaliad neu i drafod trefniant adennill misol mwy fforddiadwy.

Efallai y bydd cyfnodau adennill hirach yn bosibl, ond bydd angen i'r Cyfarwyddwr Cyllid a/neu Gyfarwyddwr y Gweithlu/Pobl ar gyfer y Sefydliad hwnnw neu eu dirprwyon enwebedig eu cymeradwyo.

Mae offer i'ch helpu i weithio allan beth sy'n fforddiadwy i'w gweld yn Atodiad D.

Mae'r Adran Gyllid yn cadw'r hawl i drosglwyddo gweithdrefnau casglu dyledion ymlaen i asiantaeth casglu dyledion unwaith y bydd gweithdrefnau lleol y Sefydliad ac ymdrechion i gasglu'r ddyled sy'n weddill wedi'u dihysbyddu.

Atal Twyll

Efallai y bydd adegau pan fydd angen i'r Gwasanaeth Atal Twyll asesu gordaliad.

Gofynnir am asesiad lefel uchel cychwynnol gan y Gwasanaeth Atal Twyll, dim ond os bodlonir **pob un o'r tri** maen prawf isod sy'n nodi y gallai fod tystiolaeth i awgrymu y gallai twyll fod wedi digwydd:

1. Nid yw'r unigolyn wedi hysbysu'r Sefydliad/Rheolwr Llinell/Gwasanaethau'r Gyflogres am y gordaliad; **ac**
2. Mae'r gordaliad wedi digwydd dros gyfnod o fwy na 3 mis; **ac**
3. Amcangyfrifir bod gwerth y gordaliad yn fwy na £5,000

Os bodlonir y tri maen prawf uchod, bydd gwasanaethau'r gyflogres yn anfon hysbysiad at y tîm Atal Twyll Lleol perthnasol gan ddefnyddio'r ffurflen adolygu yn Atodiad J.

Bydd y tîm Atal Twyll lleol yn gwneud asesiad cychwynnol ac yn rhoi gwybod o fewn 5 diwrnod gwaith os oes angen ymchwiliad, neu os gall y broses o adennill y gordaliad barhau trwy'r drefn adennill arferol. Os na cheir ymateb gan y tîm Atal Twyll Lleol o fewn 5 diwrnod gwaith, bydd gwasanaethau'r gyflogres yn gofyn am gadarnhad terfynol i barhau i adennill y gordaliad yn unol â'r weithdrefn hon ac fel y dangosir yn Atodiad E.

Mae unrhyw ordaliadau o dan asesiad cychwynnol gan dimau Atal Twyll Lleol wedi'u cynnwys o dan adran Atal Twyll y dangosfwrdd gordaliadau. Mae gan uwch gydweithwyr Gweithlu/Pobl a Chyllid o fewn Sefydliadau fynediad at y dangosfwrdd hwn i fonitro asesiadau sy'n cael eu cynnal.

Os bydd y Gwasanaethau Atal Twyll yn nodi bod angen ymchwiliad pellach, bydd gwasanaethau'r gyflogres yn gohirio adennill y gordaliad hyd nes y ceir cyngor pellach gan y tîm Atal Twyll Lleol.

Cyn i ymchwiliadau pellach ddechrau, bydd y tîm Atal Twyll Lleol yn dilyn trefn leol y Sefydliad ar gyfer hysbysu Cyfarwyddwr y Gweithlu/Pobl a/neu'r Cyfarwyddwr Cyllid am fanylion yr achos. Gall hyn gynnwys cael unrhyw gytundeb i gynnal ymchwiliad pellach os oes angen yn lleol gan y sefydliad. Os bydd unrhyw anghytundeb lleol ar y camau gweithredu cywir, bydd y tîm Atal Twyll Lleol yn ceisio cyngor gan Wasanaeth Atal Twyll cenedlaethol GIG Cymru.

Er mwyn sicrhau nad yw unrhyw ymchwiliadau troseddol posibl yn cael eu peryglu, mae'n bwysig nad oes unrhyw gysylltiad yn cael ei wneud â'r unigolyn sydd wedi cael gordaliad nes bod y tîm Atal Twyll Lleol wedi cadarnhau nad oes angen ymchwilio i'r mater ymhellach.

8. Datrys Anghydfod

Pan fo unigolyn yn gwrthod cydsynio i adennill y gordaliad a phan fo trafodaethau wedi dod i ben, dylid cyfeirio'r gordaliad at y Cyfarwyddwr Gweithlu/Pobl a/neu'r Cyfarwyddwr Cyllid neu eu dirprwyon enwebedig yn y Sefydliad gyda'r nod o ddod i gytundeb ar gyfer adennill y gordaliad, gan ystyried amgylchiadau personol yr unigolyn.

Dylid trefnu cyfarfod rhwng yr unigolyn sydd wedi cael gordaliad a Chyfarwyddwr y Gweithlu/Pobl a/neu'r Cyfarwyddwr Cyllid neu eu dirprwyon. Mae gan yr unigolyn yr hawl i ddod â chynrychiolydd Undeb Llafur neu gydweithiwr yn y gweithle gydag ef i'r cyfarfod.

Gellir gofyn hefyd i aelodau o'r tîm Cyllid neu'r Gwasanaethau'r Gyflogres ynghyd â'r Rheolwr Llinell neu'r Deiliad Cyllideb ddod i'r cyfarfod hwn os byddai hynny'n ddefnyddiol. Mae'n bosibl y bydd angen i'r Cyfarwyddwr Cyllid neu ddeiliad cyllideb awdurdodedig arall gymeradwyo canlyniad arfaethedig y cyfarfod os nad ydynt yn bresennol yn y cyfarfod.

Os yw unigolyn yn teimlo ei fod wedi cael ei drin yn annheg, fe'i hanogir i ddefnyddio'r polisi Parch a Datrys. Ni ddylid cymryd unrhyw gamau pellach i adennill y gordaliad yn ystod unrhyw broses datrys anghydfod gan gynnwys cwynion o dan y broses Parch a Datrys.

Os ydych wedi terfynu eich cyflogaeth gyda GIG Cymru ac wedi methu dod i gytundeb, efallai y gallwch gael cymorth drwy:
Acas | Making working life better for everyone in Britain (Saesneg yn unig) neu
Gwaith - Hafan (citizensadvice.org.uk/cymraeg/)
Neu eich Undeb Llafur os ydych yn dal yn aelod (os ydych yn talu trwy eich cyflog, gallwch newid i dalu trwy Ddebyd Uniongyrchol i gynnal eich aelodaeth).

Mae'n bwysig cofio bod gan Sefydliadau'r GIG hawl gyfreithiol i adennill unrhyw ordaliad. Mae Sefydliadau'r GIG yn cadw'r hawl i ddefnyddio asiantaeth casglu dyledion pe bai angen.

9. Hyfforddiant ac Ymwybyddiaeth

Dylai Sefydliadau'r GIG sicrhau bod cyflogeion neu weithwyr a rheolwyr yn ymwybodol o'r weithdrefn hon ar ddechrau eu cyflogaeth. Dylai copi o'r weithdrefn fod ar gael ar safle mewnrwyd y sefydliad GIG a dylid cyfeirio ato mewn unrhyw hyfforddiant ymsefydlu a/neu hyfforddiant i reolwyr newydd.

Gellir lleihau gordaliadau os bydd pawb yn gwneud eu rhan. Gall rheolwyr ofyn am arweiniad ynghylch sut i sicrhau bod gwybodaeth am gyflogaeth yn cael ei diweddaru'n brydlon ac yn gywir gan gynnwys gweithwyr newydd, newidiadau i gyflogaeth, terfyniadau cyflogaeth, ac absenoldebau cyflogai neu weithiwr pe bai angen.

Gall oedi cyn cyflwyno dogfennaeth gyflogres neu ddiweddariadau Hunanwasanaeth i Reolwyr achosi anghyfleustra a phryder sylweddol i staff, yn ogystal â gwaith gweinyddol ychwanegol diangen i Wasanaethau'r Gyflogres PCGC. Gall hefyd arwain at gymhlethdodau i'r rhai yr effeithir arnynt o ran materion treth a chredyd cynhwysol.

Amlinellir rolau a chyfrifoldebau pob parti y manylir arnynt yn y weithdrefn hon yn Atodiad A.

10. Llywodraethu Gwybodaeth

Bydd unrhyw ddata personol a ddefnyddir wrth gymhwyso'r weithdrefn hon yn cael eu prosesu yn unol â Rheoliad Cyffredinol ar Ddiogelu Data'r DU (UK GDPR) a fframweithiau a pholisïau strategol rheoli cofnodion perthnasol.

ATODIAD A

Gellir crynhoi cyfrifoldebau allweddol o ran y broses gordaliadau fel a ganlyn:

Bydd gwasanaethau'r gyflogres Partneriaeth Cydwasanaethau GIG Cymru (PCGC) yn: -

- Talu staff yn gywir ac ar amser yn unol â data cyflogai/gweithiwr a gedwir ar y Cofnod Staff Electronig (ESR) ar adeg rhedeg y gyflogres.

- Sicrhau fod slip cyflog manwl ar gael i'r cyflogai/gweithiwr. Slip cyflog electronig fydd hwn pan fo MyESR (Hunanwasanaeth i Weithwyr) yn cael ei ddefnyddio.

- Hysbysu staff perthnasol ynghylch dyddiadau cau ar gyfer cyflwyno Gwaith Papur Electronig er enghraifft staff newydd, newidiadau, terfyniadau cyflogaeth, a data tâl amrywiol Gwasanaethau'r Gyflogres (sharepoint.com).

- Cywiro gwallau a nodwyd.

- Cynnal asesiad o ordaliadau yn erbyn y meini prawf i gadarnhau a oes angen adolygiad gan y Gwasanaeth Atal Twyll Lleol

- Cywiro unrhyw ordaliad a nodwyd yn unol â'r weithdrefn hon ar gyfer adennill gordaliadau cyflog. Bydd hyn yn cynnwys ysgrifennu at y cyflogai/cyn-gyflogai/gweithiwr/cyn-weithwr, gan roi esboniad manwl o'r gordaliad.

- Hysbysu'r Rheolwr Llinell bod gordaliad wedi digwydd a rhoi dolen MS Forms iddo gwblhau adroddiad gordaliad. Bydd yr adroddiad yn gofyn am fanylion ynghylch pam mae'r gordaliad wedi digwydd a pha gamau adferol a gymerwyd i atal hynny rhag digwydd eto.

- Cadw cofrestr o ordaliadau i'w rhannu'n fisol/bob deufis gyda chynrychiolwyr enwebedig o bob Sefydliad. Bydd PCGC yn rhoi gwybod i'r Sefydliad GIG am ordaliadau, y rhesymau drostynt ac os yw'r rheolwr yn methu â chydymffurfio â phrosesau a gweithdrefnau sy'n ymwneud â data cyflogeion/gweithwyr dro ar ôl tro.

- Adolygu'r gofrestr o ordaliadau gyda Sefydliadau'r GIG yng nghyfarfodydd rheolaidd Rheoli Cysylltiadau Cwsmeriaid y Gyflogres

- Cydgysylltu â chynrychiolwyr undebau llafur lleol lle bo'n briodol.

- Tynnu arian o gyflog y cyflogai/gweithiwr yn unol â'r cyfnod adennill y cytunwyd arno lle bo'n briodol.

- Wrth derfynu cyflogaeth, didynnu unrhyw ordaliadau sy'n weddill, gwyliau blynyddol gormodol, gan gynnwys trefniadau aberthu cyflog o'r cyflog terfynol lle bo modd.

- Delio â materion gordaliad gyda thosturi a dealltwriaeth, gan gofio nad yw'r cyflogai/gweithiwr ar fai yn y mwyafrif helaeth o achosion.

- Sicrhau fod cyn-gyflogeion/cyn-weithwyr yn gallu cyrchu eu slipiau cyflog, P60s a P45s trwy Ddangosfwrdd Ymadawyr am gyfnod cyfyngedig ar ôl terfynu cyflogaeth.

- Cysylltu â CThEF a/neu Bensiynau'r GIG os yw gordaliad yn debygol o effeithio ar dreth neu bensiwn.

- Gweithredu'r weithdrefn hon drwy gyfrwng y Gymraeg yn unol â Safonau'r Gymraeg.

Cyfrifoldeb y Cyflogai/Cyn-gyflogai/Gweithiwr/Cyn-weithiwr:-

Rhaid i gyflogeion/cyn-weithwyr/gweithwyr/cyn-weithwyr:

- Gwirio tâl sylfaenol, oriau contract a thaliadau rheolaidd eraill sydd wedi'u cynnwys yn eu slip cyflog i sicrhau eu bod yn unol â'u contract.

- Lle bo hynny'n berthnasol, ac yn bosibl, gwirio fod oriau amrywiol yn gywir ar systemau e-amserlennu cyn i restrau dyletswyddau gael eu cwblhau.

- Codi unrhyw ymholiadau ynghylch slipiau cyflog gyda'u Rheolwr Llinell yn y lle cyntaf. Gall hyn fod mewn perthynas â chyflog contract anghywir, oriau, taliadau rheolaidd, cael oriau amrywiol ar gam neu gael unrhyw arian annisgwyl.

- Gofyn am eglurhad gan Wasanaethau'r Gyflogres os na all eu Rheolwr Llinell ddatrys unrhyw ymholiadau ar eu slip cyflog.

- Rhoi gwybod i Wasanaethau'r Gyflogres ar unwaith os canfyddir gordaliad fel y gellir dechrau'r broses adennill. Gall unrhyw gyflogai, cyn-gyflogai, gweithiwr neu gyn-weithiwr sy'n methu'n fwriadol neu o wirfodd â rhoi gwybod i Wasanaethau'r Gyflogres am ordaliad gael ei gyfeirio at y tîm Atal Twyll Lleol ac, os oes angen, yr Heddlu.

- Cytuno ar delerau adennill a sicrhau bod unrhyw ordaliadau yn cael eu hadennill yn llawn.

- Bod yn ymwybodol o ddyddiadau terfynol y gyflogres i wybod pryd i ddisgwyl yn rhesymol am daliadau teithio, hawliadau cynhaliaeth, sifftiau ar systemau e-amserlennu neu elfennau tâl amrywiol.

- Cyflwyno hawliadau treuliau a hawliadau oriau ychwanegol a weithiwyd i'w talu o fewn 3 mis. Sylwch na fydd unrhyw hawliadau sy'n hŷn na 3 mis yn cael eu prosesu i'w talu oni bai bod amgylchiadau'n atal cyflwyno'r hawliad mewn pryd.

- Sicrhau bod y sefydliad GIG yn ymwybodol o unrhyw newid cyfeiriad a manylion cyswllt trwy'u diweddaru ar MyESR (Hunanwasanaeth Gweithwyr).

- Cael cymorth a chyngor gan gynrychiolwyr Undebau Llafur lle bo'n berthnasol.

Rheolwyr Llinell:

Rhaid i Reolwyr Llinell roi gwybod i Wasanaethau'r Gyflogres am unrhyw newidiadau sy'n effeithio ar gyflogau cyn gynted ag y dônt yn ymwybodol ohonynt ac mae eu cyfrifoldebau'n cynnwys:

- Cwblhau'r hysbysiadau o newidiadau cyflogai a'u cyflwyno i Wasanaethau'r Gyflogres cyn i gyflogeion/gweithwyr ddechrau eu swydd/oriau/lleoliad newydd.
- Cwblhau'r broses terfynu cyflogaeth ar yr adeg y mae'r cyflogai/gweithwyr yn ymddiswyddo.
- Ar gyfer cyflogeion/gweithwyr sy'n rhan o gynllun Pensiwn y GIG - yn unol â Pholisi Ymddeol Sefydliadau'r GIG rhaid llenwi ffurflen terfynu o leiaf 4 mis cyn terfynu.
- I ddatrys unrhyw ymholiadau cychwynnol a dderbyniwyd gan gyflogeion/gweithwyr ynghylch oriau amrywiol a delir yn ystod y mis neu dderbyn taliadau annisgwyl, gan eu cynghori bod yn rhaid iddynt hysbysu Gwasanaethau'r Gyflogres am unrhyw ordaliadau a amheuir.
- I agor a chau absenoldeb salwch cyflogai/gweithiwr ar eu cofnod ESR ar y pwynt hysbysu.
- Rhoi gwybod i Wasanaethau'r Gyflogres am unrhyw absenoldeb di-dâl.
- Cyflwyno hysbysiad awdurdodedig o Absenoldeb Mamolaeth/Tadolaeth/Mabwysiadu/Seibiant Gyrfa. Rhaid llenwi ffurflenni cais am daliad o dan y polisïau hyn a'u cyflwyno i Wasanaethau'r Gyflogres cyn y dyddiad y mae'r cyflogai/gweithiwr yn dechrau'r cyfnod o absenoldeb.
- Gwirio manylion contract cyflogai/gweithiwr trwy'r cyfleuster Hunanwasanaeth i Reolwyr a chyllidebau misol a hysbysu Gwasanaethau'r Gyflogres ar unwaith pan fo manylion cytundebol cyflogai/gweithiwr yn anghywir.
- Sicrhau bod rotâu cyflogai/gweithiwr (lle bo'n berthnasol) yn gywir yn unol â systemau E-amserlennu. Dylid tynnu sylw Timau E-Systemau Sefydliadol at anghysondebau ar unwaith.
- Sicrhau bod llyfrau gwaith cyflogres (lle bo'n berthnasol) yn cael eu cwblhau'n gywir yn unol â phatrwm gwaith y gweithwyr/cyflogeion.
- Cefnogi unigolion sydd wedi cael gordaliad.

Bydd Adran y Gweithlu/Pobl yn:-

- Gweithredu fel cyswllt rhwng gwasanaethau'r gyflogres PCGC, y Rheolwr Llinell, y tîm Cyllid a'r cyflogai/gweithiwr lle bo angen.
- Sicrhau bod rheolwyr yn ymwybodol o'u gofynion i gyflwyno data cyflogres gan gynnwys hysbysiadau newid cyflogai/gweithiwr, hysbysiadau terfynu a data e-restru yn unol â therfynau amser cyhoeddedig ar gyfer cyflwyno'r gyflogres.

- Sicrhau bod rheolwyr yn ymwybodol o'r potensial ar gyfer gordaliadau a'u gofyniad i sicrhau bod achosion o'r fath yn cael eu cadw mor isel â phosibl.

- Sicrhau bod rheolwyr yn ymwybodol o'r Weithdrefn Adennill Gordaliadau trwy ei chynnwys ar raglenni ymsefydlu a hyfforddi Rheolwyr.

- Adolygu data gordaliadau yn rheolaidd i nodi themâu allweddol ac unrhyw feysydd lle mae gordaliadau'n digwydd yn rheolaidd gan ddod ag ef i sylw'r Rheolwyr priodol i'w uwchgyfeirio.

- Ar y cyd ag Uwch staff Cyllid, adolygu unrhyw geisiadau caledi mewn perthynas â chyfnodau adennill estynedig a chytuno arnynt ar y cyd.

- Sicrhau bod unigolion sy'n destun i'r broses gordalu yn cael eu trin yn deg ac yn dosturiol.

Bydd Timau Cyllid/Cyfrifon Derbyniadwy yn: -

- Gyfrifol am ddosbarthu anfonebau i unigolion i adennill gordaliadau.

- Cytuno ar delerau adennill yn unol â'r weithdrefn hon.

- Datblygu gweithdrefnau casglu dyledion pan na fydd modd adennill gordaliadau.

Bydd Timau Atal Twyll Lleol yn:-

- Cynnal asesiad cychwynnol o unrhyw ordaliadau a gyfeiriwyd atynt gan Wasanaethau Cyflogres PCGC sy'n bodloni'r tri maen prawf atgyfeirio

- Ymateb i unrhyw gyfeiriadau o fewn 5 diwrnod gwaith a chadarnhau i Wasanaethau'r Gyflogres p'un a all camau adennill arferol ddechrau neu a oes angen ymchwiliad pellach.

ATODIAD B

Rhesymau dros Ordaliadau

Mae'n bwysig bod yr holl wybodaeth sy'n ymwneud â phenodiadau, newidiadau a therfyniadau yn cael ei chwblhau'n brydlon ac yn gywir gan y Rheolwr Llinell. Rhaid cyflwyno Ffurflenni/Hysbysiadau Symud Staff (SMA) i Wasanaethau Cyflogres PCGC neu ddiweddaru'r manylion ar ESR trwy'r cyfleuster Hunanwasanaeth i Reolwyr (MSS) yn syth ar ôl iddynt gael eu cytuno.

Noder:

- Bydd cyflogeion neu weithwyr yn parhau i gael eu talu yn unol â'r manylion a gedwir ar ESR hyd nes y bydd gwasanaethau'r gyflogres yn cael eu cyfarwyddo i wneud fel arall (h.y. trwy ffurflen newid neu ffurflen terfynu cyflogaeth)
- Er mwyn i newidiadau gael eu hadlewyrchu yn y cyflog misol nesaf, rhaid rhoi gwybod am unrhyw newidiadau i Wasanaethau'r Gyflogres erbyn diwrnod olaf y mis cyfredol (h.y. mae'n rhaid hysbysu gwasanaethau'r gyflogres am newidiadau i'w hadlewyrchu yng nghyflog mis Ebrill erbyn 31 Mawrth).
- mae taliadau cyflog misol yn cwmpasu'r cyfnod hyd at ddiwedd y mis ac nid at y dyddiad talu yn unig.
- Os bydd cyflogai neu weithiwr yn hunan-ddatgan gordaliad cyflog, gyda'i gytundeb yn ysgrifenedig, bydd Gwasanaethau'r Gyflogres yn ceisio atal yr elfen berthnasol o'u cyflog a ordalwyd er mwyn atal unrhyw ordaliadau pellach rhag digwydd tra ymchwilir i'r mater ac y gofynnir am ddogfennaeth berthnasol.

Mae atal gordaliad rhag digwydd yn hollbwysig.

Rhaid i Sefydliadau GIG Cymru sicrhau bod rheolwyr yn cadw at bolisïau a gweithdrefnau sy'n lleihau'r posibilrwydd o ordaliadau.

Y rhesymau mwyaf cyffredin dros ordaliadau yw: -

- Hysbysiad Terfynu Hwyr – Rhaid gweithredu ffurflen terfynu, Hysbysiad Symud Staff neu ddiweddariad drwy'r cyfleuster Hunanwasanaeth i Reolwyr cyn gynted ag y bydd yn hysbys bod cyflogai neu weithiwr yn gadael ei swydd, h.y. ar ôl ymddiswyddiad, diwedd contract neu ar ôl iddo gael ei ddiswyddo.
  Rhaid ystyried a yw'r cyflogai neu'r gweithiwr wedi cymryd y swm cywir o wyliau blynyddol. Os yw'r unigolyn wedi cymryd mwy o wyliau nag y mae wedi'i gronni, gall naill ai weithio oriau ychwanegol i ad-dalu'r amser, neu ad-dalu'r arian. Os oes gwyliau blynyddol yn ddyledus i'r unigolyn, efallai y gall gymryd y gwyliau oddi ar y cyfnod rhybudd neu gellir ei dalu yn lle hynny os oes angen.
  Mae'n bwysig bod y ffurflen terfynu cyflogaeth yn cael ei chyflwyno i Wasanaethau Cyflogres PCGC cyn gynted â phosibl rhag ofn y bydd angen tynnu swm o'r taliad cyflog terfynol.
- Diweddaru oriau cytundebol cyflogai neu weithiwr yn hwyr neu'n anghywir - cyn gynted ag y cytunir ar yr oriau newydd, dylid trosglwyddo'r wybodaeth drwy'r cyfleuster

Hunanwasanaeth i Reolwyr neu ffurflen newid cyflogai. Dylai hyn fod cyn y dyddiad y mae'r cyflogai neu'r gweithiwr yn dechrau gweithio'r oriau newydd.

- Diweddaru absenoldeb cyflogai neu weithiwr (salwch, mamolaeth, absenoldeb di-dâl ac ati) yn hwyr neu'n anghywir – dylid rhoi gwybod am absenoldebau drwy'r cyfleuster Hunanwasanaeth i Reolwyr ar ESR neu gyflwyno ffurflenni i'r gyflogres cyn gynted â phosibl a'u monitro am hyd yr absenoleb. Rhaid i reolwyr sicrhau bod yr absenoldeb yn cael ei gau cyn gynted ag y bydd yr unigolyn yn adrodd ei fod yn ffit i weithio.
  Bydd Gwasanaethau'r Gyflogres (ar ran Sefydliadau'r GIG) yn talu 'tâl salwch cyfartalog' yn seiliedig ar gyfnodau absenoldeb salwch agored. Os na chaiff yr absenoldeb ei gau, gall hyn arwain at wallau.
- Adroddiadau hwyr neu anghywir am dâl ychwanegol, goramser, ar alwad, dyddiad dechrau, cyflog, bandio ac ati – dylai'r rheolwr neu'r goruchwyliwr gyflwyno gwybodaeth, newidiadau neu dâl amrywiol yn brydlon a chyda digon o amser iddynt gael eu prosesu gan Wasanaethau'r Gyflogres.
- Gwallau system - er nad yw'r gwallau hyn yn digwydd yn aml, unwaith y darganfyddir gwall yn y system, dylid cymryd camau cyn gynted â phosibl er mwyn lleihau taliadau anghywir. Gall y rhain gynnwys ESR, E-amserlenni ac E-Dreuliau.

Pan fo Sefydliadau'r GIG wedi cyflwyno cyfleuster Hunanwasanaeth i Reolwyr (MSS) yn y Cofnod Staff Electronig (ESR), dylai'r Rheolwr Llinell ddefnyddio MSS i ddiweddaru aseiniadau cyflogeion. Os na chaiff y cyfleuster MSS ei gyflwyno'n llawn, dylid rhoi gwybodaeth i Wasanaethau'r Gyflogres gan ddefnyddio'r ffurflenni/Hysbysiad Symud Staff (SMA) sydd ar gael o dan "Dogfennau Defnyddiol" ar dudalen mewnrwyd y Sefydliad trwy'r ddolen isod.

Mae'r ddolen hon hefyd yn rhoi manylion cyswllt Gwasanaethau'r Gyflogres: Gwasanaethau'r Gyflogres (sharepoint.com)

Bydd Gwasanaethau Cyflogres PCGC yn ymdrechu i gadw gwallau i'r isafswm posibl, ond gall gwallau dynol ddigwydd oherwydd cyfrifo anghywir neu gamddehongli gwybodaeth.

ATODIAD C – LLYTHYR ADDASIAD CYFLOG

Tîm Gordaliadau Cymru Gyfan PCGC
Gwasanaethau Cyflogres NWSSP
4ydd Llawr
Tŷ'r Cwmnïau
Ffordd y Goron
Caerdydd
CF14 3UB

Preifat a Chyfrinachol

Enw
Cyfeiriad 1
Cyfeiriad 2
Cyfeiriad 3
Cod Post

Ein Cyf: VPD/Rhif Aseiniad/Cyfenw
Ffôn: 02921 500100

E-bost:

Dyddiad:

PARTHED: Gordaliad Cyflog

Annwyl

Rydym yn ysgrifennu atoch i roi gwybod i chi ein bod wedi darganfod gordaliad o'ch cyflog, pensiwn a/neu dreuliau.

Y swm a ordalwyd yw **£XXX** a ddigwyddodd oherwydd bod gwybodaeth wedi'i chyflwyno'n hwyr i Wasanaethau Cyflogres PCGC yn ymwneud â newid i'ch cyflog a ddylai fod wedi'i wneud o fewn y mis diwethaf.

Mae Gweithdrefn Cymru Gyfan ar gyfer Adennill Gordaliadau yn dosbarthu gordaliad fel 'Addasiad i Gyflog' ac yn caniatáu adennill awtomatig o ordaliadau tâl gros o hyd at 30% o gyflog, gyda 0-10% yn adferadwy mewn un mis, 10-20% dros ddau fis a 20-30% dros dri mis. Roedd eich gordaliad yn **X%** o'ch cyflog felly bydd yn cael ei adennill dros X mis.

Os hoffech ragor o fanylion am y gordaliad neu os ydych yn teimlo nad yw'r adennill awtomatig arfaethedig yn fforddiadwy, cysylltwch â ni ar 02921 500100 gan ddyfynnu'r rhif cyfeirnod uchod. Mae'r tîm yn hapus i helpu a chefnogi gweithwyr a rheolwyr.

Os hoffech ragor o wybodaeth am sut yr ymdrinnir ag adennill gordaliadau, darllenwch Weithdrefn Cymru Gyfan ar gyfer Adennill Gordaliadau sydd i'w gweld ar ddolen gwefan sharepoint Gwasanaethau Cyflogres Partneriaeth Cydwasanaethau GIG Cymru Gwasanaethau Cyflogres (sharepoint.com).

Mae'r Weithdrefn hefyd yn cynnwys teclyn cyllidebu i'ch helpu i gyfrifo'r hyn y gallwch fforddio ei dalu yn Atodiad D. Os ydych yn cael eich hun mewn caledi ariannol, efallai y bydd help neu gyngor ar ddyledion ar gael gan ein Hundeb Llafur. Gallwch hefyd wirio a allech fod yn gymwys i gael unrhyw fudd-daliadau drwy Mynd i'r Afael ag Ansicrwydd Ariannol Gyda'n Gilydd|Trowch atom Ni. Cyngor ar ddyledion o ffynonellau ag enw da:- Mynnwch gyngor ar ddyledion am ddim GOV.UK (www.gov.uk).

Yn gywir,

Insert OP Team Leader Name
Tîm Gordaliadau Cymru Gyfan
Gwasanaethau Cyflogaeth y Bartneriaeth Cydwasanaethau

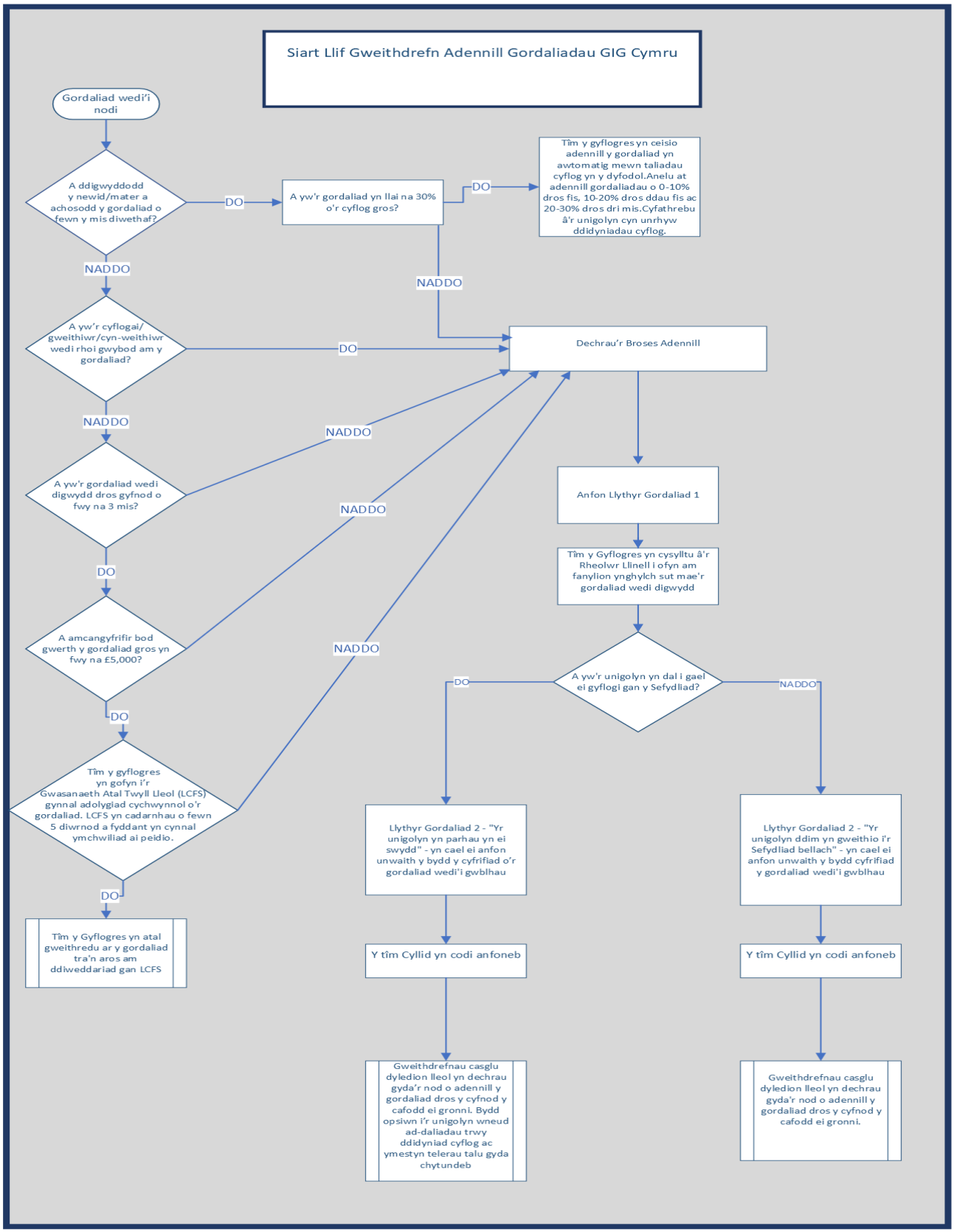
ATODIAD D – TEMPLED INCWM A GWARIANT

Appendix%20D%20 - %20Income%20and

[Teclynnau a chyfrifianellau | Helpwr Arian]

Os byddwch yn wynebu caledi ariannol, efallai y bydd cymorth neu gyngor ar ddyledion ar gael gan eich Undeb Llafur.
Gallwch hefyd wirio a allech fod yn gymwys am unrhyw fudd-daliadau yma:
[Tackling Financial Insecurity Together | Turn2us (Saesneg yn unig)]
Cyngor ar ddyledion o ffynonellau ag enw da:- [Cael cyngor ar ddyledion am ddim GOV.UK (www.gov.uk).]

ATODIAD E – DIAGRAM O'R BROSES GORDALIADAU



ATODIAD F – LLYTHYR GORDALIAD 1

Tîm Gordaliadau Cymru Gyfan PCGC
Gwasanaethau Cyflogres PCGC
4ydd Llawr
Tŷ'r Cwmnïau
Ffordd y Goron
Caerdydd
CF14 3UB

Preifat a Chyfrinachol

Enw
Cyfeiriad 1
Cyfeiriad 2
Cyfeiriad 3
Cod Post

Ein Cyf: VPD/Rhif Aseiniad/Cyfenw
Ffôn: 029 21 500055

E-bost: NWSSP.AllWalesoverpayments@wales.nhs.uk

Dyddiad:

PARTHED: Hysbysiad o Ordaliad Cyflog Posibl

Annwyl

Rydym yn ysgrifennu atoch i roi gwybod i chi ein bod wedi darganfod gwall posibl a allai fod wedi arwain at ordaliad o'ch cyflog/pensiwn a/neu dreuliau.

Roedd y gwall posibl o ganlyniad i ******Insert reason here******.

Mae tîm y gyflogres yn ymchwilio i hyn ar hyn o bryd a byddant mewn cysylltiad yn fuan i gadarnhau'r gordaliad, i ddangos cyfrifiad manwl o'r swm a rhoi manylion ar sut y gellir adennill hwn.

Rydym hefyd wedi cysylltu â'ch rheolwr i'w hysbysu o'r gordaliad posibl fel y gall ddarparu unrhyw wybodaeth ychwanegol a allai helpu i egluro cyfrifiad y gordaliad.

Nid oes angen i chi wneud unrhyw beth ar hyn o bryd, ond os hoffech gysylltu â'r **tîm Gordaliadau, gallwch gysylltu â nhw ar 02921 500055 gan ddyfynnu'r cyfeirnod uchod [VPD/Rhif Aseiniad/Cyfenw].** Mae'r tîm yn hapus i helpu a chefnogi gweithwyr a rheolwyr.

Byddwch yn ymwybodol, hyd nes bod y cyfrifiadau wedi'u cwblhau, ni fydd Gwasanaethau Cyflogres PCGC yn gallu rhoi unrhyw ffigurau gordaliad i chi. Felly, a fyddech cystal â chaniatáu amser i'r rhain gael eu cwblhau cyn cysylltu â ni. Gall gymryd hyd at 14 diwrnod o ddyddiad y llythyr hwn.

Os hoffech ragor o wybodaeth am sut yr ymdrinnir ag adennill gordaliadau, darllenwch Weithdrefn Cymru Gyfan ar gyfer Adennill Gordaliadau sydd i'w gweld ar ddolen gwefan SharePoint Gwasanaethau Cyflogres PCGC Gwasanaethau Cyflogres (sharepoint.com). Gallwch gael cymorth a chyngor gan gynrychiolwyr Undebau Llafur lle bo'n berthnasol.

Yn gywir,

Rhowch Enw Arweinydd Tîm OP
Tîm Gordaliadau Cymru Gyfan

Gwasanaethau Cyflogaeth PCGC

Gwasanaethau Cyflogres PCGC
4ydd Llawr
Tŷ'r Cwmnïau
Ffordd y Goron
Caerdydd
CF14 3UB

ATODIAD G - LLYTHYR GORDALIAD 2

Unigolyn yn parhau yn ei swydd

Preifat a Chyfrinachol

Ein Cyf: VPD/Aseiniad/Cyfenw
Adran: Gwasanaethau Cyflogres PCGC ar gyfer Gordaliadau Cymru Gyfan
Ffôn: 029 21 500055

E-bost: NWSSP.AllWalesoverpayments@wales.nhs.uk

Dyddiad:

PARTHED: Gordaliad Cyflog

Annwyl

Yn dilyn ein llythyr blaenorol dyddiedig ** [nodwch y dyddiad] ** gallwn nawr roi mwy o fanylion am eich gordaliad. Derbyniwch ein hymddiheuriadau diffuant am y gordaliad hwn ac unrhyw ofid neu anghyfleustra y gallai ei achosi i chi.

Mae'r gordaliad wedi'i gyfrifo fel a ganlyn: -

Cyfnod y Gordaliad:	
Rheswm dros y Gordaliad:	

Gordaliad Gros:	**£**
Llai	
Pensiwn:	£
Talu wrth Ennill:	£
Cyfraniadau Yswiriant Gwladol:	£
Benthyciad Myfyriwr:	£
Gordaliad Net sy'n Ddyledus:	**£**

Bydd anfoneb yn cael ei hanfon atoch yn uniongyrchol gan Adran Gyllid eich sefydliad blaenorol er mwyn dechrau adennill y gordaliad hwn.

Os bydd gennych unrhyw ymholiadau ynglŷn â sut i dalu, bydd manylion cyswllt yr Adran Gyllid yn cael eu dangos ar yr anfoneb. Gan nad ydych bellach yn gyflogedig gan eich Sefydliad blaenorol, yr opsiynau i ad-dalu fydd naill ai trwy drosglwyddiad banc, archeb sefydlog, siec neu gerdyn debyd/credyd os yw'r cyfleuster ar gael o fewn y Sefydliad.

Gallwch drefnu opsiwn adennill misol fforddiadwy neu ddewis ad-dalu'r swm yn llawn mewn un taliad. Yn ddelfrydol, dylid adennill y gordaliad dros yr un cyfnod ag y digwyddodd y gordaliad. Os hoffech drafod amserlen adennill wahanol, cysylltwch â'r Adran Gyllid.

Os oes gennych unrhyw ymholiadau ynglŷn â chyfrifo'r gordaliad, mae croeso i chi gysylltu â Thîm Gordaliadau Cymru Gyfan PCGC drwy e-bostio NWSSP.AllWalesOverpayments@wales.nhs.uk, neu gysylltu â nhw ar **02921 500055 gan ddyfynnu'r rhif cyfeirnod uchod [VPD/rhif aseiniad/Cyfenw]**. Mae'r tîm yn hapus i helpu a chefnogi gweithwyr a rheolwyr.

Rydym yn deall bod gordaliadau yn anffodus ac y gallent achosi pryder, felly ein nod yw ateb pob ymholiad yn gyflym i leihau unrhyw ofid neu ansicrwydd.

Gwasanaethau Cyflogres PCGC
4ydd Llawr
Tŷ'r Cwmnïau
Ffordd y Goron
Caerdydd
CF14 3UB

Bydd gordaliadau yn cael eu hadennill yn unol â Gweithdrefn Cymru Gyfan ar gyfer Adennill Gordaliadau, y gellir darparu copi ohoni os gofynnir amdano.

Mae'r Weithdrefn hefyd yn cynnwys offeryn cyllidebu i'ch helpu i weithio allan yr hyn y gallwch fforddio ei dalu yn Atodiad H. Gallwch hefyd gael cymorth a chyngor gan gynrychiolwyr Undebau Llafur lle bo'n berthnasol.

Yn gywir

Rhowch Enw Arweinydd Tîm OP
Tîm Gordaliadau Cymru Gyfan
Gwasanaethau Cyflogaeth PCGC

Gwasanaethau Cyflogres PCGC
4ydd Llawr
Tŷ'r Cwmnïau
Ffordd y Goron
Caerdydd
CF14 3UB

Unigolyn nad yw'n gweithio i'r Sefydliad mwyach

Preifat a Chyfrinachol

Ein Cyf: VPD/Aseiniad/Cyfenw
Adran: Gwasanaethau Cyflogres PCGC ar gyfer Gordaliadau Cymru Gyfan
Ffôn: 029 21 500055

E-bost: NWSSP.AllWalesoverpayments@wales.nhs.uk

Dyddiad:

PARTHED: Gordaliad Cyflog

Annwyl

Yn dilyn ein llythyr blaenorol dyddiedig ** [nodwch y dyddiad] ** gallwn nawr roi mwy o fanylion am eich gordaliad.

Derbyniwch ein hymddiheuriadau diffuant am y gordaliad hwn ac unrhyw ofid neu anghyfleustra y gallai ei achosi i chi.

Mae'r gordaliad wedi'i gyfrifo fel a ganlyn: -

Cyfnod y Gordaliad:	
Rheswm dros y Gordaliad:	

Gordaliad Gros:	**£**
Llai	
Pensiwn:	£
Talu wrth Ennill:	£
Cyfraniadau Yswiriant Gwladol:	£
Benthyciad Myfyriwr:	£
Gordaliad Net sy'n Ddyledus:	**£**

Bydd anfoneb yn cael ei hanfon atoch yn uniongyrchol gan Adran Gyllid eich sefydliad er mwyn dechrau adennill y gordaliad hwn. Os bydd gennych unrhyw ymholiadau ynglŷn â sut i dalu, bydd manylion cyswllt yr Adran Gyllid yn cael eu dangos ar yr anfoneb. Gan eich bod yn dal yn gyflogedig gan eich Sefydliad, mae'n bosibl adennill y gordaliad trwy ddidyniadau cyflog misol.

Gallwch drefnu opsiwn adennill misol fforddiadwy neu ddewis ad-dalu'r swm yn llawn mewn un taliad. Yn ddelfrydol, dylid adennill y gordaliad dros yr un cyfnod ag y digwyddodd y gordaliad. Os hoffech drafod amserlen adennill wahanol, cysylltwch â'r Adran Gyllid.

Os oes gennych unrhyw ymholiadau ynglŷn â chyfrifo'r gordaliad, mae croeso i chi gysylltu â Thîm Gordaliadau Cymru Gyfan PCGC drwy e-bostio NWSSP.AllWalesOverpayments@wales.nhs.uk, neu gysylltu â nhw ar **02921 500055 gan ddyfynnu'r rhif cyfeirnod uchod [VPD/rhif aseiniad/Cyfenw]**. Mae'r tîm yn hapus i helpu a chefnogi gweithwyr a rheolwyr.

Rydym yn deall bod gordaliadau yn anffodus ac y gallent achosi pryder, felly ein nod yw ateb pob ymholiad yn gyflym i leihau unrhyw ofid neu ansicrwydd.

Bydd gordaliadau'n cael eu hadennill yn unol â Gweithdrefn Cymru Gyfan ar gyfer Adennill Gordaliadau sydd i'w gweld ar wefan SharePoint Gwasanaethau Cyflogres PCGC: Gwasanaethau Cyflogres (sharepoint.com). Mae'r Weithdrefn hefyd yn cynnwys offeryn cyllidebu i'ch helpu i gyfrifo'r hyn y gallwch fforddio ei dalu yn Atodiad D. Os ydych yn canfod eich hun mewn caledi ariannol, efallai y bydd help neu gyngor ar ddyledion ar gael gan ein Hundeb Llafur. Gallwch hefyd wirio a allech fod yn gymwys i gael unrhyw fudd-daliadau drwy Tackling Financial Insecurity Together|Turn to Us. Cyngor ar ddyledion o ffynonellau ag enw da:- Cael cyngor ar ddyledion am ddim GOV.UK (www.gov.uk).

Yn gywir

Rhowch Enw Arweinydd Tîm OP

Mae Gwasanaethau Cyflogaeth yn is-adran o fewn Partneriaeth Cydwasanaethau GIG Cymru
Employment Services is a division of the NHS Wales Shared Services Partnership

Gwasanaethau Cyflogres PCGC
4ydd Llawr
Tŷ'r Cwmnïau
Ffordd y Goron
Caerdydd
CF14 3UB

Tîm Gordaliadau Cymru Gyfan
Gwasanaethau Cyflogaeth PCGC

Gwasanaethau Cyflogres PCGC ar gyfer Gordaliadau Cymru Gyfan
4ydd Llawr
Tŷ'r Cwmnïau
Ffordd y Goron
Caerdydd
CF14 3UB

ATODIAD H – LLYTHYR Y RHEOLWR LLINELL

Preifat a Chyfrinachol

Ein Cyf: VPD/Aseiniad/Cyfenw
Adran: Gwasanaethau Cyflogres PCGC ar gyfer Gordaliadau Cymru Gyfan
Ffôn: 029 21 500055
E-bost: NWSSP.AllWalesOverpayments@wales.nhs.uk

Dyddiad:

PARTHED: Gordaliad Cyflog

Annwyl Reolwr

Rydym yn ysgrifennu atoch i roi gwybod bod gordaliad cyflog posibl wedi digwydd ar gyfer aelod o staff yr ydych yn rheolwr llinell arno.

Nodir manylion y gordaliad cyflog posibl isod:

Enw:

Rhif Aseiniad:

Cyfnod y Gordaliad:

Rheswm dros y Gordaliad:

Y Camau Nesaf...

Unwaith y bydd y gordaliad wedi'i wirio a'i brosesu yn ESR, byddwch chi a'r gweithiwr yn derbyn llythyr pellach a fydd yn cadarnhau'r gordaliad ac yn dangos cyfrifiad manwl o'r swm. Gall gymryd hyd at 14 diwrnod o ddyddiad y llythyr hwn.

Yna bydd y gweithiwr yn cael anfoneb gan Dîm Cyllid eich Sefydliad gyda chyfarwyddiadau ar sut y gellir adennill y gordaliad.

Fel rheolwr yr unigolyn sydd wedi cael gordaliad, a fyddech cystal â thrafod y gordaliad gydag ef a sicrhau ei fod yn deall bod angen ad-dalu'r arian a ordalwyd a bod yn rhaid adennill pob gordaliad ni waeth pwy sydd ar fai.

Bydd angen gwneud y gweithiwr yn ymwybodol fod gan y Sefydliad yr hawl i gyflogi asiantaeth casglu dyledion neu gymryd camau cyfreithiol er mwyn adennill y ddyled os na fydd yn ad-dalu'r gordaliad.

Byddwch yn gefnogol i'ch gweithiwr os gwelwch yn dda a thynnwch ei sylw at yr offer yn Atodiad D y Weithdrefn a grybwyllir isod os oes angen help arno i weld beth sy'n fforddiadwy.

I gael manylion llawn am sut y caiff y gordaliad ei drin, cyfeiriwch at Weithdrefn Cymru Gyfan ar gyfer Adennill Gordaliadau Cyflogres sydd i'w gweld ar wefan SharePoint Gwasanaethau Cyflogres PCGC: Gwasanaethau Cyflogres (sharepoint.com)

Anfonir ffurflen hysbysu Gordaliad atoch hefyd i'w chwblhau'n electronig. Bydd yr wybodaeth a gesglir yn cefnogi eich Sefydliad i fonitro gordaliadau, deall sut y digwyddodd a pha fesurau sydd wedi'u rhoi ar waith i osgoi gordaliadau yn y dyfodol.

Os oes unrhyw gwestiynau am y gordaliad, cysylltwch â'r **Tîm Gordaliadau ar 02921 500055 gan ddyfynnu'r cyfeirnod uchod [JEC/assignment].** Mae'r tîm yno i helpu a chefnogi gweithwyr a rheolwyr.

Yr eiddoch yn gywir,

Rhowch Enw Arweinydd Tîm OP
Tîm Gordaliadau Cymru Gyfan
Gwasanaethau Cyflogaeth PCGC

ATODIAD I – DIDYNNU GORDALIAD CYFLOG

Didyniad yn uniongyrchol o Daliad Cyflog – Ffurflen Awdurdodi

Enw:	
Rhif Aseiniad:	
Bwrdd Iechyd/Ymddiriedolaeth/Awdurdod Iechyd Arbennig (SHA):	
Adran:	

Rwy'n awdurdodi Gwasanaethau Cyflogres Partneriaeth Cydwasanaethau GIG Cymru i ddidynnu'r swm o £ _____ yn uniongyrchol o'm Cyflog bob mis.

Deallaf y bydd hwn yn cael ei ddidynnu fel taliad NET ac y bydd y didyniad hwn yn parhau hyd nes y bydd y gordaliad o £ _____ wedi ei ad-dalu'n llawn.

Rhoddaf fy nghydsyniad llawn ar gyfer y didyniad hwn.

Os daw fy nghyflogaeth i ben, cytunaf y byddaf yn cysylltu â'r Adran Gyllid i drafod opsiynau i naill ai adennill gweddill y gordaliad o'm tâl terfynol neu gytuno ar sut y caiff y balans sy'n weddill ei dalu.

Llofnod _____

Ysgrifennwch eich enw mewn priflythrennau _____
Dyddiad: _____

Ar ôl ei gwblhau, anfonwch e-bost at [Sefydliadau i nodi cyfeiriad e-bost eu tîm cyfrifon derbyniadwy].
Timau Cyllid i nodi bod adennill y gordaliad yn cael ei wneud mewn rhandaliadau trwy ddidyniadau cyflog ac yna anfon y ffurflen awdurdodi didyniad hwn ymlaen at: NWSSP.AllWalesOverpayments@wales.nhs.uker mwyn i Wasanaethau'r Gyflogres weithredu

ATODIAD J – ASESIAD CYCHWYNNOL ATAL TWYLL - GWYBODAETH ANGENRHEIDIOL

Enw'r Unigolyn		
Grŵp Tâl / Rhif Tâl		
Sefydliad y GIG		
Teitl y Swydd		
Gradd Cyflog / Oriau **Llawnamser/ Rhan-amser**	Gradd	Oriau
Gweithle / Lleoliad		
Gwerth y Gordaliad Atodwch manylion y Broses Ordaliadau	**Gros**	**Net**
Cyfnod y Gordaliad	**Dyddiad o**	**Dyddiad i**
Rheswm dros y Gordaliad		
Enw cyswllt a manylion yr Adran / Rheolwr		
Manylion cyswllt Gwasanaethau'r Gyflogres		
Manylion cyswllt Gordaliad Cyflog		
Cadarnhewch pa wiriadau sydd wedi'u gwneud i wirio a yw'r unigolyn wedi cysylltu â Gwasanaethau'r Gyflogres		**Gwiriadau wedi'u gwneud gan:** **Dyddiad:**
MANYLION PELLACH AM YR UNIGOLYN:		
Cyfeiriad		
Dyddiad Geni		
Rhif Yswiriant Gwladol		
Manylion cyfrif banc		
Cwblhawyd y ffurflen gan:	**Dyddiad:**	
Ychwanegwch unrhyw fanylion pellach a allai fod o gymorth i'r Tîm Atal Twyll Lleol gyda'u hadolygiad: **Peidiwch â chysylltu ag unigolion heb ymgynghori â'ch tîm Gwasanaeth Atal Twyll Lleol.** **Rhowch wybod am unrhyw gyswllt pellach rhyngoch chi a'r unigolyn i'r tîm Atal Twyll Lleol ar unwaith.**		

ACTION LOG

WELSH AMBULANCE SERVICES UNIVERSITY NHS TRUST - AUDIT, RISK AND ASSURANCE COMMITTEE - As at 21 November 2024

Ref	Date	Agenda Item	Action Note	Responsible	Due Date	Progress/Comment	Status
55/24	21 November 2024	Audit Wales Reports	The Committee sought an indicative timeline regarding the completion of the Digital Systems report. It was agreed this would be followed up and communicated to the Committee.	Fflur Jones	16 December 2024	Update for 6 March 2025	Open
56/24b	21 November 2024	Internal Audit Reviews - Overtime Controls Internal Audit	In the report, objective 2.18 reflects the workforce as being EMT Band 4 Paramedics, this need to state EMT Band 5 and it was asked that this will be updated to reflect the change.	Jonathan Sweet	16 December 2024	Update for 6 March 2025 The Business Management Team have been tasked with engaging with Audit Colleagues with the request to amend the report narrative to reflect the correct wording.	Complete
59/24	21 November 2024	Policies - All Wales Procedure for Recovery of Overpayments Policy	The Committee will adopt the policy by way of a Chair's Action post-meeting as it was not available on Ibabs.	Alex Payne	6 March 2025	Update for 6 March 2025 Chair's action agreed on 2 December 2024	Complete

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	29 November 2024
Committee Meeting Date	21 November 2024
Chair	Peter Curran

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

1. Whilst not a matter of escalation, the committee commended the teams on two **positive Audit Wales reports** reviewed by the committee at this meeting – Review of Cost Savings, and the 2024 Structured Assessment. A significant amount of assurance was received by the committee, with further detail set out at paragraphs 5 and 6 below. Additionally, the transparency and proactivity of the Executive in including areas of risk in the Internal Audit Plan was commended, notwithstanding the probability of limited assurance outcomes.

ADVISE

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

2. The Chair is conducting quarterly **continual effectiveness reviews** in line with the National Audit Office toolkit rather than waiting to the end of the year to address this. These will continue with the Non-Executive Directors, the Executive Director of Finance and Corporate Resources and the Director of Corporate Governance/Board Secretary. A new approach to effectiveness reviews for 2024/25 was discussed, particularly as it relates to engagement in these reviews by members.

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

4. Members **reflected** that the hybrid meeting worked well again, with chat kept to a minimum which was appreciated. Directors attending for assurance on third revised dates and their candid comments was seen as positive, and a good discipline for the committee to receive assurance. Members felt the meeting focused on key areas and that papers and presentations were of good quality. Audit reports were positive; however, members recognise resource and capacity issues will continue to be challenging, particularly over the coming months. New attendees found the contributions and discussion supportive.

ASSURE

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

5. The **Audit Wales Review of Cost Savings Arrangements** report was presented. This programme of work was undertaken for all NHS bodies and this report looked at the approaches to identifying, delivering, and monitoring sustainable cost savings opportunities at WAST. This was a positive report, with Audit Wales finding that the Trust exceeded its overall 2023-24 savings target and continues to enhance its arrangements for identifying, delivering, and monitoring efficiencies and sustainable cost savings. However, opportunities exist for the Trust to reduce its reliance on non-recurrent savings, strengthen financial capabilities across the organisation, and refine its savings reporting to the board. Four recommendations were made, and the committee was assured that management actions were reasonable and timely. Further detail on the board's appetite for managing the issue of non-recurrent savings will be considered for incorporation into the 2025/26 financial plan.

6. The **Audit Wales Structured Assessment 2024** was presented and is a stand-alone item on the board's agenda for its November meeting. The programme of work focused on the Trust's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically, with a specific focus on our corporate approach to planning; corporate systems of assurance; board transparency, cohesion and effectiveness; and corporate approach to financial management. This was another positive report, with Audit Wales finding that the Trust's corporate arrangements generally support good governance and the efficient, effective, and economical use of resources. Positively, the Trust is transforming its clinical services to better manage operational pressures and demand and is making good progress in enhancing key systems of assurance to strengthen Board focus on strategic risks. Similar to the Review of Costs Savings Arrangements report, Audit Wales note that whilst financial performance is good, there is a need to move away from its reliance on non-recurrent savings to maintain organisational resilience.

7. **Audit Wales updates** were noted as follows:

   - The Follow Up Review of Quality Governance Arrangements will be presented at the Quality, Patient Experience and Safety Committee (QUEST) in February and ARAC in March. It has been issued in draft and management responses are expected imminently. Members were informed that there has been progress with 2022 recommendations, however some were in still progress.
   - Likewise, the review of unscheduled care report part two (accessing urgent and emergency care) is underway and will come to the committee in March. Part three of the review (national arrangements and leadership structures) is in the scoping phase.
   - The deep dive review of digital systems to support service resilience and transformation (an All-Wales piece of work) is in the scoping phase.
   - The independent examination of the 2023/24 charity accounts will commence on 16 December, with no escalations to the Corporate Trustee on timelines at this stage.

8. Progress against the **2024/25 Internal Audit Plan** was received and it was noted that the plan remains on track. Management responses within 15 days is currently showing as red; however, the committee was appraised of new processes in place, current capacity pressures, and the plan to reiterate the need for timeliness to the ADLT and ELT. The following Internal Audits reviews were completed during the quarter and presented to the Committee:

   - **Resourcing Policy – Limited Assurance**. The purpose of this audit was to review the Resourcing Policy, its compliance with national terms and conditions, and to assess its application as an enabler for effective resource production. Members noted that this was an area the executive felt would benefit from an independent examination when developing the 2024/25 audit plan, and therefore the assurance rating was not unexpected. Whilst some of the management actions have commenced, others will require significant consultation, for example to ensure the policy is fit for the needs of a modern service. Timelines set for these areas in particular recognise the challenges this will pose.
   - **Integrated Quality and Performance Management Framework – Reasonable Assurance**. This follows the Audit Wales Review of Quality Governance in 2022/23 which focused on quality governance arrangements, with this internal audit looking at embedding of the framework. The review returned one high priority recommendation related to the work programme and local frameworks.

     The *implementation* of the Quality and Performance Management Framework has sat with ARAC as a priority for 2024/25. The Committee were assured on the continued roll-out and embedding of quality and performance under this framework, and as foreshadowed at the September meeting members agreed to close the priority and transfer the review of effectiveness of the framework back to the Finance and Performance Committee as per their terms of reference.
   - **Overtime Controls – reasonable assurance.** The purpose of the audit was to review the process adopted for the allocation of planned overtime. There was reasonable assurance rating across all objectives and no high rated recommendations.
   - **Data Quality – reasonable assurance.** The purpose of the audit was to review the structures and processes for ensuring data quality and accurate reporting within the Trust. The report highlighted that the focus within the Trust, due to capacity, has been on the EMS CAD system. This audit was discussed in detail at the Finance and Performance Committee, with issues of resourcing and the need to strengthen data quality processes across the other data sets and systems drawn out in that committee's AAA report. Auditors noted the Trust is forging a good data culture.

9. The Committee has oversight of the **Trust's Policy** work plans and was assured that 46% of policies identified as a priority for review are now within their review date which is a significant improvement on the 14% reported post pandemic in July 2023. A re-evaluation of the policy priorities has been undertaken with the Executive Leadership Team and a new work program established for 2025/26.

10. The **All-Wales Procedure for Recovery of Overpayments** is approved and endorsed by the NHS Wales Shared Services Partnership Committee and aims to provide a consistent approach across all NHS Wales organisations replacing all previous local policies and procedures. The committee will adopt the policy by way of a Chair's Action post-meeting as it was not available on Ibabs.

11. The **losses and special payments** made during the period 01 June to 30 September 2024 amounted to £186K net repayments. The rationale for the reporting will be reviewed, noting it is required under the Standing Financial Instructions.
12. The committee's terms of reference requires it to receive assurance on the **arrangements for near miss reporting** at the Trust. Assurances were received by way of a report from the Chair of QUEST on the near miss arrangements and that committee will continue to monitor this maturing area by way of the Putting Things Right Report.
13. In private session the Committee received the counter fraud update 01 June to 30 September 2024 as well as the report on **tenders and single tender waiver requests**, noting there were no single tender waivers in the last two periods. The **Local Counter Fraud Service (LCFS)** provided an update on its work in tackling fraud, bribery and corruption in the Trust. The report provided detail of ongoing and future Counter Fraud work against the approved work plan. The Committee noted that there are currently 33 recorded ongoing investigations (37 in last reporting period), with 10 new referrals (12 in the last reporting period) having been received. The Committee discussed the themes and trends in ongoing investigations and considered, and fraud awareness promotion undertaken, including during National Fraud Week.
14. An update was received on the revised **Audit Tracker** from the Q3 2024/25 reporting period. The Committee noted that 37% of internal audit actions were closed in quarter. There were 11 actions on their third (and final) revised date; these related to the Pain Management, IM&T Infrastructure, Senior Paramedic Audits, Cyber and the 111 Commissioning Advisory Report. Directors were present to discuss the rationale the movement of these dates and any residual risks, which the committee commended.
15. The **Committee's cycle of business** monitoring report was reviewed with no matters to escalate.

RISK MANAGEMENT

The committee received assurance on the progress of the Risk Management Transformation Programme and noted that an external partner has been commissioned to assist with the development of a suite of risk appetite statements in workshops held between December 2024 and February 2025.

Specific updates were provided against the principal risk management activity in Quarter noting that Risk 594 (civil contingency) has reduced in score from 20 to 15 reflecting mitigations and actions that have been implemented and Risk 163 (Trade Union Partnerships) has reduced from 16 to 12 reflecting the positive engagement and that partnerships working well.

Members emphasised the importance of the committee's role in steering the transformation program and may consider this as a committee priority for 2025/26 noting that it is in the Terms of Reference and on the cycle of business.

COMMITTEE AGENDA FOR MEETING IN JUNE		
Chair's report on continuous committee effectiveness	Audit Wales Update Report Review of Cost Savings Arrangements	Internal Audit Progress Report Resourcing Policy Audit IQPMF Audit

COMMITTEE AGENDA FOR MEETING IN JUNE		
	Structured Assessment 2024	Overtime Controls Audit Data Quality Audit
Risk management and board assurance Risk Transformation Programme	Audit Tracker	Policy Report All Wales Recovery of Overpayments Procedure
Near Miss Report	Losses and Special Payments	Cycle of business and monitoring report

COMMITTEE ATTENDANCE						
Name	**30 April 2024**	**7 June 2024[1]**	**10 July 2024[2]**	**12 Sep 2024[3]**	**21 Nov 2024[4]**	**6 Mar 2024**
Peter Curran						
Kevin Davies						
Joga Singh						
Ceri Jackson						
Chris Turley						
Audit Wales	Fflur Jones[5]	Fflur Jones	Yvonne Thomas	Fflur Jones[6]	Fflur Jones	
Julie Boalch						
Judith Bryce					Jon Sweet	
Christian Fox						
Angie Lewis						
Carl Kneeshaw						
Osian Lloyd					From Item 7	
Trish Mills						
Liam Williams					J Turnball-Ross	
Carl Window						
Damon Turner					Until Item 10	

	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] Jason Killens and Rachel Marsh joined this meeting
[4] Bethan Evans, Non-Executive Director joined this meeting to ensure quoracy as new NED membership is implemented
[5] Darren Griffiths and Amy Lord also attended
[6] Gareth Lucy also attended

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

2024/25 COMMITTEE EFFECTIVENESS REVIEW

MEETING	Audit, Risk and Assurance Committee
DATE	6 March 2025
EXECUTIVE	Trish Mills, Director of Corporate Governance/Board Secretary
AUTHOR	Trish Mills, Director of Corporate Governance/Board Secretary
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. In previous years, members of the committee were asked to complete the extensive NAO Audit and Risk Assurance Committee Effectiveness Tool questionnaire. Recognising the need for a more engaging and efficient process, the committee adopted a new approach for the current effectiveness review, commencing in April 2024.

2. This year, a smaller subgroup of ARAC members met throughout the year to proactively address the questionnaire by identifying and addressing any gaps in advance. This preliminary work aims to streamline the effectiveness review by allowing the committee to focus on key areas of improvement and maintain continuous oversight of their responsibilities.

3. During the March meeting, the committee will have the opportunity to confirm and challenge the pre-completed questionnaire. This process is designed to ensure that the committee's responses accurately reflect its remit, operating arrangements, and areas for improvement. Members are encouraged to validate the responses and provide critical feedback where discrepancies or opportunities for enhancement are identified.

4. The meeting will focus on a few key topics identified by the group as needing further discussion. These topics include the length of meetings, the volume of papers, the process of committee induction, and the mix of skills present within the committee. Each of these areas represents a crucial aspect of the committee's functionality and effectiveness.

5. To facilitate this discussion, members will be guided through these questions via a presentation. This presentation will also include interactive elements, such as questions on menti.com, focusing on:

    - Suggestions to assist members in their roles as report writers, reviewers, and receivers of assurance.
    - Feedback on what currently works well within the committee.
    - Ideas for improvements that could be made to enhance the committee's operations.

6. Lastly, the draft of the committee's annual report for the year is presented for review and discussion. This report highlights the considerable work undertaken by the committee throughout the year and is fundamental to providing assurance to the board on the committee's performance and adherence to its responsibilities.

7. Following this committee meeting the feedback on effectiveness will be included in the annual report. This will be presented to the May committee meeting for approval, along with any priorities agreed for 2025/26 and changes if any to terms of reference, including membership.

RECOMMENDATION

8. Members are invited to assess whether the committee's remit, as outlined in its terms of reference, remains appropriate for 2025/26. Consideration should be given to any necessary amendments, additions, or removals, areas that might be better addressed by another committee, or changes to membership.

9. Members are invited to evaluate the cycle of business included in this pack. Reflecting on the hallmarks of effective assurance reporting, members are asked to propose potential improvements to enhance the strength and efficiency of assurance processes for the committee.

10. Members are asked to consider the responses to the NAO questionnaire and advise of any alterations.

11. Members are asked to take part in a Mentimeter quiz in the meeting answering the following questions:

    - What would help you as report writers/reviewers/receivers of assurance
    - What works well in this committee
    - What improvements could we make in this committee

12. Members are requested to review the draft Annual Report and provide any comments ahead of it being finalised for the May committee meeting.

KEY ISSUES/IMPLICATIONS
As set out above

REPORT APPROVAL ROUTE
NA

REPORT APPENDICES
Annex 1 – Committee remits for 2024/25 Annex 2 – NAO questionnaire Annex 3 – Committee terms of reference Annex 4 – Committee cycle of business Annex 5 – Draft committee annual report

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

2024/25 COMMITTEE EFFECTIVENESS REVIEW

SITUATION

1. Annual effectiveness reviews are designed to evaluate the efficacy of the committee, review operating arrangements, and propose changes to improve its support, challenge, scrutiny and oversight responsibilities.

2. Whilst our commitment to the duty means we adopt a continuous improvement methodology throughout the year, this annual effectiveness review is an opportunity to formally review this committee's remit and membership, consider the reports it receives, and look back at the work of the Committee in 2024/25.

BACKGROUND

Role of the Board and its Committees

3. The Trust Board is accountable for governance, risk management and internal controls at WAST. It focuses on the following key areas:

    - Developing the **strategy, vision, and purpose** of the Trust. Identifying priorities, establishing goals and objectives, applying resources, understanding risks to the achievement of objectives, and allocating funds to support the decisions that need to be made around strategic planning.

    - Shaping the **culture** of the Trust in several ways, including the way in which it engages with our people, our patients and stakeholders, the way it manages its agenda, by the nature of the discussions at the Board and the relative emphasis given to different performance criteria, by the visibility of its members in the organisation, and by where it chooses to invest time and resources. Board and committee members must live up to the highest ethical standards of integrity and probity and abide by the Nolan Principles.

    - Setting organisation wide expectations and accountability for high performance and compliance with the **duty of quality** and the **duty of candour** as set out in the Health and Care (Quality and Engagement) (Wales) Act 2020. Ensuring that all staff understand their role in the effective and high-quality provision of care in a governance framework that ensures a balance between trust, constructive debate, and effective challenge in a culture of openness and learning.

- Ensuring there is a robust system of **risk management and internal controls** in place, and that the board are sighted on the mitigations in place for the principal risks to the delivery of the strategy.

- **Holding to account,** and being held to account, for the delivery of the strategy in accordance with the strategic and performance frameworks developed by the Board.

4. The board has established several committees to support it in discharging its responsibilities effectively. These committees are designed to undertake the detailed work required to provide robust assurance, explore risks and performance issues, and examine key matters within their specific remits. By doing this 'heavy lifting,' they have the capacity to delve deeper into issues, identify assurance gaps, and set the necessary context for informed decision-making. Attached at **Annex 1** is a snapshot of the remits of all six committees of the Trust Board, and the Corporate Trustee framework.

5. Committees meet for extended periods, allowing them to afford the time and attention to critical matters that the full board cannot. This structure ensures that items are thoroughly examined and discussed, enabling a more expert understanding of their implications. Following each meeting, committees report back to the board and corporate trustee on the assurance they have received and escalate any significant issues or concerns for further consideration. This approach ensures that the board is well-informed and able to focus on strategic oversight.

ASSESSMENT

National Audit Office (NAO) Questionnaire

6. The Trust's Standing Orders, committee terms of reference, and codes of governance provide that boards should routinely assess the effectiveness of their governance arrangements, of which this committee forms an integral part. Each committee is required to submit an annual report to the board setting out its activities during the year and a review of its performance.

7. In 2022/23 and in 2023/24 members were asked to complete the NAO Audit and Risk Assurance Committee Effectiveness Tool questionnaire. This questionnaire was then reviewed alongside the terms of reference by the committee Chair, Executive lead and Corporate Governance Team. However the length and complexity of the questionnaire was an inhibitor for more fulsome engagement

and therefore in April 2024 this committee agreed a different approach for the current effectiveness review.

8. This commenced with a smaller group who have met throughout the year to review the NAO questionnaire and populate it, identifying any gaps. It was felt that this was a more manageable way to give the various elements due regard and to ensure this committee is discharging its responsibility to the board on a continuous basis, rather than at the end of the year. This group consisted of the committee Chair, Peter Curran; Non-Executive Directors Ceri Jackson and Rhiannon Beaumont-Wood; Executive Director of Finance and Corporate Resources, Chris Turley; and the Director of Corporate Governance and Board Secretary, Trish Mills. In addition to this the Chair has routinely reached out to Internal Audit and Audit Wales for feedback.

9. The completed NAO questionnaire is included in **Annex 2**. Questions where more than one member scored 'room for improvement' last year are highlighted in yellow. As this NAO questionnaire is used by a broad range of government and public bodies, the questions are not always relevant or easy to apply to us at WAST. It is therefore expected that a fuller response to these questions will provide the appropriate context for members.

10. The group identified several questions that would benefit from broader discussion and input from committee members during the March meeting. They are drawn out in Annex 2 and relate to:

    - Length of meetings and volume of papers
    - Committee induction
    - Skills mix

    Members will be guided through these during the meeting.

11. **Members are kindly requested** to review all responses to the NAO questionnaire and bring to the committee's attention any responses that may require amendment or adjustment. Members will note that this revised approach will mean that benchmarking from previous years on responses will not be available.

The remit and work programme of this Committee

12. This committee's terms of reference are attached at **Annex 3**. The purpose of the committee is to advise and assure the board and the Accountable Officer on whether effective arrangements are in place - through the design and operation of the Trust's system of assurance - to support them in their decision taking, and in discharging their accountabilities for securing the achievement of the Trust's

objectives, in accordance with the standards of good governance determined for the NHS in Wales

13. Whilst some changes to the terms of reference have been identified through the NAO questionnaire (such as the ability for ARAC to hold a private meeting without management (1.2.10)), further changes may be identified as a result of discussions at the March meeting.

14. The terms of reference are accompanied by a cycle of business (otherwise known as a work programme) for each committee. This committee's cycle is attached at **Annex 4**.

15. Cycles of business play a pivotal role in the effectiveness and efficiency of the committee. They are the basis upon which agenda are drafted to inform a fulsome commissioning of papers. The notes section contains context added from a number of sources including audit reports, directions from the committee, agreed approaches or policy positions.

16. The cycle of business should aim to cover 90% of the items expected to come before the committee. This framework enables directors and their teams to plan the internal governance pathways that each report should follow before reaching the committee.

17. The cycle of business is accompanied by a detailed schedule of submission deadlines, ensuring papers are lodged with the Corporate Governance Team in a timely manner for each committee meeting and published in line with the Trust's Standing Orders.

<u>Internal Governance and Flows of Assurance</u>

18. With the exception of the People and Culture Committee and the Charity Committee, the board has not established sub-committees reporting to its committees. Instead, the Trust has implemented internal governance structures that serve as integral components of the broader governance framework. This committee has a separate paper on the integrated governance programme before it today which expands on this, illustrating the organisational, strategic and directorate governance arms. These enable directors to:

- Address specific portfolio areas effectively;
- Foster a collaborative approach across the Trust;
- Establish robust monitoring and assurance processes;
- Escalate issues for resolution as needed;
- Formulate assurance reports to meet their accountability responsibilities to the board and relevant committees.

A well-defined cycle of business for the committee is essential to support directors in creating appropriate forums, providing clarity to report writers, and ensuring the smooth flow of reporting.

Committee reporting

19. The cycle of business will guide the type of reporting needed; however, all assurance reporting must meet high standards to support effective decision-making. The hallmarks of a good board or committee paper include:

- Clarity and accessibility, ensuring the paper is:
  - free from jargon and accessible to all board and committee members, regardless of technical expertise;
  - presented with a clear, logical structure and relevant headings;
  - focused on key issues within the committee's remit, avoiding unnecessary detail;
  - complimented by an executive summary highlighting key points for quick reference; and
  - not duplicative.

- Strategically aligned and clearly identifies key risks, their potential impact, and how these risks are managed or mitigated.

- Evidence-based and balanced, ensuring it:
  - Is drawn from robust, reliable data and evidence;
  - provides a balanced view by presenting both positive and negative findings; and
  - includes trends and comparisons (e.g., performance over time or against benchmarks).

- Offers actionable recommendations for addressing issues or enhancing performance, clearly defining next steps and responsibility for implementation.

- Uses visual aids (e.g., charts, graphs, dashboards) to present data clearly.

- Highlights the implications of findings for patients and other key stakeholders.

- Demonstrates learning from incidents, audits, and external inspections, showing how findings contribute to a culture of improvement and excellence.

By adhering to these principles, the Trust can ensure that assurance reports effectively supports the board and its committees in making informed and strategic decisions.

20. While it is essential to define the bulk of the work to be received by a board committee through the cycle of business, it is equally important to recognise that not all items received by board committees serve as assurance. Some reports provide valuable context for complex issues or deliver information that, while not strictly assurance, supports a broader understanding of the Trust's operations and strategic priorities.

21. Assurance itself extends beyond formal reporting. It includes qualitative inputs such as patient and staff stories, which bring a human perspective to the work of the committees. Additionally, the triangulation that occurs during board visits - when members engage directly with our people and patients - provides invaluable insights that complement formal assurance processes. Together, these elements enrich the ability of members to make informed and well-rounded decisions.

22. Bearing the above in mind, **members are invited to consider** the reporting that the committee receives on a regular basis in particular and reflect on and suggest improvements that may be made to strengthen and/or streamline assurance to the committee. This will be one of the menti.com questions asked during the meeting.

Annual Report

23. The committee's annual report, which outlines the significant amount of work accomplished over the year, has been prepared in draft and is attached at A**nnex 5**. This report provides assurance to the board on the discharge of the committee's responsibilities, progress against priorities, and details on membership and quorum. It is important to recognise these achievements as we discuss the questions identified by the group during the March meeting and seek further input from committee members.

24. Following this committee meeting, any amendments to the terms of reference and feedback from members on its effectiveness will be incorporated into a revised draft, which will be circulated to members for review. Any priorities for 2025/26 identified through this review will be incorporated also.

RECOMMENDATION

25. Members are invited to assess whether the committee's remit, as outlined in its terms of reference, remains appropriate for 2025/26. Consideration should be given to any necessary amendments, additions, or removals, areas that might be better addressed by another committee, or changes to membership.

26. Members are invited to evaluate the cycle of business included in this pack. Reflecting on the hallmarks of effective assurance reporting, members are asked

to propose potential improvements to enhance the strength and efficiency of assurance processes for the committee.

27. Members are asked to consider the responses to the NAO questionnaire and advise of any alterations.

28. Members are asked to take part in a Mentimeter quiz in the meeting answering the following questions:

    (a) What would help you as report writers/reviewers/receivers of assurance
    (b) What works well in this committee
    (c) What improvements could we make in this committee

29. Members are requested to review the draft Annual Report and provide any comments ahead of it being finalised for the May committee meeting.

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

WAST BOARD COMMITTEE REMITS – 2024/25

Quality, Patient Experience and Safety Committee

- Duty of Quality and Duty of Candour
- KPIs in remit
- Clinical & quality plans
- Health and Care Quality Standards
- Quality Impact Assessment
- Mental health
- Infection prevention and control
- Safeguarding
- Continual quality improvements
- Learning
- Mortality reviews
- Putting Things Right
- Clinical negligence & personal injury
- Clinical effectiveness
- Clinical audit
- Citizens voice & patient experience
- Clinical and quality governance
- Risks, audits, policies in remit

People and Culture Committee

- People & Culture plan and metrics
- KPIs in remit
- Trust Behaviours
- Health and wellbeing
- Staff & volunteer experience
- Speaking up safely
- Equality, diversity, and inclusion
- Recruitment and retention
- Trade Union relationships
- Leadership & development
- Succession plans
- Welsh language
- Health and safety
- Health and Care Standards in remit
- Registration and revalidation
- Partnerships and engagement
- Risks, audits, policies in remit

Advisory Group (WASPT) reports to this Committee with onward reporting to Board via the AAA

Finance and Performance Committee

- Long term strategic direction
- Long term financial direction
- Capital and revenue monitoring
- Financial sustainability
- Business cases and PIRs
- Compliance with statutory duties
- IMTP endorsement and delivery
- Value based healthcare
- Performance against targets set by Commissioners and Welsh Gov.
- Quality &Performance Management Framework (QPMF) outcomes
- Trust wide KPIs (MIQPR)
- Recovery plans for performance
- Demand and capacity
- Estates
- Fleet
- Environment and sustainability
- Digital systems
- Digital plan direction
- Information governance
- Information security
- Major Incident Plan and Business Continuity Plan
- Cyber resilience & security
- Risks, audits, policies in remit

Audit, Risk and Assurance Committee

- Governance and assurance
- Effective systems of good governance, risk management and internal control
- Board Assurance Framework
- Annual Report
- Audited financial accounts
- Standing Orders and SFIs
- Accounting policies
- Assurance processes
- Policies for reg. compliance
- Schedule of losses & special payments
- Single tender actions
- Internal audit (inc annual plan; reports; HOIA Opinion)
- Audit Wales (inc annual plan; ISA260; structured assessment; reports;
- QPMF implementation
- Audit management responses
- Local Counter Fraud Service
- Standards of business conduct
- Whistleblowing processes
- Patient's property
- Policies in remit

Remuneration Committee

- Contractual arrangements for staff
- Appointment, termination, remuneration, terms of service and appraisal for Chief Executive; Executive Directors (including interim); Very Senior Managers
- Redundancy, VERs, Settlement settlements

Academic Partnerships Committee

- Strategic collaboration with education providers and commercial partners
- Collaboration with partners in health, social care, local authority and third sector
- Partnership arrangements
- University Trust Status
- Plans to build capacity of whole workforce
- Research governance framework
- Risks, audits, policies in remit

Charity Committee (Corporate Trustees)

- Charity strategic direction
- Charitable funds monitoring including systems and processes
- Review by Audit Wales of accounts
  Fundraising
- Bursary Panel
- Promote the charity
- Annual Report and Financial Accounts
- Approve expenditure over £5,000
- Bids Panel
- Risks, audits, policies in remit

OVERSEE → **SUPPORT** → **CHALLENGE** → **ESCALATE**

Role of Committee	Reference	Questions	Response
Yellow = 2023/24 more than one respondent rated as 'room for improvement'. Further narrative has been added here for ARAC members			
1. Membership, Independence, Objectivity and Understanding			
Membership, Independence and Objectivity			
Essentials	**1.1.1**	The chair is a non-executive Board member and possesses an appropriate level of relevant experience.	The Chair is a Non-Executive Director (NED) and qualified Accountant
	1.1.2	In terms of numbers, membership of the ARAC is sufficient to discharge its responsibilities.	ARAC membership include three NEDs and prescribed attendees relevant to the audit, risk and assurance remit. This include the Executive Director of Finance and Corporate Resources (lead executive), Director of Corporate Governance/Board Secretary, Executive Director of Quality and Nursing, Director of People and the Assistant Director of Corporate Governance and Risk.
	1.1.3	The ARAC explores the option of bringing in additional independent, non-executive members from sources other than the Board to ensure an appropriate level of skills and experience.	Independent advisors or specialists can be invited to meetings as required. The board skills mix document is updated regularly to ensure we have the right spread of membership across committees and ARAC. Expertise is brought in during development for board or committees.
	1.1.4	The accounting officer and the finance director routinely attend meetings.	The Executive Director of Finance and Corporate Services is the lead executive and attends each meeting. The CEO is invited to each meeting and attended 3 meetings in 2024/25, including that at which the audited financial accounts and annual report was presented.
	1.1.5	The head of internal audit, head of risk, and external audit routinely attend meetings.	Confirmed
	1.1.6	ARAC members understand their responsibilities regarding identifying, declaring and resolving conflicts of interest.	ARAC approved the Standards of Business Conduct Policy and have overseen the development of the 'decision makers' register of interests. The board register of interests is included in each ARAC meeting. Board members are required to update their declarations of interest when they change, and annually to confirm them as part of the eligibility review that goes to RemCom. Members have not been called upon in 2024/25 to resolve any conflicts of interest. The Director of Corporate Governance/Board Secretary advises the board and ARAC on matters related to declarations of interest.
	1.1.7	ARAC members have a clear understanding of what is expected of them in their role, and this was set out clearly at the time of appointment.	This will be drawn out for discussion in the 6 March meeting. Induction is provided to new board members as part of board induction and governance drop in sessions were facilitated by the Director of Corporate Governance/Board Secretary in 2024/25, however a committee specific induction for ARAC is being established in Q4 of 2024/25.
	1.1.8	The ARAC has access to sufficient funding to cover the costs incurred in fulfilling its role.	Confirmed.
Good Practice	**1.1.9**	All members and attendees make valuable contributions to meetings.	This will be drawn out for discussion in the 6 March meeting. The Chair allows sufficient time for all members and attendees to raise issues and there is good engagement and discussion at meetings
	1.1.10	If any conflicts of interest are identified, the ARAC Chair is effective in ensuring the associated risks are effectively managed and continually monitored.	These have not arisen in 2024/25 however see the response to 1.1.6 above
Making the most of your time			
Essentials	**1.2.1**	The ARAC meets at least four times during the year.	Confirmed for 2024/25.
	1.2.2	The number of meetings held are sufficient to allow the ARAC to perform as effectively as possible.	Confirmed, as evidenced by the cycle of business monitoring report and committee annual report to board.
	1.2.3	Meetings are well-aligned with the audit and assurance cycle	The annual audit plans for internal audit and external audit are agreed ahead of each new financial year and the annual audit of financial accounts and review of the annual report is cycled appropriately and in line with the Welsh Government Manual for Accounts
	1.2.4	The ARAC receives information and papers far enough in advance for them to fully consider before the meeting	Papers for ARAC are published by noon seven days prior to the meeting. These are on Ibabs for members and on the Trust website for the public. This is in line with our Standing Orders. Any late papers are only uploaded following agreement from the Chair.
	1.2.5	All matters falling within the terms of reference of the ARAC are covered adequately over the course of the year or a reasonable time period.	Confirmed, as evidenced by the cycle of business monitoring report and committee annual report to board.
	1.2.6	Meetings of the ARAC are long enough to ensure that all agenda items are covered in sufficient detail.	This will be drawn out for discussion in the 6 March meeting. Confirmed, as evidenced by the cycle of business monitoring report and committee annual report to board.
	1.2.7	Deep dives are undertaken in key and emerging risk areas, and these are sufficiently detailed so the ARAC can understand the risk and challenge management.	ARAC has the monitoring of the risk management process and systems in its remit as opposed currently to individual risks to monitor. It must be assured that operationally we have a sound system of risk management and that board committees are scrutinising and monitoring appropriately. They do this by way of monitoring the risk transformation programme, by the Structured Assessment, and by the annual Internal Audit Risk Management Internal Audit and the Head of Internal Audit Opinion. The need for a deep dive on principal risks is explored at each agenda setting meeting with committee chairs and leads. Where there are areas within the remit of ARAC for a deep dive that is done from time to time (for example, lessons learned from deep dives into losses and special payments)

Good Practice	**1.2.8**	There is sufficient time between ARAC meetings and main board meetings to allow any work arising from the meeting to be undertaken and reported to the Board as appropriate.	The AAA report from ARAC to board is completed within 48 hours and distributed to the board soon afterwards. On one occasion in 2023/24 this was done verbally due to insufficient turnaround times.
	1.2.9	The ARAC Chair – and other members where relevant – keep in touch with other key attendees on a continuing basis between meetings.	ARAC members have an opportunity to keep in touch with members via other touchpoint meetings throughout the year. The NED meetings are also an opportunity for the ARAC chair to raise any issues with NED colleagues. Regular meetings between the NEDs, the Executive Director of Finance and Corporate Resource and the Director of Corporate Governance/Board Secretary started in 2024/25 to review ARAC's effectiveness via this questionnaire on a continuous basis. The ARAC Chair and the Executive Director of Finance and Corporate Resources have regular 1:1s and agenda setting meetings are attended by both.
	1.2.10	The ARAC meets in private - without the presence of management - when necessary and this time is used effectively.	The terms of reference do not currently provide for this specifically however note the response to 1.2.9 above. The TOR will be amended to reflect this requirement, however there has not been a need to date for the Chair to formally convene a meeting without the presence of management.
	1.2.11	The ARAC is provided with sufficient administrative and secretarial support to undertake its duties to the required standard.	Confirmed. The Corporate Governance Team service ARAC.
	1.2.12	The ARAC is clear on the type of skills and experience should be sought in a new member – and the chair is involved in the appointment process.	The appointment of NEDs to the board is led by Welsh Government, however WAST does take account of our skills mix on selection, and those skills are referred to by the ARAC chair on appointment of new members to ARAC
	1.2.13	Sufficient time is afforded to the different providers of assurance to the ARAC across the various lines of defence, notably risk management, internal audit and external audit.	Confirmed. The agenda always includes these three items as standard with sufficient time for discussion, scrutiny and assurance.
	1.2.14	The ARAC has a forward plan for its meetings so it can consider issues at the right time and in the right level of detail.	Confirmed. The cycle of business is in place and agreed by ARAC and is monitored at each meeting.
	1.2.15	The ARAC acts in an inclusive and respectful manner, avoids 'group think', and provides an appropriate balance between challenge and support.	This will be drawn out for discussion in the 6 March meeting. The Chair allows sufficient time for all members and attendees to raise issues and there is good engagement and respectful discussion at meetings. Ratings on internal audit reports and recommendations have been challenged and scrutiny of progress against actions has been a particular focus.
2.Skills and experience			
Range of skills			
Essentials	**2.1.1**	The ARAC possesses a good range of skills and experience in relation to governance, risk and control.	The appointment of NEDs to the board is led by Welsh Government, however WAST does take account of our skills mix on selection, and those skills are referred to by the ARAC chair on appointment of new members to ARAC. Prescribed attendees are selected for their skills and experience including that of governance, risk and control.
	2.1.2	At least one member of the ARAC has recent and relevant financial experience sufficient to allow them to analyse the financial statements and understand good financial management disciplines.	The Chair and the Executive Director of Finance and Corporate Resources are qualified Accountants
	2.1.3	The ARAC proactively identifies which skills it requires to discharge its responsibilities most effectively.	The appointment of NEDs to the board is led by Welsh Government, however WAST does take account of our skills mix on selection, and those skills are referred to by the ARAC chair on appointment of new members to ARAC. Prescribed attendees are selected for their skills and experience including that of governance, risk and control.
	2.1.4	The required skill sets for the ARAC are reviewed at regular intervals.	The membership of ARAC is updated annually in line with the review of its terms of reference
Good Practice	**2.1.5**	The ARAC draws on a sufficiently diverse membership, containing a variety of demographic attributes and characteristics.	Whilst we use the skills matrix, we do not seek and retain diversity information for all members of ARAC and the board. NED appointment take account of the need for diversity, however WAST is limited in its control of this process as NED appointments are managed by Welsh Government. This may be an area to explore with Angie Lewis as part of our ED&I work at the Trust. The board will be participating in the Welsh Government Aspiring Board Members Programme in 2025/26.
	2.1.6	The ARAC documents and maps the skills of its members so it can identify areas of strength and any skills gaps.	This will be drawn out for discussion in the 6 March meeting. Currently only board members are included on the skills mix. However prescribed attendees who are not part of that skills mix are selected for their skills and experience including that of governance, risk and control.
	2.1.7	The financial reporting expertise held by members is relevant and appropriate to the significant financial reporting risks of the organisation – particularly in respect of any complex estimates or judgements.	The Chair of ARAC and the Executive Director of Finance and Corporate Resources are qualified accountants.
	2.1.8	The ARAC benefits from a good mix of non-technical skills – for example, communication, influencing, negotiating, leadership and facilitation skills.	This will be drawn out for discussion in the 6 March meeting. Members are appointed to ARAC based on their skills and experience relevant to the committee. Many of these members, particularly those in senior positions and our NEDs, possess these skills.
	2.1.9	The ARAC uses the powers of co-opting members and procuring specialist skills where these were required.	Independent advisors or specialists can be invited to meetings as required. The board skills mix document is updated regularly to ensure we have the right spread of membership across committees and ARAC. Expertise is brought in during development for board or committees.

Training and development			
Essentials	**2.2.1**	Members who have recently joined the ARAC have been provided with induction training to help them understand their role and the organisation.	This will be drawn out for discussion in the 6 March meeting. NED members to ARAC have received board induction and there have been drop in governance sessions held and specific a TU session on governance, however the committee specific induction is a priority for ARAC and will be discussed by the committee in Q4.
	2.2.2	Members of the ARAC who are unfamiliar with corporate governance and wider practice in government are specifically upskilled in this area.	NED members to ARAC have received board induction and there have been drop in governance sessions held and specific a TU session on governance, however the committee specific induction is a priority for ARAC and will be discussed by the committee in Q4.
	2.2.3	Members keep their skills and knowledge up to date through networking and conferences to allow them to focus on key issues facing the organisation.	Audit Wales alerts ARAC to relevant information; the ARAC Chair attends the All Wales Audit Chairs Group where Audit Wales and Internal Audit also present; Members attend regular board development and board visits.
	2.2.4	The ARAC chair ensures that members have an appropriate programme of engagement with the organisation and its activities to help them understand the organisation, its objectives, business needs, priorities and risk profile.	As 2.2.1 and 2.2.2. Also, there is a Board Visits SOP which encourages members to engage with the organisation as a way of understanding it more deeply and triangulating assurance. ARAC members sit across a number of other board committees also.
Good Practice	**2.2.5**	There is a positive culture of learning and personal development within the ARAC.	This will be drawn out for discussion in the 6 March meeting. ARAC members meet regularly through the year to review effectiveness. ARAC's focus on the audit tracker outcomes and risk transformation programme have been examples of continuous improvement and learning in ARAC in 2024/25
	2.2.6	The ARAC's strategy for training and development takes account of developments in corporate governance and emerging risk areas.	This will be drawn out for discussion in the 6 March meeting. NED members to ARAC have received board induction and there have been drop in governance sessions held and specific a TU session on governance, however the committee specific induction is a priority for ARAC and will be discussed by the committee in Q4. There will be specific focus on governance and risk. The Audit Wales update report includes horizon scanning and articles of relevance to the NHS in Wales.
	2.2.7	For ARAC members unfamiliar with the operations of government and the public sector, special focus is given to this as part of their training programme	N/A for WAST
	2.2.8	The ARAC chair attends cross-governmental (if a government department) or cross-departmental (if an arm's-length body) ARAC chair meetings.	N/A for WAST
Other skills - Cyber & Digital			
Good Practice	**2.3.1**	The ARAC understands how cyber and digital risks impact on the organisation.	FPC holds the digital remit for the board and whilst ARAC reviews the cyber risks, it is FPC that reviews these in more detail. A board development session on cyber security was held in February 2024. ARAC has the opportunity to review the impact of risks on the organisation through the regular reporting of the principle risks. This sets out the risks in an 'if', 'then', 'resulting in' format which is accomanied by the controls, gaps and mitigating actions to reduce the risk and impact.
	2.3.2	The ARAC has the level of skills and expertise required to challenge management, and provide assurance to the Board that the organisation is properly managing its cyber and digital risks.	This will be drawn out for discussion in the 6 March meeting. The Chair of FPC is the Digital Champion. The board development programme in 2024/25 include a cyber security session. The digital and cyber remit of the board sits with FPC. One of the NED members of ARAC was a SIRO in their previous operational role.
Other skills - Climate change and ESG			
Good Practice	**2.3.3**	The ARAC is satisfied the organisation's approach to managing ESG risks, and making appropriate disclosures, is in line with relevant standards such as the Greening Government Commitments and Sustainability Reporting Guidance.	FPC holds the environmental and sustainability remit for the board and ARAC members have access to the AAA reporting from FPC to the board on these issues. ARAC also reviews the annual disclosure statements that are relevant as part of the annual report. PCC holds risks related to labour and workforce with the board holding the risk to reputation from partnerships and external relationships. ARAC members have access to the AAA reporting from PCC on these issues and risks. Governance risks such as standards of business conduct and board effectiveness are managed by ARAC as stated above re declarations of interest etc., as well as annual committee effectiveness reviews scrutinised by the committee
	2.3.4	The ARAC is able to effectively assess the organisation's approach to managing climate related risks.	As above, noting also that adaptation planning is developing further in 2025/26 as part of the Wellbeing of Future Generations Act
	2.3.5	The ARAC assesses the organisation's net zero strategy with sufficient detail, and at regular intervals.	FPC holds the environmental and sustainability remit for the board and ARAC members have access to the AAA reporting from FPC to the board on these issues. ARAC also reviews the annual disclosure statements that are relevant as part of the annual report.
Other skills - Projects and programmes			
Good Practice	**2.3.6**	The ARAC is appropriately sighted on significant projects and programmes throughout their lifecycle.	Programmes specific to ARAC (such as the risk transformation programme in 2024/25 and the integrated governance programme in 2025/26) are monitored by ARAC. Other programmes of work are monitored where relevant by other board committees.
	2.3.7	The ARAC has the skills and expertise to provide effective critical challenge on the financial management, delivery risks and overall progress of projects or programmes.	The appointment of NEDs to the board is led by Welsh Government, however WAST does take account of our skills mix on selection, and those skills are referred to by the ARAC chair on appointment of new members to ARAC. Prescribed attendees are selected for their skills and experience including that of finance, governance, risk and control.

Other skills - Procurement			
Good Practice	**2.3.8**	The ARAC has an appreciation of the risks associated with procurement in the public sector context.	ARAC receives reporting on losses and special payments as well as single tender waivers at each meeting. Risks associated with such transactions are drawn out as part of that discussion. Audits related to procurement are reviewed by the committee. Internal Audit advise ARAC on wider, sector procurement risks.
	2.3.9	The ARAC has the skills and expertise to challenge commercial activities and the procurement of goods and services.	The appointment of NEDs to the board is led by Welsh Government, however WAST does take account of our skills mix on selection, and those skills are referred to by the ARAC chair on appointment of new members to ARAC. Prescribed attendees are selected for their skills and experience including that of finance, commercial activities, governance, risk and control.
3. Roles and Responsibilities			
Assurance			
Essential	**3.1.1**	The ARAC helps the accounting officer and Board to formulate their assurance needs.	ARAC recently revised its title to include this important 'assurance' arm to ensure it has more focus on this. The board assurance framework that it will monitor in 2025/26 is an important element of assuring the accounting officer and the board in this regard The integrated governance programme will give an additional layer of assurance linked to the quality and performance management framework that was monitored by ARAC in 2024/25. The annual audit plan from Internal Audit and from Audit Wales also allows ARAC to test strengths of internal controls and assurance, as does the annual report and audited accounts.
	3.1.2	The ARAC assesses whether the assurance received is of sufficient quality to meet the assurance needs outlined in 3.1.1.	Confirmed as per 3.1.1
	3.1.3	The ARAC understands the key sources of assurance in the organisation, and how and why each of these sources provide assurance to them.	This will be drawn out for discussion in the 6 March meeting. Members have the skills to do so, and the integrated governance programme and the Q4 committee specific induction will build on these skills. The risk management policy approved by ARAC in 2024/25 set out the three lines of defence model and the BAF currently sets it assurances on controls along these three lines.
	3.1.4	The ARAC understands the three lines of defence model, and how this applies in practice to the organisation.	This will be drawn out for discussion in the 6 March meeting. Members have the skills and experience to do so, and the integrated governance programme and the Q4 committee specific induction will build on these skills. The risk management policy approved by ARAC in 2024/25 set out the three lines of defence model and the BAF currently sets it assurances on controls along these three lines.
	3.1.5	The ARAC is proactive in commissioning assurance work from appropriate sources where it identifies any significant risk, governance and control issues which have not been subject to sufficient review.	This has not proven necessary at this stage. Although ARAC members do review and approve the annual internal audit plan, Audit Wales' programme of work (both financial and performance) and the risks that will address.
	3.1.6	The ARAC ensures the organisation operates appropriate and effective whistleblowing practices, and this is regularly considered by the ARAC.	The oversight and monitoring of arrangements for Speaking Up Safely sit with PCC. ARAC receives assurance from the Chair of PCC annually on arrangements and did so in 2024/25.
Good Practice	**3.1.7**	The ARAC uses assurance mapping to identify where assurance is required to identify any key gaps where no assurance is provided, or where the quality of the assurance is poor.	There is more work to be done here, and the integrated governance work and the strategic BAF will strengthen this
	3.1.8	The ARAC has an effective system for monitoring management's progress with recommendations from internal and external sources.	The audit tracker is received at each ARAC meeting and each Committee meeting. Directors appear where their actions are on a third and final date.
Governance			
Essentials	**3.2.1**	The ARAC understands the Board's operating framework, including the organisation's vision and purpose.	ARAC members are aware of the Trust's IMTP and the process for developing it. ARAC also had oversight of the implementation of the QPMF in 2024/25.
	3.2.2	The ARAC understands the mechanisms which ensure effective organisational accountability, performance and risk management.	As 3.2.2. FPC now has the effectiveness of the QPMF in its remit. ARAC retains the mechanism for effective risk management and compliance with the risk management policy in its remit.
	3.2.3	The ARAC understands the role definitions, committee and other structures which support effective discharge of responsibilities, decision making and reporting.	ARAC receives the effectiveness reviews for all committees annually ahead of their presentation to board. ARAC assures the board that the committees are operating effectively, and have appropriate decision making and reporting process.
	3.2.4	The ARAC understands how appropriate ethics and values are promoted within the organisation.	ARAC has oversight of the Standards of Business Conduct Policy. The recent audit included a communications plan for this which is in place.
	3.2.5	The ARAC understands how management information is communicated to the Board and other appropriate areas of the organisation.	ARAC receives the effectiveness reviews for all committees annually ahead of their presentation to board. ARAC assures the board that the committees are operating effectively, and have appropriate decision making and reporting process. The integrated governance work will provide further understanding in 2025/26.
	3.2.6	The ARAC understands the nature of relationships with arm's-length bodies, if applicable.	WAST does not have arm's length bodies
Good Practice	**3.2.7**	Without duplicating the work of the Board, the ARAC advises on – and scrutinises the implementation of – its organisation's corporate governance policy.	WAST does not have a stand alone corporate governance policy, but will be reviewing the integrated governance handbook as part of their work programme in 2025/26. The corporate governance framework within which WAST operates is set out in our annual report which is endorsed annually by the ARAC for board approval.

Good Practice	**3.2.8**	The ARAC reconciles assurance from internal and external audit and other sources of assurance with conclusions drawn in the organisation's annual governance statement.	Confirmed. HOIA is also taken account of and included in the annual governance statement.
	3.2.9	The ARAC monitors developments in corporate governance so it can proactively advise the Board and accounting officer on any changes to assurance requirements.	As in 3.2.8 and 3.2.9, and as issues arise during the year
Risk management			
Essentials	**3.3.1**	The ARAC understands the organisation's business strategy, operating environment and the associated risks to executing the strategy.	ARAC members are aware of the Trust's IMTP and the process for developing it. ARAC also had oversight of the implementation of the QPMF in 2024/25. The BAF will draw out the associated risks to the strategy in 2025/26, including WAST's operating environment.
	3.3.2	The ARAC is satisfied that management takes an enterprise-wide view of the organisation's risks, including those that cross organisational boundaries.	ARAC receives the risk register at each meeting which takes an organisational wide view of the Trust's principle risks. Where risks cross over to health bodies, those mitigations within WAST's control are drawn out in the risk.
	3.3.3	There is a clear understanding of the role and activities of the Board in relation to managing risk.	ARAC recently approved the risk management policy where roles and responsibilities were clearly set out.
	3.3.4	The ARAC discusses with the Board how its policies, attitude to, and appetite for risk are defined and communicated across the organisation.	Discussions commenced in 2024 on the development of risk appetite statements and this will continue into 2025/26
	3.3.5	The ARAC understands and challenges the risk management framework and the assignment of responsibilities.	ARAC recently approved the risk management policy where roles and responsibilities were clearly set out.
	3.3.6	Adequate assurance has been obtained on the risk and control environment encompassing services outsourced to external providers, including shared service arrangements, and the wider supply chain.	It is expected that contractual/MOU relationships with external providers are clear in the quality requirements of the services to be provided and have checks and performance metrics included. ARAC does not have oversight of this, however in Q4 2024/25 a contractual management internal audit is being undertaken and as part of this work a centralised list of contracts/MOUs/SLAs is being developed to gain a better understanding of our external partnerships. WAST outsources many services to the NHS Wales Shared Services Partnership (NWSSP), including payroll, procurement, legal and risk services, and internal audit. The Executive Director of Finance and Corporate Resources is a member of the partnership board and escalates any issues that may arise. The meeting summary forms part of the WAST board pack.
	3.3.7	(For government departments and groups only) assurance has been obtained on risks from across the group – and there is timely communication and visibility of these risks.	N/A for WAST
Good Practice	**3.3.8**	The ARAC promotes the importance of a positive risk culture in the organisation	ARAC recently approved the risk management policy where roles and responsibilities were clearly set out. It has supported the risk transformation programme since 2022 and champions the strategic BAF and risk appetite work in committee and to the board when reporting on its work.
	3.3.9	The ARAC challenges management on whether there is a comprehensive process for identifying and evaluating risk, and for deciding what levels of risk are tolerable.	ARAC recently approved the risk management policy where roles and responsibilities were clearly set out. ARAC will lead the work to develop risk appetite and tolerance in 2025.
	3.3.10	The ARAC has sufficient understanding of the organisation to assess whether the risk register is an appropriate reflection of the risks facing the organisation.	ARAC members also attend Trust Board as well as a number of other committees where they are well placed to understand the principle risks facing the organisation. They are well inducted as board members, and are encouraged to undertake board visits where they are able to triangulate assurance information on risk.
	3.3.11	The ARAC can assess whether there are sufficient resources to manage risk effectively across the organisation.	Regular reporting on risk management is taken to ARAC, including the resource requirements for effectiveness risk management at WAST.
	3.3.12	The ARAC challenges whether management's approach to identifying risks is broad enough to effectively identify new and emerging risks.	ARAC recently approved the risk management policy where roles and responsibilities were clearly set out. ARAC will lead the work to develop risk appetite and tolerance in 2025 which will not only lead to a new way of scoring strategic risks, but will be used in decision making and when identifying new risks.
	3.3.13	The ARAC challenges management on its approach to evaluating risks, including the effectiveness of scenario planning and stress testing.	The BAF includes all the detail required for ARAC to understand the rationale for risk ratings and the actions to mitigate risk. More work is planned under the new strategic BAF to enable ARAC to evaluate strength of internal controls in place.
	3.3.14	The ARAC reviews information on 'near misses' to help determine whether the systems in place are sufficiently robust to mitigate future risk events.	Near miss reporting is within the QUEST remit, however the chair of QUEST reports to ARAC annually on this.
	3.3.15	The ARAC understands the main fraud and error risks and entry points, and challenges management to consider timely options for tackling fraud and error risks.	ARAC receives a report from the Local Counter Fraud Service at each of its closed meetings and is able to scrutinise assurance and ask questions of the LCFS lead.
	3.3.16	The ARAC considers the impact of risks and how these could impact on the ongoing resilience of the organisation.	The BAF includes all the detail required for ARAC to understand the impact of the principle risks, with the risks being articulated in the 'if', 'then', 'resulting in' format. .
Internal control			
Essentials	**3.4.1**	The ARAC critically challenges and reviews the adequacy and effectiveness of control processes in responding to risks.	Controls to mitigate risks are set out in the BAF. Assurance on controls is referenced along the three lines of defence. More work is to be done with the strategic BAF to rate assurances, but this will take some time.
	3.4.2	The ARAC challenges whether the extent of the controls in place to mitigate risks are excessive, and whether any action is needed to address this.	The BAF includes all the detail required for ARAC to understand the rationale for risk ratings and the actions to mitigate risk. More work is planned under the new strategic BAF to enable ARAC to evaluate strength of internal controls in place. Risk appetite statements will allow ARAC members to more readily access if mitigations are excessive relative to tolerance.
	3.4.3	The ARAC has a good understanding of how the organisation develops, operates and monitors the system of internal control.	Not only is this assurance given through the year via risk and policy reports, internal and external audit reports, ARAC reviews the annual report and audited financial accounts each year to gauge the strength of the internal controls and provides assurance to the board on this.

Good Practice	**3.4.4**	The ARAC seeks assurance on how any material or significant risks are managed through strategic, operational and compliance controls.	Controls to mitigate risks are set out in the BAF. Assurance on controls is referenced along the three lines of defence. More work is to be done with the strategic BAF to rate assurances, but this will take some time.
	3.4.5	The ARAC assesses whether the system of internal control would provide timely indicators of weaknesses and failings.	The BAF includes all the detail required for ARAC to understand the rationale for risk ratings and the actions to mitigate risk. More work is planned under the new strategic BAF to enable ARAC to evaluate strength of internal controls in place. HoIA opinion will provide indicators of this also.
	3.4.6	When any significant failings or weaknesses in internal control arise, the ARAC reviews management's analysis of the root cause and subsequent action plan.	The BAF includes all the detail required for ARAC to understand the rationale for risk ratings and the actions to mitigate risk. The controls are updates in line with the review schedule agreed by ARAC and new and changed actions delineated for ARAC's attention.
	3.4.7	The ARAC is satisfied that the organisation has a sound system of financial control – including the structure of delegations – which enables the organisation to achieve its objectives with good value for money.	ARAC endorses any changes to the Standing Orders, Standing Financial Instructions, Scheme of Reservation and Delegation to Officers, and committee terms of reference. As set out above, ARAC reviews the annual report and audited financial accounts each year to gauge the strength of the internal controls and provides assurance to the board on this.
	3.4.8	The ARAC has sufficient assurance over the quality of IT controls.	FPC holds the digital remit for the board and it is FPC that reviews these in more detail. ARAC are assured via the FPC AAA report to board.
	3.4.9	The ARAC is satisfied that the organisation's controls are designed to effectively prevent and detect known fraud and error risks.	ARAC receives a report from the Local Counter Fraud Service at each of its closed meetings and is able to scrutinise assurance and ask questions of the LCFS lead.
	3.4.10	The ARAC has oversight of how controls are evaluated so it can understand how effectively fraud and error risks are being addressed.	ARAC receives a report from the Local Counter Fraud Service at each of its closed meetings and is able to scrutinise assurance and ask questions of the LCFS lead.
Financial reporting			
Essentials	**3.5.1**	The ARAC reviews the clarity and completeness of disclosures in the year-end financial statements.	Confirmed
	3.5.2	The ARAC uses its understanding of the organisation to assess whether disclosures in the financial statements are set properly in context.	Confirmed - as set out above, ARAC is well placed to do so given its remit and its cycle of business.
	3.5.3	The ARAC specifically considers key accounting policies and disclosures.	Confirmed - these are included as part of the committee's cycle of business.
	3.5.4	The ARAC specifically considers assurances about the financial systems which provide the figures for the accounts.	The accounts are audited by Audit Wales and ARAC receives their audit report and ISA260.
	3.5.5	The ARAC specifically considers the quality of the control arrangements for preparing the accounts.	ARAC receives assurance on the control environment via the Executive Director of Finance and Corporate Resources in the lead up to their endorsement, including any issues arising if relevant. The annual report is prepared under a task and finish arrangement with finance representation. ARAC approves any financial control policies and procedures, and scrutinises any related internal audits. The annual structured assessment from Audit Wales reviews the financial governance arrangements at WAST.
	3.5.6	The ARAC specifically considers key judgements made in preparing the accounts, and management's consideration of their ongoing relevance.	See 3.5.5
	3.5.7	The ARAC specifically considers any disputes arising between those preparing the accounts and the auditors.	See 3.5.5. ARAC meets privately with auditors to enable such conversations to take place.
	3.5.8	The ARAC specifically considers reports, advice and findings from external audit – especially the Audit Completion Report.	See 3.5.5, but also ARAC receives an update report from Audit Wales quarterly, and the structured assessment and deep dive work annually.
Good Practice	**3.5.9**	The ARAC assures itself that accounting policies comply with relevant requirements, particularly HM Treasury's Financial Reporting Manual.	The accounts for the year end are prepared to comply with International Financial Reporting Standards (IFRS) adopted by the European Union, in accordance with HM Treasury's FReM 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, directs.
	3.5.10	In addition to receiving a detailed overview from the Finance Director, the ARAC is confident that the organisation's approach to preparing the accounts is sufficiently rigorous.	See 3.5.5
	3.5.11	The ARAC challenges that the Annual Report is fair and balanced.	ARAC members receive the annual report in draft form ahead of the meeting to endorse it and their comments and challenge are specifically sought.
	3.5.12	Where novel accounting issues, or complex judgements have arisen during the year, the ARAC has satisfied itself that management took specialist advice or enlisted expertise.	This has not arisen in 2024/25, but if that was the case it would do so. The Executive Director of Finance and Corporate Services keeps the Chair of ARAC informed of any upcoming compex judgements or changes in acconting policies or practices in their regular 1:1s.
	3.5.13	The ARAC is satisfied with management's processes for identifying and responding to the risks of fraud.	ARAC receives a report from the Local Counter Fraud Service at each of its closed meetings and is able to scrutinise assurance and ask questions of the LCFS lead.
	3.5.14	The ARAC is effective in monitoring significant financial reporting issues throughout the year, particularly those which could lead to qualification of the accounts.	This has not arisen in 2024/25, but if that was the case it would do so.
	3.5.15	In reaching a view on the accounts, the ARAC considered the implications of reports from third parties – for example, on legal matters, valuations, or reports from regulators.	This has not arisen in 2024/25, but if that was the case it would do so.
	3.5.16	The ARAC considers key matters on their own initiative rather than relying solely on the work of the external auditor.	ARAC's consideration of the accounts takes account of the full range of assurance reporting throughout the year, as well as the work of Audit Wales and their assurances.
	3.5.17	The ARAC has a detailed understanding of the organisation and its context and can successfully challenge whether the accounts provide a fair representation of activity.	ARAC members also attend Trust Board as well as a number of other committees where they are well placed to understand the principle risks facing the organisation. The Chair and the Executive Director of Finance and Corporate Resources are qualified accountants and would discuss such isues at their 121s

	3.5.18	The ARAC sufficiently challenges the going concern assessment in the context of its review of the financial statements and understanding of the business.	This has not arisen in 2024/25, but if that was the case it would do so.
	3.5.19	The ARAC offers appropriate challenge to any information which is generated through financial modelling.	This has not arisen in 2024/25, but if that was the case it would do so.
	3.5.20	The ARAC is up-to-speed with developments in financial reporting standards and can challenge their application in financial statements.	This will be drawn out for discussion in the 6 March meeting. The Chair and the Executive Director of Finance and Corporate Resources are qualified accountants and would discuss such isues at their 121s.
	3.5.21	(For departments or groups only) the ARAC has sufficient oversight of significant financial reporting risks from across the department or group.	N/A for WAST
4.Scope			
Terms of reference			
Essentials	**4.1.1**	The Audit and Risk Assurance Committee's terms of reference are agreed by the Board.	Confirmed.
	4.1.2	The terms of reference are reviewed regularly and at appropriate intervals.	Confirmed. This occurs annually.
	4.1.3	The terms of reference do not conflict with guidance in HM Treasury's Audit and Risk Committee Handbook.	Confirmed.
	4.1.4	The terms of reference make clear the ARAC's independence as a Committee.	Confirmed.
	4.1.5	The ARAC's terms of reference are made publicly available, including on the organisation's website.	Confirmed.
	4.1.6	The terms of reference allow for the ARAC to sit privately without any non-members present for all or part of a meeting if they wish.	The TOR says the Chair of Committee, External Auditor or Head of Internal Audit may request a private meeting if they consider that one is necessary. We may need to be more explicit in this.
	4.1.7	The ARAC terms of reference cover details of the ARAC membership.	Confirmed.
	4.1.8	The ARAC terms of reference cover reporting requirements to the Board.	Confirmed.
	4.1.9	The ARAC terms of reference cover the key areas of responsibility the ARAC will advise the Board and accounting officer on.	Confirmed.
	4.1.10	The ARAC terms of reference cover the rights of the ARAC over co-opting additional members or procuring specialist advice.	Confirmed.
	4.1.11	The ARAC terms of reference cover the head of internal audit and a representative from external audit will have free and confidential access to the chair of the ARAC.	Confirmed.
	4.1.12	The ARAC terms of reference cover meeting information, including the number per year, the number of members required for the meeting to be quorate, and expected invitees.	Confirmed.
	4.1.13	The ARAC terms of reference cover information requirements, including what information will be provided for each meeting, and what will be provided on request.	This is contained in the accompanying cycle of business
Good Practice	**4.1.14**	The ARAC has compared its terms of reference against those of similar profile organisations.	Confirmed.
	4.1.15	In addition to core requirements, the terms of reference contain information which allows the ARAC to function more effectively – for instance, expectations about how far in advance of meetings papers will be provided.	Confirmed and aligns with Standing Orders.
	4.1.16	The terms of reference properly reflect the role and scope of the ARAC, and are proportionate to the way the ARAC actually operates.	Confirmed.
Internal Audit			
Essentials	**4.2.1**	The ARAC performs a risk-based review of internal audit's strategy and plan.	The annual plan is based on our principle risks and is developed with ARAC and approved by ARAC.
	4.2.2	The ARAC assesses the adequacy of the budget and resources available to internal audit.	The Internal Audit fee is agreed by ARAC annually.
	4.2.3	The ARAC have reviewed the internal audit charter or terms of reference.	ARAC approves the Internal Audit Charter.
	4.2.4	The ARAC assesses the results of internal audit's work, and management's responses to the issues raised.	ARAC receives internal audit reports and the internal audit update at each meeting and the relevant director is present for each audit report presented.
	4.2.5	The ARAC reviews the annual internal audit opinion and associated annual report.	Confirmed.
	4.2.6	The ARAC assesses the performance of internal audit against applicable standards, expected performance measures, and the results of any internal or external quality assurance assessments.	The internal audit update provides performance metrics for internal audit and WAST and in 2024/25 the external quality assurance outcome was received.
Good Practice	**4.2.7**	The ARAC frames the work of internal audit in the context of other assurance activity that takes place in the first and second lines of defence.	When agreeing the annual audit plan ARAC will view this with the principle risks in mind and welcome the third line of defence review. When the strategic BAF is developed this will mature to inform the annual audit plan further.
	4.2.8	The ARAC is proactive in tracking that the recommendations agreed by management are actually implemented.	The audit tracker is received at each ARAC meeting and each Committee meeting. Directors appear where their actions are on a third and final date.
	4.2.9	The ARAC plays a role in providing support for, and acceptance of, the work of internal audit.	Internal audit is a feature of each agenda of ARAC. In addition, the Chair meets privately before ARAC meetings with the leads from internal audit and Audit Wales.
	4.2.10	The ARAC challenges whether the effectiveness of the risk, compliance and finance functions is evaluated as a part of its internal audit strategy.	The annual plan is based on our principle risks and is developed with ARAC and approved by ARAC.
	4.2.11	The ARAC considers how the individual components of the annual internal audit plan provides reasonable assurance on risk, control and governance for the organisation in totality.	The annual plan is based on our principle risks and is developed with ARAC and approved by ARAC. Internal audit reports conclude a rating of assurance from no assurance to substantial assurance on set objectives relative to the audit.

External Audit			
Essentials	**4.3.1**	The ARAC considers and makes relevant enquiries about the external auditor's planned audit approach.	The Audit Wales annual plan is presented to ARAC annually and updated quarterly.
	4.3.2	The ARAC considers the impact of the results of external audit work.	The annual structured assessment from Audit Wales and any deep dives are reviewed in detail by ARAC and actions to address any issues monitored by ARAC and other committees.
	4.3.3	The ARAC promotes co-operation between the external auditor and internal audit to maximise overall audit efficiency, capture opportunities to derive a greater level of assurance, and minimise unnecessary duplication of work.	Internal audit and Audit Wales coordinate their annual plans to ensure reduced overlap. The ARAC Chair meets with the auditors together privately ahead of each ARAC meeting to support that cooperation and scrutinise accordingly.
	4.3.4	The ARAC reviews and considers any implications for the organisation of the wider work carried out by the external auditor, for example, value-for-money reports or good practice findings.	Audit Wales report on such work in their quarterly updates. System related Audit Wales reports such as the Emergency and Unscheduled Care review will also come through ARAC where related.
Good Practice	**4.3.5**	The ARAC has a clear understanding of the objectives, scope and remit of external audit work.	Confirmed. As indicated above, they received their annual audit plan and regular updates.
	4.3.6	The ARAC reviews the scope of external audit work and – if not satisfied as to its adequacy – challenges whether additional work should be undertaken by the external auditor.	There is an opportunity to do this when presented with their annual plan, although this has not occurred in 2024/25.
	4.3.7	The ARAC satisfies itself that the level of fees payable in respect of the audit services provided is appropriate and that an effective, high quality audit could be conducted for such a fee.	The Audit Wales fee is agreed by ARAC.
	4.3.8	The ARAC is satisfied that it has a good understanding of materiality, including the benchmarks used and the calculation of materiality and performance materiality.	The materiality benchmark is drawn out for ARAC and members have a good understanding of how that is applied in the annual audit of the financial statements
	4.3.9	The ARAC considers factors that could affect the quality of the audit during the year and discusses these with the auditor.	This has not occurred in 2024/25 but there is opportunity to do so should that be required.
	4.3.10	The ARAC is satisfied that the external auditor has access to relevant expertise, for instance around pensions liabilities or property valuation.	This has not occurred in 2024/25 but there is opportunity to do so should that be required.
	4.3.11	The ARAC focusses on priority issues when undertaking its review of the results of external audit work.	ARAC bears in mind the principle risks to the organisation and the wider system when receiving the annual audit plan.
	4.3.12	The ARAC reviews the audit representation letters before they are signed by the accounting officer and gives particular consideration to matters where representation has been requested that relates to non-standard issues.	Confirmed
	4.3.13	The ARAC takes steps to ensure external audit receives quality, robust and timely audit evidence from the finance function.	Cooperation with Audit Wales is excellent so this intervention has not been required from ARAC, but there is the opportunity for them to do so if required.
	4.3.14	The ARAC is supportive of external audit's challenge of management and does not act as management's advocate.	ARAC members maintain independence as far as this is concerned and ensure a balanced view of the accounts and all structured assessment work and recommendations.
	4.3.15	The ARAC reviews and monitors management's responsiveness to the external auditor's findings and recommendations.	The responses are reviewed when the reports are received in ARAC and monitored by ARAC and other committees via the audit tracker.
5.Communication and reporting			
Communications and reporting			
Essentials	**5.1.1**	The ARAC produces a report after each meeting for the Board and accounting officer (with a copy to the head of internal audit and the external auditor) covering: - the key business taken by the ARAC, and - the ARAC's views and advice on any issues they believe the Board or accounting officer should take action on.	The AAA report from ARAC to board is completed within 48 hours and distributed to the board and ARAC members soon afterwards. On one occasion in 2023/24 this was done verbally due to insufficient turnaround times.
	5.1.2	The ARAC has effective communications with those it seeks briefings from (the executive and internal and external audit) and those it provides assurance to (the Board).	ARAC has noted a number of times during 2024/25 on the clarity of the papers and presentations.
	5.1.3	The ARAC provides an Annual Report timed to support the preparation of the Governance Statement.	ARAC prepares its annual report to the board in May each year and the detail supports the view on board and committee effectiveness in the AGS.
	5.1.4	The ARAC's Annual Report is open and honest in presenting the ARAC's views.	ARAC members receive the annual report in draft form ahead of the meeting to endorse it and their comments and challenge are specifically sought.
	5.1.5	The ARAC's Annual Report summarises the ARAC's work for the past year and how it discharges its responsibilities in accordance with the HM Treasury's ARAC Handbook.	ARAC prepares its annual report to the board in May each year and the detail supports the view on board and committee effectiveness in the AGS.
	5.1.6	There are mutual rights of access between each of the chair of the ARAC, the accounting officer, head of risk management (if a separate function), head of internal audit and the external auditor.	The Chair of ARAC has regular 1:1 meetings with the Executive Director of Finance and Corporate Resources, the Director of Corporate Governance, and the auditors (internal and Audit Wales). These individuals have free flowing access to the ARAC Chair.
	5.1.7	There are periodic discussions with key attendees outside of the formal meetings to help ensure that expectations are managed and there is mutual understanding of current risks and issues.	See 5.1.6 and in addition NEDs meeting monthly and any issues and risks can be raised there also with the ARAC chair.
Good Practice	**5.1.8**	The ARAC reports its work as transparently as possible within the limits of what is confidential and commercially sensitive.	The AAA report from ARAC to board is completed within 48 hours and distributed to the board and ARAC members soon afterwards. On one occasion in 2023/24 this was done verbally due to insufficient turnaround times. The work taken in closed ARAC is reported in open board at a high level.
	5.1.9	The ARAC has a robust mechanism for working with the Board, so expectations and accountability is clear.	See 5.1.8 and the approved terms of reference where are clear on roles and responsibilities.
	5.1.10	The ARAC uses technology to its advantage and communicates as a group in a way which is effective and efficient.	The AAA report takes advantage of IG safe tools to ensure it is developed in a timely way. Papers for meetings are uploaded to Ibabs and the board website for ease of access.

Good Practice	**5.1.11**	The reports received by the ARAC are the right level of detail, and presented in a manner which makes it easy for members to review and challenge.	ARAC has noted a number of times during 2024/25 on the clarity of the papers and presentations.
	5.1.12	Reports produced by the ARAC are proportionate: there is enough information to provide the Board with the assurance it requires, but not too much that key information is diluted.	See 5.1.8. The board has been satisfied with the level of detail from ARAC.
	5.1.13	(For government departments only) the departmental ARAC has an effective way of gaining visibility over key risks and issues arising from ARACs within the departmental group.	N/A for WAST
6.Continual improvement			
Continual improvement			
Good Practice	**6.1.1**	The Chair seeks appraisal of his or her performance from the Accounting Officer or Chair of the Board, as appropriate.	This has been addressed and will happen in the current year (from the Chair).
	6.1.2	The Chair assesses the performance of the individual members of the committee, discusses their training and development needs, and agrees a training and development plan.	We didn't believe that formal performance reviews of ARAC members is necessary in addition to their appraisals with the Chair of the Board. However, periodic catch-ups to discuss how ARAC is performing, assessing any training or developmental needs plus any other issues was felt to be beneficial.
	6.1.3	The Chair ensures a periodic review of the overall effectiveness of the ARAC.	Agreed this should be done as part of the ARAC Annual Report to the Board. We also discussed how as a Board we can apply our collective knowledge and experience to add more insight to statistical data as one example.
	6.1.4	After completing an effectiveness review, there is sufficient time and effort devoted to discussing results, and agreeing an action plan based on the outcomes.	Time is devoted to this in the ARAC meeting, and a review of the resultant annual report and terms of reference.
	6.1.5	Evaluation of performance is not done in isolation, and year-on-year trends in different areas of performance is measured.	This has occurred in the past, however it is not always a good representation of progress, especially using this NAO questionnaire. ARAC has therefore taken a different approach to effectiveness reviews in 2024/25 focused more on assurance and remit of committees.
	6.1.6	The Chair considers ways in which to obtain feedback from the executive and other key stakeholders – for example, internal and external audit – on the performance of the ARAC.	This will be built into the current year's exercise.
	6.1.7	The results of the performance evaluation are used to inform and influence succession planning - for instance in highlighting skills gaps, or a lack of diversity.	We acknowledged that we cannot cover all bases, and will highlight at agenda setting where we feel there are skills gaps in relation to certain work areas/reports coming to ARAC and will proactively ensure as best we can that the appropriate resources are obtained to apply proper scrutiny.
	6.1.8	The ARAC carefully considers the extent and method of performance evaluation – for instance, whether aspects could be externally facilitated.	Agreed and will be pursued for the next exercise.
	6.1.9	The evaluation of performance is objective and rigorous enough for meaningful conclusions to be drawn.	ARAC is of the view that sufficient time is given over in all committees to the evaluation of their effectiveness during the year as a continuous improvement model, as well as annually.

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

AUDIT, RISK AND ASSURANCE COMMITTEE

TERMS OF REFERENCE AND OPERATING ARRANGEMENTS 2024/25

1. INTRODUCTION

1.2 The Trust's Standing Orders provide that "*The Board may and, where directed by the Welsh Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees*".

1.2 In line with Standing Orders and the Trust's Scheme of Delegation, the Board shall nominate annually a committee to be known as the **Audit, Risk and Assurance Committee**. The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set out below.

1.3 The Board Committees play an important role in supporting the Board in fulfilling its responsibilities by:

- providing advice on strategic development and performance within the terms of reference;
- undertaking scrutiny and gaining assurance on key aspects of organisational performance, and supporting achievement of the Trust's strategic goals;
- carrying out specific responsibilities on the Board's behalf; and
- providing a forum where ideas can be explored in greater detail than Board meetings are able to allow, providing time and space to consider issues in greater depth.

Regular and timely reporting and escalations to the Board on the issues within the Committee's remit allow for more focused discussions by the Board.

2. PURPOSE

2.1 The purpose of the Audit, Risk and Assurance Committee ("the Committee") is to advise and assure the Board and the Accountable Officer on whether

effective arrangements are in place - through the design and operation of the Trust's system of assurance - to support them in their decision taking, and in discharging their accountabilities for securing the achievement of the Trust's objectives, in accordance with the standards of good governance determined for the NHS in Wales.

2.2 Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further.

2.3 The committee shall, in carrying out its functions and responsibilities, consider how their decisions secure an improvement in the quality of health services (the duty of quality) as outlined in The Health and Social Care (Quality and Engagement) (Wales) Act 2020. This includes but is not limited to ensuring the provision of high-quality, safe, and effective healthcare services that meet the needs of patients, service users, and their families.

2.4 The committee shall demonstrate the duty of quality through its own operating arrangements, ensuring that its processes, procedures, and decision-making mechanisms uphold the highest standards of transparency, accountability, and governance. It shall regularly review and refine its operating procedures to align with best practices and legal requirements, fostering an environment of continuous improvement. Furthermore, the committee shall monitor, assess, and report on the implementation of Health and Care Quality Standards, outcomes, and performance indicators where relevant within their remit.

3. DELEGATED POWERS AND AUTHORITY

3.1 With regard to its role in providing advice to the Board, the Committee will comment specifically upon:

(a) the adequacy of the Trust's strategic governance and assurance arrangements and processes for the maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical) designed to support the public disclosure statements that flow from the assurance process, including the Annual Governance Statement and the Annual Duty of Quality Report, providing reasonable assurance on:

(i) the organisation's ability to achieve its objectives.

(ii) compliance with relevant regulatory requirements, standards, quality and service delivery requirements and other directions and requirements set by the Welsh Government and others.

(iii) the efficiency, effectiveness, and economic use of resources; and

(iv) the extent to which the organisation safeguards and protects all its assets, including its people,

and to ensure the provision of high quality, safe healthcare for its citizens:

(b) the Board's Standing Orders and Standing Financial Instructions (including associated framework documents, as appropriate) and receive a report from the Board Secretary on any non-compliance.

(c) the accounting policies, the accounts, and the annual report of the organisation, including the process for review of the accounts prior to submission for audit, levels of error identified, the ISA 260 Report 'Communication with those charged with Governance' and managements' letter of representation to the external auditors; the Committee shall approve all financial procedures.

(d) the Schedule of Losses and Special Payments.

(e) the register of Single Tender Actions.

(f) the planned activity and results of internal audit, external audit and the Local Counter Fraud Specialist (including strategies, annual work plans and annual reports).

(g) the adequacy of executive and management's response to issues identified by audit, inspection, and other assurance activity.

(h) proposals for accessing Internal Audit services via Shared Services arrangements (where appropriate).

(i) anti-fraud policies, whistle-blowing processes, and arrangements for special investigations.

(j) any particular matter or issue upon which the Board or the Accountable Officer may seek advice.

(k) the adequacy of the arrangements for Declarations of Interests, providing an annual report to the Board to this effect.

(l) arrangements for the discharge of the Trust's responsibility as bailee for patients' property.

3.2 The Committee will support the Board with regard to its responsibilities for governance (including risk and control) by reviewing:

(a) all risk and control related disclosure statements (in particular the Annual Governance Statement and the Annual Duty of Quality Report) together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board.

(b) the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.

(c) the policies for ensuring compliance with relevant regulatory, legal and code of conduct and accountability requirements.

(d) the policies and procedures for all work related to fraud and corruption as set out in National Assembly for Wales Directions and as required by the Counter Fraud and Security Management Service.

3.3 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit, and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness.

3.4 This will be evidenced through the Committee's use of effective governance and assurance arrangements to guide its work and that of the audit and assurance functions that report to it, and enable the Committee to review and form an opinion on:

(a) the comprehensiveness of assurances in meeting the Board and the Accountable Officers assurance needs across the whole of the Trust's activities, both clinical and non-clinical; and

(b) the reliability and integrity of these assurances.

3.5 To achieve this, the Committee's programme of work will be designed to provide assurance that:

(a) there is an effective internal audit function that meets the standards set for the provision of internal audit in the NHS in Wales and provides

appropriate independent assurance to the Board and the Accountable Officer through the Committee;

(b) there is an effective counter fraud service that meets the standards set for the provision of counter fraud in the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Committee and ensure all reported fraud concerns and ongoing investigations are notified to the Committee.

(c) there are effective arrangements in place to secure active, ongoing assurance from management with regard to their responsibilities and accountabilities, whether directly to the Board and the Accountable Officer or through the work of the Board's committees.

(d) the work carried out by key sources of external assurance, in particular, but not limited to the Trust's external auditors, is appropriately planned and co-ordinated and that the results of external assurance activity complements and informs (but does not replace) internal assurance activity.

(e) the work carried out by the whole range of external review bodies is brought to the attention of the Board, and that the organisation is aware of the need to comply with related standards and recommendations of these review bodies, and the risks of failing to comply.

(f) the systems for financial reporting to the Board, including those of budgetary control, are effective.

(g) the results of audit and assurance work specific to the Trust, and the implications of the findings of wider audit and assurance activity relevant to the Trust's operations, are appropriately considered and acted upon to secure the ongoing development and improvement of the organisations' governance arrangements.

(h) monitor progress against the requirement of the Auditors' Management Letter.

(i) receive and review key Trust Annual Reports e.g., Trust Annual Report (including the Annual Governance Statement) and make recommendations to the Board for their adoption.

(j) review the content of the Corporate Risk Register and obtain assurance that control measures are in place to mitigate all identified risks.

Corporate Risks and Audit Recommendation Tracker

3.6 The Committee has overall responsibility for ensuring that corporate risks are identified and are being properly managed within the Trust and that there are processes in place to address and take forward audit recommendations. Nevertheless, each risk from the corporate risk register and Board Assurance Framework and each recommendation from the audit tracker, will be presented to an appropriate Board Committee who will be responsible for ensuring that the Trust is managing and progressing each item as planned. In addition, these Committees will follow due process to escalate any issues to Audit, Risk and Assurance Committee for oversight, scrutiny and assurance. Regular reports will be provided to individual Committees on those items for which they have responsibility for oversight and overall Trust-wide progress reports will be presented to each Audit, Risk and Assurance Committee.

Authority

3.7 The Committee is authorised by the Trust Board to investigate, or have investigated, any activity within its terms of reference. In doing so, it will have the right to seek any information it requires from any employee or inspect any books, records or documents relevant to its remit, ensuring patient/client and staff confidentiality as appropriate. All employees are directed to cooperate with any reasonable request made by the Committee.

3.8 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

3.9 The Committee is authorised to approve Trust wide policies in accordance with the policy for the Review, Development and Approval of Policies.

Chair's Action

3.10 There may, occasionally, be circumstances where decisions which would normally be made by the Committee need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Committee. This is most likely, but not exclusively, to arise with respect to approval of policies particularly given the current backlog.

3.11 In these circumstances, the Chair and the Lead Executive, supported by the

Board Secretary as appropriate, may deal with the matter on behalf of the Committee after first consulting with at least two other Members (Non-Executive Directors).

3.12 The Board Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

Access

3.13 The Head of Internal Audit and the Engagement Leads/Audit Manager of External Audit shall have unrestricted and confidential access to the Chair of the Committee.

3.14 The Committee will meet with Internal and External Auditors and the nominated Local Counter Fraud Specialist without the presence of officials on at least one occasion each year.

3.15 The Chair of Committee shall have reasonable access to Directors and other relevant senior staff.

Sub Committees

3.16 The Committee may establish sub- committees or task and finish groups to carry out on its behalf specific aspects of Committee business. Formal sub-committees may only be established with the agreement of the Board.

4. MEMBERSHIP

Members

4.1 The membership of the Committee will comprise:

Chair	Non Executive Director
Members	Three further Non Executive Directors of the Board

4.2 The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise e.g. Wales Audit Office, Internal Audit.

4.3 The Chair of the Trust shall not be a member of the Committee.

Attendees

4.4 The core membership will be supported routinely by the attendance of the following:

- Executive Director of Finance and Corporate Resources (Committee Lead)
- Director of People and Culture
- Executive Director of Quality and Nursing
- Assistant Director of Operations, National Operations & Support
- Director of Corporate Governance/Board Secretary
- Deputy Board Secretary/Head of Risk
- Head of Internal Audit
- Local Counter Fraud Specialist
- Representative of the Auditor General
- Trade Union Partners (x2)
- Other Directors will attend as required by the Committee Chair

With the permission of the Chair, those in attendance may send a deputy in their place. This, however, does not affect the right of the Chair to require those listed above to attend.

By Invitation

4.5 The Committee Chair may invite the following to attend all or part of a meeting to assist it with its discussions on any particular matter:

- the Chair of the Trust
- any other Trust officials
- any others from within or outside the Trust
- the Chief Executive (Accountable Officer)

4.6 The Chief Executive (Accountable Officer) will be invited to attend meetings of the Committee and will attend to discuss the process for assurance that supports the Annual Governance Statement and the Annual Duty of Quality Report.

4.7 The Committee Chair may extend invitations to attend committee meetings to other Directors and/or Senior Managers, and to officials from within or outside

the organisation to attend all or part of the meeting to assist with its discussions on any particular matter.

4.8 Members may send deputies in their absence who will act with their full authority. To instigate a substitution arrangement, the member of the Committee must notify the Board Secretary before the day of the meeting that he/she is unable to attend and the name of the member who will attend as the substitute.

Member Appointments

4.9 The membership of the Committee shall be determined by the Board, based on the recommendation of the Trust Chair, taking account of the balance of skills and expertise necessary to deliver the committee's remit, and, subject to any specific requirements or directions made by the Welsh Government.

4.10 Non Executive Members shall be appointed to hold office for a period of one year at a time, (Membership being reviewed by the Chairman of the Board on an annual basis) up to a maximum of their term of office. During this time a member may resign or be removed by the Board.

4.11 Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the Board, based upon the recommendation of the Trust Chair and, where appropriate, on the basis of advice from the Trust's Remuneration Committee.

Secretariat and Support to Committee Members

4.12 The Board Secretary, on behalf of the Committee Chair, shall:

(a) arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and

(b) ensure the provision of a programme of organisational development for committee members, as part of the Trust's overall board development programme developed by the Director of People and Culture.

5. COMMITTEE MEETINGS

Quorum

5.1 At least two of the four members of the Committee must be present to achieve a quorum. In the absence of the Committee Chair, one of those in attendance must be designated as Chair of the meeting.

Frequency of Meetings

5.2 Meetings shall be held no less than quarterly and otherwise as the Chair of the Committee deems necessary, consistent with the Trust's annual plan of Board business and calendar of meetings. Meeting agendas, papers and minutes shall be circulated no less seven days prior to each meeting.

5.3 The Chair of Committee, External Auditor or Head of Internal Audit may request a private meeting if they consider that one is necessary.

Withdrawal of individuals in attendance

5.4 The Committee may ask any member or individual who is normally in attendance but who is not a member to withdraw to facilitate open and frank discussion of particular matters.

6. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/ GROUPS

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, the Board retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

6.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.3 The Committee, through its Chair and members, shall work closely with the Board's other committees, including where appropriate joint (sub) committees

and groups to provide advice and assurance to the Board through the:

(a) joint planning and co-ordination of Board and Committee business; and
(b) sharing of information;

in so doing, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

6.4 The Committee will consider the assurance provided through the work of the Board's other committees and sub groups to meet its responsibilities for advising the Board on the adequacy of the Trust's overall framework of assurance.

6.5 The Committee shall embed the Trust's corporate standards, priorities and requirements, e.g., equality and human rights through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

(a) report formally, regularly and on a timely basis to the Board and the Chief Executive (Accountable Officer) on the Committee's activities. This includes verbal updates on activity, the submission of Committee minutes and written reports where appropriate throughout the year;

(b) bring to the Board and the Chief Executive (Accountable Officer's) specific attention any significant matter under consideration by the Committee; and

(c) ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive (and Accountable Officer) or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Trust.

7.2 The Committee shall provide a written, Annual Report to the Board and the Chief Executive (Accountable Officer) on its work in support of the Annual

Governance Statement and the Annual Duty of Quality Report, specifically commenting on the adequacy of the assurance arrangements, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the committee's self-assessment and evaluation.

7.3 The Board may also require the Committee Chair to report upon the committee's activities at public meetings or to community partners and other stakeholders, where this is considered appropriate, e.g., where the committee's assurance role relates to a joint or shared responsibility.

7.4 The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any sub-committees established. In doing so, account will be taken of the requirements set out in the NHS Wales Audit Committee Handbook.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum (as set out in section 5)

9. REVIEW

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

PAPER	PRE or POST C'EE FORUM	FREQUENCY	Q1a	Q1b	Q2	Q3	Q4	LEAD	PURPOSE	COMMENT
AUDIT, RISK AND ASSURANCE COMMITTEE - CYCLE OF BUSINESS 2024/25										
For the rationale for this Committee's cycle see Note 8										
Annual filings										
Annual accounts planning and emerging issues report	ELT	Annually						EDOF	Assurance	
Annual report timetable	ELT	Annually						BS	Assurance	
Audited accounts	ELT and Board	Annually						EDOF	Endorsement	
Annual report	ELT and Board	Annually						BS	Endorsement	
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	
Self-assessment against Governance Code 2017	ELT	Annually						BS	Assurance	Review of self-assessment by AC ahead of declaration of same in annual report in Q1b
Internal Audit										
Audit Plan	ELT	Annually						Internal Audit	Approval	
Internal audit reports	ELT and C'ees	Quarterly						Internal Audit	Assurance	Relevant directors to be in attendance for limited assurance reviews
Audit Wales										
Audit Plan	ELT and Board	Annually						Audit Wales	Review	SFI 3.4.1 AC must ensure cost efficient external audit service is delivered; SFI 3.4.3 AC to review plan and associated costs. Noted to Board
Update report	N/A	Quartlery						Audit Wales	Assurance	
Annual Audit Report	ELT and Board	Annually						Audit Wales	Assurance	Audit report for calendar year. Copy to Board in AAA
Structured Assessment	ELT and Board	Annually						Audit Wales	Assurance	May also be presented at other times depending upon audit plan
Other Non-Core Reports	ELT and Board	Various						Audit Wales	Assurance	Non-core reports are those outside of the Structured Assessment work and are included in the Audit Plan
Losses & Special Payments/Single Tender Waivers										
Quarterly lossess and special payments report	N/A	Quarterly						EDOF	Approval	See Note 1
Tender update report and single tender waiver request	N/A	Quarterly						EDOF	Assurance	Closed session
Counter fraud										
Counter fraud update report	N/A	Quarterly						EDOF	Assurance	Closed session. See Note 6
Counter fraud annual report	ELT	Annually						EDOF	Assurance	Closed session. See Note 6 **Not to go to Board - only ARAC**
Counter fraud update work plan	ELT	Annually						EDOF	Approval	Closed session. See Note 6
Standing Orders & Standing Financial Instructions										
Standing Orders & Standing Financial Instructions	ELT and Board	Annually						BS	Endorsement	Amendments to standing orders, standing financial instructions, scheme of reservation and delegation and associated schedules
Breach of Standing Orders & Standing Fin. Instructions	ELT	Ad Hoc						BS	Discussion/Assurance	
Governance Practice Notes	ELT	Annually						BS	Approval	Annual review of practice notes related to SOs and SFIs
Whistleblower, Declarations, Gifts & Hospitality										
Annual report on declarations of interest	ELT	Annually						BS	Assurance	Audit committee to provide report to Board on adequacy of arrangements for DOI annually
Report on gifts and hospitality	ELT	Annually						BS	Assurance	
Whistleblower report	TBC	TBC						BS	TBC	See Note 2
Other										
Near Miss Report	QUEST	Annually						TBC	Assurance	See Note 3
Quality and Performance Management Framework	ELT	Bi-Annually						EDON	Assurance	See Note 7
Policy										
Policy report	ELT	Quarterly						BS	Assurance	Position on policies including those outstanding for review etc. See Note 4
Policies	Policy Group	Ad Hoc						BS	Approval	Policies within the purview of this Committee - see Note 5
Financial procedures	TBC	Ad Hoc						EDOF	Approval	SFI 1.1.3 all financial procedures must be approved by the EDOF and Audit Committee
Risk Management										
Review of risk related elements in IMTP	STB	Annually						BS	Assurance	
Board Assurance Framework	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	This includes the annual report and amendments to TORs for all Board Committees and WASPT
Audit Committee effectiveness review annual report	Audit/Board	Annually						BS	Approval	
Audit Committee Review of Terms of Reference	Audit/Board	Annually						BS	Approval	
Audit Committee Cycle of Business annual refresh	Audit/Board	Annually						BS	Approval	
Audit Committee Review of Annual Priorities	None	Quarterly						Chair	Review	
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

Cycled for each meeting
Ad hoc item - prompt for agenda setting
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 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 (NHSCFA) have entered into a service agreement under section 83 of the Government of Wales Act 2006, to ensure that appropriate provision is in place to tackle all matters connected to Fraud, Bribery and Corruption. It is the role of the LCFS to ensure regular engagement and reporting to senior members surrounding the work completed within this field, with the audit committee being recognised as an appropriate recipient to the status and developments of the service. Service strands of hold to account, prevent and deter, inform and involve, and strategic governance
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.

AUDIT, RISK AND ASSURANCE COMMITTEE ANNUAL REPORT 2024/25

INTRODUCTION

1. The Trust's Standing Orders and Committee Terms of Reference require that Board Committees evaluate their effectiveness annually and present an annual report to the Trust Board.

2. As the factors underpinning effective governance can change, for example as people leave, organisations restructure, or strategy shifts, regular reviews of Board Committees ensure governance remains fit for purpose.

3. Standing Orders, Committee terms of reference, and Codes of Governance provide that Boards should routinely assess the effectiveness of their governance arrangements, of which the Board's Committees form an integral part.

4. The committee met on 06 March 2025 and through a facilitated discussion reviewed its effectiveness, its terms of reference, and its operating arrangements. This Annual Report reflects on the effectiveness of the committee in 2024/25 and proposes changes to terms of reference.

PURPOSE OF THE COMMITTEE

5. The purpose of the committee is to advise and assure the Board and the Accountable Officer on whether effective arrangements are in place - through the design and operation of the Trust's system of assurance - to support them in their decision taking, and in discharging their accountabilities for securing the achievement of the Trust's objectives, in accordance with the standards of good governance determined for the NHS in Wales. Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further.

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MEMBERSHIP AND ATTENDANCE

6. The committee met six times in public and four times in private session as scheduled in 2024/25 and was quorate on each occasion. Pre-meets were held with the Chair and Auditors.

7. In 2024/25 the Committee was supported by the Chair and three Non-Executive Directors (NEDs) as members, and several prescribed attendees with good attendance. In year the NED composition of the committee changed, to reflect the changed composition of the Trust Board. Professor Kevin Davies and Joga Singh left the Trust Board and therefore the committee.

8. Following her appointment in late 2024 as a NED, Rhiannon Beaumont-Wood was appointed to the committee as a member effective 01 January 2025. As at year end of the committee membership is Peter Curran, Ceri Jackson and Rhiannon Beaumont-Wood.

9. The chart below illustrates attendance of members and prescribed attendees as listed in the terms of reference for 2024/25. Audit Wales and Internal Audit were in attendance and the committee welcomed non prescribed attendees at various meetings. The Chief Executive Officer attended three meetings in 2024/25.

COMMITTEE ATTENDANCE						
Name	**30 April 2024**	**7 June 2024[1]**	**10 July 2024[2]**	**12 Sep 2024[3]**	**21 Nov 2024[4]**	**6 Mar 2024**
Peter Curran						
Kevin Davies						
Joga Singh						
Ceri Jackson						
Chris Turley						
Audit Wales	Fflur Jones[5]	Fflur Jones	Yvonne Thomas	Fflur Jones[6]	Fflur Jones	
Julie Boalch						
Judith Bryce					Jon Sweet	
Christian Fox						
Angie Lewis						
Carl Kneeshaw						
Osian Lloyd					From Item 7	
Trish Mills						
Liam Williams					J Turnball-Ross	
Carl Window						
Damon Turner					Until Item 10	

COMMITTEE VIEWS ON EFFECTIVENESS

10. In previous years, members of the committee were asked to complete the extensive NAO Audit and Risk Assurance Committee Effectiveness Tool questionnaire. Recognising the need for a more engaging and efficient process,

the committee adopted a new approach for the current effectiveness review, commencing in April 2024.

11. This year, a smaller subgroup of ARAC members met throughout the year to proactively address the questionnaire by identifying and addressing any gaps in advance. This preliminary work aims to streamline the effectiveness review by allowing the committee to focus on key areas of improvement and maintain continuous oversight of their responsibilities.

12. At its 06 March 2025 meeting the responses to that questionnaire were reviewed and several key areas discussed.

13. [add in here post 06 March 2025 the views of the committee on its effectiveness]

14. The Committee has a cycle of business that is aligned to its terms of reference. All matters scheduled for oversight and review have been brought to the Committee and in this respect, it has discharged its responsibilities in providing assurance to the Board aligned to its terms of reference

15. The Committee's business in 2024/25 included the following, full details of which are in the Committee's AAA reports and minutes provided to the Board:

    15.1. In July 2024 the Committee **endorsed the 2023/24 Annual Accounts and the Annual Report and Duty of Quality Annual Report** 2023/24 which were shortly after approved by the Board. The Audit Report (ISA 260) was also reviewed at that meeting as was the final Head of Internal Audit Annual Report and Opinion.

    15.2. The plan for development of the 2024/25 annual filings was received in March 2025 and endorsed.

    15.3. At each meeting other than in April, which is a meeting dedicated to the review of Committee effectiveness, members received an **update from Audit Wales and from Internal Audit** on their programmes of work and performance indicators (Internal Audit only).

    15.4. In April 2024 the committee received the **Audit Wales Annual Report** for the 2023/24 financial year. The report summarised the findings from the 2023 audit activity which included the audit of the 2022/23 annual report and accounts, the 2023 Structured Assessment, the national workforce review and the Trust's workforce planning arrangements. The 2024 Audit Wales Audit Plan was received in April as well.

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15.5. The following **Internal Audit Reports** were presented by Internal Auditors and discussed by this committee. They were also reviewed by the committees with specific remits over the subject area. The list below includes a mix of 2023/24 and 2024/25 Internal Audits, as the 2023/24 internal audit programme reporting was completed in year:

- Risk Management and Assurance
- Seatbelt Action Plan
- ICT Contract Management
- Volunteers Governance
- Disciplinary Case Management: Compassionate Practices
- Follow Up Action Tracker Review
- Clinical Audit
- Resourcing Policy
- Integrated Quality and Performance Management Framework
- Overtime Controls
- Data Quality
- Vehicle Accident Management
- Exposure to Fumes
- Patient Experience and Community Involvement
- Rollout of Penthrox
- 111 Digital Operations
- Energy Management

15.6. The **2024/25 Internal Audit Plan was approved** by the Committee in March 2024, as was the Internal Audit Charter and fee.

15.7. The **2025/26 Internal Audit Plan was approved** by the Committee in March 2025, as was the Internal Audit Charter and fee.

15.8. In November 2024 the Audit Wales Update presented the **WAST 2024 Structured Assessment**, along with the **Review of Cost Savings** audit report. Both of these reports were positive, and members received significant assurance from the opinions given. The committee commended the Trust on the positive nature of the reports

15.9. Two areas of **non-compliance with the standing orders** were discussed and escalated to the Board in Spring 2025. The Committee was assured that both areas were being appropriately addressed in a timely way:

- The first related to the approval of the minutes from the 2023 Annual General Meeting (AGM). Standing Order 7.2.7 requires that "A record of the meeting shall be submitted to the next ordinary meeting of the Board for agreement". It was identified in Autumn 2024 that this had

not been the case for the 2023 AGM minutes (which were taken to the 2024 AGM for approval). This oversight was corrected for the 2024 AGM, and the minutes were approved by the board in November 2024.

- The second related to non-compliance with the standing orders in regard to a procurement contract award having been made without the required sign-off by the board, as the financial limit exceeded the Chief Executive's delegated financial limit. This matter was brought to the attention of the board via the request for Chair's Action in early 2025 and the mitigating actions for strengthening internal processes to ensure future compliance with standing orders were provided.

15.10. Amendments to **Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation** were reviewed and endorsed for the Board. Governance Practice Notes (GPN) developed for interpretation and application of some parts of the Standing Orders were revised in year and also approved.

15.11. The committee has oversight of the **Trust's Policy work plan** and in year received updates on the progress against the work programme to clear the backlog of outdated policies. In November the committee heard that a re-evaluation of the policy priorities has been undertaken with the Executive Leadership Team and a revised work programme will be established or 2025/26.

15.12. The committee approved the **All-Wales Procedure for Recovery of Overpayments** via Chair's Action.

15.13. In April 2024 the committee reviewed the **self-assessment against 2017 Governance Code** and noted that there were no areas where the Trust did not comply. The committee reviewed the self-assessment against the code and were assured that the Trust complies with all elements.

15.14. The committee terms of reference require it to receive assurance on the **arrangements for whistleblowing** at the Trust, and it received an update in September. Assurances were received by way of a report from the Chair of the People and Culture Committee on the Speaking up Safely arrangements at the Trust.

15.15. The committee's terms of reference require it to receive assurance on the **arrangements for near miss reporting** at the Trust. Assurances were received in November by way of a report from the Chair of the Quality, Patient Experience and Safety Committee on the near miss arrangements

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which noted that it will committee will continue to monitor this maturing area by way of the Putting Things Right Report.

15.16. At each meeting of the committee a report against the organisational **Audit Tracker** was received – Tracker 2.0. The committee received updates regarding development of Tracker 3.0 and improved reporting, which will continue into 2025/26. Directors whose actions were on the third and final date have appeared at the committee to provide assurances on closure plans.

15.17. In March 2025 the committee received an update regarding the work on the **committee specific induction programme**.

15.18. In November an update was received regarding the **implementation of the Quality and Performance Management Framework** (QPMF), with the related internal audit report. The committee agreed that it was sufficiently assured of the progress of implementation of the Framework to transfer oversight of continual effectiveness to the Finance and Performance Committee.

15.19. Other than in April, the **losses and special payments** report is received at each meeting of the Committee. Likewise, **the Local Counter Fraud** update report and **tender and single tender waiver** reports are taken in private session.

15.20. In March 2025 the committee received assurance from the Chair of the Quality, Experience and Patient Safety Committee that the **2025/26 Clinical Audit Plan** had been approved and was being monitored quarterly by that committee.

15.21. The **Register of Interests and the Register of Gifts and Hospitality** was received in April 2024. The committee noted the next stage for the development of the Trust's register which is for the cohort of decision-makers to be held centrally and published throughout 2024, which has now been completed.

15.22. A **risk management and Board Assurance Framework (BAF)** report was provided to each meeting. In year the committee received detailed reports and presentations on the development of the Risk Transformation Programme, in partnership with BDO. This work is considering the development of a strategic BAF, the development of a series of strategic risks, the development of risk appetite statements, and the options available to reposition the Trust's highest scoring risks, risks 223 and 224. The final key area of this work is the implementation of a digital solution

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that is needed to underpin the enterprise risk and strategic risk management arrangements. The committee heard that in December and February 2025 the Board met with partners BDO to further this work.

15.23. Member **reflections** after each meeting were as follows:

- In June, the committee reflected 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 Director;
- In July, the committee reflected that 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;
- In April, the committee reflected that the reports were succinct and recognised the collective effort of all members of the teams that supported the chairs in their review of the effectiveness of their committees. The hybrid nature of the meeting was not as effective for those in the room given the configuration of the IT, however an action was agreed to review instructions for their use in all meeting rooms. The meeting was well chaired;
- In September, the committee reflected that the partnership working between the Trust and Internal Audit and Audit Wales was evident. They welcomed the maturing journey with respect to risk and the lens on all areas of audit, of risk and of assurance for this meeting in line with the Committee's name change;
- In November, the committee reflected that the hybrid meeting worked well again, with chat kept to a minimum which was appreciated. Directors attending for assurance on third revised dates and their candid comments was seen as positive, and a good discipline for the committee to receive assurance. Members felt the meeting focused on key areas and that papers and presentations were of good quality. Audit reports were positive; however, members recognise resource and capacity issues will continue to be challenging, particularly over the coming months.
- In February, the committee reflected XXX.

15.24. The 2024/25 Committee **cycle of business** was approved.

15.25. In year, the Chair took a different approach to **committee effectiveness** and conducted quarterly discussions regarding committee effectiveness, in line with the structure of the National Audit Office Toolkit, rather than

waiting under year end to hold the discussion. The output of these discussions of continual effectiveness reviews were consolidated and received at the March 2025 meeting. At the May 2025 meeting committee also reviewed the **annual reports and endorsed changes to terms of reference** for all Board Committee and Advisory Groups.

15.26. The **Committee's priorities for 2024/25** are reviewed at each meeting and a more detailed update appears later in this report. The Committee also reviews progress against its cycle of business at each meeting.

15.27. The Chair gave regular updates regarding the activity of **the All Wales Audit Committee Chairs Network**. At the September meeting the terms of reference for this group were received.

16. The Board received a highlight (AAA) report from this Committee by email circulation following each meeting which included alerts, advice, and areas of assurance. This AAA report included reporting at a high level of matters taken in private session.

17. The Committee is not serviced by any Sub-Committees or task and finish groups that this time.

PROPOSED CHANGES TO THE TERMS OF REFERENCE

18. The proposed changes to terms of reference for this committee for 2024/25 are marked up in [Annex 1] and include XXX:

[to be completed following the 06 March meeting]

19. In addition, there will be some changes to operating arrangements which include:

[to be completed following the 04 February meeting]

COMMITTEE PRIORITIES:

20. The Committee received an update on progress against its priorities at each meeting. The 2023/24 priorities were:

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Priority	Progress
• Monitor the development of the Committee specific induction programme.	- A substantive update is programmed for receipt at the March 2025 meeting of the committee, where the wider committee induction approach will be set out. - Additionally, it is noted that a joint Board and Committee Chairs and Trade Union retrospective induction took place on 12 June. Additionally, a committee member governance overview drop took place in August with another planned for September.
• Carry-over from 2023/24: Oversight of the development and implementation of the Quality & Performance Management Framework	<u>2024/2025 Update:</u> - At the November 2024 meeting of the committee, it received a position update on the progress against the Quality and Performance Management Framework (QPMF), with the related internal audit report. - In November the committee confirmed its assurance on the implementation of the QPMF and noted that oversight of the ongoing effectiveness of the Framework will be overseen by the Finance and Performance Committee (FPC). - It is noted that a refresh of the QPMF will be taken to the FPC and Trust Board in March 2025 for review and approval. Members of the Audit, Risk and Assurance Committee will therefore have sight of this development via these mechanisms. - Earlier updates by the committee noted that receipt of updates regarding the Quality and Performance Management Framework (QPMF) have been built into the Committee's Cycle of Business, twice a year (quarter one and quarter three). This preceded the

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Priority	Progress
	agreement of the committee to transfer oversight to the FPC, however. - At the September 2024 meeting it was anticipated that oversight of the QPMF will move to the Finance and Performance Committee, in line with the respective Committee Terms of Reference, when the internal audit was presented to this ARAC meeting. <u>2023/24 Update:</u> - 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.

21. It is good practice for Committees to set priorities for the forthcoming year when they review their effectiveness. Accordingly, the Committee has agreed the following priorities for 2025/26:

    [to be completed following the 06 March meeting]

22. Progress on priorities will be reported to the Committee quarterly and to the Board through its highlight report.

NEXT STEPS

23. The next steps are:
    - 23.1. Ensure changes to operating arrangements agreed at paragraph **Error! Reference source not found.** are cycled into work programme for review in 2025/26
    - 23.2. Update the cycle of business with revised terms of reference.

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RECOMMENDATION

24. The Trust Board is requested to

(a) Receive and note the contents of the Committee Annual Report for 2024/245 and analysis of its effectiveness; and

(b) Approve the changes to the Terms of Reference and operating arrangements.

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Internal Audit Progress Report

Audit, Risk and Assurance Committee

March 2025

Welsh Ambulance Services University NHS Trust

NWSSP Audit and Assurance Services

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

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

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7. Recommendation *4*

Appendix A: Progress against 2024/25 Internal Audit Plan *5*

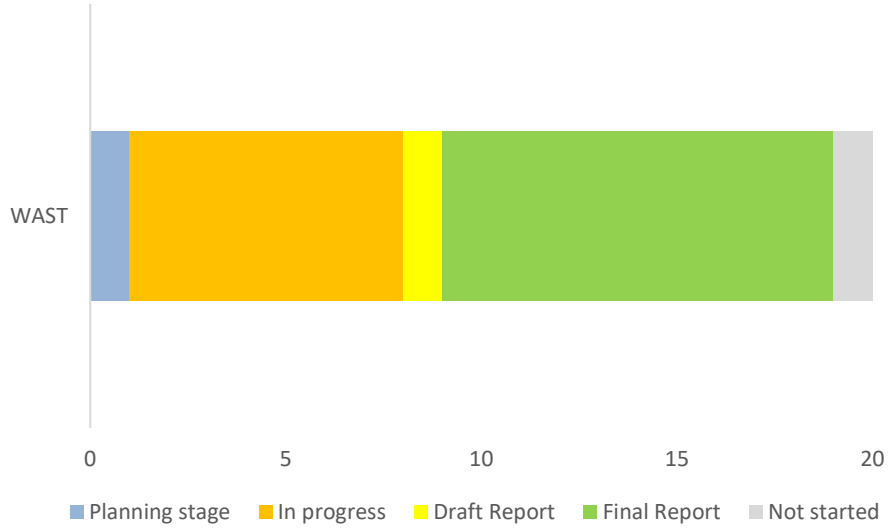
1. Introduction

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. Planning 2025/26

The draft plan has been discussed by the Executive Team and issued to Non-Executive Directors for comment. The final version is included in papers for the Committee to consider for approval.

5. 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.

6. Key Performance Indicators

Correct on 31 January 2025

Indicator	Status	Actual	Target
Operational Audit Plan agreed for 2023/24		March	By 30 June
Audits reported over planned		10	12
Work in progress		4	
Report turnaround: time from fieldwork completion to draft reporting [10 days]		8 out of 10	80%
Report turnaround: time taken for management response to draft report [15 days]		3 out of 7	80%
Report turnaround: time from management response to issue of final report [10 days]		7 out of 7	80%

Key:

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

7. 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	Planning			May / June 2025
Follow Up	In progress			May / June 2025
Contract Management	In progress			May / June 2025
Vehicle Accident Management	Final Report	Limited	There is no guidance in place to support line managers undertaking investigations into vehicle accidents; A central listing of those drivers requiring additional training, post investigation, is not maintained; The Datix system is not being used as intended for the reporting and investigation of vehicle accidents; There is a high number of accidents/damage not reported to Fleet Services through the Traffic Accident Report Form; Evidence of third-party damage is not routinely obtained which would assist with claims received; There is a lack of reporting and analysis on the number of vehicle accidents and the associated costs and themes.	March 2025
Integrated Quality and Performance Management Framework	Final report	Reasonable	Review of the Communication Plan and the Quality & Performance Management Framework's work programme to ensure that actions are clearly defined and achievable; Review of the governance structure to ensure there is sufficient oversight over the Framework and its implementation.	November 2024
Seasonal Forecasting and Modelling	Not started			June 2025
Exposure to Fumes	Final report	Reasonable	Guidance needs to be updated to inform employees that the shoreline can be re-started once it cuts off; There is no work programme in place for the cyclical	March 2025

[1] May be subject to change

Review	Status	Rating	Key matters arising	Anticipated Audit Committee[1]
			completion of Risk Assessments at Emergency Departments, which are expected to be undertaken in partnership with Trade Unions; Unannounced spot checks identified that staff are not complying with guidance set to prevent their exposure to fumes; Work is ongoing to enhance data collation in respect of fume exposure; Health & Safety Committee meetings have been cancelled due to timeliness of papers being issued.	
Patient Experience and Community Involvement	Final report	Reasonable	Enhancement of expected activity to be undertaken by the PECI Team; Regular review of survey questions posed to ensure relevancy and provision of meaningful feedback for service providers; Enhancement of the detail included in the log of public engagements; Enhancement to reporting on the impact and outcomes that engagement activities has had on service delivery.	March 2025
Rollout of Penthrox	Final Report	Reasonable	CFRs have not undertaken Omnicell cabinet training, which they are required to complete to gain access Penthrox. There are also issues for CFRs and Trust employees accessing the 'Penthrox safes' in North Wales, due to coding issues with the Abloy keys; Penthrox training compliance levels have not been updated in the Medicines Management Assurance Reports since April 2024; Instances identified where Penthrox was not administered to the patient in accordance with Protocol; A lack of reporting on the use of Penthrox and its effectiveness, and on exceptions relating to its administration; No analysis has been undertaken on the impact of Penthrox since its introduction, to confirm whether the expected benefits as set out in	March 2025

Review	Status	Rating	Key matters arising	Anticipated Audit Committee[1]
			the business case have been realised.	
Overtime Controls	Final report	Reasonable	The reporting of amendments to overtime allocations should be strengthened and supported by a documented audit trail of the rationale applied; Consideration of an automated process in the payment of overtime.	November 2024
Start of Shift Procedure	In progress			May / June 2025
Emergency Nurse Communications System Implementation	In progress			May / June 2025
111 Wales Website	In progress			May / June 2025
111 Digital Operations	Final Report	Substantial	We have identified no matters for reporting in our review.	March 2025
Data Quality	Final report	Reasonable	The focus within the Trust, due to capacity, has been on the EMS CAD system, which is the main driver of national reporting, however, there is recognition that there is a need to strengthen data quality processes and controls across the other data sets and systems. The following matters are aimed at strengthening current position: Out-of-date policies and guidance; Lack of assessment of staff digital literacy skills, and data quality specific training; Incomplete Information Asset Register; Improvements required in respect of data quality assurance reporting.	November 2024
Resourcing Policy	Final report	Limited	The Resourcing Policy to be reviewed and updated; Ongoing significant process mapping exercise to be completed to inform the development of functional Standard Operating Procedures. The different approaches being applied between services and local arrangements across Wales result	November 2024

Review	Status	Rating	Key matters arising	Anticipated Audit Committee[1]
			in an inconsistent application of the Resourcing Policy; Working Time Directive breaches are not reviewed or reported on; The process for Time Off In Lieu requires clarity; Whilst Outside Resource Authorisations decisions are recorded on GRS, there is currently no reason code assigned to them; There are timeframes for actions for both the Resource Team and staff included in the Resourcing Policy, however there is currently no Key Performance Indicator reporting.	
Occupational Health and Wellbeing Support	Draft Report	Reasonable		May 2025
Speaking Up Safely	In progress			May 2025
Capital & Estates				
Capital Systems	In progress			June 2025
Energy Management	Final Report	Substantial	Approvals did not make use of the Oracle approval hierarchy but instead were completed manually by email; In sampled months, 35% of meter readings were estimates, albeit 71% of these were then subsequently manually read within a month; Educational media created by the WAST to encourage behaviours conducive to good energy management, were not displayed in estate premises sampled.	March 2025

[1] May be subject to change

Vehicle Accident Management

Final Internal Audit Report

2024/25

Welsh Ambulance Services University NHS Trust

Limited Assurance

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Review Reference	WAS-2425-04
Fieldwork	October 2024 - December 2024
Executive Sign Off	19 February 2025
Audit Committee	6 March 2025
Executive Lead	Chris Turley, Executive Director of Finance & Corporate Services; Lee Brooks, Executive Director of Operations
Audit Team	Osian Lloyd, Head of Internal Audit; Felicity Quance, Deputy Head of Internal Audit

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

Executive Summary

Purpose

To assess the management of accidents relating to Trust vehicles, and the mitigating actions being taken to reduce the rate of occurrence.

Overview

The Trust is committed to reducing operational road risk and improving road safety for staff, including reducing the number of Road Traffic Collisions (RTCs) or Ambulance Vehicle Collisions (AVCs) for Trust vehicles engaged on Trust business. It is recognised that a significant percentage of collisions involving Trust vehicles occur while carrying our low-speed manoeuvres especially those involving reversing.

Whilst recognising the Trust's Driving at Work Policy, and that the cost of vehicle accidents to the Trust is low and it is currently in a position to better defend claims made against it, we have concluded limited assurance on this area with the following matters requiring management attention:

- There is no guidance in place to support line managers undertaking investigations into vehicle accidents.
- A central listing of those drivers requiring additional training, post investigation, is not maintained
- The Datix system is not being used as intended for the reporting and investigation of vehicle accidents.
- There is a high number of accidents/damage not reported to Fleet Services through the Traffic Accident Report Form.
- Evidence of third-party damage is not routinely obtained which would assist with claims received.
- There is a lack of reporting and analysis on the number of vehicle accidents and the associated costs and themes.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

Scope & Assurance Summary

Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	There is a policy or procedure in place highlighting the roles and responsibilities within the Trust following a vehicle accident.	1	**Reasonable**
2	Drivers have undertaken appropriate driver training courses.	2	**Reasonable**
3	Appropriate mechanisms are in place for recording of vehicle accidents and assessing any associated damage.	3, 4	**Limited**
4	Accidents are subject to appropriate investigation, with actions taken to learn and prevent recurrence.	1,3 & 5	**Limited**
5	Reports on vehicle accidents are produced and submitted to appropriate management and Trust committees for oversight and escalation.	6	**Limited**

Management Actions

3	3
High Priority	Medium Priority

Themes

Risk Types

Quality or Safety Issues

Legal & Regulatory Non-Compliance

Public Perception & Reputational Risk

Financial Loss

Findings & Agreed Action Plan

Objective 1: There is a policy or procedure in place highlighting the roles and responsibilities within the Trust following a vehicle accident.	**Reasonable**

Overview / Summary of Observations

The Driving at Work (DAW) Policy (approved by the People & Culture Committee in September 2021) establishes the expected standards for emergency and non-emergency drivers across the Trust. This includes:

- Legal requirements;
- Driver training and emergency driving procedures;
- Wearing of seatbelts and subsequent exemptions;
- Carrying children in Trust vehicles;
- Duty of driver involved in Road Traffic Collision (RTC);
- Training requirements; and
- Roles and responsibilities.

We noted that the DAW policy was due for review in September 2024, with a draft of the new policy being presented at the November 2024 People & Culture Committee for approval. Whilst a number of sections in the DAW policy had been amended, the narrative in relation to reporting of vehicle accidents remained extant.

Section 6.21 of the DAW policy it states that "*Line Managers have the responsibility to ensure an adequate investigation is commenced and all collision documentation is completed accurately and within a reasonable time*." However, no guidance or checklists are in place to assist for Line Managers with such, resulting in an inconsistent approach to investigating vehicle accidents. We were informed during the review that investigations are undertaken by experienced senior staff, typically by the Duty Operations Managers (DOMs), and they are expected to use their judgement to ensure a thorough investigation is undertaken (see **Key Finding 1**).

Key Findings		Risk & Impact	Agreed Management Action
1	**Vehicle Accident Investigation Guidance** The Trust does not have any guidance or checklists in place to support Line Managers when undertaking investigations into vehicle accidents.	Vehicle accident investigations are not undertaken / are completed inconsistently due to the lack of guidance.	**Agreed Action:** The Trust will establish a Task and Finish Group with key stakeholders to review current processes, develop and support the implementation of guidance checklists for the Line Managers to consider when undertaking investigations. **Expected Evidence of Implementation:** Triple A documentation from the meetings, including Action Logs and copies of the proposed checklist will form part of the evidence for this action, including guidance material/checklist for managers.

Key Findings		Risk & Impact	Agreed Management Action
		Medium Priority	**Officer:** Andrew Morgan, Senior Education & Development Lead
	Theme: Policies & Procedures	Control Design	**Date:** September 2025

Objective 2: Drivers have undertaken appropriate driver training courses.	Reasonable

Overview / Summary of Observations

All drivers of Trust vehicles that convey patients must complete a driving course during their induction to the Trust, for which there is both an emergency and non-emergency response course. The courses have been developed in partnership with FutureQuals (accredited organisation that delivers regulated qualifications across a diverse range of vocations and sectors), the Driver Training Advisory Group (regulatory body for ambulance driver training) and the Association of Ambulance Chief Executives (AACE). The courses are recognised across the UK and are the only driving courses used by all Ambulance Trusts.

The courses cover driving legislation; driver responsibilities; pre-driving checks and daily inspections; the system of car control; driving under routine and emergency response conditions; manoeuvring and reversing; safety systems; emergency response driving practices; navigation; adverse conditions; and human factors.

Once an employee has the FutureQuals qualification, there is no requirement for them to undertake refresher training; however, as per Section 6.19 of the DAW policy, if an employee has not been in a driving role for a period of 12 months, they will need to be re-assessed. Management advised that the Trust is looking to review this time period noting it is longer than other NHS Ambulance Services, where the period prior to re-assessment is three months.

Through discussion with the Senior Education & Development Lead (Driving) we note that following conclusion of an investigation into a vehicle accident, it is at the discretion of the line manager as to whether the individual's driving requires assessment; or if further training is required prior to commencing driving duties. However, this is not formally documented nor is a central repository maintained by the training team of those individuals who have been in receipt of such training (see **Finding 2**).

Key Findings		Risk & Impact	Agreed Management Action
2	**Driver Training Post Investigation** Where there is a need for drivers to undertake additional training post conclusion of the investigation, this is not formally documented by the line managers; or maintained within a central listing by the training department to demonstrate completion. This would allow analysis of themes and trends / repeat offenders to be identified.	Improvements to driving practices, to reduce the number of avoidable accidents, not evidenced.	**Agreed Action:** The Trust will establish a Task and Finish Group (In line with key finding 1) with key stakeholders to review current processes and documentation that is in place, agree where the central listing of documentation will be held and how this will be managed and monitored.
			Expected Evidence of Implementation: Triple A documentation from the meetings, including Action Logs and copies of the proposed process/documentation will form part of the evidence for this action including a central register with an established mechanism for monitoring and assurance.
		Medium Priority	**Officer:** Andrew Morgan, Senior Education & Development Lead
	Theme: Training & Development	Control Design	**Date:** September 2025

Objective 3: Appropriate mechanisms are in place for recording of vehicle accidents and assessing any associated damage.	Limited

Overview / Summary of Observations

The DAW policy states, when an accident occurs, the driver (if fit to do so) is required to complete a physical Traffic Accident Report form (TARF), also known as an RTI form. It is expected that the driver provides photographic evidence of the incident, positioning of the vehicles via sketch, extent of the damage, contact details of any 3rd party or witness; and a detailed statement of the incident. We note that there have been discussions to digitise the TARF for ease of completion.

DATIX

The DAW policy also states the individual *is required to record the incident on DATIX, highlighting damage and any injuries caused*. This allows the Duty Operations Managers (DOMs) to share the TARF with Fleet Services to inform them of the incident and to assess the vehicle for damage.

We requested a report from Datix for all entries that related to road traffic incidents between the period November 2023 – October 2024. This highlighted that only 63 incidents were recorded during the period (see **Key Finding 3**). From review of those incidents recorded, such is not limited to those which a high cost implication; lower cost incidents were also included in the Datix entries, including those with zero expense to the Trust. We note the disparity between this number and that recorded on the Fleetwave system.

Fleetwave

Fleet Services are made aware of damage to vehicles via TARFs being issued to a generic fleet email address, with some accidents being reported via phone calls or emails to individuals within the fleet team. The team use the bespoke 'Fleetwave' system to create a new record with its unique incident number to attach all details (TARF, pictures, verbal assessments of damage) to the incident. The system also tracks the vehicle through its repair journey and documents the costs involved in making the required repairs. During the review we were informed that a high number of vehicle damage is not reported and is identified by fleet during routine vehicle inspections. It was highlighted that another opportunity to identify damage to the vehicles is during the daily vehicle inspection (DVI), which staff are expected to undertake at the start of each shift. However discussions with the Fleet Service noted that reporting of damage via this mechanism is rare. DVIs are to be covered in more detail as part of the 'Start of Shift Procedures' internal audit review which forms part of the 2024/25 audit plan.

A report extracted from Fleetwave from between November 2023 – October 2024, during the period 796 cases of damage were uploaded into Fleetwave (compared with the 63 as per Datix) with 145 cases showing accident reason being '*unreported / unknown*' (this being the case after having been raised by the Fleet Services for review and escalation by the Operations team). The cost of repairs to these vehicles was circa £105k (See **Key Finding 4**).

Legal & Risk System

Where a claim has been made against the Trust because of an accident, such is referred to the Trust's Legal & Risk team. The team currently use a spreadsheet to record personal injury claims, road traffic collisions and damage to property. Individual SharePoint files are then set up for each claim and used to store evidence, such as CCTV footage. The legal team have also been granted access to the Fleetwave system to view documentation associated to the accident, including costs. The team does not rely on Datix records for evidence.

Key Findings		Risk & Impact	Agreed Management Action
3	**Recording Vehicle Incidents onto Datix** Recording of all vehicle incidents is a requirement of the Trust as outlined in the Driving at Work policy. However, a 12-month comparison (November 2023 – October 2024) between the number of vehicle incidents recorded on DATIX (63) to those recorded / identified on Fleetwave (796) highlights a large discrepancy between the systems, with less than 10% of incidents having been recorded on Datix. Further, noting the expectation of the DAW policy for investigations to be recorded on Datix (allowing the root cause of the accident to be identified and to determine any themes or trends), the minimal use of the system does not facilitate this wider understanding.	Vehicle related incidents are not recorded, investigated, root cause identified, or corrective action taken. Lack of recording hinders the Trusts ability to identify any themes or trends.	**Agreed Action:** Regular reporting of both DATIX and Fleetwave incidents will be incorporated into Local Business Meetings for discussions, analysis and subsequent actions to identify any themes and trends and to re-educate staff on the reporting of incidents. The Quality Team will also provide advice on improving the reporting processes using Lean methodology within the Task & Finish Group (see Key Findings 1&2). **Expected Evidence of Implementation:** Triple A documentation from the meetings, including Action Logs, work programme and any communications to staff on the reporting of incidents. This will include the DATIX report submissions to Business Meetings.
		High Priority	**Officer:** Jonathan Sweet, Head of Service OD **Date:** June 2025
	Theme: Reporting	Control Operation	
4	**Unreported Incidents / Damage** Analysis of the Fleetwave system between November 2023 – October 2024 identified that there is a large number of unreported / unknown damage being recorded on the system. Such are only being picked up once the vehicle is in the workshop for routine checks. Further analysis of the Fleetwave system highlights that a high number of incidents do not have Traffic Accident Report Forms attached to them. Other than those classed as unreported/unknown (145), and therefore would have no completed form, 125 logged incidents/damage have no form. We were informed that this figure would be higher if Fleet did not chase Operations for retrospective forms after identifying damage.	Vehicle related incidents are not investigated, which impacts on the Trust's ability to defend claims resulting in financial loss. Damaged and potentially unsafe vehicles remain on the road, causing a risk to staff, patients and the public.	**Agreed Action:** Regular reporting of both DATIX and Fleetwave incidents will be incorporated into Local Business Meetings for discussions, analysis and subsequent actions to identify any themes and trends and to re-educate staff on the reporting of incidents. The Quality Team will also provide advice on improving the reporting processes using Lean methodology within the Task & Finish Group (see Key Findings 1&2). **Expected Evidence of Implementation:** Triple A documentation from the meetings, including Action Logs, work programme and any communications to staff on the reporting of incidents. This will include the DATIX report submissions to Business Meetings.
		High Priority	**Officer:** Jonathan Sweet, Head of Service OD **Date:** June 2025
	Theme: Reporting	Control Operation	

Objective 4: Accidents are subject to appropriate investigation, with actions taken to learn and prevent recurrence	Limited

Overview / Summary of Observations

The Driving at Work Policy highlights that is the responsibility of the Line Managers to ensure that all work accidents, incidents and near misses are reported, recorded and remedial or other action is taken to prevent reoccurrence. This requires them to undertake an adequate investigation of all collisions, and to ensure documentation is completed accurately and within a reasonable timescale. Datix is configured to automatically send an alert to DOMs when an accident is reported for investigation. However, as noted in audit objective 1, there is no set guidance for the managers to follow to undertake investigations (see **Key Finding 1)**.

Datix is the tool by which the investigations should be documented and recorded (see objective 3), however noting the low number of incidents reported on the system, and the high number of incidents without a TARF, discussion with members of the Senior Operations Team advised that there is a lack of assurance that **all** accidents would have been investigated in an appropriate and timely manner and for any lessons learnt to be shared (see **Key Finding 3**)

During the review we were informed that review of incidents has concluded that a high number occur at low speeds such as reversing / manoeuvring or on narrow roads. Action has been taken to limit the number of these incidents by introducing preventative measures such as the requirement to have a banksman, installing parking cameras and updates to the vehicle's online SatNav systems, so the vehicles avoid narrow country lanes where possible. Action has also been taken by the Trust by re-issuing guidance for completing DVIs and the importance using seatbelts; further, notices on the use of handbrake (whilst parking on inclines) and reversing and manoeuvring have been issued by the Learning and Development team. Although we were informed that learning is taken from incidents, we did not evidence such happening systematically.

For those investigations that are undertaken, support is available by the Driver Education Team who can supply advice on a case-by-case basis. When it is identified that the accident was caused by poor / reckless driving from the Trust employee, Driver Education will review the incident utilising all information available to them including CCTV footage, noting that CCTV is only stored for 30 days, so any delay in reporting incidents affects the availability of the CCTV. A report is issued to Operations colleagues outlining a rationale for the review, a timeline of relevant findings based on observations from the CCTV footage and a summary of the investigation, highlighting any violations of road traffic law or where the driver has fallen below the expected level of a competent and careful emergency response ambulance driver. It is then the decision of the line manager if further assessment or training is required (see objective 2).

Legal & Risk Weekly Meeting

Claims made by third parties against the Trust are reviewed by the legal team prior to accepting any liability. Weekly meetings are held by the legal team to discuss those cases where there is likelihood of contention and Geo-tracking, CCTV, TARF and pictures will be reviewed to determine the fault of the accident and the extent of the damage. During the review we observed a meeting and identified the benefit of the evidence available as claims were able to be disproven at the meeting.

Further testing on a sample of five Legal claims found that all claims had sufficient data to assess and contest claims, but it was noted that no picture evidence of third-party damage was available (see **Key Finding 5**). Between November 2023 – October 2024 the legal team closed a total of 402 cases classed as damage to vehicles, noting that due to the nature of the incidents these cases can span over a number of years.

Key Findings		Risk & Impact	Agreed Management Action
5	**Evidence of Third-Party Damage** Discussions held with the legal team noted that pictures are not routinely taken of the damage inflicted to third party property post an accident. This was further supported in our review of a sample of five legal claims where photographic evidence was not available. Providing such would help the Trust in contesting claims received; and look to lower attributed costs if there was sight of the damage at the point of impact.	Unnecessary costs incurred by the Trust from paying excessive repair costs to third parties.	**Agreed Action:** Ensuring that staff are properly trained and held accountable for reporting accidents is crucial. The Trust will establish a Task and Finish Group (same group as documented in Key Findings 1&2) with key stakeholders to review the audit recommendation and devise a communications strategy/training materials to be circulated to teams. This can be further enhanced/implemented via the local business meetings.
			Expected Evidence of Implementation: Triple A documentation from the meetings, including Action Logs and copies of the proposed strategy will form part of the evidence for this action, including the comms strategy and a copy of the training materials/guidance to staff.
		Medium Priority	**Officer:** Andrew Morgan, Senior Education & Development Lead **Date:** September 2025
	Theme: Information, Data Quality & Data Accuracy	Control Design	

Objective 5: Reports on vehicle accidents are produced and submitted to appropriate management and Trust committees for oversight and escalation.	Limited

Overview / Summary of Observations

Local Business Meetings / Senior Operations Team (SOT)

Management advised that vehicle incidents are routinely reported to both these forums. However, from review of the papers for the 12-month period of November 2023 to October 2024, minimal reporting was noted:

- Local Business Meeting – September 2024 (South Central meeting): one incident was included in the 'Accident/Injury Classification Reported Incidents EMS Central' graph. It was also stated that the information would be based on Datix entries, noting the lack of incidents on Datix, any information supplied would be grossly inaccurate;
- The AAA (Alert, Assure and Advise) report from Ambulance Care to SOT (December 2024) highlighted points for inclusion in the notice to be issued on the safe use of handbrakes; and
- Senior Operations Team – July 2023: report of the deep dive exercise which reviewed incidents received in relation to Road Traffic Incidents, damage to vehicles and property during the period of May 2022 to January 2023. The report highlighted a number of issues and recommendations, including a lack of entries onto Datix (which we have also identified during the course of this review – see **Finding 3**). We also note that there has been a lack of monitoring of these recommendations at SOT (see **Finding 6**).

Quality, Patient Experience and Safety (QuEST) Committee

The Committee receives a 'Putting Things Right' report as a standing item on the agenda. Part of the report highlights the number of cases received and closed by the legal team monthly, including those relating to road traffic accidents (and damage to property) and Personal Injury (PI) from RTCs. As at September 2024, the total claims open were 228 and 68 respectively.

It is noted that these figures reported in the PTR report do not relate to all accidents within Trust, just those that are referred to Legal & Risk Services.

Audit Committee

In accordance with the Standing Financial Instructions (SFIs) all losses and special payments made are to be reported to the Audit, Risk and Assurance Committee on a regular basis. A review of the 2023/24 papers and 2024/25 papers to date, noted that a report based on the losses and special payments is issued to each Audit Committee. Part of the makeup of the losses and special payments report includes the cost of vehicle repairs. In 2022/24 this amounted to a total £176,838, this figure has already been surpassed for the current 2024/25 year with vehicle repairs totalling £190,815 (to 30 September 2024).

Key Findings		Risk & Impact	Agreed Management Action
6	**Lack of reporting and monitoring of vehicle accidents within the Operations Directorate** After reviewing the Senior Operating Team papers issued to us, there is a distinct lack of reporting on vehicle accidents. The only information issued to the group was a deep dive into vehicle accidents in July 2023. No further monitoring on the recommendations made in the deep dive has been undertaken since. We were informed that the local Business meetings also report on vehicle accidents, but this was not evidenced during the review. The reporting functionality of the Fleetwave system is not used to its full capacity, which could provide datasets regarding trends / themes of accident repairs and potential scope for learning amongst the drivers for discussion at meetings.	The true extent of vehicle accidents, including number of accidents and costs of accidents is not sited at local level through to Board.	**Agreed Action:** Regular reporting of both DATIX and Fleetwave incidents will be incorporated into Local Business Meetings for discussions, analysis and subsequent actions to identify any themes and trends and to re-educate staff on the reporting of incidents, the detail of which will be shared at SOT through the AAA reports. The Quality Team will also provide advice on improving the reporting processes using Lean methodology within the Task & Finish Group (see Key Findings 1&2). **Expected Evidence of Implementation:** Triple A documentation from the meetings, including Action Logs, work programme and any communications to staff on the reporting of incidents. This will include the DATIX report submissions to Business Meetings.
		High Priority	**Officer:** Jonathan Sweet, Head of Service OD **Date:** June 2025
	Theme: Reporting	Control Operation	

Appendix A

Assurance Opinion

Substantial	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
Reasonable	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
Limited	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
Unsatisfactory	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
Advisory	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 Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Disclaimer

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

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The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

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 management of the Welsh Ambulance 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.

Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

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

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

Exposure to Fumes

Final Internal Audit Report

December 2024

Welsh Ambulance Services University NHS Trust

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

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

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Auditors:	Osian Lloyd, Head of Internal Audit; Felicity Quance, Deputy Head of Internal Audit; Ross Hughes, Principal Auditor
Executive sign-off:	Liam Williams, Executive Director of Quality & Nursing
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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.

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Executive Summary

Purpose

To evaluate the actions being taken by the Trust to ensure the health and wellbeing of staff exposed to fumes as a result of delays in handovers of care at hospital.

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- Guidance needs to be updated to inform employees that the shoreline can be re-started once it cuts off.
- There is no work programme in place for the cyclical completion of Risk Assessments at Emergency Departments, which are expected to be undertaken in partnership with Trade Unions.
- Unannounced spot checks identified that staff are not complying with guidance set to prevent their exposure to fumes
- Work is ongoing to enhance data collation in respect of fume exposure, via Data Vault.
- Health & Safety Committee meetings have been cancelled due to timeliness of papers being issued.

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

Report Opinion

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

Assurance summary[1]

Objectives		Assurance
1	Guidance documents	Reasonable
2	Monitoring and managing compliance with the Workplace Exposure Limits.	Reasonable
3	Reporting of emissions and their impact	Reasonable

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Update guidance on the use of shorelines	2	Operation	Medium
2	Risk assessment work programme	2	Operation	Medium
3	Non-compliance with guidance	2	Operation	Medium
4	Enhancing data collation via Data Vault	2	Design	Medium
5	Timeliness of Health & Safety Committee papers	3	Operation	Medium

1. Introduction

1.1 Under Section 7 of the Health and Safety at Work Act 1974, employees have a duty to take reasonable care for the health and safety of themselves and others who may be affected by their acts or omissions whilst at work. This extends to co-operating to enable the employer to fulfil its legal duty to protect workers from exposure to hazardous substances, and to comply with the Control of Substances Hazardous to Health Regulations 2022 (COSHH)

1.2 Short term exposure to diesel exhaust fumes can cause coughing, and irritation of the eyes, nose, throat and respiratory tract. Long tern exposure may lead to serious health effects, including increasing the risk for lung cancer. Workplace Exposure Limits (EH40/2005), as defined by the Health & Safety Executive indicates the following limits for fumes along with the British occupational exposure limits for combustion gases (which is the reference used by the Trust):

Substance	Long term exposure limit (8-hour reference period)	Short term exposure limit (15-minute reference period)
Carbon Monoxide	23 mg.m^3	117 mg.m^3
Carbon Dioxide	9,150 mg.m^3	27,400 mg.m^3
Nitrogen Dioxide	0.96 mg.m^3	1.91 mg.m^3
Nitrogen Monoxide	2.5 mg.m^3	-

1.3 As a result of long delays being incurred in the transfer of care of patients between the Trust and Health Boards, and staff running the engines of ambulances outside Emergency Departments, there is increased reporting of incidents relating to diesel fumes exposure within the Trust. During quarter 3 (2023/24) such had increased by 7% with 47 incidents recorded. There has been a decrease those reported for 2024/25 with 29 incidents being reported between April and October.

1.4 The Trust's Health & Safety department has been working with Occupational Health team, Operational Managers, Trade Unions, the Fleet department and health boards to identify short and long-term solutions to the exposure being sustained, which are compounded by handover delays due to wider system pressures, including a requirement to complete fume risk assessments.

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

- Non-compliance with Health & Safety Executive, and other legislative requirements;
- Reputational risk by failing to address concerns / safety issues raised by Trust staff, health board staff and patients, which could lead to them coming to harm due to exposure to fumes; and
- The Board may not be aware of serious concerns relating to impact of exposure to fumes across hospital sites.

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	-	5	-	5
Total	-	7	-	7

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

Objective 1: There is clear and documented guidance in place for limiting staff exposure to fumes.

2.3 As we would expect, there is no standalone policy outlining the Trust and staff's roles and responsibilities towards limiting exposure to diesel fumes, as this should not occur given the target time to handover a patient from the an ambulance to hospital is fifteen minutes. However, the Trust's Health and Safety Policy does make reference to substances covered within the scope of the Control of Substances Hazardous to Health (COSHH) 2002 (as per para 1.1).

2.4 The Quality, Safety and Patient Experience (QSPE) Directorate have recently issued two Safety Notices (via email and also accessible on SharePoint) which are associated with diesel fumes:

- Diesel Fumes: Staff control measures whilst outside Emergency Departments (EDs): issued January 2024. The notice outlines the work that has been undertaken by the Trust to establish the risk presented by diesel fumes and the means of mitigating the risk associated with it; as well as setting out the personal responsibilities and actions required of staff, including how to use a shoreline connection.
- Air Purifiers Onboard Vehicles: issued May 2024. The notice outlines that the Trust has installed two air purifying units (AirBubble38i) on all its Emergency Medical Service (EMS) ambulance fleet (see para 2.23).

2.5 The Health and Safety Siren page also has a specific section in relation to diesel fumes, which sets out the precautions to take to limit exposure. It also provides details of the risk assessments (see para 2.8) undertaken at EDs across NHS Wales for 2022/23 and 2023/24. However, there are opportunities to strengthen the Siren page to capture the mitigating actions the Trust has put in place and the mechanisms to manage and monitor compliance (see ***objective 2***).

Conclusion:

2.6 The Health and Safety policy includes references to substances covered within the scope of COSHH with a link to further guidance. There is reference, on Siren, to the precautions to limit exposure to diesel fumes; and recent guidance has been issued to further support employees to limit their exposure whilst awaiting patient offload outside EDs. However, there are opportunities to strengthen the Siren page. Noting this, **reasonable** assurance has been determined.

Objective 2: Mechanisms are in place to monitor and manage compliance with the Workplace Exposure Limits, with appropriate mitigating actions identified where applicable.

2.7 A number of activities have been taken to review the concentration of fumes outside EDs, to lower the risk of exposure for Trust and Health Board employees as well as the general public, including:

- Risk Assessments.
- Environmental testing.
- Installation of shorelines.
- Installation of air purifiers; and
- Spot checks and Quality & Support Days.

Risk Assessments

2.8 Since 2022/23, the Trust's Health & Safety team have been undertaking risk assessments to assess the significant hazard presented by exposure to diesel engine exhaust emissions (DEEE) (as indicated by visible soot build up and odour). Each site will be allocated a risk score, scored on a five x five matrix against severity and likelihood (max risk score 25). (See Table 1 below)

Table 1: Emergency Department Risk Ratings per most recent Risk Assessments

Hospital Emergency Department	Current Risk Level to Trust Employees	Expected Risk Level to Trust Employees with Additional Controls
2024/25		
Bronglais	4	2
The Grange	4	2
Princess of Wales	4	4
Prince Charles	4	4
Glan Clwyd	4	2
Glangwili	4	2
Prince Phillip	4	2
Royal Glamorgan	4	4
Withybush	4	2
Wrexham Maelor	4	2
Ysbyty Gwynedd	4	2
2022/23		
Morriston	9	6

Hospital Emergency Department	Current Risk Level to Trust Employees	Expected Risk Level to Trust Employees with Additional Controls
Royal Gwent	3	No further controls noted on risk assessment
University Hospital Wales	9	6
University Hospital Llandough	3	3
Singleton	Not evidenced	

2.9 A remedial action plan is included within the risk assessment, tailored to the specific site, to help lower the DEEE within the area reviewed (see para 2.34).

2.10 We did not evidence a schedule in place to ensure that all EDs are risk assessed on a regular basis. Based on the risk assessments undertaken it was noted that the following five EDs have not been assessed since the original assessment in 2022 – Singleton, Royal Gwent, University Hospital Llandough, Morriston and University Hospital Wales; for which the latter two had a risk score of 9. **(See Matter Arising 2)**

2.11 On review of the 2022/23 risk assessments, it was noted only two of the 15 were undertaken in partnership with the Trade Unions. None of the risk assessment forms for 2023/24 or 2024/25 captured that a Trade Union partner was present. (**See Matter Arising 2)**

Environmental Testing

2.12 In addition to the risk assessments, in March 2024 the Trust procured the services of SOCOTEC UK Ltd, to conduct environmental testing outside EDs to monitor the 'Respirable Elemental Carbon and Combustion Gases (CO2, CO, NO2 and NO)' over a 24hr period within the ambulance bays. Seven sites are to be monitored as part of this contract and, at audit fieldwork completion, only one had yet to be completed (Glangwili Hospital Emergency Department).

2.13 During the course of audit fieldwork, we observed a monitoring visit undertaken at Morriston (10 September 2024). Through discussion, and review of the SOCOTEC report, we understand that there is currently no workplace exposure limits for elemental carbon in the UK. However, the Association for German Studies has set an occupation exposure limit of 0.05 mg.m-3 for the respirable fraction. It is this level that is being used as a guide for testing, but note that it isn't a legally binding limit in the UK.

2.14 The monitoring consists of both static monitoring on the ambulance bay central pillars and personal monitoring on Trust personnel (usually paramedic and health and safety officer assisting in the testing), to measure the carbon levels in the area over the 24-hour period (noting personnel monitors are for as long as they are stationed in the bay awaiting off-loading, or for an 8-hour period). A report is then produced to capture the results along with any recommendations identified, and these are presented to the Health & Safety Committee (for further details on reporting, see ***objective* 3**)

2.15 So far, the testing by SOCOTEC has concluded that all 'Respirable Elemental Carbon and Combustion Gases' are below the monitoring thresholds at the sites

visited, with the exception of three personal monitors showing a result exceeding the 0.05mg, with clearly stated explanations for the possible increased levels recorded.

Shoreline Cables and Use

2.16 In consultation with the health boards, the Trust began installing shoreline cables outside Emergency Departments in 2022. The cable allows emergency vehicles to be connected to the mains power outlet, reducing the need for the ignition to be on and therefore lowering diesel fumes being emitted from the vehicle.

2.17 Whilst guidance has been issued on the use of shorelines (see para 2.4) we have been advised that concerns have been raised as the shoreline switches off after a short period of time (15 minutes), therefore not maintaining the use of the onboard heater (the dual heaters provide air conditioning during warmer conditions). This has led to engines being left running to keep the heater on. We were advised by the Health and Safety Team that there is a way to override this, however we note that no formal communication of such has been issued to Trust employees **(Matter Arising 1)**.

Data Vault

2.18 In recognition of the data that has been collated in recent years regarding diesel fumes, the Trust are in the process of creating a central repository (data vault) for such. Information to be collated will include, time spent by staff outside ED awaiting offload, how many vehicles are there during the wait, time spent by staff on breaks, time spent by staff in depot. (**See Matter Arising 4)**

Quality & Support Days / Spot Checks

2.19 From December 2023 the Trust introduced Quality & Support days. These consist of the EMS & Ambulance Care Management Teams locating themselves across hospitals, ambulance stations, renal units and other Trust locations to complete reviews of observed practice covering vehicle and equipment condition, PPE and uniform requirements, the safe use of equipment. As the coverage has evolved, included in the review is also whether shorelines are being utilised when awaiting handover:

Table 2: Shoreline usage by vehicles when available

Month	Yes	No	N/A (No shoreline available due to the number of vehicles already in waiting in the ambulance bay)
February 2024	105	6	45
March 2024	169	10	96
April 2024	158	18	144
June 2024	30	3	26
July 2024	128	11	122
August 2024	86	8	95
September 2024	64	7	102

2.20 In addition, the Health & Safety Team undertake unannounced inspections, to ensure staff are compliant with the shoreline guidance and individual guidance.

2.21 From April 2024 to June 2024, 23 inspections were undertaken with the following issues reported:

- 74% of available shorelines were not being utilised;
- Additionally, staff were frequently observed congregating behind vehicles – the position of which is directly related to the vehicle engine exhaust;
- Over 20% of the audits highlighted that crews were not complying with any control measures;

It was noted that shoreline compliance reported during un-announced visits was significantly lower than during pre-announced Quality & Support days.

2.22 To address these issues, with effect from June 2024, Education & Development included diesel fume management around shoreline and vehicle heater within all new driver induction programmes. These require sign off by inductees and Education & Development staff. **(See Matter Arising 3)**

Equipment Trials

2.23 The Trust has installed air purifying units (AirBubble38i) into all its EMS ambulance fleet. The units have HEPA (high-efficiency particulate absorbing) and VOC (volatile organic compounds) filters and are designed to remove 99%+ of particles from the air. Whilst there is primarily a clinical need for these units (i.e. IPC control measures), there are other benefits to staff and patients as other airborne particles, including some diesel fumes, are also filtered which aid in mitigating against other issues.

2.24 The Trust is also trialling the use of other equipment to reduce diesel fume exposure:

- Electric (Dyson) Heaters: to lower the emissions of fumes from the onboard heaters, the Trust is looking to trial these heaters in EMS vehicles for a one-week period (in October 2024) at the Grange University Hospital ED.
- Local Exhaust Ventilation (LEV) System: designed to reduce employee's exposure to airborne contaminants, such as fumes in the workplace, by capturing the emission at source and transporting it to a safe emission point or to a filter/scrubber.

2.25 On conclusion of the heater trial, the Trust is looking to undertake a trial for a LEV system, from both vehicle exhaust and heater exhaust vents, for a two-week period, again at the Grange University Hospital ED.

2.26 The Trust will compare the results of these trails to determine which option will be best suited to the Trust, noting that the introduction of the heaters will be more cost effective than the LEV system.

Conclusion:

2.27 The Trust has put in place a number of mechanisms and controls to help lower its employee's exposure to diesel fumes; including environmental testing and are continuing to seek new initiatives to limit employee exposure to fumes. Unannounced spot checks are undertaken to confirm adherence to such, but this has highlighted staff non-compliance. There is no formal risk assessment schedule in place with some high-risk scoring EDs not having been reviewed since 2022. Further, work needs to progress with the establishment of a data vault to enable a central repository for all fume related information. Noting this, we have determined **reasonable** assurance for this objective.

Objective 3: Reporting of emissions, and their impact, is undertaken with issues escalated as appropriate.

2.28 There is a defined reporting framework in place for the reporting of emissions:

Fume Mitigation Task & Finish Group

2.29 The pan-Wales Fume Mitigation Task & Finish Group was established in September 2024, which we understand replaces the previous working groups that were in place for each health board. At the date of reporting, two meetings had been held (September & October 2024). A highlight report has been produced from the October meeting and is to be issued to the next Executive Leadership Team, prior to being presented at the next Health & Safety committee.

Health & Safety Committee (H&SC)

2.30 The main reporting group for diesel fume exposure is the national Health & Safety Committee. Whilst we have been provided with either agendas, papers, minutes and / or action logs from five meetings held between February 2023 to May 2024, eight meetings should have been held during this period. Summary reports (including results from the static testing) were presented and remedial action plan updates and review of the minutes for each meeting noted in-depth discussions around the issues associated with DEEE.

2.31 During discussions with the Trade Union Representative, it was noted that some H&SC meetings were cancelled due to a timeliness issue in getting the Committee papers out to attendees in sufficient enough time for them to read, review and discuss the papers with colleagues prior to the meeting. **(See Matter Arising 5)**

Welsh Ambulance Service Partnership Team (WASPT)

2.32 WASPT is a forum which is attended by both Trust senior management, including the Chief Executive, Board Secretary and Trust directors, and representatives from the Trade Union Partners, GMB, UNITE, UNISON and the RCN, to discuss any issues or concerns within the Trust. From review of the papers for the eight meetings held during the period April 2023 – September 2024, diesel fume exposure has been a key topic of discussion.

2.33 Further, to facilitate transparency between the Trust and the Trade Unions, in December 2023, a report was issued to WASPT consolidating the results of the

third-party static testing undertaken at all ED locations between April 2022 – March 2023. Results were also noted for the two occasions where Elemental Carbon exceed the EU limit during personal testing, with explanations provided by the third party highlighting that these were due to guidance not being followed.

2.34 A report was also issued to the December meeting detailing the remedial actions raised during the Trust Risk Assessments. This highlighted the status of all 87 actions; of which, at the date of audit fieldwork, 68 were closed and 19 were in progress.

2.35 An AAA (Alert, Advise, Assure) report is prepared for each WASPT meeting and included in the papers for the People and Culture Committee.

Executive Leadership Team (ELT)

2.36 The Executive Team are updated on the issues related to Diesel Fumes and the work being undertaken within the Trust to lower the risk associated with the issue. Two reports have been presented to ELT since the start of the financial year (July and September), which detail the work being undertaken to lower DEEE, results from static monitoring and unannounced spot checks, updates on the actions within the remedial action plans, and potential new initiatives including the costings.

People & Culture Committee (PCC)

2.37 A review of the PCC papers between May 2023 – August 2024 (six meetings) identified that there has been coverage of diesel fume exposure at all meetings – through both the WASPT and Health & Safety Committee updates.

2.38 A review of the minutes for May 2024 identified that an in-depth discussion around the issue with DEEE was held, focusing on the concerns raised by staff around diesel fumes and the work being undertaken to limit the risk being presented to staff. The minutes state that the Chair has '*confidence that the Trust were sighted of the issues with diesel fumes and that the Committee will continue to monitor the position via the Health & Safety updates and H&SC AAA reports'*.

2.39 We note that information on diesel fumes is reported to Trust Board via highlight reports from WASPT and PCC. The Health and Safety annual report issued to July Board meeting noted the ongoing work undertaken by the Trust to lower potential exposure to diesel fumes.

Conclusion:

2.40 The Trust has a clear reporting framework to be regularly sighted on the issues related to diesel fumes. In addition, the Health & Safety Team have recently set up a pan-Wales Fume Mitigation Task & Finish Group. It was noted that the papers for the Health & Safety Committee are not routinely issued in a timely manner and has resulted in some meetings being cancelled by the Trade Unions. Accordingly, we assign **reasonable** assurance for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Update guidance on the use of shorelines (Operation)			Impact
During the course of fieldwork, we were informed that some of the shorelines trip the on-board heaters after a 15-minute period. This has led to engines being left running to keep the heaters on. We were advised by the Health and Safety Team that there is a way to override this issue (turn on the ignition and press the climate button in the Genisys system). However, there is no evidence of this being shared and communicated with the relevant users.			Potential risk of: • Trust employees increasing the risk of exposure to fumes
Recommendations			**Priority**
1.1	The Trust should formally communicate to staff that the manner by which the diesel heaters can be re-started should the shoreline trip.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	The Trust has undertaken previous communications to inform staff of this issue. Further action will be taken to seek systematic improvement and will ensure that clear guidance on restarting diesel heaters after shoreline trips is communicated cross all relevant staff to promote operational safety and efficiency. A review of former safety notices will be undertaken, and a further formal safety notice will be issued to relevant staff groups. Training has been reviewed: information on shoreline use is now included in induction training and Trust driving courses for new entrants and staff moving into EMS from Ambulance Care too.	December 2024 Completed	Nicola White, Head of Health & Safety Jo Kelso, Head of Workforce Education & Development

	Information will be provided in the 5-yearly High Speed Driving Assessment from FY 2025/26. Information will also be produced through the Workforce Education & Development Learn365 platform on the use of shorelines to ensure the topic is incorporated in training and education sessions.	Completed March 2025	Jo Kelso, Head of Workforce Education & Development Nicola White, Head of Health & Safety

Matter Arising 2: Risk assessment work programme (Operation)	Impact
There is currently no schedule in place to ensure that all EDs are risk assessed on a regular basis. Based on the risk assessments undertaken, it was noted that the following five EDs have not been re-assessed since 2022 – Singleton, Morriston, Royal Gwent, University Hospital Wales and University Hospital Llandough. It was also noted that Risk Assessments had been reported as being undertaken in partnership with the Trade Unions. On review of the risk assessments that have been undertaken between 2022 – 2024, only two of the assessments highlight that a Trade Union Partner was present.	Potential risk of: • The Trust not seen to be demonstrating transparency.

Recommendations		Priority
2.1	The Trust should have a risk assessment work programme in place to ensure that all EDs are risk assessed on a regular basis.	**Medium**
2.2	For transparency, and good practice, the Trust should invite Trade Union Partners to attend when undertaking the onsite ED Risk Assessments.	

Agreed Management Action		Target Date	Responsible Officer
2.1	The Trust is committed to reviewing sites as per the frequency deemed appropriate following risk assessment undertaken by a Health & Safety professional. Following introduction of additional control measures for Winter 2024, the Trust will develop a work programme for risk assessment review for all EDs ensuring assessments are conducted annually.	January 2024	Nicola White, Head of Health & Safety

2.2	Scheduled dates for the assessments (as per 2.1) will be made available for Trade Union Partners to attend ED risk assessments ensuring transparent and collaborative practices.	January 2025	Nicola White, Head of Health & Safety

Matter Arising 3: Non-compliance with guidance (Operation)	Impact
From April 2024 to June 2024, 23 unannounced inspections were undertaken at EDs to assess whether staff were complying with Trust guidance. The following issues were reported: • 74% of available shorelines were not being utilised; • Over 20% of the audits highlighted that crews were not complying with any control measures; and • Staff were frequently observed congregating behind vehicles – the position of which is directly related to the vehicle engine exhaust. It was noted that shoreline compliance reported during unannounced visits was significantly lower than during pre-announced Quality & Support days.	Potential risk of: • Trust employees increasing the risk of exposure to fumes

Recommendations		Priority
3.1	The Trust need to reiterate to staff the importance to following guidance to ensure their safety and lower their exposure to diesel fumes.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
3.1	Mandatory safety notice to be distributed to all operational staff on the updated controls for fume mitigation and the importance of implementing them during delays at EDs, along with evidence that it has been read and understood. The action will be presented at SOT (Senior Operations Team) and a feedback mechanism will be discussed and created to monitor the situation.	January 2025	Nicola White, Head of Health & Safety Sonia Thompson, Assistant Director of Operations (EMS)

Matter Arising 4: Enhancing data collation via Data Vault (Design)			Impact
In recognition of the data that has been collated in recent years regarding diesel fumes, the Trust are in the process of creating a central repository (data vault) for such. The intention is to track Trust where paramedics are positioned during their shifts to capture the time they spend within EDs where fume build up is at its highest. Information to be collated will include time spent by staff outside ED awaiting offload, how many vehicles are there during the wait, time spent by staff on breaks, time spent by staff in depot etc.			Potential risk of: • Lack of transparency in data maintained for fume exposure.
Recommendations			**Priority**
4.1	The development of the data vault should be completed to ensure the relevant data is recorded from the earliest possible stage.		**Medium**
4.2	To ensure completeness of such, the Trust should ensure that the systems currently used are designed to routinely capture the information required.		
Agreed Management Action		**Target Date**	**Responsible Officer**
4.1	The Trust has completed the data vault to capture accurate and comprehensive data on potential incidents where fume exposure could have occurred, ensuring transparency and informed decision making. Now the digital architecture is complete, further development is required to capture broader data sources (e.g. risk assessments). The Trust will finalise the development of the data vault system to centralise and track staff exposure data effectively.	March 2025	Aled Williams, Assistant Director Digital
4.2	Where possible, any relevant data source will be automated for transfer into the Data Vault.	As above	Nicola White, Head of Health & Safety

Matter Arising 5: Timeliness of Health & Safety Committee papers (Operation)			Impact
The main reporting group for diesel fume exposure is the national Health & Safety Committee. Whilst we have been provided with either agendas, papers, minutes and / or action logs from five meetings held between February 2023 to May 2024, eight meetings should have been held during this period. Through discussion with the Trade Union Partner Representative, it was noted that the papers for the National Health & Safety Committee were not issued to them in a timely manner. Such has meant the Trade Union members did not have sufficient time to read, review and discuss the papers prior to the meeting. This has also resulted in meetings being cancelled.			Potential risk of: • Issues with fume exposure not being identified or escalated to Trust Board.
Recommendations			**Priority**
5.1	The designated deadline to issue Health & Safety Committee papers, prior to the meeting date, should be adhered to. This will allow the Trade Unions to have sufficient time to review and discuss key matters within the papers and avoid meetings being cancelled.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
5.1	The Trust has reviewed the Committee terms of reference and undertaken an organisational development workshop with Committee members. Going forward, there will be enforced adherence to deadlines for issuing Health & Safety Committee papers to ensure timely review by Trade Union members preventing meeting cancellations.	January 2025	Nicola White, Head of Health & Safety

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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Patient Experience & Community Involvement

Final Internal Audit Report

November 2024

Welsh Ambulance Services University NHS Trust

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

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

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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

Purpose

To provide assurance on compliance with the Health and Social Care Quality Engagement Act and alignment with the Trust's IMTP.

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- Enhancement of expected activity to be undertaken by the PECI Team;
- Regular review of survey questions posed to ensure relevancy and provision of meaningful feedback for service providers;
- Enhancement of the detail included in the log of public engagements; and
- Enhancement to reporting on the impact and outcomes that engagement activities has had on service delivery.

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

Report Opinion

		Trend
Reasonable	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.	N/A

Assurance summary[1]

Objectives		Assurance
1	Framework for public engagement practice	Reasonable
2	Output from public engagement activities	Reasonable
3	Reporting and monitoring of progress and outcomes	Reasonable

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Enhancement of expected PECI Team activity	1	Design	Medium
2	Enhancements required to the public engagements log	2	Design	Medium
3	Regular review of survey questions and responses	2	Operation	Medium
4	Reporting of impact and outcomes of improvements to service provision	3	Design	Medium

1. Introduction

1.1 Effective service user, carer and public engagement is vital in helping develop more effective services that better meet patients' needs, with higher quality user experience, greater community support, improved staff morale, and higher levels of productivity and efficiency. Welsh Government guidance on public engagement and consultation requires health bodies and trusts to have in place arrangements for continuous engagement with the public through which most significant service change plans will be shared. NHS bodies are expected to monitor quality and safety at board level and throughout the entirety of services, partnerships, and care settings.

1.2 The Welsh Ambulance Services University NHS Trust (the Trust) captures and reports the experience of patients and their families directly using the Trust's continuous engagement model and various channels for experience feedback. Although there is a subjective nature to this indicator of quality, experiences and feedback are essential components for monitoring and serving as quality indicators, as outlined in the Health and Social Care (Quality and Engagement) (Wales) Act.

1.3 Patient experience at the Trust is influenced by the many interactions people have with its staff, their expectations when in need, and their first and lasting impressions of those interactions.

1.4 Management of this patient experience is through the Patient Experience and Community Involvement (PECI) Team, which sits within the Quality, Safety & Patient Experience (QSPE) Directorate; and we note the recognition received for their work in this area. Most recently, being named as 2024 finalists in the Patient Experience Network National Awards (PENNA) within the following categories:

- Engagement/Championing the Public – for work on improving the experiences of people with learning disabilities.
- Innovative use of technology/social and digital media – for work with children and young people in developing the blue light app based on evidence-based research, using technology and digital solutions to engagement.
- Partnership Working to improve the Experience – for promoting work undertaken across all health, social care, business and voluntary sectors to reach, engage and improve experiences of communities across Wales.

1.5 The risks considered during the course of this review included the Trust failing to implement an effective and continuous approach to engagement; and non-compliance with legislation and guidance on public consultation.

2. Detailed Audit Findings

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

	Recommendation Priority			
	High	Medium	Low	Total
Control Design	-	3	-	3
Operating Effectiveness	-	3	-	3
Total	-	6	-	6

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

Objective 1: The Trust has a framework in place which sets out the approach to ensuring the application of good and effective public engagement practice, and in accordance with the Act.

2.3 The responsibility for formal engagement and public consultation within the Trust sits with the Partnerships and Engagement Directorate, and the PECI Team has an important role to support and contribute to this work.

2.4 The Trust's Engagement Framework was approved by Board in July 2022. This is being supported through the Engagement Framework Delivery Plan which was presented to Board in January 2023; and sets out, at high level, the proposed phases of engagement and potential consultation required with stakeholders, staff and the public.

2.5 The Plan provides detail as to the phasing in of proposed engagement, spanning an indicative period of two years, linked to the Trust's vision of altering its traditional service model and how it will manage demand differently. The model is reliant on engagement with the public and partners to develop a model where more patients are referred to other services, e.g. pharmacies, or are treated in their home, by an advanced paramedic or the Falls Service.

2.6 At the conclusion of our fieldwork, we were advised that this document has recently been recast as the Programme Engagement Plan supporting the Trust's Clinical Model Transformation (CMT) programme. We understand that while in essence the tenets of the plan remain the same, the revised version provides further detail and messaging and has been shared with the Citizen Voice Body for Health and Social Care (Llais) at a national level. We note that the plan was submitted for approval to the September meeting of the CMT Board, with the minutes noting some areas for refinement; and we note that delivery and implementation of such will be monitored at the CMT Board.

2.7 The National Health Service (Wales) Act 2006 requires Local Health Boards and NHS Trusts, with regard to services they provide or procure, to involve and consult citizens. The Delivery Plan outlines the Trust's approach to ensuring there is a

shared understanding of issues and gain public support for, and input into, options for change as:

- To begin a dialogue with the public/interest/patient groups on future direction of travel/provision of services.
- To ensure public is aware of challenges, reasons for them, what has been done to-date to tackle them and why more of the same is no longer sustainable; and
- To gain support for the development of options.

2.8 The Plan does not outline the details of its approach to public engagement, but we note that this is in the early stages of being reviewed for update (see para 2.6), recognising that engagement is phased across stakeholders (with the public not being in the first phase).

2.9 We were able to evidence a significant level of engagement activity that has informed the development of the Trust's IMTP 2024-27 (refer to ***audit objective* 2**), and we note that the QSPE Directorate's Local Delivery Plan sets out a range of objectives for the PECI Team on their wider delivery linked to the IMTP. Whilst the PECI Team have a schedule of activity in place, we understand that they were set an objective to better define population understanding through the lens of economic status, geography, ethnicity and age, however there was no evidence of this (see **Matter Arising 1**). Activity defined should formally capture areas such as:

- The geographical coverage.
- The targeted level of survey responses and characteristics.
- The services being surveyed; and
- The feedback mechanism.

2.10 Government guidance, following the establishment of Llais, requires sustained and continuing engagement with citizens, Llais and staff, as well as partners, on a routine basis. The engagement should give people and organisations the opportunity to understand the NHS body's aspirations and achievements and the challenges it faces so they can influence and inform decisions about service changes.

2.11 Therefore, it is important for WAST to demonstrate that it has been listening and taking appropriate action on the feedback it receives. The guidance states that NHS bodies should undertake stakeholder mapping to help identify stakeholders and those who can help the NHS engagement with them. Such is evidenced within the identified phases of the Delivery Plan.

Conclusion:

2.12 The Trust's Engagement Framework and supporting Delivery Plan (which has recently evolved to a Public Engagement Plan to support the Clinical Model Transformation programme) set out the principles for public engagement with service change proposals for which the responsibility sits with the Partnerships and

Engagement Directorate, with input from the PECI Team. The QSPE Directorate's LDP set out a range of objectives for the PECI Team on their wider delivery; however, there is a need to better define and coordinate its activities. Therefore, we have provided **reasonable** assurance for this objective.

Objective 2: Experiences and feedback received from public engagement activities are considered to inform service change.

2.13 Service changes arise from a wide variety of sources and may be incorporated into Trust delivery plans as individual IMTP deliverables, or as part of a broader transformation programme. The Transformation Support Office support the strategic transformation agenda across the organisation.

2.14 As per para 2.9, the PECI Team has a schedule in place to capture public engagement activity. However, this was not explicitly evidenced as linked to planned service transformation, within the Trust, indicating there is a lack of a systematic approach to engaging with operational services to enable a more defined approach to their patient experience and community involvement work. PECI are not always aware of the service changes that require engagement, and would drive their activity, which should be based on an assessment of the scale, scope and impact of the proposed service change against set criteria (see **Matter Arising 1**).

2.15 The PECI Team logs all public engagements undertaken onto the CIVICA database. As at the date of fieldwork, since January 2024, 147 events had been recorded. Included in the information recorded is the detail of the PECI Team member who attended the event, the number of people engaged with; and the learning outcomes taken from the event, the themes of which will be discussed at Quality Management Group for onward consideration at Service quality groups, if applicable. However, we note that no details are recorded on the database for questions asked (and by whom), the key actions following the event; and whether, once action has been taken has such been communicated to the member of the public. (see **Matter Arising 2**).

2.16 A review of the events attended found that the geographic spread of these events was not consistent (ref para 2.7). The PECI Team acknowledge this location disparity and are taking steps to address it (see **Matter Arising 2**).

2.17 We do, however, recognise where action has been taken as a result of the engagement activities. For example,

- The development of a 'blue light app' for children which helps them understand the services offered by the Trust and how to engage with its services.
- Engagement with the Learning Needs community to understand the accommodations and adjustments that would be needed when attending a patient with additional needs. This has resulted in the development of a new ePCR tab, live from 1 October, providing prompts to responders to ensure better support for Autistic, Learning Disability and Neurodiverse patients across Wales.

- Reminiscence Interactive Therapy Activity (RITA) recognising the patient feedback and safety concerns for patients living with dementia, as well as those with sensory loss, and how important the environment is for them when receiving ambulance care. The Trust has received several awards for its work in this area.

2.18 Further, the team use patient stories to work with patients, their families and their carers to share their experiences through videos and case studies. These allow readers to experience the frustration and obstacles faced by patients or their carers and are used to inform Trust Board, train staff and implement service change.

2.19 The PECI Team also undertakes four core surveys that are constantly available to the public on its website:

- 999 EMS - Experience Survey (*October 2023 – March 2024: 69 responses).*
- NHS 111 Telephony service – Experience Survey (*October 2023 – March 2024: 100 responses).*
- NHS 111 Website – Experience Survey (*October 2023 – March 2024: 228 responses).*
- Non-Emergency Patient Transport Service (NEPTS) – Experience Survey (*October 2023 – March 2024: 702 responses).*

2.20 As reported in the PECI bi-annual report to the Quality, Patient Experience and Safety (QuEST) committee (May 2024), the volume of responses (as per para 2.16) was an area which needed to be addressed to ensure that analysis of responses was meaningful (see **Matter Arising 3**). We understand that the PECI Team is in the process of submitting a Data Protection Impact Assessment (DPIA) to the Information Commissioner's Office, post engagement with the Trust Public Network to demonstrate engagement with the affected stakeholders, with the objective being to permit users of the service to be sent a text message inviting them to a survey.

2.21 As well as recognising the importance of increasing the response rate to surveys to shape the future delivery of WAST services; there is a need for the questions included to be reviewed to ensure they remain relevant to allow the responses to provide meaningful feedback to those delivering the services (see **Matter Arising 3**). We were only able to ascertain survey questions having been reviewed by one service (the 999 clinical contact centre).

2.22 Survey responses/feedback is reported to the Quality Management Group (meets weekly), and onward to QuEST yet we were not able to identify that services had formally responded where there is a suggestion that there is a need to address a weakness (see **Matter Arising 4**).

Conclusion:

2.23 There is a process for the analysis, assessment and reporting of engagement responses, which has led to service change, but further enhancements are required to review the integrity of the content of surveys as well as to complete the feedback loop. Whilst acknowledging the extent of engagement that is undertaken, there is

no systematic approach to planning engagement based on known transformation projects. Therefore, we have therefore provided **reasonable** assurance for this objective.

Objective 3: Committees and Board oversee the overall approach to public engagement, and the progress and outcomes of the service development activities.

2.24 The Quality Management Group (QMG) is a weekly quality group chaired by the Assistant Director of Quality Governance, and reports into the Clinical & Quality Governance Group. The QMG's role is to '*ascertain the performance of the Trust across the quality domains and enablers, as set out in the Statutory Guidance and Quality Standards 2023, utilising expertise to assess, assure and inform stakeholders of organisational performance'*. As stated in the QMG terms of reference, one of its duties is to *listen to, and act upon, the experience of services with communities and service users, so that services are designed to meet the needs of the citizens that the Trust serves.*

2.25 Review of the agendas for the QMG notes the standing agenda item for Citizen Voice and Patient Experience. Further, review of the AAA (Alert, Advise and Assure) reports prepared post the QMG meetings notes the detail of the updates that have been provided regarding actions taken post receipt of patient feedback/experience.

2.26 Reporting is also undertaken to the QuEST committee through the bi-annual report produced by the PECI team. The last report, presented to the May 2024 meeting, covered the period October 2023 to March 2024. The report sets out the key themes arising from feedback during the period as well as the focus of the team's work programme for the same period.

2.27 Assurance on the activities of the PECI Team have also been provided to Trust Board through the AAA report. However, we noted there is minimal reporting on the impact the engagement activities have had, where applicable, on improvements to service delivery. See **Matter Arising 4**

2.28 The first Duty of Quality Annual Report was issued in July 2024 for 2023/24. This has been shared in the public domain and provides information setting out the quality of services provided by the Trust; and the systems in place to identify and implement improvements. There is a section included on '*Listening to our citizens'* setting out the work undertaken in the year.

Conclusion:

2.29 An appropriate reporting framework is in place to detail the public engagement that has been undertaken; with external reporting to the wider population and stakeholders through the Duty of Quality Annual Report. Further work is required to strengthen the reporting on the impact and outcomes that engagement activities have had on service delivery. Noting this, we have provided **reasonable** assurance for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Enhancement of expected PECI Team activity (Design)	Impact
Government guidance states that NHS bodies should undertake stakeholder mapping to help identify stakeholders and those who can help the NHS engagement with them. Such is evidenced within the identified phases of the Trust's Delivery Plan however it doesn't outline the details of its approach to public engagement. Whilst we were able to evidence a significant level of engagement activities, and also understand that the PECI Team were set an objective to better define population understanding through the lens of economic status, geography, ethnicity and age, however there was no evidence of this. Activity defined should formally capture areas such as: • The geographic coverage. • The targeted level of survey responses and characteristics. • The services being surveyed; and • The feedback mechanism. Further, the schedule of activity was not explicitly evidenced as linked to planned service transformation within the Trust, indicating there is a lack of a systematic approach to engaging with operational services to enable a more defined approach to their public engagement and community involvement.	Potential risk of: • Unrepresentative feedback. • Lack of buy-in from services. • Failure to communicate service change.

	Recommendations	Priority
1.1	The PECI team's work plan should be reviewed to better define and coordinate their activity.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
1.1	1. A Masterclass in the use and effectiveness of the PECI team intelligence and feedback to be undertaken with Trust ADLT in Q4 2024/25.	March 2025	Leanne Hawker, Head of Patient Experience and Community Involvement
	2. PECI team to continue ongoing input and liaison with regard the CMT Programme and Engagement Plan to ensure alignment and support to community conversations and involvement.	February 2025	
	3. PECI team to devise a proforma for directorates and quality improvement programmes/projects to request support and involvement to their scheme of work.	April 2025	
	4. PECI team to develop a population health-based approach to analysing interventions and involvement across Wales, enhancing reporting to inform where variation occurs and linking with Clinical and Quality teams to confirm how/where PECI team can support increased improvements in outcomes.	August 2025	

Matter Arising 2: Enhancements required to the public engagements log (Design)			**Impact**
A log of all public engagements is maintained by the PECI team. As at the date of audit fieldwork, 147 events had been logged since January 2023. The log records the PECI team member who attended, the number of people engaged with, and the learning outcomes taken from the event. However, it does not require the user to log what questions were asked and by whom, the key actions following the event and whether once action was taken was this fed back to the member of the public. A review of the events attended found that the geographic spread of these events was not consistent (see Matter Arising 1). We understand that the geographically spread was not as wide as the PECI team would have liked due to capacity constraints.			Potential risk of: • The Public do not receive feedback to their questions. • WAST cannot demonstrate its level of engagement with the public. • Feedback does not geographically reflect the whole of Wales.
Recommendations			**Priority**
2.1	The log of public engagements should be enhanced to identify what questions were asked, by whom, what action followed the event; and evidence of feedback provided to the originator of the question.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	The PECI reporting tool (engagement log) will be enhanced to offer the opportunity for individuals to have their personal details recorded to enable feedback on questions asked and offer feedback on actions taken as a result. A section will be included with link to evidence of email/correspondence sent in response to question/feedback.	December 2024	Leanne Hawker, Head of Patient Experience and Community Involvement

Matter Arising 3: Regular review of survey questions and responses (Operation)	Impact
It is recognised by the Trust that survey participation from the public needs to improve. Whilst the 999 service had the fewest number of survey feedback, 69 people between October 2023 and March 2024, the 111Wales survey was completed by 100 people in the same period. Survey responses to the 111Wales website were 228 people and for the NEPTS 702 surveys were completed. To be able to place more emphasis on the answers provided by survey responses it is important for the Team to continue their efforts to increase survey participation. As well as volumes another important aspect for surveys to play an important role in shaping the future delivery of WAST services it is important for the questions to be reviewed by operations, to ensure that the questions remain relevant and are that the responses are providing meaningful feedback to those delivering the services. We were only able to ascertain survey questions being reviewed by one service (the 999 call centre). Whilst survey and feedback is reported to the weekly Quality Management Group, and also to QUEST we were not able to identify that services formally respond to feedback where there is a suggestion that there is a need to address a weakness. Where improvements were identified and reported following feedback from the public, such as issues faced by users with learning difficulties accessing 999 services, the improvements to the service were led by the PECI team not the Service itself.	Potential risk of: • Survey feedback does not reflect the general view of service users. • Lack of buy in from operational services. • Failure to address operational weaknesses.

Recommendations		Priority
3.1	The Team should continue its work to increase survey responses to ensure there is significant level of response, to provide a level of assurance that responses reflect the views of the public.	**Medium**
3.2	Survey questions should be reviewed, at least annually, by Services and PECI, to ensure that the questions are still relevant and that the responses provide meaningful information for service providers, to identify any negative feedback which needs to be addressed.	
3.3	There should be a formal mechanism in place, to confirm that services have reviewed feedback and provide an update of the action taken, where applicable.	

Agreed Management Action		Target Date	Responsible Officer
3.1	1. A Data Protection Impact Assessment (DPIA) covering contacting 999 user by SMS Text message will be submitted to the Information Commissioner in November. The DPIA will identify and address risks and issues including what are the reasonable expectations of callers/patients to be contacted (this would be the first time in our Trust history that 999 callers would be contacted in this way), the lawful basis and opt-out process. A final public consultation on the proposal has been recommended; we will share details with the Trust's People & Community Network and invite feedback that will be included in the DPIA. The DPIA will be presented to IGSG in November before submission to the ICO. 2. Liaising with Fleet to explore use of QR Codes on vehicles to enable patients/families to access feedback surveys whilst waiting. 3. Liaising with PTR team the feasibility of including links to experiences surveys in all PTR touchpoints and correspondence.	December 2024 March 2025 March 2025	Leanne Hawker, Head of Patient Experience and Community Involvement
3.2	QMG will be the forum for annual review of survey questions. Terms of reference to be updated to include this requirement.	December 2024	Leanne Hawker, Head of Patient Experience and Community Involvement
3.3	QuEST will continue to receive assurance through QMG and other Trust groups that services have reviewed feedback and action has been taken, where applicable, as a result of PECI public engagement and involvement.	November 2024	Leanne Hawker, Head of Patient Experience and Community Involvement

Matter Arising 4: Reporting of impacts and outcomes of improvements to service provision (Design)	Impact
The bi-annual report from PECI includes details on the focus of their work programme as well as the key themes arising from feedback received for that period. Whilst assurances on the delivery of work is provided within the Trust, we noted there was minimal reporting undertaken in respect of the impact of this feedback / wider engagement activities has had in relation to service delivery, where applicable. There is scope to enhance the reporting within the CIVICA database (see Matter Arising 2) to collate the data to provide this feedback loop; as well as to enhance the reporting through Equality Impact Assessments.	Potential risk of: • The Trust not demonstrating the impact of engagement on service delivery.

Recommendations		Priority
4.1	Reporting should be enhanced to demonstrate the impact feedback and engagement activities have had on service provision.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
4.1	The CIVICA system hosts data around patient experience, developing a proposal form for engagement (see 1.1 above) will enable us to report enhanced impact from activities and demonstrate whether services are listening/acting on feedback.	April 2025	Leanne Hawker, Head of Patient Experience and Community Involvement

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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Rollout of Penthrox

Final Internal Audit Report

2024/25

Welsh Ambulance Services University NHS Trust

Reasonable Assurance

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Review Reference	WAS-2425-9
Fieldwork	December 2024 – January 2025
Executive Sign Off	21 February 2025
Audit Committee	6 March 2025
Executive Lead	Andy Swinburn, Director of Paramedicine
Audit Team	Osian Lloyd, Head of Internal Audit; Felicity Quance, Deputy Head of Internal Audit

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

Executive Summary

Purpose

To assess the impact of the rollout of Penthrox on patients and staff, following the recent announcement that it can be administered by ambulance crews and Community First Responders.

Overview

Penthrox is an inhaled analgesic designed for self-administration using a handheld device under supervision. It can be used in isolation or in conjunction with other analgesic options such as Paracetamol, Entonox and Morphine.

In May 2023, the use of Methoxyflurane (Penthrox) was introduced by the Welsh Ambulance Services University NHS Trust (the Trust) for Urgent Care Ambulance Care Assistants (ACA2s), Emergency Medical Technicians (EMTs), Paramedics and Community First Responders (CFRs), to administer for the emergency relief of moderate to severe pain in conscious adult patients with newly sustained traumatic injury and associated pain.

The use of Penthrox by CFRs is a first by any UK Ambulance Trust and follows the Trust's approval, in January 2023, for analgesia (pain relief) to be issued to CFRs.

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

- CFRs have not undertaken Omnicell cabinet training, which they are required to complete to gain access Penthrox. There are also issues for CFRs and Trust employees accessing the 'Penthrox safes' in North Wales, due to coding issues with the Abloy keys.
- Penthrox training compliance levels have not been updated in the Medicines Management Assurance Reports since April 2024.
- Instances identified where Penthrox was not administered to the patient in accordance with the Methoxyflurane (Penthrox) Protocol.
- There is a lack of reporting on the use of Penthrox and its effectiveness, and on exceptions relating to its administration.
- No analysis has been undertaken on the impact of Penthrox since its introduction, to confirm whether the expected benefits as set out in the business case have been realised.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

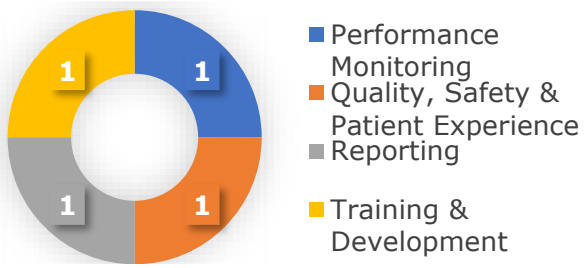
Scope & Assurance Summary

Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	The Trust has appropriate policies and procedures in place setting out the requirements for the administration of Penthrox, with appropriate steps undertaken to manage and communicate its introduction across the organisation.	-	**Substantial**
2	Training on the administration of Penthrox is available for all appropriate members of staff, with compliance monitored and reported accordingly.	1 & 2	**Reasonable**
3	The administration of Penthrox is carried out in accordance with the policy and operating procedures.	3	**Reasonable**
4	Management information relating to the use of Penthrox and its efficacy is regularly monitored and reported to an appropriate forum.	2 & 4	**Limited**

Management Actions

0	4
High Priority	Medium Priority

Themes



Risk Types

Quality or Safety Issues

Legal & Regulatory Non-Compliance

Findings & Agreed Action Plan

Objective 1: Introduction of Penthrox and associated policies and procedures	Substantial

Overview / Summary of Observations

Prior to the introduction of Penthrox, the Trust conducted a trial on the use of the analgesia with 99 trained Emergency Medical Technicians (EMTs) in the Central & West region over an eight-month period between October 2018 and May 2019. Evaluation of the analgesia was positive, with 353 units administered during the period and all those surveyed during the trial stating its impact was beneficial.

The Clinical Directorate put forward a business case to add the analgesia to the Trusts drug formulary for paramedics, EMTs, Ambulance Care Assistant 2 (ACA2) and Community First Responders (CFRs). In addition, the Clinical Directorate put a separate business case forward to introduce an additional storage module into the Omnicell Cabinets, which would allow for the safe storage and distribution of Penthrox to both Trust employees and volunteers on completion of the Penthrox training.

A Penthrox Project Group was set up to support its rollout, with membership comprised of key stakeholders and clinical leads, with a Project Initiation Document and Implementation plan put in place to outline objectives and monitor progress. A review of the Group's papers identified that highlight reports were produced for seven of the 10 meetings held; with action logs, issue logs and lesson learnt logs updated when required. The group also produced a Methoxyflurane (Penthrox) Training Plan (see objective 2), and a proposal on how the Clinical Audit Team could undertake a review into the safe and effective care to patients administered Penthrox.

We note that the project for rolling out Penthrox within the Trust has recently received recognition by winning the NHS Wales Effective Care award 2024.

<u>Policies & Procedures</u>

The Trust has created the Methoxyflurane (Penthrox) Protocol to ensure the safe handling and administration of Penthrox. The protocol was approved by the Ambulance Practice Steering Group; and issued to the Clinical Quality Governance Group (CQGG) for noting. On approval the protocol was issued via a Clinical Notice (April 2023), and made available via the Trust's Siren SharePoint site.

Guidance on the use of Penthrox is also available on the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) app, which is included on all Trust issued tablets. However, it was confirmed during discussions with the Head of Medicines Management that the JRCALC guidance did not reflect all the Trust's criteria for the use of Penthrox, therefore such has been replaced in the app with Trust appropriate guidance.

The CFRs were issued the protocol via email when it was first approved, and also through the Penthrox training module which is available via the Trust's volunteer learning website. New volunteers to the Trust have access to the protocol via their induction training. We note that the CFRs do not have access to SharePoint at present, but the Trust is looking to implement a volunteer management system ('Assemble') to issue important updates and documents to all its volunteers.

Objective 2: Training	Reasonable

Overview / Summary of Observations

Penthrox Training Process

As noted in Objective 1, the Trust developed the Methoxyflurane (Penthrox) Training Plan. This outlined that staff training requirements would consist of a bespoke training video, created in partnership with Galen Ltd (provider of Penthrox), followed by completion of an assessment via MS forms. The knowledge assessment form also includes a declaration that the Methoxyflurane (Penthrox) Protocol has been reviewed. The training video outlines the license for use, who can administer, preparation for use, administration, contraindications, possible adverse reactions for the user, disposal and how to replenish stock levels.

The training module went live in April 2023 and the Trust issued a Clinical Notice at the same time, via Siren and JRCALC, making employees aware of the requirements prior to having access to Penthrox and providing hyperlinks to the protocol, the training package and the Omnicell training checklist (see below for further details). As Penthrox was introduced to the CFRs, they were required to undertake the same training module as Trust employees, which included the completion of a knowledge assessment. With effect from July 2024, the Penthrox training was incorporated into the new CFR induction course.

Omnicell Cabinet

It was noted that it was the intention of the Trust to initiate Omnicell cabinet training for all CFRs, delivered by their respective CFR leads, and upon completion advise the Medicines Management team for access to be granted accordingly. To date, there are 643 CFR user profiles currently listed on the Omnicell system, however, only 21 of those have had their fingerprints enrolled to facilitate access. **See Key Finding 1.** Therefore, currently, in order to obtain Penthrox, the CFR requires a Duty Operations Manager (DOM) or CFR Lead from the Trust to access on their behalf.

Due to the limited number of Omnicell cabinets in North Wales, and the subsequent geographical challenge, therefore, for some CFR groups to access these, the Trust has installed six Penthrox safes at strategic stations where CFRs can replenish stock levels as and when needed. However, the safes require access via an Abloy key so, as per the current arrangements with the Omnicell, they require a DOM from the Trust to access on behalf of the CFR. These safes are only accessible by the relevant DOMS for this specific purpose and therefore Abloy keys for this group require updating to grant access. The Medicines Management Team were supplied with a list of DOM colleagues who would require access to these safes and Abloy keys were updated. To date, Abloy records show there are only seven DOMs who have access to the Penthrox safes enabled. There is a stockpile of Penthrox within the safes not being used which we understand has a use by date of August 2025. **See Key Finding 1**

Training Compliance

Prior to Penthrox going live in May 2023, each health board area had to evidence that 50% of staff had undertaken and passed the Penthrox training module before it could go live within the respective areas. In addition, only those that have undertaken the training are granted access to the module within Omnicell that stores the Penthrox supply.

To ensure that compliance rates are monitored, the Penthrox signoff process has been added to the Medicines Management database, with the compliance levels reported monthly via the Medicines Management Assurance Report (MMAR). A review of the MMAR for December 2024 noted that the pan Wales Average Compliance rate was 93%. However, on analysis it was identified that this figure has not been updated within the MMAR since April 2024. Training compliance for CFRs is held on a separate database. However, no update has been provided since July 2024 - this is due to the Penthrox training being incorporated into the new starter induction pack and the MS knowledge form required to demonstrate completion no longer being completed. We were informed that all CFRs have been re-issued the training video and knowledge form and there is an expectation for such to be completed by 28th February 2025 or have access to Penthrox removed (see **Key Finding 2**).

Key Findings		Risk & Impact	Agreed Management Action
1	**CFR Access to Replenish Penthrox Supply** Not all CFRs have access to either the Omnicell cabinets or the Penthrox Safes to replenish stock levels after use. To replenish the CFR requires a senior Trust employee (usually a DOM) to meet them at an Omnicell Cabinet or Penthrox safe to gain access and replenish supply. Further, the Penthrox safes require Abloy keys to gain access. To date, only seven DOMs on the Abloy records have access.	CFRs are unable to replenish Penthrox stock after use, which could lead to diminished levels of patients' safety and experience. Risk of financial loss due to expiry of Penthrox supply held in Penthrox safes with limited access	**Agreed Action:** CFR leads are required to confirm the names and PIN of all current CFRs, to allow the Medicines Management team to check them against those CFRs already on the Omnicell system. North Wales Locality Managers to update the names and pay/ESR numbers of all DOMs that require access to the Penthrox safes. This will allow the Medicines Management team to check them against DOMs that already have the Penthrox access permission on their Abloy keys. **Expected Evidence of Implementation:** Omnicell system report for CFRs with registration and fingerprint enrolment numbers. Abloy key access registration report for North Wales Penthrox safes.
		Medium Priority	**Officer:** Judith Bryce, Assistant Director of Operations / Huw Jackson, Head of Medicines Management
	Theme: Training & Development	Control Operation	**Target Implementation Date:** 30 May 2025
2	**Training Compliance Reporting** Penthrox Training Compliance is reported via the monthly 'Medicines Management Assurance Reports' to the Ambulance Practice Steering Group. A review of the reports between May 2024 – December 2024 identified that the figures had not been updated for either Trust employees or volunteers (CFRs) since April 2024 Further, noting the change in approach of training for CFRs, the knowledge assessment was not being completed. The original training module has been reissued to all CFRs with an expectation to be completed by 28 February 2025 to retain permissions to administer Penthrox.	Training Compliance not accurately reflected.	**Agreed Action:** All CFRs are required to complete Penthrox training which includes confirmation of completion via the MS Forms knowledge checker. Following confirmation of Penthrox learning, CFR leads/DOMs are required to register CFR users fingerprints on an Omnicell cabinet (subject to CFRs reasonable area of operation and proximity to a cabinet). **Expected Evidence of Implementation:** Omnicell system report for CFRs with registration and fingerprint enrolment numbers.
		Medium Priority	**Officer:** Judith Bryce, Assistant Director of Operations / Huw Jackson, Head of Medicines Management
	Theme: Performance Monitoring	Control Operation	**Target Implementation Date:** 30 May 2025

Objective 3: Administration of Penthrox	Reasonable

Overview / Summary of Observations

As per the protocol, Penthrox should be administered in the following circumstances: *(1) to a patient for emergency relief of moderate to severe pain (pain score equal to or greater than 4 out of 10); (2) in conscious adult patients (18 years and over) who are able to follow and comply with all instructions; (3) with newly sustained traumatic injury and (4) associated pain from fractures, dislocations, significant lacerations or burns.*

The protocol also gives a comprehensive list of contraindications in which Penthrox should not be administered, including to *patients under 18 years old; mild pain score (between 0-3); pregnancy or breastfeeding mothers; chronic pain associated with a longstanding condition; and respiratory depression*.

We requested a report from the Electronic Patient Clinical Records (ePCR), for the period 1st October 2023 – 30th September 2024, providing data where Penthrox was administered to the patient. From review of the dataset the following was identified:

- There was a total of 5,866 doses of Penthrox administered during the period.
- In total, 3,508 doses of Penthrox (60%) had recorded a 'before' and 'after' pain score;
- Where both a 'before' and 'after' pain score was recorded, a total of 9 patients gave a higher pain score after administration, whereas 511 patients stated there was no change in pain levels;
- Pain scores were not taken before or after each different type of analgesia administered so it is therefore difficult to assess their effectiveness;
- In terms of administration, 3,834 doses were administered to patients over 65 years old, with 62% of administrations to females.
- It was also noted that Penthrox was used in conjunction with other analgesia in the majority of incidents within the period reviewed, and this included Entonox on 1,043 occasions.
- There were a number of exceptions to the protocol noted from review of the data. **See Key Finding 3**

Further analysis identified that some of the closure reasons recorded would fall under contraindications for the use of Penthrox, this included 87 administrations to patients suffering with a head injury, dizziness or disorientation. Other administrations, outside the protocol, included Collapsing, Pyrexia, Urinary Tract Infection, Convulsion, Alcohol Abuse, Overdose, Sepsis, Cardiac Arrests and Hyperglycaemia. It was noted that additional closure reasons can be picked up on the ePCR record that gives a reason for administration of Penthrox - this was true for 21 of 85 l closure reasons for collapsed patients, but not for the other closure reasons (as per the dataset provided). **See Key Finding 3**

It was also noted that if staff realise that they administered Penthrox outside of the protocol, then they are required to complete a Datix incident form. During the period reviewed there were only 38 entries associated with Penthrox opened on the Datix system, and we noted a lack of reporting of such incidents. **See Key Finding 4**

Key Findings		Risk & Impact	Agreed Management Action
3	**Administration of Penthrox – exceptions to protocol** Analysis of the ePCR data extracted for the administration of all Penthrox units for a 12 month period highlighted that a number of administrations went against the Methoxyflurane (Penthrox) Protocol, with the following identified: • 1,049 (18%) units were administered without obtaining a pain score; • 22% did not obtain a pain score after administration; • 26 patients under the age of 18 were administered the drug; • 17 units were administered where a pain score did not reach the threshold for Penthrox (0-3); • In addition, it was noted that the reasons for administration of Penthrox fall under the protocol's contraindications, including Head injuries (87), Collapse (63 with no further reasoning, 84 in total) Urinary Tract Infections (5), Alcohol Abuse (3), Drug Overdose (1), Sepsis (4), Hyperglycaemia (1) and Cardiac Arrest (1). • Not all contraindications were recorded onto Datix, with only 38 incidents reported during the period.	Risk to patients' safety, due to inappropriate administration of the analgesia.	**Agreed Action:** Annual Medicines Management Assurance Report (MMAR) for the 2024/25 financial year to include an overview of Penthrox administrations and provide breakdown on protocol breaches/errors/themes, and quality of Datix investigations. **Expected Evidence of Implementation:** MMAR annual report – due May 2025
	Theme: Quality, Safety & Patient Experience	**Medium Priority** Control Operation	**Officer:** Huw Jackson, Head of Medicines Management **Target Implementation Date:** 31 May 2025

Objective 4: Monitoring and Reporting	Limited

Overview / Summary of Observations

On review of the Board and Committee papers since the Rollout of Penthrox (May 2023), we failed to identify that any reporting on the use of Penthrox and its effectiveness, training compliance, nor issues or exceptions relating to its administration. **See Key Finding 4**

As noted in objective 1, the Trust implemented a business case for the introduction of Penthrox into the Trust. Part of the business case outlined that the introduction of Penthrox would lead to a number of benefits to the Trust:

- *Dramatically reduced carbon footprint compared to Entonox (Entonox has 298 times the global warming effects of C02).*
- *Improve patient care and pain relief options for patients suffering traumatic injuries.*
- *Improve patient access to pain relief by training and equipping all emergency patient facing staff to be able to provide a standardised analgesia option which is not reliant on clinical grade.*
- *Improve clinical services offered by EMS, UCS and partner roles the Trust devolves health care provision to, in order to avoid extended periods of suffering for patients in the community.*

On discussion with the Directorate, we were informed that due to limited resources, the team have yet been unable to produce any reports to highlight the benefits realisation outlined in the business case.

However, did note that there was some reporting on Penthrox to the following two Groups:

Clinical intelligence and Assurance Group

The Clinical Intelligence and Assurance Team undertook a review into the ePCR data where Methoxyflurane had been administered to patients between 01/08/2023 – 31/08/2023. The report and its findings were issued to the Clinical Intelligence and Assurance Group. The key findings from the review highlighted:

- 460 patients received Penthrox during the period
- 43 patients required an additional dose;
- 16.1% did not have a pain score recorded prior to first dose;
- 32.6% did not have a pain score recorded prior to the second dose;
- 4.3% (20 cases) administered Penthrox outside the protocol, including to patients - under 18 (3), no trauma (4), history of alcohol abuse (2), head injuries (2) and medical contradiction (2).

Ambulance Practice Steering Group

The Head of Medicines Management produces a monthly Medicines Management Assurance report that is presented to the Ambulance Practice Steering Group, as noted in Objective 2 the reports highlight the training compliance levels for the use of Penthrox for both Trust employees and Community First Responders. **See Key Finding 4**

Key Findings		Risk & Impact	Agreed Management Action
4	**Reporting / Benefits Realisation** A review of the Board and Committee papers identified a lack of reporting on the use of Penthrox and its effectiveness, training compliance, nor any issues or exceptions relating to its administration. There has been no reporting within the Trust to analyse if the rollout of Penthrox has realised the benefits outlined in the Business Case submitted prior to rollout.	The board are not aware of any issues associated with Penthrox. The intended benefits outlined prior to the introduction of Penthrox are not being met.	**Agreed Action:** MMAR annual report (due May 2025) will include a specific section on Penthrox use by Trust users. The report will be presented to QuEST. **Expected Evidence of Implementation:** MMAR annual report (2024/25) to be considered by QuEST. Medicines Management Team to respond to any request for further information/tasks following QuEST review.
		Medium Priority	**Officer:** Huw Jackson, Head of Medicines Management
	Theme: Reporting	Control Operation	**Target Implementation Date:** 30 June 2025

Appendix A

Assurance Opinion

Substantial	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
Reasonable	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
Limited	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
Unsatisfactory	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
Advisory	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 Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

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The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

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Public Sector Internal Audit Standards

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

111 Digital Operations

Final Internal Audit Report 2024/25

Welsh Ambulance Services University NHS Trust

Substantial Assurance

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Review Reference	WAST-2425-14
Fieldwork	October / November 2024
Executive Sign Off	18th December 2024
Audit, Risk & Assurance Committee	March 2025
Executive Lead	Jonny Sammut Director of Digital
Head of Internal Audit	Osian Lloyd
Deputy Head of Internal Audit	Martyn Lewis, IT Audit Manager

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Audit and Assurance Services

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

Executive Summary

Purpose

To assess whether the digital operation of 111 is safe and effective, with mitigation plans in place for any weaknesses identified and tracked to resolution.

Overview

The new 111 system, provided by MIS Emergency Systems Ltd and Priority Dispatch Solutions (PDS), integrates the MIS-111 Patient Management System with the PDS Emergency Communications Nurse System clinical triage and Call Prioritisation and Streaming Service non-clinical triage systems. The system has been successfully implemented onto a secure architecture which provides improved security and resilience. There are processes for monitoring performance of the system to prevent incidents and an appropriate system administration process is in place.

Training was provided to all staff prior to implementation, and enhanced support was available to staff in the early stages. Ongoing training is provided to new staff and performance of users is monitored.

The contract sets out the required system performance and there are regular review meetings between WAST and the supplier to ensure system performance is appropriate and to discuss any identified issues.

We have concluded substantial assurance on this area. We have identified no matters for reporting in our review.

Scope & Assurance Summary

	Objectives	Related Findings	Assurance
1	Provision of 111 digital services is monitored, reliable, secure and data is protected.	1	**Substantial**
2	Staff within the 111 service have received appropriate training and support on the new system to ensure they have the skills required.	1	**Substantial**
3	Management of the digital operation of 111 is appropriate, with the performance of the new system being monitored to ensure it meets the contractual requirements and with risks to service provision identified and managed appropriately.	1	**Substantial**

Findings & Agreed Action Plan

Objective 1: Provision of 111 digital services is monitored, reliable, secure and data is protected	**Substantial**

Overview / Summary of Observations

The main supplier of the replacement system for the 111 Wales service is MIS Emergency Systems Ltd who provide the MIS-111 Patient Management System. Additionally, the solution includes the use of the Emergency Communications Nurse System (ECNS) for clinical triage and the Call Prioritisation and Streaming Service (CPSS) for Call Taker assessment, both supplied by Priority Solutions International. The combined system has replaced the legacy CAS system and integrated with existing processes.

The software is installed on a resilient IT infrastructure across mirrored data centres. In order to move to the CAS platform, WAST has upgraded the infrastructure with new servers which were introduced on a server-by-server basis so as not to disrupt the 111 service. All servers are new, 2024 models and are monitored for central processing unit (CPU) load, disk free space, number of terminal sessions with alerts for any discrepancies. Daily backups are run and stored both on the local servers and also onto the backup system and failover protocols are in place.

Management of the system is undertaken by WAST, with incident and events being managed appropriately as per the process reviewed within our previous audit work, and there is a formally defined system administration process.

A system security plan was developed as part of the project, which clearly sets out the security requirements, and the new system includes significant security features, including compliance with Cyber Essentials Plus and DCB (Data Coordination Board) 129 standards, separation from vulnerable systems and enhanced access controls. Security is reinforced by monitoring tools such as Microsoft Defender, Sophos, Fortianalyser, and Paessler Router Traffic Grapher (PRTG), ensuring robust protection against cyber threats.

The security plan also specifies user access controls which is role-based with multi-factor authentication, and privileged account management is in place. Only authorised users with NADEX credentials can access the system, while back-end access is restricted to trained administrators under strict protocols. We also note that regular risk assessments are defined as part of the system administration role. User access permissions will be subject to periodic review going forward, noting one hasn’t been undertaken yet following the system’s recent implementation.

The plan remains a living document, subject to regular updates and reviews to address emerging risks and support continuous improvement in system security and performance.

Objective 2: Staff within the 111 service have received appropriate training and support on the new system to ensure they have the skills required	**Substantial**

Overview / Summary of Observations

The Trust developed a robust training programme for the 111 system rollout which included all staff. The training was grounded in International Academies of Emergency Dispatch (IAED) standards and covered call triaging, communication and critical thinking, and used a variety of learning methods, including online resources, role-play, and self-reflection exercises. Training plans were also in place for new starters and staff who were off sick during implementation with progress tracked through OneNote logs, ensuring staff met training milestones.

All 111 call takers are required to pass an externally certified exam prior to taking calls. The training department keep a record of who has attended and passed/failed. In addition, all staff had to spend 3 full shifts in the office on the new system before they were allowed to work from home. The high call volumes ensured that staff had ample opportunity to become familiar with the new system during this time.

During and after implementation, staff received extensive support, such as live Q&A sessions, two weeks of on-the-floor assistance at 111 centres, and guidance for returning staff. Additional resources, like self-directed modules and demonstration videos, allowed staff to refresh skills as needed.

Performance is monitored using the Live Supportive Practice Assessment Tool, which provides real-time feedback during use of the system, and through competency checks, key performance indicators (KPIs), and regular reviews.

While no formal long-term feedback forum for users was established, live drop-in sessions enabled staff to raise questions during implementation.

Objective 3: Management of the digital operation of 111 is appropriate, with the performance of the new system being monitored to ensure it meets the contractual requirements and with risks to service provision identified and managed appropriately	**Substantial**

Overview / Summary of Observations

The 111 Patient Management System (MIS) contract establishes a clear framework of Key Performance Indicators (KPIs) and Service Level Agreements (SLAs) to ensure service quality. Specific performance standards are noted including 99.95% uptime, help desk response times, and a quality control system. There is a requirement for monthly performance monitoring reports, alongside audits and verifications in order to provide accountability, and we note that current performance meets contractual requirements. The contract also includes a structured Dispute Resolution Procedure for issue escalation and mediation, ensuring continuous collaboration.

Regular review meetings are held between WAST and the supplier to evaluate system performance, address issues, and implement corrective actions. We noted that the system is still in the process of being fully implemented, with regular meetings taking place to address ongoing recorded issues. However, no formal minutes are currently being recorded for these meetings. The implementation team is actively working to establish a more structured forum in the near future, which will include the documentation of meeting outcomes to enhance transparency, accountability, and communication across the team.

The system was implemented rapidly in 4 months, with the implementation team acknowledging they had to make decisions on the day and would have liked to have had more time to engage with stakeholders and formalise meetings with suppliers. Subsequent to the implementation, a lessons learned exercise has been undertaken, which noted the benefits of regular meetings, proactive decision-making, and early stakeholder involvement, including beta testing with call handlers and thorough training for engineers.

Risks to delivery of the system and its impact on WAST were identified as part of the project management process and these were monitored and managed appropriately. The lessons learned exercise included a review of the risk management process, with risks now forming part of the overarching risk management structure.

Appendix A

Assurance Opinion

Substantial	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
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Prioritisation of Findings

Priority	Explanation
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Estates Assurance - Energy Management

Final Internal Audit Report

2024/25

Welsh Ambulance Services University NHS Trust

Substantial Assurance

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Review Reference	WAS-SSU-2425-20
Fieldwork	December 2024 – January 2025
Executive Sign Off	18 February 2025
Audit Committee	March 2025
Executive Lead	Chris Turley, Director of Finance
Audit Team	Huw Richards, Head of Internal Audit

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Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

Noting rising costs of energy, effective management and control of energy costs has been risk assessed as an area of potential benefit for audit.

This audit was undertaken in line with the 2024/25 audit plan.

The audit was undertaken to determine the adequacy of, and operational compliance with, the established systems for the management and control of energy consumption within the Trust and also considered other supporting regulatory and procedural requirements.

The audit included a review of both central monitoring and site-based implementation of controls (including sample testing).

Overview

The Welsh Ambulance Trust (WAST) had signed up to the national NHS energy contract, which was managed via the Welsh Energy Group and Welsh Energy Operational Group, which was attended by WAST representatives. WAST had made significant steps toward reducing fossil fuel use within the estate, including investing in an ongoing programme focused on implementing renewable energy sources - including ground source heat pumps and photovoltaic panels.

The move to the new NHS Wales energy contract in 2023 had presented some issues, including difficulties in providing accurate energy forecasts to participating organisations. Recognising the robust data monitoring processes operated at the Trust, the impact of the national issues had not been as significant as seen elsewhere.

Other programmes of improvement have included movement sensor LED lighting, zoned building areas with climate control, and a clear, pragmatic building management policy.

The recording/ monitoring of energy use and management of the invoicing position with the energy provider, were well controlled and the information provided informed decisions related to improving energy efficiency.

The WAST had also been successful in gaining annual reaccreditation of ISO14001 (Environmental Management) and continue to be the only ambulance trust in UK to hold this status.

We have concluded **substantial** assurance in this area. The matters requiring management attention included:

- Approvals did not make use of the Oracle approval hierarchy but instead were completed manually by email,
- In sampled months, 35% of meter readings were estimates, albeit 71% of these were then subsequently manually read within a month.

Full details of matters arising are detailed within the Findings & Agreed Action Plan. The following opportunities for enhancement have been identified that do not impact the overall opinion and are highlighted for management information:

- Legacy small appliances were observed to be in use in the WAST estate that were not A rated, contrary to the Building Management Policy.

Scope & Assurance Summary

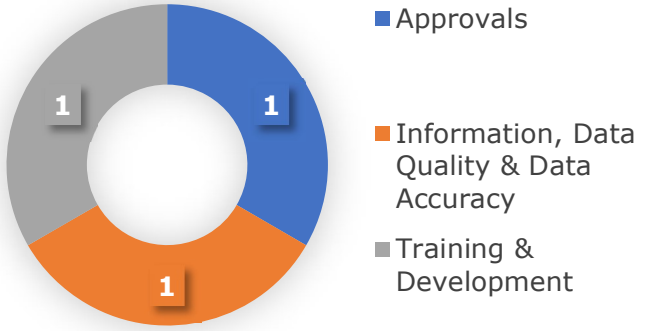
	Objectives	Related Findings	Assurance
1	Governance – To ensure that key roles had been assigned, and responsibilities of key staff were understood. An appropriate forum had been assigned with responsibility and accountability for overseeing Energy efficiency/ consumption.	-	**Substantial**
2	Contracts – Recognising the national contracts in place, to obtain assurance that the Trust obligations under the national contract arrangements were fully understood and applied.		**Substantial**
3	Data Capture – Appropriate systems were in place to capture data on energy consumption in a timely manner.	1	**Reasonable**
4	Data Validation - Adequate checks were undertaken to verify the quality/ reliability of the data - any anomalies were fully investigated.		**Substantial**
5	Monitoring and reporting – Monitoring and reporting arrangements were in place to ensure that anomalies were understood, benchmarking was undertaken where appropriate and resulting action was tracked.		**Substantial**
6	Energy Awareness – Appropriate training for general and key energy staff focused on increasing awareness of obligations. Other initiatives were established to increase awareness e.g. intranet pages.	2	**Reasonable**
7	Payments – energy related billing was verified, authorised, and processed in accordance with contractual payment terms.	3, 4	**Reasonable**
8	Risk Management – Assurance that systems and controls in place to manage energy-related risks, and that there are appropriate arrangements to escalate as appropriate - this includes appropriate risk mitigation strategies.		**Substantial**

Management Actions

0 High Priority

3 Medium Priority

Themes



Risk Types

Financial Loss

Choose an item.

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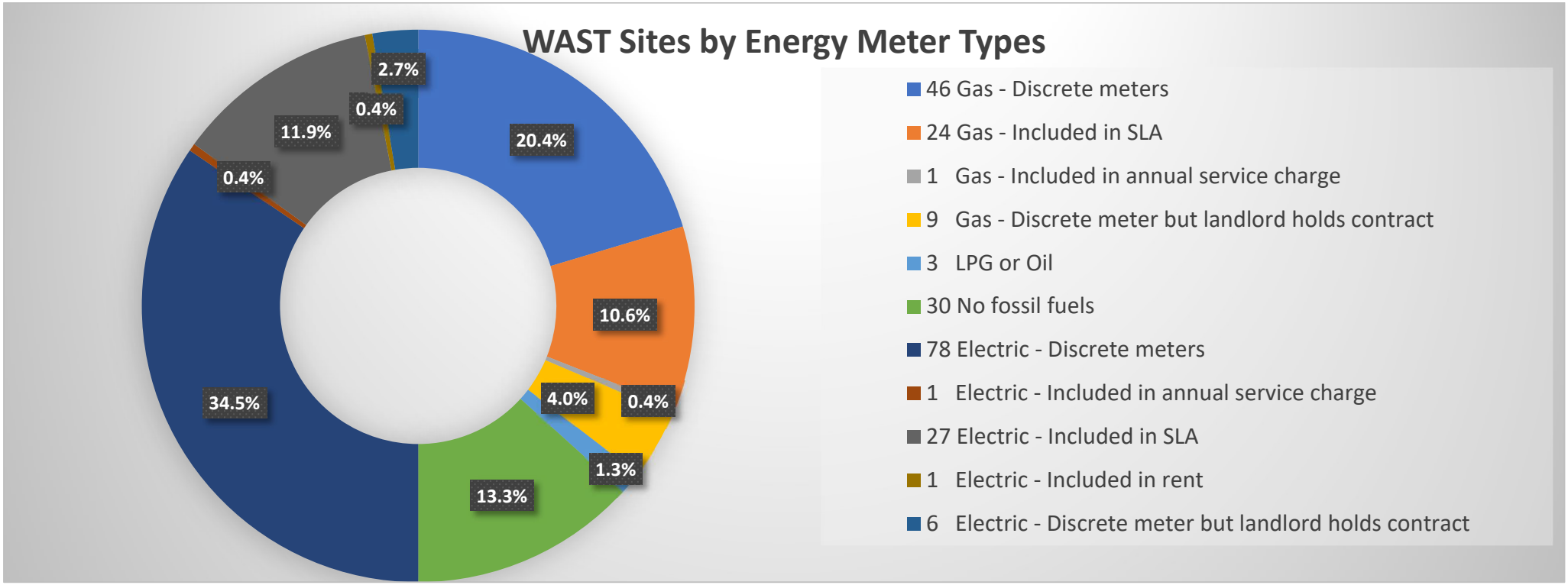
Welsh Ambulance Services University NHS Trust, Energy Management - At a Glance

The WAST operates from ambulance stations across the whole of Wales, with a central headquarters based in St Asaph, North Wales and two regional headquarters in South Wales. The service was forecast to use 2,950,676 kWh of Gas, and 2,414,181 NBP of Electric across 2024-25 (a total of £1,013,241).

The service had a total of 124 energy meters, with the remainder either billed to landlord or included in other charges:



Additionally, because of ongoing investment programmes, by March 2025, 19 sites will have Photovoltaic (PV) panels for solar power, and 9 will have Ground Source Heat pumps. More sites will be included in the programme across 2025-26.

Electricity emissions have increased by 15% in the past 12 months. This is not unexpected due to increased numbers of electrically fed heating systems and plug in EV vehicles. This has been offset by 193k kWh of renewable energy generated by PV arrays on Trust premises.

Due to these low carbon heating retrofits and closure of inefficient estate, total heating emissions have reduced by 23%. 35% of the estate no longer use fossil fuels.

Findings & Agreed Action Plan

Objective 1: Governance	Substantial

Overview / Summary of Observations

The WAST had produced a Decarbonisation Action Plan (DAP) in response to the Welsh Government's NHS Wales Decarbonisation Strategic Delivery Plan (NHSW- DSDP). The plan had a range of actions which frame the Trust's decarbonisation response and spans all directorates across the Trust.

A report was submitted to the Welsh Government on 14th April 2024 and feedback was received in June 2024 confirming WG's assessment of the WAST reporting status as Amber which aligned to the self-assessment provided.

On a day-to-day basis the Trust employs an experienced and qualified Sustainability and Environment Manager and Sustainability and Environment Officer, and there were clear process notes relating to recording and reporting of energy use, whilst a reader-friendly Building Management policy outlined pragmatic ways to reduce energy use.

The WAST had also been successful in their annual reaccreditation of ISO14001 (Environmental Management) and continue to be the only ambulance trust in UK to hold this status.

Objective 2: Contracts	Substantial

Overview / Summary of Observations

In October 2023, the Trust entered a new all-Wales NHS energy contract with Crown Commercial Services (CCS), managed by NWSSP: Procurement Services. This change was due to the existing supplier exiting the market, citing volatility since 2021.

In June 2024 NWSSP sent out a summarised PowerPoint showing the trends over the last quarter in energy and sent it to each HB and Trust. The WAST were asked to review their meters and usage, which they did, and confirmed that forecasts appeared reasonable, adjusting for any future changes that were known including new meters. The detailed forecast showed rates and movements, whilst a sustainability report showed movements considering closures of inefficient stations and increased PV installation.

The contracted rates were referred to regularly to ensure invoicing received was accurate and WAST members regularly provide feedback at national forums and provided feedback on the proposed contract renewals.

Objective 3: Data Capture	Reasonable

Overview / Summary of Observations

The WAST has an expansive estate covering a wide geographic area – additionally, a significantly high number of estate sites may also not be manned full-time and/ or have management in attendance full time.

There was a clear policy for capturing meter readings/ energy usage, which were then sent to a central Account Payable email address, where they were collated and submitted to the Energy Supplier as one feed. 35% of submissions sampled were based on an estimated reading. This was clearly linked to the profile of the WAST estate and the requirement to read meters within fixed date ranges.

The non-receipt of readings was monitored and was actively chased – 71% of those estimated readings were subsequently provided as a true/ actual reading to the Energy Supplier within 1 month. Most of the estate's meters were still manually read, and the Trust would benefit from expediating their current work to move existing meters to smart meters, albeit it is understood that they are limited by the capacity of the energy provider to install these.

	Key Findings	Risk & Impact	Agreed Management Action
1	35% of sampled readings were estimated. Although it was noted that these were appropriately chased with 71% of them being submitted within a month, this also represented a risk that invoices may be issued by the energy provider for incorrect values affecting the timing of the cashflow of the Trust. The Trust has advised that: "Monthly updates via WEOG meetings with the energy provider include smart meter/AMR rollout update. WAST are a member of WEOG and participate actively with this meeting. The trusts previous Environment and Sustainability Manager was also in contact with the energy provider's booking team to facilitate progress of this roll out. It however must be noted that WAST has no control over the speed and efficiency of the energy provider's smart meter roll out and can only raise as a concern at WEOG meetings.	That energy usage is incorrectly captured resulting in invoices being issued by the energy provider for incorrect values, affecting the timing of the cashflow of the Trust.	**Agreed Action:** The new Environment and Sustainability Manager, in post March 2025 will be an active participant of WEOG and will endeavour to progress roll out at a quicker pace.

	As there is a procedure in place to ensure that invoices are adjusted to actual reads in a timely manner, therefore the impact on Trust cashflow should be virtually insignificant.”		**Expected Evidence of Implementation:** Minutes of WEOG showing new manager as an attendee and continuing to raise smart meter implementation, if it remains an issue.
		Medium Priority	**Officer:** Head of Estates
	Theme: Information, Data Quality & Data Accuracy	Control Operation	**Target Implementation Date:** 30th June 2025- please note this is the implementation date of the new manager attending WEOG and not installation of a Trust wide AMR/Smart meter project, WAST has little control on that timescale.

Objective 4: Data Validation	Substantial

Overview / Summary of Observations

Meter readings were recorded electronically on a central shared drive on a file which compared month-on-month movements with invoice values and volumes received from energy companies. There were some expected discrepancies due to reading dates and invoice date ranges, however these were ratified and determined as materially appropriate.

Agreed rates charts were also saved electronically on a central shared drive, and these were reconciled periodically to the invoices being received from the energy provider.

During the audit it was possible to review the movements on the invoices to the readings, and the readings taken during site visits to the recoded readings and no anomalies were noted.

Objective 5: Monitoring and Reporting — Substantial

Overview / Summary of Observations

The Trust completed a variety of reporting including:

- granular reporting by meter of all readings vs. invoiced values, and recording whether the reading was estimated, read by the energy provider or read by the Trust,
- recording charted energy information over a 7-year period, which was compared to various external information including the average temperature for the month and other factors to identify where energy use had been unexpected.

The analysis was often used to support decisions such as closures of inefficient sites; but also, to focus and prioritise investment e.g. with photovoltaic panels, trickle chargers, ground source heat pumps and full LED movement sensor lighting.

During site visits it was possible to see the outcome of investments. The application of the building management policy was also tested in site visits which found that windows were predominantly double glazed in older buildings, whilst the South-West headquarters visited was based in a relatively new building, built on Passivhaus principles with sealed windows, climate-controlled air conditioning and Brise Soleil to limit building overheating. Chillers were based in chiller rooms to the exterior of the building with exposed grill facings.

On all visits thermostats were set within guided ranges, and lighting was noted to be movement sensor driven. Doors between zones were kept shut, whilst shutters to ambulance garages had rubber draught excluders and were in good condition.

Ground source heat pump and photovoltaic installations were observed.

Small appliance use was noted in sites visited, and included wall mounted hot water boilers. New appliances were noted to all be 'A' rated. In some areas kettles and fan heaters were observed to be supplementing more energy efficient appliances and some older unrated "household" appliances were noted to be in use: it would be recommended that these are replaced with 'A' rated appliances at the end of their useful life.

Sites were visited at various times and lights were noted to be off in the South-West office outside of core operating hours.

The WAST found benchmarking of data very difficult due to the very differing locational profile of the WAST, but a noticeable difference in the quality and extent of issue logging, which was also shared with the energy provider, noting the issue by meter.

Over time, the resolutions achieved were clear to see, including receipt of credit notes from the energy provider and sustained attempts to resolve longer term issues. Issues had also been escalated via the Welsh Energy Operational Group.

Objective 6: Energy Awareness	Reasonable

Overview / Summary of Observations

A booklet had been provided to staff regarding energy use which contextualised the benefit to the Trust and the environment of steps that could be taken to mitigate and lower emissions, and discussed the requirements of ISO14001 and what individual staff members could do to help the Trust meet the standard.

Some of the topics covered in this awareness exercise included drawing attention to "opening up and closing down" procedures and asked staff to find out what they were and if they were in place, and to not only consider facilities temperatures, but to provide feedback to the estates team.

Links to the Estates portal were provided for readers to find out more about environmental issues.

Evidence was provided during the audit of educational media/ posters created by the WAST for display around the WAST estate. During visits to the South-West headquarters, no posters were observed to have been displayed.

Whilst on an ambulance station visit non-WAST generated posters were noted as being displayed in relation to turning off appliances when not in use, and whilst there was clear evidence amongst staff of energy awareness, the WAST posters were not on display.

	Key Findings	Risk & Impact	Agreed Management Action
2	Educational media created by the WAST to encourage behaviours conducive to good energy management, were not displayed in estate premises sampled. The Trust have advised: "The new Environment and Sustainability Manager starting March 2025, will be tasked with updating current training materials, plus communication materials to encourage reduced use of energy, this will be supported by WAST communications team. As the new manager starts in post March 2025 and requires bedding in time, plus the imminent ISO14001 internal audit requirements, this will be scheduled in for an appropriate time."	Behaviours adopted by the WAST employees are not conducive to efficient energy usage, increasing reputational risk and increasing financial cost to the Trust.	**Agreed Action:** Handover meeting between previous environment and sustainability manager and new environment and sustainability manager booked for 18th March. This handover will include the requirement to address training concerns, and to allow time to develop a comms plan at an appropriate juncture. **Expected Evidence of Implementation:** Email from new Environmental Manager to Communications for support, including some wider comms via internal IT avenues and directorate notices.
		Medium Priority	**Officer:** Head of Estates **Target Implementation Date:** 30th September 2025
	Theme: Training & Development	Control Operation	

Objective 7: Payments	Reasonable

Overview / Summary of Observations

A sample review of invoicing and payments found the process to be well managed and tracked, despite a labour-intensive manual process of approval.

Invoices and credit notes were entered onto Oracle in a timely manner and there was a clear path between the issues log/ agreed actions by the energy provider and the credit notes and receipts which were being received.

In the sample of 9 invoices which were reviewed in detail, the volumes appeared to be reasonable and paid accordingly.

One invoice had been entered onto Oracle system and then removed, whilst another was missing from Oracle entirely. It was unclear what had happened with these two invoices, but both relate to an ambulance station where incorrect invoicing had been provided by the energy supplier since the recent acquisition of the site.

It was noted that WAST Standing Financial Instructions 11.19 'No purchase order, no pay", state that there should be purchase orders for all invoices, however the All of Wales Standing Financial Instructions waiver energy invoices. Whilst Purchase Orders were not therefore required in this case, it would be beneficial for either purchase ordering or the approval hierarchy in Oracle to be utilised to streamline and strengthen the control processes around approvals and coding of energy invoices which was currently subject to an unwieldy manual emailed process.

Whilst the tracking of invoices was noted to be detailed and regularly undertaken, a strategy for a more system driven approach to approvals would be lower risk and would additionally make it easier to identify correct posting to Health Board/ Trust and distributions (nominals) on Oracle. It would also avoid manual coding in most cases. A key finding has been raised in relation to this matter.

Key Findings		Risk & Impact	Agreed Management Action
3	The invoices sampled had been approved for payment manually using emails: • The invoice was sent by the local team to the WAST AP email • The Sustainability and Environment Manager had picked up the invoice and forwarded it to the Sustainability and Environment Officer. • The Sustainability and Environment Officer had coded the invoices on Oracle before confirming they had done so to the Sustainability and Environment Manager. • The Sustainability and Environment Manager had forwarded the approval request to the Assistant Director if over their own authorisation limit. • The Assistant Director had returned the approval to the Sustainability and Environment Manager. • The Sustainability and Environment Manager had forwarded the approval to the WAST AP email address requesting approval. On an uncomplicated single invoice and payment scenario, whilst the payment was not delayed, this had resulted in 9 emails and 8 separate email addresses. A strategy should be considered to use a system driven approach to managing invoicing which would allow an invoice to be more easily matched and coded to the correct Trust and distributions on Oracle and would allow for approvals to be facilitated via a system approval hierarchy linked to the Trust's Scheme of Delegation.	Inefficient processing of invoices and payment resulting in financial loss and risk to reputation	**Agreed Action:** We will review the current energy invoice receipt, approval and payment processing arrangements with a view to streamline current arrangements maximise efficiency. **Expected Evidence of Implementation:** Discussion meeting between Assistant Director and Director of Finance regarding team any required change to approval thresholds and streamlined authorisation process.
		Medium Priority	**Officer:** Head of Estates
	Theme: Approvals	Control Operation	**Target Implementation Date:** 30th June 2025

Objective 8: Risk Management	Substantial

Overview / Summary of Observations

Risks had been adequately raised at the Wales Energy Group or WEOG meetings.

Internally, risks were reflected in the activities of the Environment, Decarbonisation and Sustainability work programme in their Environment, Decarbonisation & Sustainability Update.

A detailed Risk Register was reviewed at each Programme Board meeting and was regularly updated. This Risk Register was also linked to work on the Corporate Risk Register, and the risk that decarbonisation initiatives including those related to delivery of investments schemes such as installation of renewables (e.g. photovoltaics) had been formally adopted at the Corporate Risk Register level and was included in the Board Assurance Framework.

The Environment, Decarbonisation & Sustainability Update was reviewed and approved by:

- Capital Management Board – 23rd August 2024
- Executive Leadership Team – 11th September 2024
- Finance and Performance Committee – 17th September 2024

Appendix A

Assurance Opinion

Substantial	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
Reasonable	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
Limited	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
Unsatisfactory	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
Advisory	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 Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Disclaimer

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

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Welsh Ambulance Service 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.

The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

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 management of the Welsh Ambulance Service 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.

Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

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

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Internal Audit Plan 2025/26

Welsh Ambulance Services University NHS Trust

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Shared Services Partnership
Audit and Assurance Services

1. Introduction

This document sets out the Internal Audit Plan for 2025/26 (the 'Plan') detailing the audits to be undertaken and information of the corresponding resources. It also contains the Internal Audit Mandate and Charter which defines the over-arching purpose, authority and responsibility of Internal Audit and the Key Performance Indicators for the service.

The Accountable Officer (the Chief Executive) is required to certify, in the Annual Governance Statement, that they have reviewed the effectiveness of the organisation's governance arrangements, including the internal control systems, and provide confirmation that these arrangements have been effective, with any qualifications as necessary including required developments and improvement to address any issues identified.

The purpose of Internal Audit is to provide the Accountable Officer and the Board, through the Audit, Risk and Assurance Committee, with an independent and objective annual opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control. The opinion should be used to inform the Annual Governance Statement.

Additionally, the key findings and agreed actions from internal audit reviews may be used by Trust management to improve governance, risk management, and control within their operational areas.

In January 2025 new Global Internal Audit Standards (the 'Standards') became effective and apply to UK public sector audits from 1 April 2025 to align with the financial year. These new standards replace the previous guidance: the Public Sector Internal Audit Standards. The new Standards are accompanied by a UK public sector application note (the 'Application Note'), which provides public sector interpretations and additional requirements for the Standards. The new Standards require that a risk based internal audit plan is created that supports the achievement of the organisation's objectives.

Accordingly, this document sets out the risk-based approach and the Plan for 2025/26. The Plan will be delivered in accordance with the Internal Audit Mandate and Charter and the agreed KPIs, which are monitored and reported to you. All internal audit activity will be provided by Audit & Assurance Services, a part of NHS Wales Shared Services Partnership (NWSSP).

1.1 National Assurance Audits

The proposed Plan includes assurance audits on some services that are provided by other organisations on behalf of NHS Wales. These are: Digital Health and Care Wales (DHCW); NHS Wales Shared Services Partnership (NWSSP); and the NHS Wales Joint Commissioning Committee (JCC), which replaced Emergency Ambulance Services Committee (EASC) and Welsh Health Specialised Services Committee (WHSSC) from April 2024. These audits will be included in Appendix A when agreed formally. These audits are part of the risk-based programme of work for DHCW, NWSSP and Cwm Taf Morgannwg UHB (for the JCC), but the results, as in previous years, are reported to the relevant health organisations and are used to inform the overall annual Internal Audit opinion for those organisations.

2. Developing the Internal Audit Plan

2.1 Link to the Global Internal Audit Standards

The Plan has been developed in accordance with Principle 9: Plan Strategically, which includes Standard 9.4 – Internal Audit Plan, of the Standards, and the accompanying Application Note, which provides public sector interpretations and additional requirements for the Standards, to enable the Head of Internal Audit to meet the following key objectives:

- the need to establish risk-based plans to determine the priorities of the internal audit activity, consistent with the organisation's goals;
- provision to the Accountable Officer of an overall independent and objective annual opinion on the organisation's governance, risk management, and control, which will in turn support the preparation of the Annual Governance Statement;
- audits of the organisation's governance, risk management, and control arrangements which afford suitable priority to the organisation's objectives and risks;
- improvement of the organisation's governance, risk management, and control arrangements by providing line management with recommendations arising from audit work;
- confirmation of the audit resources required to deliver the Internal Audit Plan;
- effective co-operation with Audit Wales as external auditor and other review bodies functioning in the organisation; and
- provision of both assurance (opinion based) and consulting engagements by Internal Audit.

2.2 Risk based internal audit planning approach

Our risk-based planning approach recognises the need for the prioritisation of audit coverage to provide assurance on the management of key areas of risk, and our approach addresses this by considering:

- the organisation's risk assessment and maturity;
- the organisation's response to key areas of governance, risk management and control;
- the previous years' internal audit activities; and
- the audit resources required to provide a balanced and comprehensive view.

Our planning considers the NHS Wales Planning Framework and other NHS Wales priorities and is mindful of significant national changes that are taking place. In addition, the Plan aims to reflect the significant local changes occurring as identified through the Integrated Medium-Term Plan (IMTP) and other changes within the organisation, assurance needs, identified concerns from our discussions with management, and emerging risks.

We will ensure that the plan remains fit for purpose by recommending changes where appropriate and reacting to any emerging

issues throughout the year. Any necessary updates will be reported to the Audit, Risk and Assurance Committee in line with the Internal Audit Mandate and Charter.

While some areas of governance, risk management and control will require annual consideration, our risk-based planning approach recognises that it is not possible to audit every area of an organisation's activities every year. Therefore, our approach identifies auditable areas (the 'audit universe'). The risk associated with each auditable area is assessed and this determines the appropriate frequency for review.

In addition, we will, if requested, also agree a programme of work through both the Director of Corporate Governance (Board Secretary) and Directors of Finance networks. These audits and reviews may be undertaken across all NHS bodies or a particular sub-set, for example at Health Boards only.

Therefore, our Plan is made up of several key components:

1) Consideration of key governance and risk areas: We have identified several areas where an annual consideration supports the most efficient and effective delivery of an annual opinion. These cover the Governance, the Board Assurance Framework, Risk Management, Clinical Governance and Quality, Financial Sustainability, Performance Monitoring & Management, and an overall assessment of Digital and Information Technology. In each case we anticipate a short overview to establish the arrangements in place including any changes from the previous year with detailed testing or further work where required.

2) Organisation based audit work – this covers key risks and priorities from the Board Assurance Framework and the Corporate Risk Register, together with other auditable areas identified and prioritised through our planning approach. This work combines elements of governance and risk management with the controls and processes put in place by management to effectively manage the areas under review.

3) Follow up - this is follow-up work on previous 'limited' and 'unsatisfactory' assurance reports as well as other medium and high priority recommendations. Our work here also links to the organisation's recommendation tracker and considers the impact of their implementation on the systems of governance and control.

4) Work agreed with the Directors of Corporate Governance, Directors of Finance, other executive peer groups, or Audit Committee Chairs in response to common risks faced by several organisations. This may be advisory work to identify areas of best practice or shared learning.

5) The impact of audits undertaken at other NHS Wales bodies that may impact on the Trust, namely NWSSP, DHCW, and the JCC.

6) Where appropriate, Integrated Audit & Assurance Plans will be agreed for major capital and transformation schemes and charged for separately. Health bodies are able to add a provision for audit and assurance costs into the final business case for major capital bids.

These components are designed to ensure that our internal audit programmes comply with all of the requirements of the

Standards, supports the maximisation of the benefits of being an all-NHS Wales wide internal audit service, and allows us to respond in an agile way to requests for audit input at both an all-Wales and organisational level.

2.3 Link to the Trust's systems of assurance

The risk based internal audit planning approach integrates with the Trust's systems of assurance; therefore, we have considered the following:

- A review of the Board's vision, values and forward priorities as outlined in the Integrated Medium Term Plan (IMTP);
- An assessment of the Trust's governance and assurance arrangements and the contents of the corporate risk register;
- Risks identified in papers to the Board and its Committees (in particular the Audit, Risk and Assurance Committee and the Quality, Patient Experience and Safety Committee);
- Key strategic risks identified within the corporate risk register and assurance processes;
- Discussions with Executive Directors regarding risks and assurance needs in areas of corporate responsibility, including compliance and ethics programmes;
- Cumulative internal audit knowledge of governance, risk management, and control arrangements (including a consideration of past internal audit opinions);
- New developments and service changes;
- Legislative requirements to which the organisation is required to comply;
- Planned audit coverage of systems and processes provided through NWSSP, DHCW, and the JCC;
- Work undertaken by other supporting functions of the Audit, Risk and Assurance Committee including Local Counter-Fraud Services (LCFS) and the Post-Payment Verification Team (PPV), where appropriate;
- Work undertaken by other review bodies, including Audit Wales and Healthcare Inspectorate Wales; and
- Coverage necessary to provide assurance to the Accountable Officer in support of the Annual Governance Statement.

2.4 Audit planning meetings

In developing the Plan, in addition to consideration of the above, the Head of Internal Audit has met and spoken with a number of Trust Executive and Non-Executive Directors to discuss current areas of risk and related assurance needs. The draft Plan has been provided to the Trust's Executive Management Team and the Non-Executive Directors to ensure that Internal Audit's focus is best targeted to areas of risk.

3. Audit risk assessment

The prioritisation of audit coverage across the audit universe is based on both our and the organisation's assessment of risk and assurance requirements as defined in the Board Assurance Framework and corporate risk register.

The maturity of these risk and assurance systems allows us to consider both inherent risk (impact and likelihood) and mitigation (adequacy and effectiveness of internal controls). Our assessment also considers corporate risk, materiality or significance, system complexity, previous audit findings, and potential for fraud.

4. Planned internal audit coverage

4.1 Internal Audit Plan 2025/26

The Plan is set out in Appendix A and identifies the audit assignments, lead executive officers, outline scopes, and proposed timings. It is structured under the six components referred to in section 2.2.

Where appropriate the Plan refers to key strategic risks identified within the corporate risk register and related systems of assurance, together with the proposed audit response within the outline scope.

When developing the audit scope, in discussion with the responsible executive director(s) and operational management, the scope, objectives and audit resource requirements, and timing will be refined in each area.

The scheduling takes account of the optimum timing for the performance of specific assignments in discussion with management, and Audit Wales requirements if appropriate.

The Audit, Risk and Assurance Committee will be kept appraised of performance in delivery of the Plan, and any required changes, through routine progress reports to each Audit, Risk and Assurance Committee meeting.

Most of the audit work will be undertaken by our regionally based teams with support from our national capital and estates team, in terms of capital audit and estates assurance work, and from our Digital and IT team, in terms of information governance, IT security and digital work.

4.2 Keeping the plan under review

Our risk assessment and resulting Plan is limited to matters emerging from the planning processes indicated above.

Audit & Assurance Services is committed to ensuring its service focuses on priority risk areas, business critical systems, and the provision of assurance to management across the medium term and in the operational year ahead. As in any given year, our Plan will be kept under review and may be subject to change to ensure it remains fit for purpose. To this end, the need for flexibility and a revisit of the focus and timing of the proposed work will be necessary at some point during the year.

Consistent with previous years, and in accordance with best professional practice, an unallocated contingency provision has been retained in the Plan to enable Internal Audit to respond to emerging risks and priorities identified by the executive team

and endorsed by the Audit, Risk and Assurance Committee. Any changes to the Plan will be based upon consideration of risk and need and will be presented to the Audit, Risk and Assurance Committee for approval.

Regular liaison with Audit Wales, as your External Auditor, will take place to coordinate planned coverage and ensure optimum benefit is derived from the total audit resource.

5. Resource needs assessment

The Plan has been put together based on the planning process described in this document. The Plan includes sufficient audit work to be able to give an annual Head of Internal Audit opinion in line with the requirements of Standard 11.3 – Communicating Results, and Application Note 10B – Overall conclusions and annual reporting.

Audit & Assurance Services confirms that it has the necessary human, financial and technological resources to deliver the agreed plan.

Provision has also been made for other essential audit work including planning, management, reporting and follow-up.

If additional work, support or further input necessary to deliver the plan is required during the year over and above the total indicative resource requirement a fee may be charged. Any change to the plan will be based upon consideration of risk and need and presented to the Audit, Risk and Assurance Committee for approval.

The Standards enable Internal Audit to provide consulting services to management. The commissioning of these additional services by the Trust, unless already included in the plan, is discretionary. Accordingly, a separate fee may need to be agreed for any additional work.

Under the approach we have adopted for a number of years, the top slice provided to us to undertake the internal audit programme is supplemented by an additional charge for work undertaken over and above the 'top slice' arrangements. To this end the Trust has agreed to pay an additional £50,099 to cover this additional audit work.

Also, under the approach we have adopted since the formation of NWSSP we charge for the specialist Capital and Estates work delivered as a part of the agreed plan. For 2025/26 this additional charge is £26,811, which reflects previous years requirements. The audit of major programmes/projects will be facilitated through the Integrated Assurance and Approval Plans agreed at the respective business cases approved and funded by Welsh Government. There are currently no Trust projects proposed for review facilitated through the Integrated Assurance and Approval Plan process during 2025/26. Therefore, the Trust will be charged an additional amount of £76,910 which is over and above the 'top slice' recharge agreed as part of NWSSP's overall funding for 2025/26.

6. Action required

The Audit, Risk and Assurance Committee is invited to consider the Internal Audit Plan for 2025/26 and:

- approve the Internal Audit Plan for 2025/26;
- approve the Internal Audit Mandate and Charter; and
- note the associated Internal Audit resource requirements and Key Performance Indicators.

Osian Lloyd
Head of Internal Audit
Audit and Assurance Services
NHS Wales Shared Services Partnership

Appendix A: Internal Audit Plan 2025/26

Planned output, Outline scope, Review reference, Review type	Corporate Risk Register Reference	Lead Executive Director	Planned start
1 Risk Management and Assurance (Assurance) Review the on-going development, implementation and application of the Trust's Risk Management and Board Assurance processes.		Director of Corporate Governance	Q4
2 Welsh Language Standards (Assurance) To provide an assurance on the arrangements in place to comply with the requirements of the Standards.	201	Director of Corporate Governance	Q3
3 Follow Up (Assurance) To review the systems in place to monitor progress with the implementation of actions in response to internal audit reports.		Director of Corporate Governance / Executive Team	Q4
4 Budget Setting (Assurance) To review how the Trust allocates resources to meet its agreed budget. *Scope to be reviewed as part of planning.*	139	Director of Finance and Corporate Resources	Q3
5 Clinical Equipment (Assurance) To evaluate the effectiveness of the arrangements put in place to record, monitor and replace clinical equipment.	139	Director of Finance and Corporate Resources / Director of Paramedicine	Q2
6 Clinical Model Transformation Programme Management (Assurance) High level review of the governance arrangements in place to ensure that identified workstreams are managed effectively as formal strategic change programmes, with appropriate assurance reporting mechanisms in place.	223, 100	Director of Strategy, Planning and Performance	Q3

Planned output, Outline scope, Review reference, Review type	Corporate Risk Register Reference	Lead Executive Director	Planned start
7 Integrated Medium Term Plan (IMTP) Development Process (Assurance) Review of the process undertaken for the development of the IMTP, including the mechanisms to identify priorities, engagement with stakeholders and alignment to national criteria.	100	Director of Strategy, Planning and Performance	Q1/2
8 Cymru High Acuity Response Unit (CHARU) (Assurance) A review of the effectiveness of the unit to ensure improvements in the patient care delivered.	223, 100	Director of Paramedicine / Director of Operations	Q2
9 Remote Clinical Support (Assurance) To evaluate the effectiveness of the arrangements put in place to provide clinical support to front line staff. *Scope to be reviewed as part of planning.*	223	Director of Paramedicine / Director of Quality and Nursing / Director of Operations	Q3
10 Manchester Arena Inquiry (Assurance) To review the progress made by the Trust to address and learn from the recommendations raised from the Manchester Arena Inquiry. To assess the governance and reporting arrangements established, and include a validation exercise to support the closure of actions	594	Director of Operations	Q1
11 Capacity Management Plan (Ambulance Care) (Assurance) To provide an assurance on the arrangements in place to ensure that the requirements of the Plan are applied appropriately. To consider the consistency of decision making and how these are communicated to patients.		Director of Operations	Q3

Planned output, Outline scope, Review reference, Review type	Corporate Risk Register Reference	Lead Executive Director	Planned start
12 High Risk Record Policy (Assurance) A review of the mechanisms in place to record and store information in relation to High-Risk Records. To include focus on how this is acted upon to inform the Trust's response to requests for assistance, to ensure the safety and security of its employees and service users.	160	Director of Operations	Q4
13 Data management practices / Devolved data (Assurance) To review the use of data and provision of information in areas outside digital, and the processes in place to ensure compliance with standards and best practice.	623	Director of Digital	Q1/2
14 Emerging technology adoption (Assurance) To assess the robustness of the processes in place to ensure the effective and safe use of new and emerging technologies, such as Artificial Intelligence and automation.	623	Director of Digital	Q2/3
15 Business continuity (Assurance) To examine the processes in place to enable the provision of services in the event of disruption to the digital environment, and the response and recovery processes.	260	Director of Digital	Q3/4
16 Organisational Change Policy (Assurance) To evaluate the processes in place within the Trust to effectively manage organisational change.	163	Director of People and Culture	Q1
17 Mandatory In-Service Training (MIST) (Assurance) To review the impact of the new arrangements, which replaced the old mandatory Continuing Professional Development face-to-face days, and		Director of People and Culture	Q2

Planned output, Outline scope, Review reference, Review type	Corporate Risk Register Reference	Lead Executive Director	Planned start
its effectiveness on the application of statutory and mandatory training requirements.			
18 Job Evaluation (Assurance) To assess how effectively the requirements of the NHS Job Evaluation Handbook are being applied by the Trust.		Director of People and Culture	Q4
19 Capital Provision (Assurance) *Scope to be confirmed.*		Director of Finance and Corporate Resources	Q3/4
20 Estates Assurance: Fire Safety (Assurance) The previous Fire Safety review undertaken in 2020/21 determined Limited Assurance. The current audit will build on the issues identified at the previous review and assess the controls and practices in place operating within the Trust to ensure that the key fire safety regulatory requirements are adequately addressed, and appropriate management arrangements are embedded throughout the organisation.		Director of Finance and Corporate Resources	Q2/3

Appendix B: Key performance indicators (KPI)

KPI	SLA required	Target 2025/26
Audit plan 2025/26 agreed/in draft by 30 April	✓	To deliver plan
Audit opinion 2025/26 delivered by 31 May	✓	To deliver opinion
Audits reported versus total planned audits, and in line with Audit, Risk and Assurance Committee expectations	✓	varies
% of audit outputs in progress	No	varies
Report turnaround fieldwork to draft reporting [10 working days]	✓	85%
Report turnaround management response to draft report [15 working days maximum]	✓	80%
Report turnaround draft response to final reporting [10 working days]	✓	95%

Appendix C: Internal Audit Mandate and Charter

1 Introduction

1.1 This Mandate and Charter is produced and updated annually to comply with the Global Internal Audit Standards (introduced from 1 April 2025 for the UK Public Sector). The Standards (with specific reference to Standard 6.1 Internal Audit Mandate and 6.2 Internal Audit Charter) require the production and maintaining of an Internal Audit Mandate and Charter that, at a minimum, sets out:

- The purpose of Internal Auditing;
- a commitment to adhere to the Global Internal Audit Standards;
- the Mandate, including the scope and types of services to be provided, and the Board's responsibilities and expectations regarding management's support of the internal audit function; and
- the organisational position and reporting relationships, including Independence.

The Mandate and Charter are complementary to the relevant provisions included in the organisation's own Standing Orders and Standing Financial Instructions.

1.2 The terms 'board' and 'senior management' are required to be defined under the Standards and therefore have the following meaning in this Mandate and Charter:

- Board means the Board of Welsh Ambulance Services University NHS Trust with responsibility to direct and oversee the activities and management of the organisation. The Board has delegated authority to the Audit, Risk and Assurance Committee in terms of providing a reporting interface with internal audit activity; and
- Senior Management means the Chief Executive as being the designated Accountable Officer for Welsh Ambulance Services University NHS Trust. The Chief Executive has made arrangements within this Mandate and Charter for an operational interface with internal audit activity through the Director of Corporate Governance (Board Secretary).

1.3 Internal Audit seeks to comply with all the appropriate requirements of the Welsh Language (Wales) Measure 2011. We are happy to correspond in both Welsh and English.

2 Purpose and responsibility

2.1 Internal audit is an independent, objective assurance and advisory function designed to add value and improve the operations of the Welsh Ambulance Services University NHS Trust. Internal audit helps the organisation accomplish its objectives by bringing a systematic and disciplined approach to evaluate and improve the effectiveness of governance, risk management and control processes. Its mission is to enhance and protect organisational value by providing risk-based and objective assurance, advice and insight.

2.2 Internal Audit is responsible for providing an independent and objective assurance opinion to the Accountable Officer, the Board and the Audit, Risk and Assurance Committee on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. In addition, internal audit's findings and recommendations are beneficial to management in securing improvement in the audited areas.

2.3 The organisation's risk management, internal control and governance arrangements comprise:

- the policies, procedures and operations established by the organisation to ensure the achievement of objectives;
- the appropriate assessment and management of risk, and the related system of assurance;
- the arrangements to monitor performance and secure value for money in the use of resources;
- the reliability of internal and external reporting and accountability processes and the safeguarding of assets;
- compliance with applicable laws and regulations; and
- compliance with the behavioural and ethical standards set out for the organisation.

2.4 Internal audit also provides an independent and objective consulting service specifically to help management improve the organisations risk management, control and governance arrangements. The service applies the professional skills of internal audit through a systematic and disciplined evaluation of the policies, procedures and operations that management have put in place to ensure the achievement of the organisations objectives, and through recommendations for improvement. Such consulting work contributes to the opinion which internal audit provides on risk management control and governance.

3 Independence and Objectivity

3.1 Independence is described in the Global Internal Audit Standards as the freedom from conditions that threaten the ability of the internal audit activity to carry out internal audit responsibilities in an unbiased manner. To achieve the degree of independence necessary to effectively carry out the responsibilities of the internal audit activity, the Head of Internal Audit will have direct and unrestricted access to the Board and Senior Management, in particular the Chair of the Audit, Risk and Assurance Committee and Accountable Officer.

3.2 Organisational independence is effectively achieved when the auditor reports functionally to the Audit, Risk and Assurance Committee on behalf of the Board. Such functional reporting includes the Audit, Risk and Assurance Committee:

- approving the internal audit mandate and charter.
- approving the risk based internal audit plan.
- approving the internal audit resource plan.
- receiving outcomes of all internal audit work together with the assurance rating. and

- reporting on internal audit activity's performance relative to its plan.

3.3 While maintaining effective liaison and communication with the organisation, as provided in this Mandate and Charter, all internal audit activities shall remain free of untoward influence by any element in the organisation, including matters of audit selection, scope, procedures, frequency, timing, or report content to permit maintenance of an independent and objective attitude necessary in rendering reports.

3.4 Internal Auditors shall have no executive or direct operational responsibility or authority over any of the activities they review. Accordingly, they shall not develop nor install systems or procedures, prepare records, or engage in any other activity which would normally be audited.

3.5 This Mandate and Charter makes appropriate arrangements to secure the objectivity and independence of internal audit as required under the standards. In addition, the shared service model of provision in NHS Wales through NWSSP provides further organisational independence.

3.6 In terms of avoiding conflicts of interest in relation to non-audit activities, Audit & Assurance has produced a Consulting Protocol that includes all of the steps to be undertaken to ensure compliance with the relevant Standards that apply to non-audit activities.

4 Authority and Accountability

4.1 Internal Audit derives its authority from the Board, the Accountable Officer and Audit, Risk and Assurance Committee. These authorities are established in Standing Orders and Standing Financial Instructions adopted by the Board.

4.2 The Minister for Health and Social Services has determined that internal audit will be provided to all health organisations by the NHS Wales Shared Services Partnership (NWSSP). The service provision will be in accordance with the Service Level Agreement agreed by the Shared Services Partnership Committee and in which the organisation has permanent membership.

4.3 The Director of Audit & Assurance leads the NWSSP Audit and Assurance Services and after due consultation will assign a named Head of Internal Audit to the organisation. For line management (e.g. individual performance) and professional quality purposes (e.g. compliance with the Global Internal Audit Standards), the Head of Internal Audit reports to the Director of Audit & Assurance.

4.4 The Head of Internal Audit reports on a functional basis to the Accountable Officer and to the Audit, Risk and Assurance Committee on behalf of the Board. Accordingly, the Head of Internal Audit has a direct right of access to the Accountable Officer, the Chair of the Audit, Risk and Assurance Committee and the Chair of the organisation if deemed necessary.

4.5 The Audit, Risk and Assurance Committee approves all Internal Audit plans and may review any aspect of its work. The Audit, Risk and Assurance Committee also has regular private meetings with the Head of Internal Audit.

4.6 In order to facilitate its assessment of governance within the organisation, Internal Audit is granted access to attend any

committee or sub-committee of the Board charged with aspects of governance.

5 Relationships

5.1 In terms of normal business the Accountable Officer has determined that the Director of Corporate Governance will be the nominated executive lead for internal audit. Accordingly, the Head of Internal Audit will maintain functional liaison with this officer.

5.2 In order to maximise its contribution to the Board's overall system of assurance, Internal Audit will work closely with the organisation's Director of Corporate Governance in planning its work programme.

5.3 Co-operative relationships with management enhance the ability of internal audit to achieve its objectives effectively. Audit work will be planned in conjunction with management, particularly in respect of the timing of audit work.

5.4 Internal Audit will meet regularly with the external auditor, Audit Wales, to consult on audit plans, discuss matters of mutual interest, discuss common understanding of audit techniques, method and terminology, and to seek opportunities for co-operation in the conduct of audit work. Internal Audit will make available their working files to the external auditor for them to place reliance upon the work of Internal Audit where appropriate.

5.5 The Head of Internal Audit will establish a means to gain an overview of other assurance providers' approaches and output as part of the establishment of an integrated assurance framework.

5.6 The Head of Internal Audit will take account of key systems being operated by organisation's outside of the remit of the Accountable Officer, or through a shared or joint arrangement, such as the Digital Health and Care Wales, NHS Wales Shared Services Partnership, and NHS Wales Joint Commissioning Committee.

5.7 Internal Audit strives to add value to the organisation's processes and help improve its systems and services. To support this Internal Audit will obtain an understanding of the organisation and its activities, encourage two-way communications between internal audit and operational staff, discuss the audit approach and seek feedback on work undertaken.

5.8 The Audit, Risk and Assurance Committee may determine that another Committee of the organisation is a more appropriate forum to receive and action individual audit reports. However, the Audit, Risk and Assurance Committee will remain the final reporting line for all our audit and consulting reports.

6 Standards, Ethics, and Performance

6.1 Internal Audit must comply with the Global Internal Audit Standards and the UK Public Sector Application Note in discharging its responsibilities.

6.2 Internal Audit will operate in accordance with the Service Level Agreement (updated 2024) and associated performance standards agreed with the Audit, Risk and Assurance Committee and the Shared Services Partnership Committee. The Service Level Agreement includes several Key Performance Indicators, and we will agree with each Audit Committee

which of these they want reported to them and how often.

7 Scope

7.1 The scope of Internal Audit encompasses the examination and evaluation of the adequacy and effectiveness of the organisation's governance, risk management arrangements, system of internal control, and the quality of performance in carrying out assigned responsibilities to achieve the organisation's stated goals and objectives. It includes but is not limited to:

- reviewing the reliability and integrity of financial and operating information and the means used to identify measure, classify, and report such information;
- reviewing the systems established to ensure compliance with those policies, plans, procedures, laws, and regulations which could have a significant impact on operations, and reports on whether the organisation is in compliance;
- reviewing the means of safeguarding assets and, as appropriate, verifying the existence of such assets;
- reviewing and appraising the economy and efficiency with which resources are employed, this may include benchmarking and sharing of best practice;
- reviewing operations or programmes to ascertain whether results are consistent with the organisation’s objectives and goals and whether the operations or programmes are being carried out as planned;
- reviewing specific operations at the request of the Audit, Risk and Assurance Committee or management, this may include areas of concern identified in the corporate risk register;
- monitoring and evaluating the effectiveness of the organisation's risk management arrangements and the overall system of assurance;
- ensuring effective co-ordination, as appropriate, with external auditors and other regulators; and
- reviewing the Annual Governance Statement prepared by senior management.

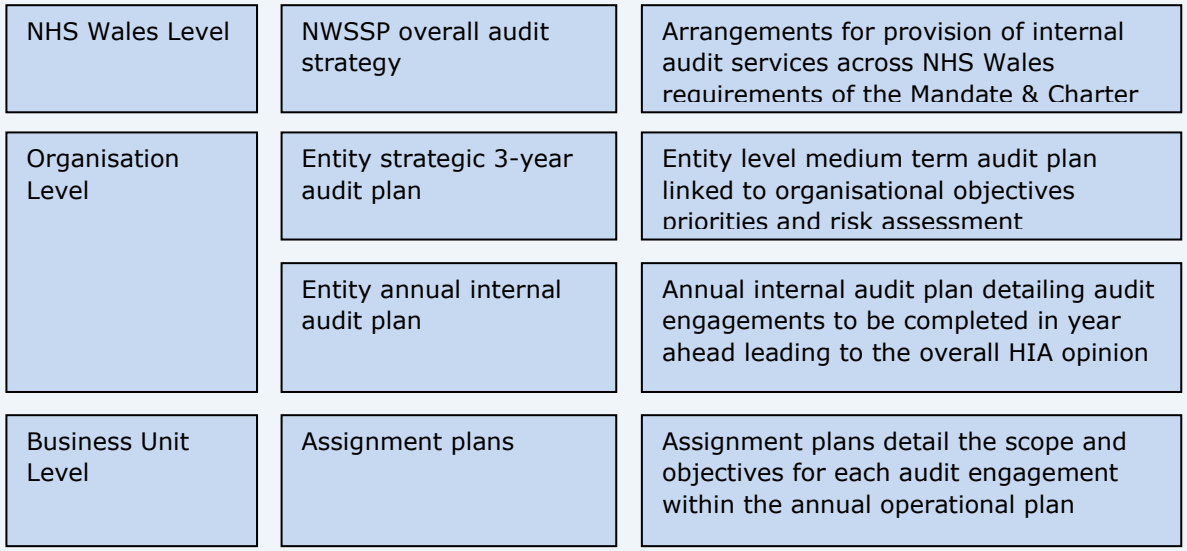
7.2 Internal Audit will devote particular attention to any aspects of the risk management, internal control and governance arrangements affected by material changes to the organisation’s risk environment.

7.3 If the Head of Internal Audit or the Audit, Risk and Assurance Committee consider that the level of audit resources or the Mandate and Charter in any way limit the scope of internal audit or prejudice the ability of internal audit to deliver a service consistent with the definition of internal auditing, they will advise the Accountable Officer and Board accordingly.

8 Approach

8.1 To ensure delivery of its scope and objectives in accordance with the Mandate and Charter and Standards, Internal Audit has produced an Audit Manual (called the Quality Manual). The Quality Manual includes arrangements for planning the audit work. These audit planning arrangements are organised into a hierarchy as illustrated in Figure 1.

Figure 1: Audit planning hierarchy



8.2 NWSSP Audit & Assurance Services has developed an overall audit strategy which sets out the strategic approach to the delivery of audit services to all health organisations in NHS Wales. The strategy also includes arrangements for securing assurance on the national transaction processing systems including those operated by DHCW and NWSSP on behalf of NHS Wales.

8.3 The main purpose of the Strategic 3-year Audit Plan is to enable the Head of Internal Audit to plan over the medium term on how the assurance needs of the organisation will be met as required by the Standards and facilitate:

- the provision to the Accountable Officer and the Audit, Risk and Assurance Committee of an overall opinion each year on the organisation's risk management, control and governance, to support the preparation of the Annual Governance Statement;
- audit of the organisation's risk management, control and governance through periodic audit plans in a way that affords suitable priority to the organisation's objectives and risks;
- improvement of the organisation's risk management, control and governance by providing management with

constructive recommendations arising from audit work;

- an assessment of audit needs in terms of those audit resources which 'are appropriate, sufficient and effectively deployed to achieve the approved plan';
- effective co-operation with external auditors and other review bodies functioning in the organisation; and
- the allocation of resources between assurance and consulting work.

8.4 The Strategic 3-year Audit Plan will be largely based on the Board Assurance Framework where it is sufficiently mature, together with the organisation-wide risk assessment.

8.5 An Annual Internal Audit Plan will be prepared each year drawn from the Strategic 3-year Audit Plan and other information and outlining the scope and timing of audit assignments to be completed during the year ahead.

8.6 The strategic 3-year and annual internal audit plans shall be prepared to support the audit opinion to the Accountable Officer on the risk management, internal control and governance arrangements within the organisation.

8.7 The annual internal audit plan will be developed in discussion with executive management and approved by the Audit, Risk and Assurance Committee on behalf of the Board.

8.8 The NWSSP Audit Strategy is expanded in the form of a Quality Manual and a Consulting Protocol which together define the audit approach applied to the provision of internal audit and consulting services.

8.9 During the planning of audit assignments, an assignment brief will be prepared for discussion with the nominated operational manager. The brief will contain the proposed scope of the review along with the relevant objectives and risks to be covered. In order to ensure the scope of the review is appropriate it will require agreement by the relevant Executive Director or their nominated lead and will also be copied to the Director of Corporate Governance.

9 Reporting

9.1 Internal Audit will report formally to the Audit, Risk and Assurance Committee through the following:

- An annual report will be presented to confirm completion of the audit plan and will include the Head of Internal Audit opinion provided for the Accountable Officer that will support the Annual Governance Statement.
- The Head of Internal Audit opinion will:
  a) State the overall adequacy and effectiveness of the organisation's risk management, control and governance processes;
  b) Disclose any qualification to that opinion, together with the reasons for the qualification;
  c) Present a summary of the audit work undertaken to formulate the opinion, including reliance placed on work by other assurance bodies;

d) Draw attention to any issues Internal Audit judge as being particularly relevant to the preparation of the Annual Governance Statement;

e) Compare work undertaken with the work which was planned and summarise performance of the internal audit function against its performance measurement criteria; and

f) Provide a statement of conformity in terms of compliance with the Global Internal Audit Standards and associated internal quality assurance arrangements.

- For each Audit, Risk and Assurance Committee meeting a progress report will be presented to summarise progress against the plan. The progress report will highlight any slippage and changes in the programme. The findings arising from individual audit reviews will be reported in accordance with Audit, Risk and Assurance Committee requirements; and
- The Audit, Risk and Assurance Committee will be provided with copies of individual audit reports for each assignment undertaken unless the Head of Internal Audit is advised otherwise. The reports will include an action plan on any recommendations for improvement agreed with management including target dates for completion.

9.2 The process for audit reporting is summarised below:

- Following the closure of fieldwork and the resolution of any queries, Internal Audit will discuss findings with operational managers to confirm understanding and shape the reporting stage.
- Operational management will receive discussion draft reports which will include any proposed recommendations for improvement within 10 working days following the discussion of findings. A copy of the draft report will also be provided to the relevant Executive Director.
- The draft report will give an assurance opinion on the area reviewed in line with the criteria at Appendix B (unless it is a consulting review). The draft report will also indicate priority ratings for individual report findings and recommendations.
- Operational management will be required to respond to the draft report in consultation with the relevant Executive Director within 15 working days of issue, identifying actions, identifying staff with responsibility for implementation and the dates by which action will be taken.
- The Head of Internal Audit will seek to resolve any disagreement with management in the clearance of the draft report. However, where the management response is deemed inadequate, or disagreement remains then the matter will be escalated to the Director of Corporate Governance. The Head of Internal Audit may present the draft report to the Audit, Risk and Assurance Committee where the management response is inadequate or where disagreement remains unresolved. The Head of Internal Audit may also escalate this directly to the Audit, Risk and Assurance Committee Chair to ensure that the issues raised in the report are addressed appropriately.
- Reminder correspondence will be issued after the set response date where no management response has been

received. Where no reply is received within 5 working days of the reminder, the matter will be escalated to the Director of Corporate Governance. The Head of Internal Audit may present the draft report to the Audit, Risk and Assurance Committee where no management response is forthcoming.

- Internal Audit issues a Final report to Executive Director within 10 working days of receipt of complete management response. Within this timescale Internal Audit will quality assess the responses, and if necessary, return the responses, requiring them to be strengthened.
- Responses to audit recommendations need to be SMART:
  - Specific
  - Measurable
  - Achievable
  - Relevant / Realistic
  - Timely.
- The relevant Executive Director, Director of Corporate Governance and the Chair of the Audit, Risk and Assurance Committee will be copied into any correspondence.
- The final report will be copied to the Accountable Officer and Director of Corporate Governance and placed on the agenda for the next available Audit, Risk and Assurance Committee.

9.3 Internal Audit will make provision to review the implementation of agreed action within the agreed timescales. However, where there are issues of particular concern provision maybe made for a follow-up review within the same financial year. Issue and clearance of follow up reports shall be as for other assignments referred to above.

9.4 Timescales are to be included in all initial scopes sent prior to commencing an audit.

10 Access and Confidentiality

10.1 Internal Audit shall have the authority to access all the organisation's information, documents, records, assets, personnel and premises that it considers necessary to fulfil its role. This shall extend to the resources of the third parties that provide services on behalf of the organisation.

10.2 All information obtained during a review will be regarded as strictly confidential to the organisation and shall not be divulged to any third party without the prior permission of the Accountable Officer. However, open access is granted to the organisation's external auditors.

10.3 Where there is a request to share information amongst the NHS bodies in Wales, for example to promote good practice and learning, then permission will be sought from the Accountable Officer before any information is shared.

11 Irregularities, Fraud & Corruption

11.1 It is the responsibility of management to maintain systems that ensure the organisation's resources are utilised in the manner and on activities intended. This includes the responsibility for the prevention and detection of fraud and other illegal acts.

11.2 Internal Audit shall not be relied upon to detect fraud or other irregularities. However, Internal Audit will give due regard to the possibility of fraud and other irregularities in work undertaken. Additionally, Internal Audit shall seek to identify weaknesses in control that could permit fraud or irregularity.

11.3 If Internal Audit discovers suspicion or evidence of fraud or irregularity, this will immediately be reported to the organisation's Local Counter Fraud Service (LCFS) in accordance with the organisation's Counter Fraud Policy & Fraud Response Plan and the agreed Internal Audit and Counter Fraud Protocol.

12 Quality Assurance

12.1 The work of internal audit is controlled at each level of operation to ensure that a continuously effective level of performance, compliant with the Global Internal Audit Standards, is being achieved.

12.2 The Director of Audit & Assurance will establish a quality assurance and improvement programme designed to give assurance through internal and external review that the work of Internal Audit is compliant with the Global Internal Audit Standards and to achieve its objectives. A commentary on compliance against the Standards will be provided in the Annual Audit Report to the Audit, Risk and Assurance Committee.

12.3 The Director of Audit & Assurance will monitor the performance of the internal audit provision in terms of meeting the service performance standards set out in the NWSSP Service Level Agreement. The Head of Internal Audit will periodically report service performance to the Audit, Risk and Assurance Committee through the reporting mechanisms outlined in Section 9.

13 Resolving Concerns

13.1 NWSSP Audit & Assurance was established for the collective benefit of NHS Wales and as such needs to meet the expectations of client partners. Any questions or concerns about the audit service should be raised initially with the Head of Internal Audit assigned to the organisation. In addition, any matter may be escalated to the Director of Audit & Assurance. NWSSP Audit & Assurance will seek to resolve any issues and find a way forward.

13.2 Any formal complaints will be handled in accordance with the NWSSP complaint handling procedure. Where any concerns relate to the conduct of the Director of Audit & Assurance, the NHS organisation will have access to the Managing Director of Shared Services.

14 Review of the Internal Audit Mandate and Charter

14.1 This Internal Audit Mandate and Charter shall be reviewed annually and approved by the Board, taking account of advice from the Audit, Risk and Assurance Committee.

Simon Cookson
Director of Audit & Assurance
NHS Wales Shared Services Partnership
February 2025

Disclaimer

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 Mandate and Charter as approved by the Audit, Risk and 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.

The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given regarding the advice and information contained.

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 management of 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.

Global Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Global Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023. Please note that new Global Internal Audit Standards apply from April 2025, and all future audit work will comply to these new Standards.

Archwilio Cymru
Audit Wales

Annual Audit Report 2024 – Welsh Ambulance Services University NHS Trust

Audit year: 2023-24

Date issued: January 2025

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

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

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

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Summary report

About this report

1 This report summarises the findings from my 2024 audit work at the Welsh Ambulance Services University NHS Trust (the Trust) undertaken to fulfil my responsibilities under the Public Audit (Wales) Act 2004. That Act requires me to:

- examine and certify the accounts submitted to me by the Trust, and to lay them before the Senedd;
- satisfy myself that expenditure and income have been applied to the purposes intended and are in accordance with authorities; and
- satisfy myself that the Trust has made proper arrangements for securing economy, efficiency, and effectiveness in its use of resources.

2 I report my overall findings under the following headings:

- Audit of accounts
- Arrangements for securing economy, efficiency, and effectiveness in the use of resources

3 This year's audit work took place at a time when NHS bodies were continuing to respond to a broad set of challenges associated with the cost-of-living crisis, the climate emergency, inflationary pressures on public finances, workforce shortages, and an ageing estate. In addition, NHS bodies are still dealing with the legacy of the COVID-19 pandemic. My work programme, therefore, was designed to best assure the people of Wales that public funds are well managed.

4 We largely continued to work and engage remotely where possible through the use of technology, but some on-site audit work resumed where it was appropriate to do so. This inevitably had an impact on how we deliver audit work but has also helped to embed positive changes in our ways of working.

5 The audited accounts submission deadline was shortened by two weeks from the previous year to 15 July 2024. The financial statements were certified on 12 July 2024, meaning the deadline was met. This reflects a great collective effort by both my staff and the Trust's officers.

6 The focus and approach of my performance audit work continues to be aligned to the post-pandemic challenges facing the NHS in Wales and is conducted in line with INTOSAI[1] auditing standards.

7 This report is a summary of the issues presented in more detailed reports to the Trust this year (see **Appendix 1**). I also include a summary of the status of work still underway, but not yet completed.

[1] INTOSAI (International Organisation of Supreme Audit Institutions) is a global umbrella organisation for the performance audit community. It is a non-governmental organisation with special consultative status with the Economic and Social Council (ECOSOC) of the United Nations.

8 **Appendix 2** presents the latest estimate of the audit fee that I will need to charge to cover the costs of undertaking my work, compared to the original fee set out in the 2024 Audit Plan.

9 **Appendix 3** sets out the audit of accounts risks set out in my 2024 Audit Plan and how they were addressed through the audit.

10 The Chief Executive and the Executive Director of Finance and Corporate Resources have agreed the factual accuracy of this report. We will present it to the Audit and Risk Assurance Committee on 6 March 2025. The Board will receive the report at a later Board meeting and every member will receive a copy. We strongly encourage the Trust to arrange its wider publication. We will make the report available to the public on the Audit Wales website after the Board have considered it.

11 I would like to thank the Trust's staff and members for their help and co-operation throughout my audit.

Key messages

Audit of accounts

12 I concluded that the Trust's accounts were properly prepared and materially accurate and issued an unqualified audit opinion on them. My work did not identify any material weaknesses in internal controls (as relevant to my audit) however, I brought some issues to the attention of officers and the Audit, Risk and Assurance Committee in my Audit of Accounts Report.

13 I identified no material financial transactions within the Trust's 2023-24 accounts that were not in accordance with authorities or not used for the purpose intended, and so I have issued an unqualified opinion on the regularity of the financial transactions within the Trust's 2023-24 accounts.

14 I placed no substantive report alongside my opinion this year as there were no issues to report.

Arrangements for securing efficiency, effectiveness, and economy in the use of resources

15 My programme of Performance Audit work has led me to draw the following conclusions:

- The Trust exceeded its overall 2023-24 savings target and continues to enhance its arrangements for identifying, delivering, and monitoring efficiencies and sustainable cost savings. However, opportunities exist for the Trust to reduce its reliance on non-recurrent savings, strengthen financial capabilities across the organisation, and refine its savings reporting to Board.

- The Trust has made some improvements to its quality governance structures, including responding to the duties of quality and candour. However, there is scope for further improvements in some areas to strengthen assurance relating to the quality and safety of its service.
- The Trust's corporate arrangements generally support good governance and the efficient, effective, and economical use of resources. Positively, the Trust is transforming its clinical services to better manage operational pressures and demand and is making good progress in enhancing key systems of assurance to strengthen Board focus on strategic risks. The Trust has strong financial performance, supported by good financial planning, which enabled it to meet its financial duties for 2023-24 and the three-year period 2021-24.

16 These findings are considered further in the following sections.

Detailed report

Audit of accounts

17 Preparing annual accounts is an essential part of demonstrating the stewardship of public money. The accounts show the organisation's financial performance and set out its net assets, net operating costs, gains and losses, and cash flows. My annual audit of those accounts provides an opinion on both their accuracy and the proper use ('regularity') of public monies.

18 My 2024 Audit Plan set out the key risks for audit of the accounts for 2023-24 and these are detailed along with how they were addressed in **Exhibit 4**, **Appendix 3**.

19 My responsibilities in auditing the accounts are described in my Statement of Responsibilities publications, which are available on the Audit Wales website.

Accuracy and preparation of the 2023-24 accounts

20 I concluded that the Trust's accounts were properly prepared and materially accurate and issued an unqualified audit opinion on them. My work did not identify any material weaknesses in internal controls (as relevant to my audit) however, I brought some issues to the attention of officers and the Audit, Risk and Assurance Committee.

21 The unaudited accounts were produced for audit in line with agreed timescales, however, a number of misstatements, both corrected and uncorrected were identified. These misstatements had no impact (individually or in aggregate) on the Trust's retained surplus position but took additional time to confirm and agree as part of the audit process.

22 I must report issues arising from my work to those charged with governance (the Audit, Risk and Assurance Committee) for consideration before I issue my audit opinion on the accounts. My Financial Audit Manager reported these issues on 10 July 2024. **Exhibit 1** summarises the key issues set out in that report.

Exhibit 1: issues reported to the Audit, Risk and Assurance Committee

Issue	Auditors' comments
Uncorrected misstatements	**Note 13 Property, plant and equipment** Our audit identified an error in the depreciation charged in-year for an Information Technology asset. This was due to an incorrect asset life being applied. This resulted in an overcharge of depreciation of £513,000 to the Statement of Comprehensive Income. Our audit also identified an understatement of £158,000 in the depreciation charged in-year for 7 assets, as useful lives had not been allocated to these assets. This resulted in no depreciation being charged to the Statement of Comprehensive Income in respect of these assets. The net effect of these misstatements is an overcharge of £355,000 of depreciation to the Statement of Comprehensive Income. However, as depreciation is fully funded by Welsh Government this results in an overclaim of £355,000 of funding from the Welsh Government. However, management has informed us that Welsh Government is not expected to seek to recover this amount from the Trust, given the value and its immateriality. Therefore, this uncorrected misstatement has no impact on the Trust's retained surplus position at year end.
Corrected misstatements	Numerous amendments were made to the accounts, the most significant being in relation to the following notes: Property, Plant and Equipment, and Intangibles (Notes 13 and 14); Capital commitments (Note 25); Losses and special payments - analysis (Note 26.3). None of these misstatements resulted in an impact on the Trust's retained surplus position.

Issue	Auditors' comments
Other significant issues	Our audit this year has identified a number of misstatements, both corrected and uncorrected. These misstatements had no impact (individually or in aggregate) on the Trust's retained surplus position but took additional time to confirm and agree as part of the audit process. We will work with the Trust to plan for the audit of its 2024-25 accounts with the aim of making the process as efficient as possible. This will be particularly important given the intention for audit deadlines to be brought further forward for the 2024-25 financial year.

23 I also undertook a review of the Whole of Government Accounts return. I concluded that the counterparty consolidation information was consistent with the Trust's financial position on 31 March 2024 and the return was prepared in accordance with the Treasury's instructions.

24 My separate independent examination of the charitable funds accounts is complete with the closing findings reported to the Charitable Funds Committee on 14 January 2025. The Auditor General certified the final accounts on 30 January, allowing the accounts to be filed by the Charity Commission's statutory deadline of 31 January.

Regularity of financial transactions

25 The Trust's financial transactions must be in accordance with the authorities that govern them. It must have the powers to receive income and incur expenditure. Our work reviews these powers and tests that there are no material elements of income or expenditure which the Trust does not have the powers to receive or incur.

~~26~~ I identified no material financial transactions within the Trust's 2023-24 accounts that were not in accordance with authorities or not used for the purpose intended, and so I have issued an unqualified opinion on the regularity of the financial transactions within the Trust's 2023-24 accounts.

27 I placed no substantive report on the accounts alongside my opinion this year as there were no issues to report.

28 I have the power to place a substantive report on the Trust's accounts alongside my opinions where I want to highlight issues. Where the Trust fails one of its financial duties – to break even over a three-year period and to have an approved three-year plan in place – or my opinion is qualified, I will issue a substantive report.

29 The Trust met both of its financial duties reporting a surplus of £85,000 at the end of the financial year. The Trust also achieved its statutory financial duty to achieve break-even over a three-year rolling period for 2021-22 to 2023-24, reporting an overall three-year surplus of £222,000. As a result, my opinions were unqualified, so I did not issue such a report for these issues.

Arrangements for securing efficiency, effectiveness, and economy in the use of resources

30 I have a statutory requirement to satisfy myself that the Trust has proper arrangements in place to secure efficiency, effectiveness, and economy in the use of resources. I have undertaken a range of performance audit work at the Trust over the last 12 months to help me discharge that responsibility. This work has involved:

- reviewing the effectiveness of the Trust's cost savings arrangements;
- assessing the extent to which the Trust has implemented my 2022 recommendations on quality governance; and
- undertaking a structured assessment of the Trust's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically.

31 My conclusions based on this work are set out below.

Review of cost savings arrangements

32 My review examined whether the Trust has an effective approach to identifying, delivering, and monitoring sustainable cost savings opportunities. It considered the impact these arrangements had on the Trust's 2023-24 year-end position and highlighted where arrangements may need to be strengthened for 2024-25 and beyond.

33 My work found that the Trust exceeded its overall 2023-24 savings target and continues to enhance its arrangements for identifying, delivering, and monitoring efficiencies and sustainable cost savings. However, opportunities exist for the Trust to reduce its reliance on non-recurrent savings, strengthen financial capabilities across the organisation, and refine its savings reporting to Board.

34 The Trust has a good understanding of its cost drivers, which include pay, utilities, and service pressures. It makes appropriate use of data from various sources to identify cost-saving opportunities, such as internal reviews and benchmarking. Planning for savings is improving, with a focus on both efficiencies and income generation. The Trust uses a risk-based process to select its cost improvement schemes.

35 Whilst the Trust has a good track record of achieving its savings targets, it needs to reduce its reliance on non-recurrent savings. Furthermore, it needs to address any

gaps in the financial literacy, competencies, and expertise of staff if it is to maximise the identification and delivery of savings and efficiencies in 2024-25 and beyond.

36 The Trust has effective arrangements in place for overseeing delivery of savings, with regular reporting to the Board and Finance and Performance Committee. However, there is a need to ensure consistency in savings reports by using the same figures to avoid confusion. The Trust regularly reviews the risks associated with savings planning and delivery and proactively learns from its experiences to improve its savings processes.

Quality Governance Follow up Review

37 My work considered the Trust's progress in implementing the recommendations we made in our 2022 quality governance review as well as the assurance provided to the Board that the Trust is taking steps to respond to the requirements of the Act.

38 My work found that whilst the Trust can demonstrate some progress in implementing the recommendations arising from the 2022 Review of Quality Governance Arrangements, it still had more to do to address the recommendations in full. Specifically, my review found that:

- Delivery of the Trust's Quality Strategy for 2021-24 has continued to be slower than planned due to ongoing resourcing and capacity issues, and there is also a need to improve progress reporting on strategic delivery.
- The Trust approves the Clinical Audit Plan annually and provides regular updates on its progress to the Quality, Patient Experience and Safety (QuESt) Committee; however, the reporting of outcomes and learning from clinical audit work could be strengthened.
- Whilst the Trust has implemented the new framework for mortality reviews, the timeliness of the completion of these reviews varies and there is scope for more consistent reporting of mortality review activity, outcomes, and learning.
- Whilst PADR (Performance Appraisal and Development Review) completion rates have improved since the original review, they continue to be below the Trust's target rate.
- The Trust has a standard operating procedure for Board members conducting visits, however, the frequency and coverage of visits are variable. Furthermore, the Trust currently does not capture and report feedback and learning to the Board.
- Compliance with the new national process for jointly investigating serious incidents with partners is strong with activity regularly monitored by the QuESt committee.
- The Trust continues to face challenges in reporting patient outcomes due to differing patient systems in place across NHS organisations. However, there is more the Trust can and should do to triangulate and identify themes and learning from this information.

39 The Trust has taken steps to implement the duties of quality and candour, however, there are weaknesses in the clarity of reporting progress and there is scope to improve training compliance and monitoring. Before the Health and Social Care (Quality and Engagement) Act 2020 came into effect in April 2023, the Trust assessed its readiness against the Welsh Government baseline. The Trust also held Board sessions to raise awareness of the new Act. Staff were supported via e-learning modules to help understand and respond to the new requirements. While training is in place for the Duties of Quality and Candour, technical difficulties has made it difficult for the Trust to monitor compliance which creates a risk that there is insufficient staff understanding of the new requirements. The Trust has developed an Implementation Plan and tracks its progress in implementing the requirements under the Duties of Candour and Quality using the Welsh Government roadmap. However, there is scope for the Trust to strengthen the assurance it provides within its progress reports to the QuESt Committee.

Structured assessment

40 My 2024 structured assessment work took place at a time when NHS bodies were continuing to respond to a broader set of challenges associated with the cost-of-living crisis, the climate emergency, inflationary pressures on public finances, workforce shortages, and an ageing estate. In addition, NHS bodies are still dealing with the legacy of the COVID-19 pandemic. More than ever, therefore, NHS bodies and their Boards need to have sound corporate governance arrangements that can provide assurance to themselves, the public, and key stakeholders that the necessary action is being taken to deliver high-quality, safe and responsive services, and that public money is being spent wisely.

41 My team focussed on the Trust's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically, with a specific focus on: Board transparency, effectiveness, and cohesion; corporate systems of assurance; corporate approach to planning; and corporate approach to managing financial resources. Auditors also paid attention to progress made to address previous recommendations.

42 At the time of my structured assessment work, the Trust was subject to Level One status under the Welsh Government's escalation and intervention arrangements].

Corporate approach to planning

43 My work considered whether the Trust has a sound corporate approach to planning. I paid particular attention to the organisation's arrangements for:

- producing and overseeing the development of strategies and corporate plans, including the Integrated Medium-Term Plan; and
- overseeing the delivery of corporate strategies and plans.

44 My work found that the Trust continues to have a generally sound approach to producing strategies and corporate plans, including the development of an ambitious Clinical Model Transformation Programme. However, opportunities remain to strengthen Board oversight of the development and delivery of the Trust's Integrated Medium-Term Plan.

45 The Trust continues to pursue its long-term strategic framework, "Delivering Excellence, Our Vision for 2030", which focusses on altering its traditional service model to manage demand differently. The Trust has generally good arrangements for producing strategies and corporate plans. It has made good progress recently in developing an ambitious Clinical Model Transformation Programme to transform service delivery and its IMTP for 2024-27 was approved and submitted on time. Whilst the Trust was able to produce an approvable Integrated Medium-Term Plan for 2024-27 (IMTP 2024-27), the Board should have been more involved in scrutinising the draft version prior to approving the final plan before it was submitted to Welsh Government.

46 The IMTP 2024-27 contains clear objectives and outcome-based milestones, with a strong focus on delivery. Overall delivery of the IMTP is overseen by the Strategic Transformation Board, though specific relevant actions are monitored by the Clinical Model Transformation Board and the Integrated Strategic Planning and Development Group. Quarterly progress updates are provided to the Finance and Performance Committee and the Board. There is greater focus on the impact of plan delivery in progress reports, with good scrutiny provided by members. However, the Trust needs to urgently clarify to Board the impact of the Clinical Model Transformation Programme on wider delivery of the IMTP 2024-27.

Corporate systems of assurance

47 My work considered whether the Trust has a sound corporate approach to managing risks, performance, and the quality and safety of services. I paid particular attention to the organisation's arrangements for:

- overseeing strategic and corporate risks;
- overseeing organisational performance;
- overseeing the quality and safety of services; and
- tracking recommendations.

48 My work found that the Trust continues to strengthen its corporate systems of assurance and is taking positive steps to enhance its Board Assurance Framework (BAF). However, opportunities remain to strengthen the Trust's framework for managing organisational performance and overseeing the quality and safety of services.

49 The Trust is in the third and final year of its risk management transformation programme. Part of the programme relates to enhancing the Trust's BAF to focus more explicitly on the risks to achieving the organisation's strategic objectives. The Trust continues to have reasonable performance management arrangements in place in line with its Quality and Performance Management Framework. However, the framework requires some updating, particularly in relation to key roles. The Trust continues to report performance against approved metrics via Monthly Integrated Quality and Performance Reports, with appropriate scrutiny and challenge provided by the Board. The Trust has also improved its systems for tracking and actioning audit recommendations, with regular reporting to the Audit, Risk, and Assurance Committee (ARAC).

Board transparency, effectiveness, and cohesion

50 My work considered whether the Trust's Board conducts its business appropriately, effectively, and transparently. I paid particular attention to:

- Public transparency of Board business
- Arrangements to support the conduct of Board business
- Board and committee structure, business, meetings, and flows of assurance

- Board commitment to hearing from staff, users, other stakeholders
- Board skills, experiences, cohesiveness, and commitment to improvement

51 My work found that recent changes to Board membership have been managed well and the Board has continued to conduct its business effectively. The Trust continues to demonstrate a strong commitment to public transparency and continuous improvement. The Trust remains committed to hearing from patients, staff, and other stakeholders; however, opportunities remain to enhance these arrangements further.

52 The Trust continues to hold in-person Board meetings which are open to the public to observe. The public can also submit questions to the Board, and we found that they receive comprehensive responses which are tracked via an action log. Committee Chairs determine whether meetings are held virtually only or using a hybrid approach, where members can join either in-person or online. The majority of the Trust's committees meet virtually, which is decided during agenda setting meetings. Board and committee meetings are well-chaired, with good quality information provided to support effective scrutiny and decision-making. The Trust plans to strengthen its reports further by including a greater level of analysis and trend information.

53 The Trust continues to have proper arrangements for conducting Board and committee business, including updating its Standing Orders and policies. In addition, the Trust has made significant progress in reviewing its policies.

54 The Trust uses patient and staff stories to inform Board business. However, staff stories do not currently follow the same process for patient stories, and it is not always clear how the Trust is using this intelligence to provide assurance or promote improvement. Furthermore, there is scope for the Trust to improve the process for feeding back intelligence from Board visits and patient experience reports.

55 The Trust has managed recent changes to Board membership well and put a supportive induction process in place for new members. The Board Development Programme continues to provide valuable learning and discussion opportunities. The Board and its committees continue to undertake effectiveness reviews. However, the response rates for some committees were low, particularly for the ARAC and People and Culture Committee. The ARAC is working to improve rates by completing its effectiveness review in stages throughout the year rather than as an annual exercise.

Corporate approach to managing financial resources

56 My work considered whether the Trust has a sound corporate approach to managing its financial resources. I paid particular attention to the organisation's arrangements for:

- achieving its financial objectives;
- overseeing financial planning;

- overseeing financial management; and
- overseeing financial performance.

57 My work found that the Trust continues to have strong financial performance supported by effective financial planning. However, the Trust needs to improve its arrangements for identifying and reporting recurrent saving schemes.

58 The Trust continued its good record of meeting its financial duties in 2023-24, recording a small revenue surplus of £85,000, and achieving breakeven over the rolling three-year period 2021-22 to 2023-24. The Trust is on course to meet its financial objectives for 2024-25.

59 The Trust has a clear approach to financial planning. It also has effective financial management arrangements and controls in place, with no significant concerns identified by internal audits. The Trust's financial statements for 2023-24 received a clean audit opinion.

60 The organisation's savings target for 2024-25 is £6.4 million. However, a significant portion (43%) comes from non-recurrent savings, which potentially creates a risk to organisational resilience and financial sustainability. The Trust has recently improved the clarity of its financial reports by specifying whether savings schemes are recurrent or non-recurrent. Oversight and scrutiny of financial performance by the Board and the Finance and Performance Committee is effective, with appropriate challenge and support. However, opportunities remain to strengthen the content and presentation of finance reports.

Reports issued since my last annual audit report

Exhibit 2: reports issued since my last annual audit report

The following table lists the reports issued to the Trust in 2024.

Report	Date
Financial audit reports	
Audit of Financial Statements Report	June 2024
Opinion on the Financial Statements	July 2024
Independent examination of the charitable funds' accounts	December 2024

Report	Date
Performance audit reports	
Review of Cost Savings Arrangements	August 2024
Quality Governance Follow up Review	September 2024
Structured Assessment 2024	October 2024
Other	
2024 Audit Plan	April 2024

My wider programme of national value-for-money studies in 2024 included reviews that focused on the NHS and pan-public-sector topics. These studies are typically funded through the Welsh Consolidated Fund and are presented to the Public Accounts Committee to support its scrutiny of public expenditure. Reports are available on the Audit Wales website.

Exhibit 3: performance audit work still underway

There are several performance audits that are still underway at the Trust. These are shown in the following table, with the estimated dates for completion of the work.

Report	Estimated completion date
Urgent and emergency care: Arrangements for Managing Demand	March 2024
Review of Digital Transformation	May 2024

Appendix 2

Audit fee

The 2024 Audit Plan set out the proposed audit fee of £200,483 (excluding VAT). My latest estimate of the actual fee is £210,483, which includes an increase of £10,000 in the audit of financial statements due to the numerous misstatements identified during our audit and the additional time taken to confirm and agree the correct figures.

In addition to the fee set out above, the audit work undertaken on the shared services provided to the Trust by the NHS Wales Shared Services Partnership cost £641.

Appendix 3

Audit of accounts risks

Exhibit 4: audit of accounts risks

My 2024 Audit Plan set out the risks of material misstatement and/or irregularity for the audit of the Trust's 2023-24 accounts. The table below lists these risks and sets out how they were addressed as part of the audit.

Audit risk	Proposed audit response	Work done and outcome
The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.32-33].	My audit team will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for bias; and • evaluate the rationale for any significant transactions outside the normal course of business.	Audit work over journal entries and accounting estimates found no evidence of management override of controls and provided assurance that the accounts were free from material error.
There is an inherent risk that you will fail to meet your first financial duty to break even over a rolling three-year period. However, your reported position at month 11 shows a year-to-date surplus of £108,000 and a forecast of break-even which is consistent with the Minister's	My audit team will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for bias; • perform detailed testing on a sample of key transactions before and after year	The work was carried out as proposed. Our audit work provided assurance that the accounts were free from material error and that the year-end surplus position for 2023-24 was appropriate.

Audit risk	Proposed audit response	Work done and outcome
published control total. This, combined with the outturns for 2021-22 and 2022-23, would result in a rolling three-year surplus of £137,000. While the financial position of the Trust is robust, the existence of such a financial duty increases the risk that management judgements and estimates could be biased in response.	end to ensure they are accounted for in the correct accounting period; and • perform detailed testing on a sample of key year end balances to ensure they are appropriate and complete.	
Our 2022-23 audit identified £110,000 of transactions that had been recorded in the 2022-23 accounts, despite reflecting transactions arising from 2023-24. There is therefore an inherent risk that we could uncover similar transactions in our 2023-24 audit, which could be material in value and require amendment	My audit team will perform detailed testing on a sample of key transactions before and after year end to ensure they are accounted for in the correct accounting period.	The work was carried out as proposed. My team did not identify any issues.
From 1 December 2023, the Losses and Special Payments Register (LaSPaR) used to calculate the losses and many of the provisions balances in the accounts has been decommissioned.	My audit team will: • test the completeness and accuracy of data transfer from the LaSPaR system to the excel based spreadsheets;	The work was carried out as proposed. Our work in this area identified some misstatements which we reported to those charged with governance in the Audit Report. These were corrected by Management.

Audit risk	Proposed audit response	Work done and outcome
For the remainder of 2023-24, a model Excel spreadsheet has been used to record losses and special payments and calculate year-end balances. There is a risk that transactions and balances related to losses and special payments are misstated due to: • the data transfer between LaSPaR and the Excel model not being complete and accurate; and/or • the Excel model miscalculating balances, due to formula errors and/or incorrect data entry. Furthermore, the subjective nature of estimating provisions for clinical negligence and personal injury claims (and the need for expert external input) gives rise to increased audit risk.	• review the year-end Excel spreadsheet to ensure that there are no significant errors or issues; • confirm Excel entries back to supporting evidence (e.g. Quantum reports) on a sample basis; and • confirm the competence and objectivity of expert opinion informing the value of such estimates.	
The revised accounting standard for leases (IFRS 16) was adopted by the Financial reporting Manual (FreM) from 2022-23 onwards. IFRS 16 significantly changes	My audit team will: • consider the completeness of the lease portfolios identified by the Trust needing to be	The work was carried out as proposed. One issue was reported to those charged with governance in the Audit Report which was corrected by Management.

Audit risk	Proposed audit response	Work done and outcome
how most leased assets are accounted for and there are also significant additional disclosure requirements arising. As 2023-24 is the second year of adoption, there is a risk that the accounting and disclosure requirements will be incomplete as it will take time for IFRS 16 requirements to be fully embedded.	included in IFRS 16 calculations; • review a sample of calculated asset and liability values and ensure that these have been accounted for and disclosed in accordance with the Manual for Accounts and FReM; and • ensure that all material disclosures have been made appropriately.	
There is significant investment in capital projects and a risk that capital classified as Assets Under Construction is materially mis-stated: • Capital expenditure up to month 11 was reported at £10m, with a forecast of £23m at year end. • There is an element of judgement needed when determining the amount of costs to be capitalised on each project and the valuation of these assets at the end of the year.	My audit team will: • understand the reasons for the peak in capital expenditure predicted in month 12 and assess impact on audit approach; • perform detailed testing on a sample of additions and capital accruals; • for vehicles under construction by third parties, review the contractual terms and assess whether the criteria for recognising the assets have been met; and • review and challenge whether any assets under	The work was carried out as proposed. Our work in this area identified some misstatements which we reported to those charged with governance in the Audit Report. These were corrected by Management.

Audit risk	Proposed audit response	Work done and outcome
	construction require impairment.	
Senior Officer Remuneration is an area of complexity and significant interest in the accounts each year. As an area of specific interest for the audit, we apply a lower materiality level in our review of this area.	My audit team will review these disclosures in detail to ensure that they are reasonable and in line with legislative requirements.	The work was carried out as proposed. Audit work confirmed that the disclosures in this area of the accounts were materially complete and accurate.
Related Party Disclosures is an area with a lower materiality level in our review of this area as there are risks of incorrect or incomplete disclosures being made.	My audit team will review these disclosures in detail to ensure that they are reasonable, complete and in line with the FReM	The work was carried out as proposed. No issues were identified from the work completed

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

Archwilio Cymru
Audit Wales

Welsh Ambulance Services University NHS Trust

Outline Audit Plan 2025

Audit Year: 2024-25
Date issued: February 2025

This document has been prepared as part of work performed in accordance with statutory functions. Further information can be found in our Statement of Responsibilities.

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

About Audit Wales

Our aims:

Assure

the people of Wales that public money is well managed

Explain

how public money is being used to meet people's needs

Inspire

and empower the Welsh public sector to improve

Our ambitions:

Fully exploit our unique perspective, expertise and depth of insight

Strengthen our position as an authoritative, trusted and independent voice

Increase our visibility, influence and relevance

Be a model organisation for the public sector in Wales and beyond

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Introduction

This Outline Audit Plan specifies my statutory responsibilities as your external auditor and to fulfil my obligations under the Code of Audit Practice. It also sets out details of my audit team and key dates for delivering my audit team's activities and planned outputs. I intend to share a Detailed Audit Plan later in the year following the completion of my planning work. It will set out my estimated audit fee and the work my team intends to undertake to address the audit risks identified and other key areas of audit focus during 2025.

Adrian Crompton
Auditor General for Wales

My audit responsibilities

Audit of financial statements

I am required to issue a report on your financial statements which includes an opinion on their 'truth and fairness' and the regularity of income and expenditure, and the proper preparation of key elements of your Remuneration and Staff Report. I lay them before the Senedd together with any report that I make on them. I will also report by exception on a number of matters which are set out in more detail in our Statement of Responsibilities.

I do not seek to obtain absolute assurance on the truth and fairness of the financial statements and related notes but adopt a concept of materiality. My aim is to identify material misstatements, that is, those that might result in a reader of the accounts being misled. The levels at which I judge such misstatements to be material will be reported to you in my Detailed Audit Plan.

I am also required to certify a return to the Welsh Government which provides information about the Trust to support preparation of the Whole of Government Accounts.

Performance audit work

I must satisfy myself that the Trust has made proper arrangements for securing economy, efficiency, and effectiveness in its use of resources. I do this by undertaking an appropriate programme of performance audit work each year.

My work programme is informed by specific issues and risks facing the Trust and the wider NHS in Wales. I have also taken account of the work that is being undertaken or planned by other external review bodies and by internal audit.

Fees and audit team

In January 2025 I published the fee scheme for the year, approved by the Senedd Finance Committee. This sets out my fee rates. My fee rates for 2025-26 have increased by an average of 1.7% because of unavoidable inflationary pressures.

I will provide an estimate of your fee in my Detailed Audit Plan in May 2025, following completion of my detailed risk assessment.

Your engagement team:

Dave Thomas	**Engagement Director & Audit Director (Performance Audit)**
Gareth Lucey	**Audit Director (Financial Audit)**
Yvonne Thomas	**Audit Manager (Financial Audit)**
Darren Griffiths	**Audit Manager (Performance Audit)**
Amy Lord	**Audit Lead (Financial Audit)**
Fflur Jones	**Audit Lead (Performance Audit)**

We confirm that our audit team members are all independent of the Trust and your officers.

Audit timeline

We set out below key dates for delivery of our audit work and planned outputs.

Planned output	Work undertaken	Report finalised
2025 Outline Audit Plan	January - February 2025	February 2025
2025 Detailed Audit Plan	February – April 2025	April 2025
Audit of financial statements work: • Audit of Financial Statements Report • Opinion on the Financial Statements.	March – June 2025	June 2025
Performance audit work: • Structured Assessment, incorporating a deeper dive into estates management. • In terms of local project work, my early planning work suggests there would be value in reviewing the transfer and discharge service. However, my planning work might also highlight other areas worthy of review. Therefore, the exact focus of my local project work will be confirmed in my detailed Audit Plan in April 2025.	Timescales for individual projects will be discussed with you and detailed within the specific project briefings produced for each study.	

Audit quality

My commitment to audit quality in Audit Wales is absolute.

I believe that audit quality is about getting things right first-time.

We use a three lines of assurance model to demonstrate how we achieve this.

We have established an Audit Quality Committee to co-ordinate and oversee those arrangements. We subject our work to independent scrutiny by QAD[1] and our Chair acts as a link to our Board on audit quality. For more information see our Audit Quality Report 2024.

.

Our People

The first line of assurance is formed by our staff and management who are individually and collectively responsible for achieving the standards of audit quality to which we aspire.

- Selection of right team
- Use of specialists
- Supervisions and review

Arrangements for achieving audit quality

The second line of assurance is formed by the policies, tools, learning & development, guidance, and leadership we provide to our staff to support them in achieving those standards of audit quality.

- Audit platform
- Ethics
- Guidance
- Culture
- Learning and development
- Leadership
- Technical support

Independent assurance

The third line of assurance is formed by those activities that provide independent assurance over the effectiveness of the first two lines of assurance.

- EQCRs
- Themed reviews
- Cold reviews
- Root cause analysis
- Peer review
- Audit Quality Committee
- External monitoring

[1] QAD is the Quality Assurance Department of ICAEW.

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Audit Wales

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Audit Wales

Quality Governance Follow-up Review – Welsh Ambulance Services University NHS Trust

Audit year: 2023-4

Date issued: September 2024

Document reference: 4055A2024

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

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

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

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Summary report

Introduction

1 Quality should be at the ‘heart’ of all aspects of healthcare and ‘putting quality and safety’ above all else is one of the core values underpinning the NHS in Wales.

2 The drive to improve quality has been reinforced in successive health and social care strategies and policies over the last two decades. In June 2020, the Health and Social Care (Quality and Engagement) (Wales) Act 2020 (the Act) became law. The Act has strengthened the duty to secure system-wide quality improvements, as well as placing a duty of candour on NHS bodies, requiring them to be open and honest when things go wrong to enable learning. The Act indicates that quality includes, but is not limited to, the effectiveness and safety of health services and the experience of service users.

3 During 2021-22, the Auditor General reviewed quality governance arrangements across all Health Boards and Trusts in Wales. That work focused on:

- operational and corporate approaches to quality governance;
- organisational culture and behaviours;
- strategy, structures, and processes; and
- information flows and reporting.

4 Our 2022 review of quality governance at the Welsh Ambulance Services NHS Trust (the Trust) found that whilst many facets of its quality governance arrangements were working well, improvements were required to ensure the Trust is fully informed on issues relating to the quality and safety of its services. We also found the Trust also needed to strengthen serious incident reporting across organisational boundaries. We made eight recommendations for the Trust to address, which are shown in **Appendix 1**.

5 Since undertaking our 2022 review, the specific requirements underpinning the Duties for Candour and Quality (introduced under the Act) have been agreed, and all health bodies should have made good progress to implement arrangements to meet those requirements.

6 This quality governance follow-up review therefore will not only assess the Trust’s progress in implementing the recommendations we made in our 2022 quality governance review but will also consider the assurance provided to the Board that the Trust is taking steps to respond to the requirements of the Act.

7 The methods we used to deliver our work are summarised in **Appendix 2**.

Key findings

8 Overall, we found **the Trust has made some improvements to its quality governance structures, including responding to the duties of quality and candour. However, there is scope for further improvements in some areas to strengthen assurance relating to the quality and safety of its services**.

Implementation of previous audit recommendations

9 We found **whilst the Trust can demonstrate some progress in implementing previous audit recommendations, there remains more to do to fully address the recommendations**.

10 Our review of progress against our 2022 quality governance review recommendations found that three of the past eight recommendations have been completed. The completed recommendations relate to the Trust's information on and monitoring of clinical audits, developing better arrangements for board member visits and implementing recommendations relating to the joint investigation framework. We superseded our recommendation on monitoring the delivery of the Quality Strategy 2021-24.

11 For four recommendations, we found that, whilst action has been taken to address them, there is more to do to consider them complete. These included reaching the Trust's target for Personal Appraisal and Development Reviews (PADRs), progressing its plans to address the mortality review backlog, increasing its triangulation of quality performance information across metrics, and continuing to work with partners to join up information to support identifying outcomes and information. We will continue to monitor progress to implement these four remaining recommendations alongside the new recommendations arising in this review.

Responding to the requirements of the Duty of Candour and Duty of Quality

12 We found **the Trust has taken steps to implement the duties of quality and candour, however, there are weaknesses in the clarity of reporting progress and there is scope to improve training uptake and monitoring**.

13 Prior to the implementation of the Health and Social Care (Quality and Engagement) Act 2020 came into effect in April 2023 the Trust assessed its readiness against the Welsh Government baseline.

14 The Trust held Board sessions to raise awareness of the new Act. Staff were supported via e-learning modules to help understand and respond to the new requirements. However, there remain challenges. While training is in place for the duties of quality and candour, low compliance rates and difficulties understanding

how many staff had completed some training creates a risk that there is insufficient staff understanding.

15 The Trust told us it tracks progress to implement requirements under the duties of Candour and Quality using the Welsh Government roadmap and has developed an implementation plan. However, there is scope to strengthen assurance through greater clarity within progress reports to the Quality, Patient Experience and Safety (QuESt) committee. Finally, due to a backlog of policies overdue for review, the Trust has yet to review and update key policies as appropriate to reflect the requirements of the duties of quality and candour.

Recommendations

16 The status of our 2022 audit recommendations is summarised in **Exhibit 1**. **Appendix 1** contains our assessment of progress for each of our 2022 recommendations.

Exhibit 1: status of our 2022 recommendations

Completed	In progress	No action	Superseded	Total
3	4	0	1	8

17 **Exhibit 2** details the new recommendations arising from this review. The Trust's response to our 2024 recommendations is summarised in **Appendix 3,** which also contains updated management actions against the 2022 recommendations that we considered to be incomplete (ie in progress) at the time of our review.

Exhibit 2: 2024 recommendations

Recommendations
Quality Strategy R1 As the Trust develops a new Quality Plan in 2024, it should ensure that delivery is achievable within the resources available. The plan should clearly detail the funding required, the risks of under-delivery (due to capacity and resource constraints) and be underpinned with an implementation plan.
Quality Strategy monitoring R2 There is scope to strengthen quality strategy implementation plan delivery reporting. To enhance clarity, the Trust should, in its progress reports:

Recommendations

2.1 provide timescales for the expected delivery of each action;
2.2 differentiate between the progress of individual actions and strategic outputs; and
2.3 ensure that progress reports are reported regularly and are included in the QuESt cycle of business.

Clinical Audit Plan

R3 There are opportunities to further enhance reports on the Trust's Clinical Audit function, by:

3.1 more clearly highlighting any changes made to the approved Clinical Audit Plan; and
3.2 capturing key findings, outcomes and learning from completed audits.

Duty of Candour and Quality training

R4 The Trust should take steps to increase uptake rates for duty of quality and duty of candour training, to ensure staff have a good understanding of their responsibilities under the requirements.

Policy review

R5 The Trust should ensure that its Putting Things Right and Adverse Incident policies are updated to reflect the requirements of the Duty of Candour and Duty of Quality as soon as is reasonably possible.

Detailed report

Implementation of 2022 audit recommendations

18 We considered the Trust's progress in implementing each of our 2022 audit recommendations.

Quality Strategy delivery recommendation

2022 Recommendation 1

We found that delivery of the Trust's renewed Quality Strategy (2021-2024) has been severely hampered by resource pressures caused by the pandemic and a lack of funding to support four senior quality lead posts which are central to delivery.

The Trust should update its implementation plan outlining how it will deliver its quality ambitions.

19 We considered whether the Trust had taken additional steps to outline how it will deliver its Quality Strategy. We expected to see the following:

- a resourced supporting Quality Implementation Plan with suitable monitoring arrangements.

20 We found **delivery of the Quality Strategy 2021-2024 has continued to be slower than planned due to ongoing resourcing and capacity issues, and there is scope to improve progress reporting**.

21 The Trust monitors delivery of its Quality Strategy 2021-2024 via an implementation plan. This implementation plan was updated in May 2023 and February 2024, and delivery reported to the Quality, Experience and Safety Committee (QuESt) as part of an implementation plan progress report. The Board is kept up to date of progress by QuESt's 'Alert, Assure, Advise' reports which highlight key issues discussed during each meeting and are discussed at Board meetings.

22 However, progress in delivering the Quality Strategy 2021-2024 has been slower than intended, with the May 2023 progress report showing that only half of the actions were complete or on-track. The report to QuESt in February 2024 showed improved progress, in that nearly two-thirds of the listed actions for delivering the quality implementation plan were either complete or on track at the time of reporting. Outstanding actions as of February 2024, included actions such as developing training on the Trust's new quality management system and undertaking an evaluation of roles and responsibilities for quality across the organisation.

23 The Trust told us there are several reasons for why delivery has been off-track for some actions, including pressures caused by ongoing waves of COVID-19, winter

peaks in demand, and workforce industrial action. However, the most significant issue has been a continued lack of capacity. In 2022, we commented on issues in securing funding for the four senior quality lead posts set out in the Quality Strategy 2021-2024. Since that time, the Trust has undergone an internal restructure to provide two of these posts which have now been filled, as well as a senior quality governance lead, and invested into its Putting Things Right team. However, the inability to fund and recruit to these posts at the outset of the Strategy lifecycle has impacted the Trust's ability to deliver all of the actions of its Quality Strategy at the pace it intended.

24 As the Trust looks to develop a new Quality Plan in 2024[1], it should take steps to ensure that its ambitions are achievable and resourced. The Trust should be clear at the outset what the cost implications are for delivering its quality ambitions, as well as the risks associated with under-delivery (such as capacity and resource constraints). **We have superseded our 2022 Recommendation 1 with 2024 Recommendation 1 to reflect ongoing quality resource challenges and because a new Quality Plan is being developed**.

25 There is significant scope to improve the clarity of reporting progress to deliver the implementation plan. The progress reports presented in May 2023 and February 2024 did not detail the expected timescales for achieving actions listed within the implementation plan. Consequently, it was difficult for committee members to understand how off-track actions were at the point of reporting and the associated risks. It was also unclear as to whether the reports measure the completion of specific actions or delivery of strategic outputs, as, in some instances multiple actions were grouped together and, in others, multiple strategic outputs were grouped together. Progress reporting to QuESt has been irregular to date, with only two updates [in May 2023 and February 2024] at the time of writing, however, during our fieldwork, the Trust informed us that it is intending to introduce quarterly updates from August 2024 **(2024 Recommendation 2**).

Clinical Audit Plan recommendations

2022 Recommendation 2

We found that the clinical audit plan is not approved in a timely manner and the QuESt Committee does not have adequate oversight of progress and delivery.

The Trust should ensure that:

2.1 The QuESt Committee scrutinises and approves a clinical audit plan ahead of each financial year.

[1] The Quality Strategy 2021-2024 will be replaced with a Quality Plan.

2.2 The QuESt Committee receives quarterly updates on delivery of the approved clinical audit plan, and assurance reports including learning and improvement actions resulting from this work.

26 We considered whether the Trust has an annually approved clinical audit plan with routine reporting on delivery progress and resulting improvement actions. We expected to see the following:

- annually approved clinical audit plans, with regular progress reports received by QuESt; and
- evidence of learning from clinical audit and associated improvement actions.

27 We found **the Trust approves the Clinical Audit Plan annually and there are regular updates on progress of the Plan to QuESt, although there remains scope to improve reporting of outcomes and learning**.

28 The Clinical Audit Plan is informed by a variety of sources, including discussions at internal clinical groups, submissions from clinical managers and clinical directorates and identified as required due to clinical service changes. The Trust's Clinical Audit function was reviewed in March and April 2024 by Internal Audit which provided a reasonable assurance opinion. Amongst the key matters raised in the report was a need to strengthen the alignment between the Clinical Audit Plan and the Trust's Clinical Strategy, the operational risk register, and strategic priorities as set out in the Integrated Medium Term Plan. The Trust has identified actions to address Internal Audit's recommendations and plans to implement them during 2024-25.

29 QuESt approved the Clinical Audit Plan in both 2023-24 and 2024-25. **We consider 2022 Recommendation 2.1 to be completed**.

30 However, whilst the Trust emphasises in the Clinical Audit Plan that it may adjust the audit programme when it is appropriate to do so (for instance, to appropriately prioritise a new clinical audit), delivery progress reports have not consistently highlighted changes to the Plan and QuESt is not asked to approve any changes **(2024 Recommendation 3**).

31 QuESt has received quarterly delivery progress updates against the Clinical Audit Plan since May 2023. **We consider 2022 Recommendation 2.2 to be completed**.

32 Whilst more recent clinical audit progress reports have provided a better summary of progress, there remains scope for reports on clinical audit to provide stronger assurance to the QuESt on its activity. The accompanying clinical audit tracker provides members with an update on recommendations arising from clinical audits, however, our review found that papers could more clearly identify the key issues raised as they only capture recommendations, and progress reports do not currently highlight any findings from clinical audits. The Internal Audit review found that actions to address recommendations are monitored via relevant internal

groups. However, it remains difficult for QuESt members to be assured about the outcomes of clinical audit activity, and whether learning from clinical audits is becoming embedded to improve the Trust's performance without the inclusion of further narrative within progress reports **(2024 Recommendation 3**).

Mortality review recommendations

2022 Recommendation 3

The QuESt Committee does not receive adequate assurances on mortality reviews. The Trust should ensure the QuESt Committee receives quarterly update reports to include:

3.1 The number of reviews undertaken, and the numbers of reviews required but not yet complete.

3.2 Any significant concerns, lessons learned and what changes have been made as a result.

3.3 Updates on actions to address the mortality review backlog.

Updates on progress implementing the all-Wales Learning from Mortality Reviews Framework.

2022 Recommendation 4

The Trust has a significant backlog of mortality reviews.

The Trust should develop an action plan to reduce the backlog, reporting progress at each QuESt meeting.

33 We considered whether QuESt receives adequate assurance on mortality reviews[2], including progress to address the significant 2022 backlog, and implement lessons learnt from reviews. We expected to see the following:

- the all-Wales learning from mortality reviews framework implemented[3];
- evidence of learning from mortality reviews;
- a reduction in the mortality review backlog; and
- regular mortality review updates received by QuESt.

34 We found **the Trust has implemented the new national framework for mortality reviews, however, it has not yet progressed as planned, as there is fluctuating performance relating to delivering timely mortality reviews and**

[2] Mortality reviews are conducted when a patient dies whilst in the Trust's care, including whilst waiting for an ambulance to arrive.

[3] The All-Wales Learning from Mortality Review Model Framework was originally introduced in August 2021 and then revised in September 2022.

there is scope for more consistent reporting of mortality review activity, outcomes and learning.

35 The Trust has made improvements to the information presented to QuESt on mortality reviews since our last review. However, while QuESt receives regular information on mortality reviews, the information is not consistently reported, which makes it difficult to understand progress and ongoing challenges. Our review of papers found that the Trust has reported its backlog figure to four of the past six meetings, and only in August 2023 did QuESt receive data on how many referrals had been received compared to how many were awaiting review. **We consider 2022 Recommendation 3.1 to be in progress**.

36 Challenges in undertaking timely mortality reviews at the time of our 2022 review had led to a backlog which stood at 800 in August 2022. Data reported to QuESt since 2022 suggests that performance has fluctuated significantly. The reported backlog in August 2023 was 298, which increased to 800 in February 2024 and then reduced to 600 in May 2024. This position will be exacerbated by the deteriorating performance within the broader urgent and emergency care system, and further pressure is likely to arise from the new statutory role of the Medical Examiner introduced in September 2024. Whilst the backlog is lower than it was at the time of our 2022 review, it remains high. We have not seen evidence of an action plan with a clear trajectory to reduce the backlog and sustainably keep it at a more manageable level. However, QuESt does receive assurance that all referrals are screened on receipt by a member of the patient safety team and escalated as required. **We consider 2022 Recommendations 3.3 and 4 to be in progress**.

37 Key themes arising from mortality reviews have been reported through various reports to QuESt in three of the six meetings held between November 2022 and May 2024. The May 2023 report indicated that identified learning from mortality reviews was being provided to paramedics. The August and October 2023 reports highlighted key themes largely relating to delays in the community, call categorisation and end of life care. However, there was no reference to lessons learned and resulting actions. **We consider 2022 Recommendation 3.2 to be in progress**.

38 In September 2022, the Trust's Clinical Quality Governance Group (CQGG) approved the all-Wales Learning from Mortality Reviews Framework. The Framework provides a co-ordinated and systematic all-Wales approach to the mortality review process to enable local and national implementation of learning. To implement the Framework, in October 2023 the Trust established a Learning from Deaths Forum which reports to the CQGG. **We consider 2022 Recommendation 3.4 to be complete.**

Appraisal and Development Review recommendation

2022 Recommendation 5

The Trust has low Personal Appraisal and Development Reviews (PADR) compliance rates, for example, in June 2022, the Trust's compliance was 59% against the 85% target.

As part of embedding its new behaviours, the Trust should ensure that PADR rates are improved and set out the actions it will take to achieve this.

39 We considered whether the Trust has improved completion rates for its Personal Appraisal and Development Reviews (PADR), which were achieving 59% against the 85% target at the time of our review in 2022. We expected to see the following:

- improved PADR compliance; and
- robust plans in place to achieve further improvements and the required 85% target.

40 We found **whilst PADR completion rates have improved since our original review, they continue to be below the Trust's target rate**.

41 PADR rates have improved since our original review, with reported monthly rates remaining above 70% since August 2022, and at an average of 74% for the year 2023-24. However, performance continues to remain below the Trust's target of 85%.

42 There is regular monitoring of PADR compliance. The Trust's People and Culture Committee continues to monitor PADR compliance via the workforce scorecard at each meeting. However, there are ongoing challenges which make reaching the 85% target difficult. Lower compliance continues to be primarily within operational Emergency Medical Services, where staff are required to be booked out of operational duties to attend the PADR meeting with their manager. This is recognised as an ongoing logistical barrier to improving PADR performance, particularly given the service pressures currently facing the Trust. The Trust has plans to further improve performance by gaining insights into how it can increase rates in areas with lower compliance. However, The Trust informed us that it was also considering re-evaluating its target within this context. **We therefore consider 2022 Recommendation 5 to be in progress**.

Board member walkabout recommendation

2022 Recommendation 6

Prior to the pandemic, Board members regularly participated in ambulance ride-outs and station visits, but these were ad-hoc in nature and feedback was not collated in a structured way.

Now that visits can restart, the Trust should develop a standard operating procedure which clarifies the process, frequency of the visits, and ensures coverage across the Trust's operations and geographical areas. It should also include a standard template to capture feedback and learning.

43 We considered whether the Trust has developed a clear process for visits by Board members across the organisation's business and to consistently capture learning by hearing directly from patients and staff. We expected to see the following:

- a clear standard operating procedure in place, with a standard template to capture feedback and learning; and
- a schedule of Board walkabouts covering all areas of service delivery.

44 We found **the Trust has a standard operating procedure for Board members conducting visits, however, the frequency and coverage of visits, whilst increasing, are variable, and it currently does not consistently capture and report feedback and learning to the Board**.

45 The Trust has a clear process to support Board members to undertake visits. In 2022, the Trust established a Standard Operating Procedure for Board Visits which includes prompts and a template for capturing feedback and suggested actions.

46 Our observations of Board and committee meetings show that Board members highly value opportunities to hear from staff and patients directly, such as via staff and patient stories. However, although the Standard Operating Procedure for Board Visits includes a form for capturing feedback, the Trust does not currently require Board members to complete it, with it tending to be used only to raise a formal concern. The Trust said this is to avoid the process becoming too bureaucratic. Instead, Board members often provide direct informal feedback or seek further information to the relevant directors via email or during Board development meetings. However, this provides only limited feedback and the Trust would likely benefit from providing further opportunities for reporting back on learning from visits, such as via Non-Executive Director meetings or regular sessions at board development. This would strengthen the Board's ability to triangulate the intelligence gathered with other information, to highlight any areas of concern or risk or to celebrate and share good practice.

47 The Trust's Chair refers to recent visits he has undertaken via the Chair's report to each Board meeting. More recently this report also includes a list of visits undertaken by the Vice-Chair. As part of its Standard Operating Procedure for visits, the Trust also has a process for recording the location and timing of Board visits, which provides an interactive heat map. The heat map shows visits in real time and overseen via bi-annual updates to the Executive Leadership Team and the Board. The 2023-24 heat map shows significant variation in the geographical and service area coverage, as well as the number of visits made by each Board member. Generally, rural areas received fewer visits, with higher numbers of visits

in urban areas, and particularly in Cardiff and Swansea. In addition, the frequency of visits to administrative service areas was higher than to ambulance stations and 111 centres. Except for the Chair, Non-Executive Directors conducted fewer visits than other Board members, due in part to the limited time contractually available for Non-Executive Directors to undertake their roles. We are aware that there has been an increase in the number of visits since April 2024, as well as increased coverage of areas in central Wales.

48 While the Trust does not currently have a forward schedule for board visits, at the time of our fieldwork, it was considering how to increase the number and geographical coverage of future visits. The Trust told us it was considering resuming its pre-2023 practice of geographically rotating its Board meetings around Wales to provide greater opportunities for Board members to meet and engage with Trust staff across Wales. **We therefore consider 2022 Recommendation 6 to be complete**.

Joint Escalation Framework recommendation

2022 Recommendation 7

The Joint Investigations Framework in place with health bodies is no longer effective. The Emergency Services Ambulance Committee is coordinating action to strengthen those arrangements.

The Trust must ensure that the recommendations made by the Delivery Unit are effectively responded to in a timely fashion and progress reported regularly to the Board and QuESt.

49 We considered whether the Trust has strengthened the process for addressing serious incidents where other organisations are involved in the care of the patient. We expected to see the following:

- an effective Joint Investigations Framework in place for serious patient incidents; and.
- recommendations made by the Delivery Unit addressed, with evidence of progress being reported to Board and the QuESt committee.

50 We found **compliance with the new national process for jointly investigating serious incidents with partners is strong, with activity regularly monitored by the QuESt committee**.

51 In 2022, the Delivery Unit raised concerns around the application of the Joint Investigation Framework in place to address serious patient safety incidents. In response, a task and finish group was established between partners to refine the Joint Investigations Framework. The NHS Wales National Policy on Patient Safety Incident Reporting and Management was updated in April 2023 to ensure consistent practices across Wales. QuESt approved the adoption of the National Policy and its supporting appendices in August 2023.

52 QuESt did not receive updates against the recommendations made by the Delivery Unit in 2022 by way of its audit tracker, as the audit tracker is limited to recommendations made by internal and external audit and Healthcare Inspectorate Wales. However, we understand that the Trust considers each of the four recommendations (which included the establishment of a task and finish group to review the Joint Investigations Framework) to have been completed.

53 The numbers and general themes of incidents falling under the Joint Investigations Framework (both shared and received) are reported to each QuESt meeting within the quarterly Putting Things Right Report. Interviewees felt confident that the Joint Investigation process has improved due to stronger governance arrangements, including weekly meetings between the Trust and health boards to discuss each incident.

54 There has not, to date, been an assessment of the effectiveness of the new Joint Investigations Framework for managing incidents with health bodies. However, in late 2023, Internal Audit undertook a review of the Trust's compliance with the Joint Investigation Framework and provided a reasonable assurance opinion. The report was received by the Audit, Risk and Assurance Committee in May 2024. It included six recommendations, two of which were medium priority and four of which were low priority. One of the key matters raised in the report related to a need for the Trust's Adverse Incident and Reporting Policy to be more aligned to the NHS Wales National Policy on Patient Safety Incident Reporting and Management. The Trust has committed to a full policy review once the Welsh Government updated Putting Things Right Regulations are available (due Autumn 2024). **We therefore consider 2022 Recommendation 7 to be complete**.

Quality performance reporting and learning recommendation

Recommendation 8

We found that QuESt is well served with quality information, but there are opportunities for improvement. The Trust should:

8.1 Develop a system to triangulate learning themes across its quality assurance reports. This should ensure clarity about what improvement actions have been taken as a result and how learning has been disseminated across the organisation.

8.2 Enhance COVID-19 reporting in the integrated quality and performance report, by including information about the harm caused to patients by ongoing service pressures caused by the virus.

8.3 Work with health bodies so that there are systems to determine the outcomes for patients who have received emergency ambulance services. This should particularly seek to understand the consequence and harm resulting from service failures such as long ambulance waits.

8.4 Develop patient outcome measures to support its existing quality measures.

55 We considered whether the Trust has enhanced its performance information by triangulating information from different sources and developing a greater number of patient outcome measures. We expected to see the following:

- enhanced performance reporting and monitoring arrangements which support triangulation and identification of themes;
- effective joint working with health boards to monitor outcomes for patients, including focus on the consequences of long ambulance waits; and
- patient outcome measures in place, which are routinely monitored.

56 We found **the Trust continues to face challenges in reporting patient outcomes due to difficulties in joining up information across organisations. However, there is more the Trust can and should do to triangulate themes across metrics and identify learning**.

57 The Trust has established mechanisms for monitoring and reporting on performance data, but could do more to identify themes and analysis. Quality metrics are mainly reported via the Monthly Integrated Quality and Performance Reports (MIQPR) and quarterly Putting Things Right Reports. The MIQPR contains data on clinical outcomes, such as, the percentage of 'Stroke Patients with Appropriate Care', as well as quality indicators, such as, percentage of 'Concerns Response within 30 Days', and numbers of patients who did not receive an ambulance due to receiving a 'Can't Send' response. The Putting Things Right Report includes data relating to the numbers and trends of concerns and incidents. Both reports are received at each QuESt meeting. The Putting Things Right report summarises some of the key themes from joint investigations and incidents, but not others, such as, concerns or mortality reviews. However, neither reports provide triangulation across metrics to identify main themes, and there is limited information on what is being done to address challenges and identify and implement learning. **We therefore consider 2022 Recommendation 8.1 to be in progress**.

58 Our review of the Trust's MIQPR found that it continued to report on COVID-19 in relation to its impact on staff, sickness absence rates, and vaccination rates. We did not find any measures within the report relating to the impact of COVID-19 on harm to patients. However, given the decreased level of risk posed by COVID-19 since 2023, **we consider 2022 Recommendation 8.2 to be superseded**.

59 The Trust has good arrangements to engage with the public through its People Engagement and Community Involvement Team and hear feedback from patients. Patient feedback is considered alongside complaints and incidents information. However, there is a significant data weakness, because information governance rules do not enable the Trust to track outcomes for patients who were treated via Consult and Close or referred to an alternative (non-ambulance) pathway, ie

whether they later required and accessed further services. The Trust informs us that it is proactively engaging with the Information Commissioners Office to try and find solutions that enable better systematic access to patient feedback.

60 The Trust has implemented the electronic Patient Clinical Record (ePCR) which links up information between the Trust and health boards, and allows feedback on patient outcome for some conditions (such as, return of spontaneous circulation, stroke bundles, fractured neck of femur), however, these indicators are limited in number. The Trust has plans to develop further measures for falls and older people, however, at present there continue to be issues with the completeness of records in ePCR, which is inhibiting the quality of data. **We consider 2022 Recommendation 8.4 to be in progress**.

61 Currently, the Trust's performance reports provide some information on potential harm to patients, such as modelled scenarios on the level of harm likely to occur due to the level of handover delays experienced in the preceding month. However, as discussed in **paragraph 59,** the identification of actual patient harm across the whole Urgent Care Pathway is challenging, partly due to incomplete ePCR records, and also because impacts to patients are not always immediately apparent. The Trust is taking steps to provide more clarity on actual harm caused, such as, by working with colleagues from the All-Wales Tissue Viability Network to determine how to identify avoidable harm across the system in respect of pressure damage. The Trust is also working on developing a Civica Patient Experience dashboard which will provide improved level of detail on experiences, including actionable improvements that the Trust could make, for instance, in how they move and handle patients. **We consider 2022 Recommendation 8.3 to be in progress**.

Responding to the requirements of the Duty of Candour and Duty of Quality

62 We considered the extent to which the Trust has taken steps to implement both the Duty of Quality and Duty of Candour. We expected to see the following:

- the Trust has considered what it needs to do to implement the duties of Quality and Candour, with plans in place to address any gaps.
- the Trust has clear arrangements in place for monitoring implementation which reflects the timescales and risks associated with delivering the plan.
- progress in implementing the duties of quality and candour is routinely reported to the Board and its committees.
- board members have sufficient awareness and have received appropriate training in relation to the duties of quality and candour.
- roles and responsibilities in relation to implementing the duties of quality and candour at all levels of the organisation are clearly documented and understood. The Trust has assessed the skills/capability and capacity required to implement the duties of quality and candour at both a corporate

and operational level and has put appropriate arrangements in place to address any shortfalls and gaps.

- staff training has been delivered to raise awareness of the requirements under the two duties. The Trust has identified appropriate strategic, senior, and operational leadership to oversee and deliver the duties. All staff understand their respective responsibilities.
- the Trust has reviewed and appropriately updated its existing policies and standing operating procedures as required.

63 We found **the Trust has taken steps to implement the duties of quality and candour, however, there are weaknesses in the clarity of reporting progress and there is scope to improve training compliance and monitoring**.

64 The Health and Social Care (Quality and Engagement) Act 2020 came into force on 1 April 2023. The Trust assessed its preparedness for complying with the requirements of the Duty of Quality and Duty of Candour using an assessment against the Welsh Government baseline position, which it reported in February 2023. It subsequently assessed itself against the Welsh Government implementation road map in August 2023 and developed an implementation plan in October 2023. Within the Trust's self-assessment against the implementation road map in August 2023, it marked its progress as 'yellow' (organisation has identified that delivery is at risk but manageable or behind schedule but within tolerance) and indicated confidence in being compliant with the Act in relation to specific aspects, such as, falls prevention, but concerns remain related to the pace of implementation due to resources, particularly in relation to the Duty of Candour.

65 The Trust's implementation plan is monitored at an operational level by the Trust's Quality Management Group, but there is scope to better describe progress to QuESt. Monitoring of the Trust's response to the Act has been listed as QuESt's key priority for 2022-23, 2023-24 and 2024-25. However, our review of papers received by QuESt found that it is not always easy to understand the Trust's progress. Despite the October 2023 update report stating that QuESt would have oversight of the implementation plan, the plan has not been formally received by the committee to date. Therefore, updates to QuESt in 2023-24 have mainly commented on the ongoing activity of the Trust, rather than providing a balanced view of progress to implement actions within timescales. While minutes evidence some challenge from members to clarify progress, papers could better highlight progress and ongoing issues and risks to better equip members' understanding in advance of meetings.

66 The Trust has taken steps to provide Board members with an understanding of the new requirements under the duties of quality and candour. It organised a Board development session in March 2023, prior to the enforcement of the legislation, and, at the time of our review, further separate sessions on each duty were planned for later in 2024.

67 The Trust has identified appropriate strategic and senior leadership to the implementation of the duties of quality and candour across the organisation. The

Executive Director of Quality and Nursing is the identified strategic lead for the duties, whilst the duty of quality is assigned at a senior level to the Assistant Director of Quality Governance, and the Duty of Candour is assigned at a senior level to the Assistant Director of Quality and Nursing. As discussed in **paragraph 23**, the Trust undertook a restructure and secured investment into its quality and Putting Things Right teams, including a Senior Quality Governance Lead and a Quality Governance Lead for Putting Things Right during 2023 and early 2024.

68 Training for staff has also been delivered to support compliance. External training on quality management systems was procured for a select number of staff, which interviews suggest was helpful. In January 2024, the Trust introduced e-learning modules on both duties, which staff across the organisation are asked to complete. However, a technical error has meant that the system failed to recognise the completion of the Duty of Candour course by participants, meaning completion rates are unavailable. Completion rates for the Duty of Quality training were 33.2% as at June 2024. The Trust was considering options for increasing compliance at the time of our fieldwork, such as, making the training mandatory, making it more user-friendly and more visibly promoted by leaders in the organisation **(2024 Recommendation 4**). More broadly, the Trust has raised awareness amongst its staff of the new requirements through its intranet site, as well as during its annual Chief Executive Officer Roadshow sessions. The training has been incorporated into induction training for new starters.

69 Reports to QuESt during 2023 stated that, going forward, policies due for renewal should consider and reflect the requirements under the duties of quality and candour. Positively, as the Trust undertakes policy review, its clinical quality governance group ensures a quality lens is applied during the process. The Putting Things Right policy and Adverse Incident policy (due to be reviewed in March and April 2023 respectively) were highlighted as key policies to be updated considering the Act. However, whilst the Trust did adopt the National Patient Safety Policy and supporting appendices, we could find no evidence that the two policies (Putting Things Right policy and Adverse Incident policy) have been updated (**2024 Recommendation 5**).

Appendix 1

Our 2022 quality governance recommendations

Exhibit 3 sets out the recommendations we made in our 2022 review of quality governance arrangements at the Trust and our current assessment of progress made to meet those arrangements.

2022 Recommendations	Audit Wales assessment of completeness (as at August 2024)
Recommendation 1 – Quality Strategy delivery We found that delivery of the Trust's renewed Quality Strategy (2021-2024) has been severely hampered by resource pressures caused by the pandemic and a lack of funding to support four senior quality lead posts which are central to delivery. The Trust should update its implementation plan outlining how it will deliver its quality ambitions.	**Superseded**
Recommendation 2 – Clinical Audit Plan We found that the clinical audit plan is not approved in a timely manner and the QuESt Committee does not have adequate oversight of progress and delivery. The Trust should ensure that: 2.1 the QuESt Committee scrutinises and approves a clinical audit plan ahead of each financial year; and 2.2 the QuESt Committee receives quarterly updates on delivery of the approved clinical audit plan and assurance reports, including learning and improvement actions resulting from this work.	**Completed**

2022 Recommendations	Audit Wales assessment of completeness (as at August 2024)
Recommendation 3 – Mortality reviews The QuESt Committee does not receive adequate assurances on mortality reviews. The Trust should ensure the QuESt Committee receives quarterly update reports to include: 3.1 the number of reviews undertaken, and the numbers of reviews required but not yet complete; 3.2 any significant concerns, lessons learned and what changes have been made as a result; 3.3 updates on actions to address the mortality review backlog; and 3.4 updates on progress implementing the all-Wales Learning from Mortality Reviews Framework.	**In progress**
Recommendation 4 – Mortality reviews The Trust has a significant backlog of mortality reviews. The Trust should develop an action plan to reduce the backlog, reporting progress at each QuESt Committee.	**In progress**
Recommendation 5 – Personal Appraisal and Development Reviews (PADR) The Trust has low PADR compliance rates, for example, in June 2022, the Trust's compliance was 59% against the 85% target. As part of embedding its new behaviours, the Trust should ensure that PADR rates are improved and set out the actions it will take to achieve this.	**In progress**

2022 Recommendations	Audit Wales assessment of completeness (as at August 2024)
Recommendation 6 – Board member walkabouts Prior to the pandemic, Board members regularly participated in ambulance ride-outs and station visits, but these were ad-hoc in nature and feedback was not collated in a structured way. Now that visits can restart, the Trust should develop a standard operating procedure which clarifies the process and frequency of the visits, and ensures coverage across the Trust's operations and geographical areas. It should also include a standard template to capture feedback and learning.	**Completed**
Recommendation 7 – Joint Escalation Framework The joint investigations framework in place with health bodies is no longer effective. The Emergency Services Ambulance Committee is coordinating action to strengthen those arrangements. The Trust must ensure that the recommendations made by the Delivery Unit are effectively responded to in a timely fashion and progress reported regularly to the Board and QuESt Committee.	**Completed**

2022 Recommendations	Audit Wales assessment of completeness (as at August 2024)
Recommendation 8 – Quality performance reporting and learning We found that the QuESt Committee is well served with quality information, but there are opportunities for improvement. The Trust should: 8.1 develop a system to triangulate learning themes across its quality assurance reports. This should ensure clarity about what improvement actions have been taken as a result and how learning has been disseminated across the organisation. 8.2 enhance COVID-19 reporting in the integrated quality and performance report, by including information about the harm caused to patients by ongoing service pressures caused by the virus. 8.3 work with health bodies so that there are systems to determine the outcomes for patients who have received emergency ambulance services. This should particularly seek to understand the consequence and harm resulting from service failures such as long ambulance waits. 8.4 develop patient outcome measures to support its existing quality measures.	**In progress**

Appendix 2

Audit methods

Exhibit 4 sets out the methods we used to deliver this work. Our evidence is limited to the information drawn from the methods below.

Element of audit approach	Description
Documents	We reviewed a range of documents, including: • Quality Strategy 2021-24; • Internal Audit reports (namely relating to Clinical Audit and Joint Investigation Framework); • Mortality Review reports: • Putting Things Right reports; • MIQPRs; and • Annual Quality Report.
Interviews	We interviewed the following: • Executive Director of Quality and Nursing; • Executive Director of Paramedicine; • Assistant Director of Quality Governance; • Senior Quality Governance Lead; • Assistant Director of Clinical Development; • Chair of Quality, Experience and Safety (QuESt) Committee; • Board Secretary;

Element of audit approach	Description
	• Assistant Board Secretary; and • Senior Workforce Transformation Manager.
Observations	We observed the following meeting(s): • QuESt February 2024 • QuESt May 2024 • Board May 2024

Appendix 3

Organisational response to 2022 and 2024 audit recommendations

Exhibit 5 sets out the Trust's response to our new audit recommendations.

Ref	Recommendations	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R1	**Quality Strategy** As the Trust develops a new Quality Plan in 2024, it should ensure that delivery is achievable within the resources available. The plan should clearly detail the funding required, the risks of under-delivery (due to capacity and resource constraints) and be underpinned with an implementation plan.	The Quality Strategy is now in development with a change of nomenclature to Quality Plan, acknowledging that the long-term organisational strategy is Delivering Excellence: Our vision for 2030. The approach to development has been approved by committee including engagement with internal and external stakeholders and is expected to be approved in Q4 2024-25 for implementation in Q1 2025-26. The quality plan is intended to identify deliverables that follow the principles of the duty of quality being efficient and effective, as well as demonstrating commitment to value based health care. With this in mind the intention is to deliver the quality plan within our	30 June 2025	Assistant Director of Quality Governance

Ref	Recommendations	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
		existing structures without additional investment and through use of our existing infrastructures and networks. The approval of the Quality Plan including the executive summary which sets out the need to ensure that the plan is deliverable within existing establishment constraints will close this action. This will be demonstratable through approved papers and minutes from QuESt committee.		
R2	**Quality Strategy monitoring** There is scope to strengthen quality strategy implementation plan delivery reporting. To enhance clarity, the Trust should, in its progress reports: 2.1 provide timescales for the expected delivery of each action;	The approved Quality Plan will be supported by a robust implementation plan clearly articulating measurable actions and timescales for delivery against responsible and accountable owners. Updates will be provided via the governance structures to ensure regular updates are provided to QuESt via the cycle of business. The Assistant Director of Quality Governance will work with Corporate Governance leaders to	30 March 2026	Assistant Director of Quality Governance

Ref	Recommendations	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	2.2 differentiate between the progress of individual actions and strategic outputs; and 2.3 ensure that progress reports are reported regularly and are included in the QuESt cycle of business.	ensure a clear cycle of updates and escalation is included within the implementation plan. The review of minutes from QuESt committee which includes these progress reports, through four cycles of business will close this action.		
R3	**Clinical Audit Plan** There are opportunities to further enhance reports on the Trust's Clinical Audit function, by: 3.1 more clearly highlighting any changes made to the approved Clinical Audit Plan; and 3.2 capturing key findings, outcomes and learning from completed audits.	We will review the communication lines between CQGG, ELT and QuESt to provide clearer visibility on the key findings, outcomes and learning identified through Clinical Audit reports. Whilst amendments to approved clinical audit plans should not be delayed as a result of timescales associated with the cycle of business, quarterly updates will include more detail on the changes to the approved plan including the rationale.	31 March 2026 31 March 2026	Head of Clinical Intelligence and Assurance

Ref	Recommendations	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
		The review of minutes from QuESt committee which includes these findings, through four cycles of business will close this action.		
R4	**Duty of Candour and Quality training** The Trust should take steps to increase compliance rates for duty of quality and duty of candour training to ensure staff have a good understanding of their responsibilities under the requirements.	Access to both Duty of Quality and Duty of Candour training is available via ESR, with Duty of Quality training also available via Learning@Wales. It is important to balance not just the compliance to the training request but also the impact that training has. In order to increase uptake rates the Duty of Quality training, content has been duplicated onto Learn365 which allows the training to be more accessible and stress-free increasing uptake and engagement. Quality Management Group are now monitoring a similar approach for the Duty of Candour training.	30 September 2025	Assistant Director of Quality Governance

Ref	Recommendations	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
		Engagement with the training is monitored via the Education and Development Team as well as by the Quality Management Group. Local teams will receive regular updates on their compliance with this training and will receive support via QMG on how to improve uptake rates of training. Highlight reports from QMG to CQGG which include the actions taken to increase uptake rates alongside the current completion rates across the organisation will close this action. This will be demonstrable through three Alert, Advise, Assure (AAA) Highlight reports.		
R5	**Policy review** The Trust should ensure that its Putting Things Right and Adverse Incident policies are updated to reflect the requirements of the Duty of Candour and	The Putting Things Right Policy and the Adverse Incident Policy were both updated and approved through the Policy Group to include references to the Duty of Quality and Duty of Candour on 25 April 2023. These updated	Complete	Assistant Director of Putting Things Right

Ref	Recommendations	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	Duty of Quality as soon as is reasonably possible.	policies were subsequently published on 1 June 2023. Both Policies have been subject to a content check by the Assistant Director of Putting Things Right to confirm this content is in place. **This action is complete**		
2022 R3	**Mortality reviews** The QuESt Committee does not receive adequate assurances on mortality reviews. The Trust should ensure the QuESt Committee receives quarterly update reports to include: 3.1 the number of reviews undertaken, and the numbers of reviews required but not yet complete; 3.2 any significant concerns, lessons learned and what changes have been made as a result;	The learning from deaths forum and associated sub groups' Terms of Reference include the sharing of learning at a local level as well as contributing to learning on a national basis. This information is shared via the Alert, Advise, Assure (AAA) highlight report. The content of the highlight report will be reviewed through governance processes to ensure consistency of reporting aligned to the Agendas of these fora. Four highlight reports which include this consistency of data alongside QuESt committee minutes will close action 3.1.	31 December 2025. 31 December 2025.	Assistant Director of Putting Things Right.

Ref	Recommendations	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	3.3 updates on actions to address the mortality review backlog; and 3.4 updates on progress implementing the all-Wales Learning from Mortality Reviews Framework.	A twice yearly paper communication learning from mortality is shared with QuEST committee to provide assurance on the process, completion rates, themes and associated improvements. The QuESt committee minutes where these papers are discussed will close action 3.2 The Trust recognises that further development work is required on the national electronic Mortality Review module in the Datix Cymru system to improve the recording of trends and themes that in turn support learning and improvement. The Trust is engaged regularly in the National Mortality Safety and Learning Network and the Once for Wales Datix Cymru Mortality Review workstream to inform this development work and ensure that the unique nature of our services within the Welsh context is being appropriately represented. Updates provided on engagement with the all-Wales Learning from Mortality Reviews framework demonstrated through QuESt committee	31 December 2025. 3.4 assessed as Complete during 2024 review	

Ref	Recommendations	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
		minutes across two cycles of business will close action 3.4 A PTR Improvement plan is currently in place which includes actions to address the backlog of ME referrals. Following the introduction of governance forums ME referrals are contemporaneously triaged in line with framework. The organisation acknowledges the need to fully mature the structures and learning themes and believes these will occur over time within the new governance structures. Updates provided on the PTR improvement plan which specifically set out the work undertaken to reduce the backlog demonstrated through QuESt committee minutes across two cycles of business will close action 3.3		

Ref	Recommendations	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
2022 R4	**Mortality Reviews** The Trust has a significant backlog of mortality reviews. The Trust should develop an action plan to reduce the backlog, reporting progress at each QuESt Committee.	A PTR Improvement plan is currently in place which includes actions to address the backlog of ME referrals. Following the introduction of governance forums ME referrals are contemporaneously triaged in line with framework. The organisation acknowledges the need to fully mature the structures and learning themes and believe these will occur over time within the new governance structures. Updates provided on the PTR improvement plan which specifically set out the work undertaken to reduce the backlog demonstrated through QuESt committee minutes across two cycles of business will close this action.	31 December 2025	Assistant Director of Putting Things Right.
2022 R5	**Personal Appraisal and Development Reviews (PADR)** The Trust has low PADR compliance rates, for example in June 2022 the Trust's compliance was 59% against the 85% target. As part of embedding its new	We are implementing a range of measures aimed not only at increasing compliance but also at enhancing the quality and value of PADR conversations. The Trust is committed to improving PADR compliance while also ensuring that these reviews provide real value to staff and managers. We will continue to	31 December 2025	Head of Culture and Organisational Development

Ref	Recommendations	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	behaviours, the Trust should ensure that PADR rates are improved and set out the actions it will take to achieve this.	monitor progress and adjust our strategies as necessary, while also considering how our target metrics or measures of success can better reflect our commitment to meaningful and impactful conversations. Minutes of People and Culture committee where updates are received regarding compliance to target and actions taken to improve the value to staff and managers across three cycles of business will close this action.		
2022 R8	**Quality performance reporting and learning** We found that the QuESt Committee is well served with quality information, but there are opportunities for improvement. The Trust should:	Through our Quality Performance Management Framework we will explore how we can draw focus across departments and directorates to triangulate information identifying themes for learning and improvement. This will be used either for internal continual improvement where this is within our boundaries or to share as part of external collaborative working both with		Assistant Director of Commissioning and Performance

Ref	Recommendations	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	8.1 develop a system to triangulate learning themes across its quality assurance reports. This should ensure clarity about what improvement actions have been taken as a result and how learning has been disseminated across the organisation. 8.2 enhance COVID-19 reporting in the integrated quality and performance report by including information about the harm caused to patients by ongoing service pressures caused by the virus. 8.3 work with health bodies so that there are systems to determine the outcomes for patients who have received emergency ambulance services. This should particularly seek to understand the consequence and harm resulting	health boards and commissioners. Committee minutes containing reference in both the MIQPR and PTR report which includes triangulation of metrics across two cycles of business will close action 8.1. Action 8.2 has been superseded the audit report will provide evidence of closure of this action. Whilst we remain limited by data accessibility we continue to pursue patient outcome data through ePCR as well as linking our critical systems to the Welsh Demographic Service allowing the first steps into linking remote clinical assessment with patient outcomes. The ability to achieve truly robust outcome measures without data linkage is limited, we continue to work with DHCW to resolve barriers to data sharing across NHS Wales. Three Alert, Advise, Assure (AAA) Highlight reports from Information Governance Steering	30 September 2025 8.2 Superseded in 2024 review. 30 September 2025	

Ref	Recommendations	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	from service failures such as long ambulance waits. 8.4 develop patient outcome measures to support its existing quality measures.	Group will provide evidence of this ongoing work and will close both action 8.3 and 8.4	30 September 2025	

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

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

AGENDA ITEM No	**9**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**5**

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

MEETING	Audit, Risk and Assurance Committee
DATE	06 March 2025
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 progress update on the risk management transformation programme, assurance in respect of the management of the Trust's principal risks, a brief update on the planned 2024/25 Internal Audit Risk Management Review and to seek committee's approval on the revised governance on reporting cycles.

   Risk Management Transformation Programme

2. The next phase of the Risk Transformation Programme is underway with details drawn out throughout the report. This includes work with the Board on development of a suite of Risk Appetite statements, an electronic risk management solution and continued work to reposition the Trust's highest rated Risks 223 and 224.

   2024/25 Internal Audit Risk Management Review

3. The Corporate Governance team met with the Internal Auditor from Shared Services to discuss the topic of this year's review which will primarily focus on the Board Assurance Framework (BAF). The terms of reference will be agreed before the end of February with the fieldwork commencing in early March 2025.

   Board Assurance Framework

4. A summary of the principal risks (Annex 1) and a detailed description contained within the BAF (Annex 4) is included in the report.

5. 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).

6. The principal risks are updated as at 19 February 2025 having been reviewed in line with the agreed schedule (Annex 3). Focus has continued to be given to the risk ratings, controls, assurances, gaps, and mitigating actions identified and taken to support risks to achieve their target score.

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

8. 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.

9. A second workshop took place on the 13 February 2025 with members of the Risk Owners senior teams to continue the design and development of a different approach to managing and monitoring these risks; distinguishing between areas that are within the Trust's control and those that are not.

10. Members are asked to note the increase in score for **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* from 15 (3x5) to 20 (4x5).

11. 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.

12. 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.

<u>Electronic Risk Management System</u>

13. The expectation was that a digital solution would be in place before the end of the financial year that supports our enterprise risk management, strategic risk management and the production of a digital BAF; however, this timeline may not be achievable with the level of considerations that need to be factored into the solution and in particular testing of this with stakeholders.

Risk Reporting Schedule 2025/26

14. Members are asked to approve the reporting cycle for 2025/26 which takes a slightly different governance approach this year and ensures no duplication of reporting at committees and board meetings and up to date data at each.

RECOMMENDATION:

15. Members are asked to consider and discuss the contents of the report and:
    a) Note the progress of the Risk Management Transformation Programme: specifically, the development of risk appetite statements.
    b) Note the update on the 2024/25 Risk Management Internal Audit Review.
    c) Note the next steps in relation to a digital risk management solution.
    d) Note the ongoing repositioning of Risks 223 and 224.
    e) Note the increase in score for Risk 260 from 15 (3x5) 20 (4x5). The detail will be discussed in Closed Session of Finance & Performance Committee.
    f) Approve the revised risk reporting governance and cycle for 2025/26
    g) Receive assurance on the review and attention to the principal risks, including their review at ADLT, ELT and at relevant Committees.
    h) 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 (03 February 2025) • Executive Leadership Team (19 February 2025) • Audit, Risk and Assurance Committee (06 March 2025) • Finance & Performance Committee (18 March 2025) • Trust Board (27 March 2025) • Quality, Safety & Patient Experience (09 May 2025) • People & Culture Committee (15 May 2025)

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 – Risk Reporting Schedule 2025/26

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 report has several elements, firstly to provide an update on the risk management transformation programme and assurance in respect of the management of the Trust's principal risks. Additionally, it provides short updates on the procurement of an electronic risk management system and proposed scope of the 2024/25 Risk Management Internal Audit review and finally it seeks committee's approval on the revised governance on reporting cycles for 2025/26.

BACKGROUND

2. The Risk Management Transformation Programme is reported and monitored through the Corporate Governance Directorate's Local Directorate Plan and to the Audit, Risk & Assurance Committee for oversight.

3. The direction of travel and next steps for the Risk Management Transformation Programme was presented in detail to and supported by the ELT and Committee in September 2024 and reinforced by the recommendations made by our external consultants, BDO.

4. This is in addition to 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.

5. 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.

6. 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

<u>Risk Management Transformation Programme</u>

7. The next phase of the Risk Transformation Programme is underway to develop a suite of Risk Appetite statements with external support commissioned in December 2024 to work alongside the Board and key stakeholders across the Trust on this.

8. This element of the programme will address the one outstanding Internal Audit recommendation; action 596 is due to be completed in March 2025; however, it is likely that this work will be finalised in May 2025.

9. The risk appetite statements 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.

10. Two specific work streams have been delivered by BDO; the first was risk appetite training with the Board on 02 December 2024. This provided a refresher on what risk appetite is and how this can effectively be employed as a key strategic tool to enhance decision making. The second was a risk appetite workshop delivered to the Board on 20 February 2025, as part of the Board Development Programme, to review draft risk appetite statements aligned to the Trust's strategic objectives and to begin the discussion on defining the level of appetite for each one.

11. The team will continue the work to define and finalise the draft risk appetite statements with the Board and support them to agree and set the appetite against each of the Trust's six strategic objectives over the next quarter.

12. Once the risk appetite statements are final and have been approved by the Board and the appetite set against each of the strategic objectives, there are a number of next steps to be taken described below at a high level:

    1) Setting risk appetite thresholds and tolerances.
    2) Developing a suite of strategic risks against the strategic objectives.
    3) Designing risk appetite monitoring metrics.
    4) Setting up a reporting mechanism to monitor compliance against the risk appetite limits.

13. The team can begin exploring the design and development of a strategic BAF in more detail once key component elements such as the risk appetite and strategic risks have been agreed. The goal of the strategic BAF is to provide assurance to the Board that the key risks to the strategic objectives are being managed effectively.

14. Additionally, this will provide the Board with a clear and comprehensive view of both the strategy and what good looks like in 2028, and the strategic risks which will support effective and strategic decision making.

<u>Electronic Risk Management System</u>

15. In relation to the electronic risk management solution; the Trust will remain on

the current Datix Risk Web module at no additional cost until November 2027. The Trust's team is considering several digital solutions with the support and expertise of digital colleagues including options to buy then build our own electronic platform within two years.

16. The expectation was that a digital solution would be in place before the end of the financial year that supports our enterprise risk management, strategic risk management and the production of a digital BAF; however, this timeline may not be achievable because of the complexities of designing the system. All elements of the BAF first need to be developed, i.e., the risk appetite statements, the level of appetite and tolerances and a suite of strategic risks. It is vital that we get this right before procuring or building a new system.

17. The intention is that the new system will remove, as far as possible, the manual nature of updating of the BAF and ensures a clear cross reference to the Corporate Risk Register (CRR) and enterprise risk management.

Principal Risks

18. The ELT approved the principal risk activity described in this paper and considered the full review of each risk undertaken throughout December 2024 and January 2025 by Risk Owners and the ADLT.

19. 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.

20. 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.

21. 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.

22. The number of lost hours due to handover delays remained significant reported at 25,199 in December 2024.

23. Handover delays continue to present patient safety risks and extended waits in the community with a deteriorating Red performance being outside of what is acceptable to deliver a safe emergency service.

24. 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.

25. There are a range of efficiencies described in the report that the Trust has undertaken in mitigation of these two risks. Three key ones being that a new Clinical Safety Plan was released in December 2024 to enable the Trust to manage risk more effectively at a system level, ensuring that patients are not unnecessarily directed to Emergency Departments (EDs) when they can be safely managed through other pathways.

26. Additionally, the Trust is on track to reach the Advanced Paramedic Practitioner (APP) recruitment target for this financial year; the evidence of utilising APPs illustrates a dramatic impact on ED avoidance with more patients being managed safely within the community.

27. A third example is the activation of the Care Planning and Winter Desk initiatives provide additional oversight and pre-emptive measures to address seasonal demand surges. These efforts are crucial to sustaining system resilience and minimising patient harm.

28. 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.

<u>Repositioning of Risks 223 and 224</u>

29. To support the continued, detailed review and mitigation of these highest scoring risks, a second workshop took place on 13 February 2025 with members of the Risk Owner's senior teams to contribute to the design and development of a different approach to managing and monitoring those areas that are within the Trust's control and those that are not.

30. The proposed approach involves separating internal and external controls, assurances and gaps into those that the Trust manages and those that it monitors. Additionally, the group will test separate risk scores for internal and external mitigations, clearly demonstrating the impact of actions taken. This will not affect the overall score of 25 (5x5) which reflects the severity of patient harm and death. The group will meet fortnightly to progress this work over the next quarter.

31. The Quality, Patient Experience and Safety Committee (QuEST) reviewed both risks at its meeting in February 2025 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.

32. The Committee Secretary & Associate Director of Corporate Services and the Assurance & Risk Officer from the Joint Commissioning Committee (JCC) attended the QuEST meeting in February 2025 to consider the Trust's approach to these risks, how the committee meeting agendas are structured and how the reports it receives demonstrates the mitigations against these risks. The Trust's risk team will continue to meet with colleagues from the JCC to explore approaches to mitigating these risks from a system perspective given these remain the highest scoring risks on the JCC's new risk register as well.

33. Both risks were presented to the Finance & Performance Committee (FPC) and the People & Culture Committee (PCC) meetings in January and February 2025 respectively to continue to ensure that all perspectives and elements of the risks are considered and reviewed.

34. **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 of 20 (5x4) remains static during this quarter; however, the Health and Wellbeing Plan 2025-2029 and People and Culture Plan 2023-2026 provide strategic direction for relevant initiatives to support the mitigation of this risk.

35. **Risk 201** *A loss of stakeholder confidence that damages the Trust's reputation*, remains static at a score of 20 (4x5) 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. Significant winter pressures including the recent declaration of a critical incident mean that the risk to Trust reputation remains significant.

36. **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* has increased in score from 15 (3x5) to 20 (4x5) due to the escalated world conflicts and recent increase in targeted cyber-attacks against NHS organisations. This risk will be reported to the closed session of the FPC in the next round to

provide committee with information on the planned mitigations to target score given the sensitive and security based nature of these mitigations.

37. **Risk 641** *The Trust's inability to implement the learning from all relevant Manchester Arena Inquiry (MAI) recommendations impacting its response to a major incident/mass casualty incident* remains static at a score of 20 (4x5). This risk is taken in open session of the Board in full transparency. However, members will note that the actions to address individual recommendations are not included in detail in the BAF extract. This is for reasons of sensitivity and security.

38. **Risk 542** *Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan* remains static at a score of 16 (4x4).

39. **Risk 558** *Deterioration of staff health and wellbeing as a consequence of both internal and external system pressures,* **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* and **Risk 623** *Failure to comply with Data Protection Legislation* all remain unchanged this period and static at a score of 15 (3x5).

40. **Risk 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* and **Risk 163** *Maintaining Effective & Strong Trade Union Partnerships* remain unchanged at a score of 12 (3x4).

41. **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.

<u>2024/25 Internal Audit Risk Management Review</u>

42. The Corporate Governance team met with Peter Stephenson, Internal Auditor, NWSSP to discuss the topic of this year's review which will primarily focus on the Board Assurance Framework (BAF); assessing the Trust's current tools and reporting framework, the work that is underway to move us towards a Strategic BAF including the development of key elements such as risk appetite statements and strategic risks.

<u>Risk Reporting Schedule 2025/26</u>

43. Members are asked to approve the reporting cycle for 2025/26 which follows a slightly different governance approach this year. The revised cycle ensures committees receive timely risk updates within their remit after ELT approval of the activity. The revised governance factors in six reporting cycles instead of four,

aligning with six board meetings and six FPC meetings and prevents duplication of reporting across meetings throughout the year.

RECOMMENDED

44. Members are asked to consider and discuss the contents of the report and:
    a) Note the progress of the Risk Management Transformation Programme: specifically, the development of risk appetite statements.
    b) Note the update on the 2024/25 Risk Management Internal Audit Review.
    c) Note the next steps in relation to a digital risk management solution.
    d) Note the ongoing repositioning of Risks 223 and 224.
    e) Note the increase in score for Risk 260 from 15 (3x5) 20 (4x5). The detail will be discussed in Closed Session of Finance & Performance Committee.
    f) Approve the revised risk reporting governance and cycle for 2025/26
    g) Receive assurance on the review and attention to the principal risks, including their review at ADLT, ELT and at relevant Committees.
    h) 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.	**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	Executive Director of Operations	**25 (5x5)** →
224 QuEST	Significant handover delays outside A&E departments impacts on access to definitive care being delayed and affects the trust's ability to provide a safe and effective service.	**IF** patients are significantly delayed in ambulances outside A&E departments **THEN** there is a risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised **RESULTING IN** patients potentially coming to harm and a poor patient experience	Executive Director of Quality & Nursing	**25 (5x5)** →
160 PCC	High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service.	**IF** there are high levels of absence **THEN** there is a risk that there is a reduced resource capacity **RESULTING IN** an inability to deliver services which adversely impacts on quality, safety and patient/staff experience	Director of People & Culture	**20 (5x4)** →
201 PCC	A loss of stakeholder confidence that damages the Trust's reputation.	**IF** there is an inability of the Trust to deliver its core services because of system or organisational pressures **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	Director of Partnerships & Engagement	**20 (4x5)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		strategic vision, a failure to deliver its strategic ambition, damage to reputation and increased external scrutiny		
260 FPC	A significant and sustained cyber-attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems.	**IF** there is a large-scale cyber-attack on WAST, NHS Wales and interdependent networks which shuts down the IT network and there are insufficient information security arrangements in place **THEN** there is a risk of a significant information security incident **RESULTING IN** a partial or total interruption in WAST's ability to deliver essential services, loss or theft of personal/patient data and patient harm or loss of life	Director of Digital Services	**20 (4x5)** ↑ **15 (3x5)**
641 FPC	The Trust's inability to implement the learning from all relevant Manchester Arena Inquiry (MAI) recommendations impacting its response to a major incident/mass casualty incident	**IF** the Trust has not fully implemented the MAI recommendations AND a major incident or mass casualty incident is declared **THEN** there is a RISK that the Trust's Incident Response will be suboptimal **RESULTING IN** avoidable patient harm and/or death, detriment to staff wellbeing, reputational damage and potentially expose the Trust to legal liability	Executive Director of Operations	**20 (4x4)** →
542 FPC	Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan	**IF** there is a lack of resources and available technology and infrastructure **THEN** there will be a failure to deliver the commitments outlined in	Executive Director of Finance & Corporate Resources	**16 (4x4)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		the action plan and within the Welsh Government timelines **RESULTING IN** negative environmental and social impacts causing and reputational damage		
558 PCC	Deterioration of staff health and wellbeing in as a consequence of both internal and external system pressures	**IF** significant internal and external system pressures continue **THEN** there is a risk of a significant deterioration in staff health and wellbeing within WAST **RESULTING IN** increased sickness levels, staff burnout, poor staff and patient experience and patient harm	Director of People & Culture	**15 (3x5)** →
594 FPC	The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death.	**IF** a major incident or mass casualty incident is declared **THEN** there is a risk that the Trust cannot provide its pre-determined attendance as set out in the Incident Response Plan and provide an effective, timely or safe response to patients **RESULTING IN** catastrophic harm (death) and a breach of the Trust's legal obligation as a Category 1 responder under the Civil Contingency Act 2004.	Executive Director of Operations	**15 (3x5)** →
623 FPC	Failure to comply with Data Protection Legislation	**IF** the Trust fails to comply with and demonstrate it is meeting the accountability requirements under the Data Protection Act, the UK General Data Protection Regulation (GDPR) and the Common Law Duty of Confidentiality **THEN** the Trust will breach its legal obligations and potentially cause	Director of Digital Services	**15 (3x5)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		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.		
100 FPC	Failure to persuade JCC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience.	**IF** WAST fails to persuade 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 and staff and key outcomes within the IMTP not being delivered	Executive Director of Strategy Planning & Performance	**12 (3x4)** →
163 PCC	Maintaining Effective & Strong Trade Union Partnerships	**IF** the response to tensions and challenges in the relationships with Trade Union partners is not effectively and swiftly addressed and trust and (early) engagement is not maintained **THEN** there is a risk that Trade Union partnership relationships increase in fragility and the ability to effectively deliver change is compromised **RESULTING IN** a negative impact on colleague experience and/or services to patients.	Director of People & Culture	**12 (3x4)** →
139 FPC	Failure to Deliver our Statutory Financial	**IF** the Trust does: • not achieve financial breakeven and/or	Executive Director of Finance &	**8 (2x4)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
	Duties in accordance with legislation.	• 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	Corporate Resources	

Annex 2 - Risk Scoring Matrix

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

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

Annex 3 - Frequency of Risk Review

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

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:	22/01/2025	TREND	25 (5x5)
		Date of Next Review:	22/02/2025	➡	

IF	THEN	RESULTING IN
significant internal and external system pressures continue	there is a risk of an inability and/or a delay in ambulances reaching patients in the community	patient harm and death

	Likelihood	Consequence	Score
Inherent	4	5	20
Current	5	5	25
Target	2	5	10

IMTP Deliverable Numbers: 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

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 November were 20,993 and December were 25,199.**

The impacts on patients waiting for extended periods of time both in the community and then outside emergency departments is well documented (AACE Delayed Hospital Handovers: Impact assessment of patient harm, 2021) and includes pressure damage, acute kidney injury, deconditioning, poorer outcomes, and extended recovery times. Delays across the system continue to be the focus of patient safety incidents, complaints, Coronial enquires and redress / claims. The effectiveness of our controls in many areas are dependent on external partners acknowledging and having ownership of the risk across the urgent and emergency care system. Key to moving the position is to continue to work in collaboration influencing system partners, being present and engaging in key conversations, whilst continually seeking opportunities internally to swiftly identify and mitigate the risks within our control and share those with relevant system partners that we cannot control. Of note, recent data analysis highlights the increased levels of red activity which has doubled since the pre covid period, plus an average increased on scene time of circa 10 minutes. Both measures are reflective of an increasingly challenged system with WAST crews fully exploring admission avoidance alternatives.

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

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

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. Regional Escalation Protocol	1. Daily conference calls to agree RE levels in conjunction with Health Boards
2. Immediate release protocol	2. The Immediate Release Protocol is a Nationally agreed NHS Wales protocol. Refusals by Health Boards are Datixed by WAST and compliance report shared weekly with the Health Board Chief Operating Officers (COOs). V1.3 has been reviewed, updated and released (August 2024).
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

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	22/01/2025	TREND	25 (5x5)
		Date of Next Review:	22/02/2025		

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

	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.
9. Clinical Safety Plan (CSP)	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. **New CSP released 17th December 2024, released to enables the Trust to manage risk more effectively at a system level, ensuring that patients are not unnecessarily directed to EDs (can't send) when they can be safely managed through other pathways. In doing so we help to reduce demand on EDs and therefore hospital handover delays, support a better working environment for staff and ensure improved ambulance availability for those who need them most.**
10. Recruitment and deployment of CFRs	10. 11 new onboarding courses for June to December with projection of 110 new CFRs by 3rd 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.

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	Likelihood	Consequence	Score
Inherent	4	5	20
Current	5	5	25
Target	2	5	10

	• 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 31st March 2024. Holding area in Swansea and YGC remains ongoing.
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. Undertake the next 5-year strategic EMS Demand and Capacity review (the 2019 version will run out this year – 2024)	27. Review has been undertaken and has been reported to closed FPC committee July 2024 and Trist Board July 2024. This review details the level of resourcing required in different handover lost hour scenarios with different ways to respond to it e.g. traditional model or evolved CRN.
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 4 hour 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 Morriston 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.

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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

10. There is currently no JCC implementation plan associated with the 2023 Demand and Capacity Review	10. The requirements for a funded implementation plan for the review i.e. resource envelope change from the JCC. The review is being reported to JCC board development session in August 2024 and is expected to go to JCC committee later this year. The expectation is that the 2025/26 commission intentions will respond to the review.

Please note that the gaps listed are not WAST's and are therefore outside of the control of WAST

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Exploring Rural model options (Paused during Pandemic Response) – subject to funding through IMTP. Now refreshed to wider rural model opportunities to include recruitment of CFRs. Additional funding has been sourced to increase posts within the volunteer function.	Assistant Director of Operations EMS / Assistant Director of Operations – National Operations & Support	Superseded	Rural model superseded by Action 9 below (Recruitment and deployment of CFRs)
2. Leading Change Together (forum to progress workforce related work streams jointly with TUPs)	ADLT Sub-Group	30.09.22 - Superseded	
3. Recruit and train more Advanced Paramedic Practitioners – Value Based Healthcare Fund bid for up to 50 WTE (I) [Source: Action Plan presented to Trust Board 28/07/22]	Director of Paramedicine / Director of People & Culture	**Superseded**	**16/01/2025 APP growth has been steady throughout the year, focussing mainly on CTM and AB Health boards which have had the lowest APP numbers. We are on track to reach our recruitment target for the year 120.7 FTE.** **A standardised training route including clinical placements in Primary Care has been supported for all trainees and the development of APP Nav models which are co-located in each Health board have been prioritised to support the UCRS Transformation work, with 49 APPs working rotationally in 6 out of 7 Health boards in an APP Nav model.** **Despite successful funding bids to support APP growth from external sources, we continue to link closely with strategic partners to showcase the impact of APPs in WAST and develop partnership working across the Health Board regions.** 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. May 24 - 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	Aug 24 – 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	Assistant Director of Integrated Care (with SRO through CMT Board)	March 2025	Phase 1 for winter

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	22/01/2025	TREND	25 (5x5)
		Date of Next Review:	22/02/2025		

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

			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 **Commissioning** & Performance	Completed	ORH modelling underway. Initial findings January 2024, full report to Trust Board and JCC 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	Superseded with the implementation of the new model (ref: Action 5)	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 in partnership with St John Ambulance Cymru to deliver the CWR element. Initial phase due to conclude in March 2024, further extended to May 2024 due to SJAC funding accommodating extension arrangement. • NHS Charities Together (grant) funding obtained through external application, to develop internal volunteer capacity/volunteer workforce as CWRs. Piloting of the CWR model commenced in Spring 2024, with an expansion of the model in mid-October. Recruitment, onboarding and training continues with aspiration to recruit CWRs across Wales. • The SBRI innovation challenge has supported a phase 2 delivery of the digital ward model: enabling remote clinicians to care for patients in a 'virtual ward' capacity. It is envisioned this will enable patients to reach to right care at the right time, whilst being monitored remotely. The pilot has commenced for care homes in Wales, and a dedicated remote clinician is supporting the initiative generating organisational learning to expand remote care planning role the Trust can provide for the NHS Wales. The pilot initiative will conclude in March 2025. • The work will form part of the RICs workstream from September 2024.
9. Maximise the opportunity from Consult and Close: - Successful resolution without ambulance (double EMS) - Successful resolution without conveying to ED		March 2025	Trust ambition is to improve Consult and Close rate, with an improvement plan in place to achieve this. The Trust has however already achieved the inclusion of Mental Health Practitioners in CSD, a key contributor to the achievement of Consult and Close rates. Consult and Close compliance remains around 14%. Action plan activities therefore continue with a review of triage processes which may lead to shorter triage durations, along with increase in staffing, which together will enable more triages to take place, thus increasing the number of successful resolutions without a double EMS ambulance and numbers conveyed to an ED.

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	22/01/2025	TREND	25 (5x5)
		Date of Next Review:	22/02/2025		

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

10. Palliative Care Paramedic Unit	Assistant Director of Operations	**March 2025**	**16/01/2025 - At the end of the 3-year pilot, evaluation has been shard via an SBAR in SOT on 14th January and subsequently SLT on 21st January. This may potentially be BAU if approved.** Reducing demand via APPs – 15th 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.
11. 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	**February 2025**	• 01/10/2024 - The review of the unscheduled care report part 2 (accessing urgent and emergency care) is underway and will come to the committee in November 2024. • 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.
12. Royal Glamorgan Early Diagnostic	Executive Director of Operations	**August 2024**	• Initial data from Qlik shows that there has been no reduction in N2H times however data received from Health Board show indication of patient benefit to reach earlier diagnostic. Local meetings this month to discuss findings and explore opportunities. • May 24 – 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:	28/01/2025	TREND	25 (5x5)
		Date of Next Review:	28/02/2025	➡	

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

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

IMTP Deliverable Numbers: 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 Q4 2024/25

- 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 November were 20,993 and December were 25,199.** 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.

Improvement actions led by Welsh Government and system partners include:

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

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. WAST Serious Clinical Incident Forum (SCIF) is in place to discuss patient safety incidents, learning and improvement actions to prevent future harm, working in collaboration with Health Boards / NHS Wales Executive Delivery Unit under the Joint Investigation Framework which was formalised in the National Patient Safety Policy in May 2023. Sharing of potential case of serious avoidable harm/death with Health Boards for investigation when response delay associated with system congestion is the primary cause. CNO and CMO plus peer group and COOs regularly updated on patient safety incidents.	1. Patient safety reporting and escalation through the Serious Clinical Incident Panel (SCIF), Patient Safety Highlight Reports, Health Board specific reports in place with escalation through WAST governance framework. **Increased collaboration through the Serious Case Incident Forum (SCIF), Mortality Review Group, and the Learning from Events Meeting (LFEM). These platforms emphasise joint investigations, shared learning, and actionable insights to prevent future harm and improve patient outcomes.**
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	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. Agreement was that sub-groups would be formed to meet more frequently to gather themes / evaluation / develop more consistency which would include

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

	aligning the outputs / outcomes with the 'Six Goals for Urgent and Emergency Care' work. An event reviewing the effectiveness of the Joint Investigation Framework is currently being scoped nationally.
3. WAST and system compliance with National Standards - 15-minute handover (NHS Wales Hospital Handover Guidance v2 (May 2016)	3. Monthly Integrated Quality and Performance Report, Health Informatics reports.
4. WAST Clinical Notice in place - Escalating a clinical concern with a deteriorating patient outside the Emergency Department National Early Warning Score (NEWS) trigger of 5 or above for escalation to hospital clinicians. NEWS data available via EPCR (electronic patient care record).	4. NEWS data now available via ePCR and escalation system in place via local managers and the Operational Delivery Unit.
5. Workstreams put in place to meet requirements of *Right care, right place, first time Six Goals for Urgent and Emergency Care A policy handbook 2021–2026.* Goal 4 incorporates the reduction of handover of care delays through collective system partnership.	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 *Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover* (undertaken 2021). WAST has senior representation at this meeting. – assurance is that HIW approve and sign off WAST elements and Health Board elements of recommendations.	14. Workshop set up by the Deputy Chief Ambulance Commissioner to respond to the findings in the Health Care Inspectorate Wales (HIW) Report Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover (undertaken 2021). WAST has senior representation at this meeting. A collective response from WAST and Health Boards is being overseen by JCC.
15. Escalation of patient safety concerns by Trust Board: featured in provider reports to the Joint Commissioning Committee (JCC); been the subject of Accountable Officer correspondence to the NHS Wales Chief Executive; numerous escalations to professional peer groups initiated by WAST Directors; and coverage at Joint Executive Meetings with Welsh Government. Evidence submission to Senedd Health and Social Care Committee. Written evidence submitted during Q4 21/22 to the committee to assist their inquiry into Hospital Discharge and its impact on patient flow through hospitals.	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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	Likelihood	Consequence	Score
Inherent	5	5	25
Current	5	5	25
Target	3	2	6

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 Joint Commissioning Committee (JCC) 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 JCC.
	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.
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.

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

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	• Timeframes awaited via Emergency Department Quality & Delivery Framework (EDQDF).
2. Implement patient safety dashboards (live and look back data) triangulating quality metrics / KPIs and performance data sourcing health informatics resource.	Assistant Director of Quality & Nursing	Q3 2024/25	• Incremental improvements to quality and safety data and information to enable triangulation / collective intelligence at Trust and system level. • 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.	• Monthly meetings continue to be held and networking through EDoNS.
4. Recruit and train more Advanced Paramedic Practitioners.	Director of Paramedicine	Q4 2024/25	• 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	•Overnight falls service extension and future modelling • Night Car Scheme extension agreed to 31 September 2024 (2 regional resources) • Utilisation rates continue to be monitored: • Nighttime utilisation: - Q2 65% Q3 64% Q4 to date 64% April 2024 - 67% • Daytime utilisation: - 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 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.

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	Likelihood	Consequence	Score
Inherent	5	5	25
Current	5	5	25
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6. Duty of Quality, Duty of Candour and new Quality Standards implementation from April 2023 with development of a Quality Monitoring System supporting monitoring and oversight systems in place and embedded. Quality Report development underway – mandatory requirement to publish 2024/25 (no fixed date for publication nationally).	Executive Director of Quality & Nursing	Q4 2024/25	• Monthly updates to progress against actions following the baseline assessment and readiness returns continued. • 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. • **Still underway**
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 **Extended**	• 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 **continuation of the LUSCII solution Continued expansion of the Connected Support Cymru initiative, leveraging digital and telehealth platforms.** **Recruitment efforts for Community Welfare Responders (CWRs) are ongoing, with engagement across Wales to bolster capacity and resilience**.
8. Organisational change process (OCP) of Putting Things Right Team (PTR) to enable increased capacity across all functions to manage increasing complexity and demands.	Executive Director of Quality & Nursing	Q2 2024/25	• OCP commenced 25.09.2023 and the consultation period has concluded with the final new structure confirmed. Next steps are to recruit to vacant positions which has commenced. It is anticipated that all positions will be filled by May 2024 (taking notice periods into account). Recruitment is progressing well with multiple applications for each post and some internal promotion opportunities. • 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	• 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	• 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	• Fundamentals of Care meeting, chaired by the Executive Director of Quality & Nursing held on 08.03.2024.
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)
13. Development of the RICS service.	**Executive Director of Quality & Nursing**	**Q4 2024/2025**	• **Winter Desk and Care Planning Initiatives:** • **The aim of Care Planning is for clinicians to provide holistic management of a patient's care journey through WAST by carrying out ongoing monitoring where appropriate to ensure patients flow to the most suitable disposition to meet their needs. The aim of Care Planning is for clinicians to provide holistic management of a patient's care journey through WAST**

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:	28/01/2025	TREND	25 (5x5)
		Date of Next Review:	28/02/2025	➡	

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

			by carrying out ongoing monitoring where appropriate to ensure patients flow to the most suitable disposition to meet their needs. • Activation of the Care Planning and Winter Desk initiatives, providing operational oversight and pre-emptive measures to address seasonal demand surges. These efforts are crucial to sustaining system resilience and minimising patient harm. • Deployment of specialists in respiratory care and pediatrics, addressing critical clinical gaps and improving care pathways. • The remote clinical care leadership is growing, with the addition of two new specialist roles to complement the existing and growing multidisciplinary expert team. The addition of specialist clinicians in remote care for pediatric and respiratory care is a significant step forward in our commitment to enhancing patient care and aligning with our organisational plans to care for more patients in more alternative ways than traditional ambulance responses. • We will welcome a pediatric nurse specialist and a physiotherapist respiratory specialist in early February 2025 and look forward to understanding more about how their wealth of advanced clinical experience and expertise can contribute positively to safe person-centered outcomes for patients who often require the help and assistance of both 999 and NHS 111 Wales. • Ongoing progress in appointing a Learning Disabilities Specialist to further enhance equity and inclusion in care delivery.

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:	22/01/2025	TREND	20 (5x4)
		Date of Next Review:	22/02/2025	➡	

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

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

IMTP Deliverable Numbers: 13, 14, 15, 22, 24, 25, 26

EXECUTIVE OWNER	Director of People	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 Health and Wellbeing Plan 2025-2029 and People and Culture Plan 2023-2026 provide strategic direction for relevant initiatives**.

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. **Significant policy frameworks and strategies embedded across the organisation including** Managing Attendance at Work Policy, **R&R, Speaking Up and the Health and Wellbeing Plan** in place and followed **with support from the P&C team.**	1. (a) Audits undertaken by People Services Team (b) Outputs reviewed **(c) Process reviews** **(d) PS team engagement on additional activities which could be delivered** **(e) Case support, advice and guidance with action planning to reduce absence** **R&Rs addressed in timely way to reduce risks of sickness absence.** **Compassionate Practices approach engaged.** **Referral of colleagues to appropriate levels of support** **Policy reviews to ensure policies and procedures are fit for purpose in line with agreed time frames Completed - 28/11/23** **Speak Up Safely process introduced from the start of October 2023 including the appointment of one Trust guardian. The Health and Wellbeing Plan 2025-2029 and People and Culture Plan 2023-2026 provide strategic direction for initiatives to improve the workplace, in line with HEIW Best Practice Guide for Organisations. These documents support us in ensuring that our offer is focused, and evidence driven.**
2. Operational Workforce Recruitment Plans, **roster reviews and implementation to actively address demand and capacity and ensure** sufficient resources **to meet** workload pressure	2. **Maintenance of the workforce establishment to seek to ensure that colleagues are not unnecessarily stretched through vacancies**
3. Return to Work interviews are undertaken - SharePoint Sway document ensuring accurate reporting of reason for absence and identifying any additional support required	3. Process regularly reviewed and managers are trained and coached on the need to complete returns to work promptly
4. Training for managers on all aspects of Managing Attendance – ensures focus is high and understanding of why this is important is maintained	4. **Managing Attendance training register of attendees.**
5. **Reporting to Board, CASC, PCC, ELT, SLT, SOT,** Directors **and managers on sickness data**. **Leadership reporting includes deep dives and analysis of data.**	5. **Appropriate reporting for assurance to a range of audiences with feedback and support for further action.**
6. People Services & Occupational Health & Wellbeing support/Employee Assistance Programme- providing professional support	6. **Managers have access to specialist advice and guidance from People and Culture team colleagues**
7. Suicide first aiders, **TRIM, Peer Support Networks, coaching and mentoring framework in place giving** additional layers of **support, Health and Wellbeing Steering Group in place**.	7. **Reporting in place on numbers of suicide first aiders and demand for support. Reporting on access to TRIM. Promotion of wellbeing support across WAST.**
8. Staff surveys- assess levels of engagement and wellbeing	8. **Use of** HIVE survey tool **and insight data from the NHS Wales staff survey provides feedback on overall** engagement and wellbeing
9. Stress risk assessments- identify measures that can be taken to address issues	9. Reference to the assessments during attendance management line manager training and to **the use of stress risk assessments promoted to managers**
10. External agencies support e.g., St John Ambulance, Fire and Rescue- if needed at times of increased demand pressure	10. **SLA Agreements.**

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:	22/01/2025	TREND	20 (5x4)
		Date of Next Review:	22/02/2025	➡	

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

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

11. **Guidance for managers on alternative duties and** monthly reviews of colleagues on Alternative duties	11. **Action planning and timeboxed activities to support in a timely way.**
12. Sickness audits for localities- provides additional level of detail **and additional support for areas with higher sickness levels to support work to reduce those levels**	12. **Delivery of audits and follow up actions**
13. **Review of top 100 cases -carried out monthly**	13. **Provides a focus on higher risk cases where more intense action or support may be required.**
14. **Delivery of specific projects and pieces of work to support the reduction of sickness absence across the organisation.**	14. Offers assurance to ELT 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
15. Work in Confidence system implemented and **Guardian appointed to support colleagues coming forward with concerns and potentially reducing levels of stress and avoiding sickness absence**.	15. External Management (2nd Line of Assurance) **and Audit**.
16. Strengthen Speaking Up Safely Arrangements policy and advice and roll out of **increased awareness of routes to speak up** and raising concerns.	16. Monitor **SUS** concerns and they are dealt with in agreed timeframes and assessed whether absence related to mental health and anxiety reduces.
17. Actions identified from the Managing Attendance Audit implemented	17. Agendas, minutes etc.
18. PADR review undertaken and now including wellness questions	18. Underway and now BAU – **ensures managers are talking about individuals' wellbeing and what additional support or signposting can be provided**
19. **Specific interventions on all** long-term sickness absence cases to ensure there is a tailored, individual action plan which identifies interventions that will support a return to work as soon as reasonably possible.	19. PADRs undertaken and questions asked; Discussion on levels of long-term sick absence is undertaken in a variety of forums including JCC, ELT and PCC.
20. Accountability meetings on attendance management between People Services and senior ops managers to ensure this issue is given sufficient focus on priorities **and ADs hold their senior teams accountable for their team figures**	20. Meetings taking place and active on operational areas experiencing high levels of absence
21. **TU engagement on attendance issues e.g.** muscular skeletal conditions is discussed regularly at the H&S Committee and relevant additional interventions are identified	21. Included on agendas and outcomes are available for discussion at H&SC.
22. 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.	22. Director of People 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 **are difficult to control as they are linked to system wide challenges**
	Absence data is not updated in a timely manner into ESR by managers
Opportunities to improve education and communication with managers about resources available and how to implement it e.g., stress risk assessments	**Further roll out and access to learning around sickness absence on process, supporting docs and on how to approach managing attendance**

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	31/05/25	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. **This will form part of Management Essentials being launched in quarter one.**
2. Areas of business where attendance management has improved significantly to share learning across WAST	**AD for Culture, Inclusion and Wellbeing**	**31/6/25**	**Staff story at PCC in 2024 and visit to another area with low absence in 2024.**

Risk ID 160	High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service	Date of Review:	22/01/2025	TREND	20 (5x4)
		Date of Next Review:	22/02/2025	➡	

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

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

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	31/06/25	Discuss at PCC Business Meeting and share at ELT/PCC with recommendations. **Looked at London Team Based Working model, given that LAS have attributed TBW to improvement in attendance rates.**
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 Culture **Change**	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	**Proposed** Evaluation of pilot **in EMSC** after 6 months to assess if there has been a reduction in sick absence in specific areas where this approach has been **adopted following culture work with teams.**
6. Development of the 2024/25 Managing Attendance Plan (see below for individual actions.	Deputy Director of People	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 of People	31.03.2025	
8. Coaching for managers on cases on one and locality basis.	Deputy Director of People	**Complete and BAU**	**In place and BAU**
9. Increase manager support on data interpretation and analysis	Deputy Director of People	31.0**9**.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 of People	**Complete and BAU**	**225 applications for flexible working received post awareness raising. Ongoing work with managers on approving / seeking a mutually agreeable outcome with the requester.**
11. Culture work on creating the sense of team and peer responsibility / ownership	AD for Culture Inclusion and Wellbeing	31.0**9**.2025	**Incorporated in Our WAST Way – Leadership at all levels and the through the culture champions network, with focus on Our Best behaviours.**
12. Analyse link between hot spots and the culture in these areas to address cultural issues	AD for Culture, Inclusion & Wellbeing	31.03.2025	**111 and 999 sickness levels reviewed: link to repetitive roles, exposure to distressed patients. Additional management layers in CCC should start to show positive impact on attendance. Consideration to be given to whether change management approach being applied in these areas is having an impact**
13. Identify opportunities to improve roles – flexibility, control, confidence	Deputy Director of People / ADs, Operations	31.03.2025	**Work to be undertaken to review whether any correlation between approved flexible working requests and attendance rates**
14. Opportunities to adapt the work environment. **Link to Risk 224 and Risk 558 regarding the risk with the impact on WAST colleagues of overruns as well as patients.**	Deputy Director of People ADs, Operations **Directorate colleagues**	31.03.2025	**ELT discussion via WASPT regarding feedback from TUPs on operational overruns and shift patterns.**
15. Review workloads **and hours of work undertaken by colleagues. Including colleagues not on GRS.**	Deputy Director of People /ADs, Operations	31.03.2025	
16. Review patterns of absence	Deputy Director of People	31.03.2025	**Increase in STS, respiratory, coughs, colds etc.; example of targeted interventions put in place in response to identified patterns (Integrated Care). Reporting to ELT in Feb 25 on some of the findings.**
17. Development of a mental health referral pathway	AD for Culture, Inclusion and Wellbeing	31.03.2025	**Scoping being carried out by Head of Workplace Wellbeing, links with existing provision and access to appropriate support and guidance for managers**.

Risk ID 160	High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service	Date of Review:	22/01/2025	TREND	20 (5x4)
		Date of Next Review:	22/02/2025	➡	

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

18. Develop the team around the person model / individual support network	Deputy Director of People and Culture	31.03.2025	
19. Increase lifestyle advice and guidance	AD for Culture, Inclusion and Wellbeing	31.03.2025	**Occupational Health and Wellbeing Team developing expertise in specific areas; calendars of events; health promotion.**
20. Undertake proactive testing to identify undiagnosed conditions	AD for Culture, Inclusion and Wellbeing	31.03.2025	**Health checks ready to be rolled out as soon as capacity allows.**
21. Review reporting on OH	AD for Culture, Inclusion and Wellbeing	31.03.2025	
22. Review opportunities on men's mental health e.g. support groups	AD for Culture, Inclusion and Wellbeing	31.03.2025	**WAST voices ensure that proactive support for men's mental health, links with Men's Shed's, specific webinars and targeted campaigns and events.**

Risk ID 201	A loss of stakeholder confidence that damages the Trust reputation	Date of Review:	27/01/2025	TREND	20 (4x5)
		Date of Next Review:	27/02/2025	➡	

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

	Likelihood	Consequence	Score
Inherent	4	5	20
Current	4	5	20
Target	3	5	15

IMTP Deliverable Numbers: 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 Q4 2024/25

The risk score remains constant at 20 (highly likely and catastrophic). The organisation's reputational risk is one which is long-standing and entrenched. At the time of writing, conversations with key, mission critical stakeholders remain live in respect of the Trust's proposed clinical service model/transformation programme. **The focus is currently on key clinical stakeholders in response to feedback received by both Welsh Government and Commissioners. We continue to keep colleagues at Llais updated. Currently both performance matters and transformation proposals present reputation risk. Significant** winter **pressures including the recent declaration of a critical incident mean that** the risk to Trust reputation remains significant.

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, **CMT etc**
2. Revised engagement framework delivery plan **is now described as the programme engagement plan and continues to be updated and revised** to reflect feedback from stakeholders and revised timelines for strategy engagement	2. **Reported at CMT at each meeting on who has been engaged with and risks that are emerging etc**
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 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 **have been undertaken 2024/25.**	7. **Was** 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. **Minuted meetings, action logs and Board papers**
12. Internal Quality and Performance monitoring in the Trust and raising system issues	12. **Data provided though reporting to Committee and Board for scrutiny and feedback.**
13. Reputation audit launched on 09 April 2024 and ran until 01 May 2024.	13. **High-level results presented at People and Culture Committee on 09 May and at Board Development on 27 June to assist the Trust to understand the impact of the reputation audit and to support our approach to stakeholder engagement.**
14. Development of a Winter Media Plan	14. **Monitored daily by the team and updated based on media coverage and public sentiment.**

GAPS IN CONTROLS	GAPS IN ASSURANCE
1. Managing the narrative of the media	1.
2. Strategic collaboration – further work needed to formalise opportunities – to think about how this translates into an action	2.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Roll out of **Programme Engagement** Plan	Director of Partnerships & Engagement	Q4 24/25 and continued	**Roll out underway**.
2. Board Development Session on political landscape	**Director of Partnerships & Engagement**	**Q3-4 2025/26**	**To be finalised in the programme.**

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:	07/02/2025	TREND	20 (4x5)
		Date of Next Review:	07/03/2025		

IF	THEN	RESULTING IN
IF there is a large-scale cyber-attack on WAST, NHS Wales and interdependent networks which shuts down the IT network and there are insufficient information security arrangements in place	THEN there is a risk of a significant information security incident	RESULTING IN a partial or total interruption in WAST's ability to deliver essential services, loss or theft of personal/patient data and patient harm or loss of life

	Likelihood	Consequence	Score
Inherent	4	5	20
Current	4	5	20
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

The risk has been fully reviewed in the cycle and the **risk score has increased given escalated tension around various conflicts around the world, the decrease in the relationship between UK and Russia, and Russia's threat to the UK's critical national infrastructure along with the recent increase in targeted cyber-attacks against NHS organisations.** 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.

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

Risk ID 260	Significant and Sustained Cyber Attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems	Date of Review:	07/02/2025	TREND	20 (4x5)
		Date of Next Review:	07/03/2025		

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	4	5	20
Target	2	5	10

18. Information Security Policy refreshed and approved.	
19. Suite of business continuity exercises that departments can undertake to test their plans are available via EPRR.	19.
20. The cyber risk is reviewed and monitored	20. The ongoing cyber threat to the organisation is continually monitored using daily comms feeds and automated alerts from various external sources via ICT security team and reported to AD of Digital and DPO. The corporate cyber risk assessment will be reviewed monthly at the Digital Leadership Group informed by the threat and intelligence monitoring and national strategic trends.
21. SIRO in place and ISMS evolving in line with refresh of Trust information Security Policy	**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, **continued education and awareness as per improvement plan.**	1.
2. 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. **Revised procurement guidance to be disseminated via ADLT.**	

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. **Continued implementation and** development of the Trust Cyber Improvement Plan	Senior ICT Security Specialist	Next checkpoint date **31.01.2025**	Implementation of Cyber Improvement Plan actions ongoing and regularly reported into ICT SMT, DLG, IGSG and FPC.

Risk ID 641	The Trust's inability to implement the learning from all relevant Manchester Arena Inquiry (MAI) recommendations impacting its response to a major incident/mass casualty incident	Date of Review:	16/12/2024	TREND	20 (4x5)
		Date of Next Review:	16/01/2025	➡	

IF	THEN	RESULTING IN
the Trust has not fully implemented the MAI recommendations AND a major incident or mass casualty incident is declared	there is a RISK that the Trust's Incident Response will be suboptimal	avoidable patient harm and/or death, detriment to staff wellbeing, reputational damage and potentially expose the Trust to legal liability.

	Likelihood	Consequence	Score
Inherent	5	5	25
Current	4	5	20
Target	2	3	6

IMTP Deliverable Numbers:

EXECUTIVE OWNER	Executive Director of Operations	ASSURANCE COMMITTEE	Finance & Performance Committee

Risk Commentary

Following the Manchester Arena Incident in May 2017, whereby twenty-two (22) innocent people were sadly killed, and the subsequent Public Inquiry (MAI), ambulance services across the UK have reviewed their ability to respond to a Major Incident. WAST has undertaken its own review and has identified sixty-eight (68) of the MAI recommendations as being pertinent to the ambulance service and/or multi-agency preparedness and response. Once these recommendations have been implemented then the risk will be mitigated to target; however, additional financial resources are required to do this.

As part of the Trust's ongoing commitment to deliver the necessary change against the MAI recommendations, a dedicated team was established in June 2023 to investigate and assure the Board that all necessary organisational processes were in place should an incident occur in Wales. Since the beginning of this project, significant progress has been made in addressing the recommendations (as identified in the 'Controls' section below) and the Trust is better prepared because of the work undertaken to date.

As part of the ongoing work, the Trust has completed a series of investigations and developed a series of 'Capability Reports' to demonstrate and explain where remaining challenges to an anticipated Major Incident could occur. The capability gaps identified are detailed in the below reports, which were shared with the Board, and are supported by a significant base of evidence produced as part of the 'R105' self-review process. The reports are:

- **R106 Capability Report**
- **Capability to Prepare**
- **Capability to Respond**
- **Capability of Specialist Assets**

The reports identify that a significant proportion of the MAI recommendations remain outstanding, and the Trust is unable to progress these further or fully implement the identified learning without financial support. The reports highlighted what is needed to complete or significantly progress twenty (20) MAI recommendations and forms the basis of the 'Gaps in Controls' and 'Actions' sections. Transitioning these gaps and actions across into the 'Controls' section when achieved will act as a longitudinal method of tracking progress of completion against the MAI recommendations, and the associated risk reduction as this occurs. If the Trust is unable to implement the MAI recommendations fully, there remains a risk to the public, the organisation, and commissioners in the event of a mass casualty incident.

This Board Assurance Framework (BAF) extract is supported by a more detailed appendix of itemised actions required to permit greater scrutiny of remaining gaps and actions, as well as a detailed repository of control measures that have been successfully implemented.

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. Forty-four (44) of the pertinent MAI Recommendations have been implemented into WAST practice through the work undertaken to date.	1. MAI recommendations that have been marked as implemented by the EPRR MAI Project are authorised and ratified by Operations Senior Leadership Team and cascaded via the approved governance route (AAA) to ELT and Trust Board. This forms a documented governance route for rationale for completion and details of this are recorded in the EPRR share drive alongside evidence of compliance. Additional details of assurance are provided in the annex to this Corporate Risk. Ongoing monitoring and assurance of lessons learned is captured through BAU processes and the established debriefing/lessons learned process such as the Organisational Learning Spreadsheet.
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Four (4) outstanding MAI Recommendations, identified as pertinent to WAST by the self-assessment, require action against to implement the associated learning **(REF: MAI recommendations 1, 26, 88, 111).** These are not included in the R106 funding request.	1. Work is progressing against these recommendations as part of the ongoing MAI project. It is anticipated that these recommendations can be implemented without additional financial support. Regular updates on these four recommendations are provided through the regular 'touch point' meetings with EPRR HoS, ADO for National Operations & ED of Ops, with periodic updates to SLT that are then cascaded via the approved governance route.

Risk ID 641	The Trust's inability to implement the learning from all relevant Manchester Arena Inquiry (MAI) recommendations impacting its response to a major incident/mass casualty incident	Date of Review:	16/12/2024	TREND	20 (4x5)
		Date of Next Review:	16/01/2025	➡	

IF the Trust has not fully implemented the MAI recommendations AND a major incident or mass casualty incident is declared	**THEN** there is a RISK that the Trust's Incident Response will be suboptimal	**RESULTING IN** avoidable patient harm and/or death, detriment to staff wellbeing, reputational damage and potentially expose the Trust to legal liability.

	Likelihood	Consequence	Score
Inherent	5	5	25
Current	4	5	20
Target	2	3	6

2. Twenty (20) outstanding MAI Recommendations that have been submitted to Trust commissioners via the 'R106' process as requiring financial support to implement the learning **(REF: MAI recommendations 16, 17, 20, 23, 24, 25, 50, 53, 71, 84, 85, 86, 87, 92, 105, 106, 108, 109, 117, 124).**	2. The outstanding recommendations are not able to be implemented independently by WAST and may remain unresolved until such time that additional financial resources and practical arrangements are in place to support this work. Trust commissioners have been notified of this via the formal R106 submission completed in August 2024.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Implement the learning relating to forty-eight (48) recommendations identified in the MAI report as pertinent for WAST **(REF: Outstanding MAI recommendations 1, 26, 88, 111).**	Assistant Director of Operations, National Operations & Support	March 2025	This programme of work is underway, with nearly all recommendations completed. 4 recommendations remain outstanding, with a plan in place to implement all these recommendations.
2. Submit evidence to Commissioners demonstrating that additional funding is required to implement a further twenty (20) recommendations identified in the MAI report **(REF: MAI recommendation R106).**	Assistant Director of Operations, National Operations & Support	March 2025	A formal submission of requirements has been submitted to commissioners for consideration and approval. Commissioners have been engaged with since early 2024 to raise awareness and facilitate early discussion. The Trust is awaiting a formal response to the submission.
3. Implement the necessary amendments to Trust infrastructure, resourcing level and equipment required to address the remaining recommendations once funding has been made available. (**REF: MAI recommendations 16, 17, 20, 23, 24, 25, 50, 53, 71, 84, 85, 86, 87, 92, 105, 106, 108, 109, 117, 124).**	Assistant Director of Operations, National Operations & Support	March 2029	An assortment of 20 proposals rests with commissioners at present. As these proposals are funded, capabilities gaps will be addressed and an associated reduction in the risk score can be expected. Some of these proposals may take several years to implement (e.g. a North Wales HART Unit) which is reflected in the target date. Other proposals could be accomplished in a much shorter timeframe if funded. Once the implementation of infrastructure, resourcing and equipment has occurred, WAST will either be compliant with the MAI recommendations, or, in some circumstances, may need to undertake further work to integrate the MAI learning into practice (e.g. once the EPRR Training & Exercising Team have established, they will then need to provide sufficient levels of exercising to comply with the exercising-related MAI recs).

Risk ID 542	Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan	Date of Review:	27/01/2025	TREND	16 (4x4)
		Date of Next Review:	27/02/2025	➡	

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 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 **continue to** meet. Noting some progress on positive movement to actions within the DAP. **Recent progress is focussing on implementation of PHEV and BEV SRVs**.

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 BELP 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	

Risk ID 542	Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan	Date of Review:	27/01/2025	TREND	16 (4x4)
		Date of Next Review:	27/02/2025	➡	

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 reputational damage

	Likelihood	Consequence	Score
Inherent	5	4	20
Current	4	4	16
Target	2	4	8

3. Procurement of an electronic fleet of vehicles – this is not currently possible for anything other than a car/van (limited)
4. 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 potential 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	Not needed. Action closed.	Workstreams were 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)	**Actions taken in line with investment provided to implement rapid charging by end of March 2025 at a small number of sites. Confirmed adequate charging provision for the replacement of 20 x PHEV and 10 x BEV in March/April 2025.**
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	**Position remains that only vans can currently be purchased. This will be delivered by March/April 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	**Not being progressed**	To be further discussed with relevant Directors**. It is unlikely that a NED Champion role will be allocated in the near future.**
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	**Discussions ongoing regarding enhanced resource requirements to implement low carbon emission vehicles. Targeted Estate Fund (TEF) bids being developed by 31st Jan 2025.**

Risk ID 558	Deterioration of staff health and wellbeing in the face of continued system pressures as a consequence of workplace experiences	Date of Review:	16/01/2025	TREND	15 (3x5)
		Date of Next Review:	16/02/2025	↑	

IF	THEN	RESULTING IN
significant internal and external system pressures continue	there is a risk of a significant deterioration in staff health and wellbeing within WAST	increased sickness levels, staff burnout, poor staff and patient experience and patient harm

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

IMTP Deliverable Numbers: 13, 14, 21, 26

EXECUTIVE OWNER	Director of People	ASSURANCE COMMITTEE	People & Culture Committee

Risk Commentary

This risk should be considered alongside Risk 160 as the resulting increased sickness levels mentioned above will be addressed by the same controls and assurances. The ongoing system pressures including long handover delays, overruns, missed breaks and the perpetuating impact of increased sickness levels continues to **remain a challenge to mitigate this risk** . 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. Work on reducing shift overruns continues with various pilots being run to test viable options which could be implemented. **Proposed increase in score as a result of system pressures. Whilst we are seeking to address this and it will take time to have an impact. Adding in the potential future financial pressures (leaving vacant posts open for longer), will further exacerbate this issue**

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
13. The new Health and Wellbeing Plan 2025-2029 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 2025-2029 is 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. **This plan was created in line with the HEIW Best Practice Guide for Organisations**
14. Occupational Health & Wellbeing team with range of support options for individual mental health intervention **signposting**, MSK support, reasonable accommodations and recommendations, supported by mental and physical health expert clinicians.	15. Current waiting times **are just above the national SLA of 29 days, at 31 days.** , External providers meet quarterly and provide monthly engagement figures. Reporting into OHW operational team meeting and MIQPR.
15. Wellbeing **Service providing** training, **consultation and advice to** line managers **supporting members of staff with severe and complex health and wellbeing challenges. Including REACT training that supports managers with difficult conversations**.	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. **These offers are now evaluated via user experience questionnaires which are reported to the health and wellbeing steering group. Wellbeing training uptake numbers is reported into the OHW Operational Team Meetings.**
16. TRiM **(Trauma Risk Management Network) in place to support staff following exposure to potential traumatic events and materials. The approach of watchful waiting by a clinician or peer supporter means we can support those who have been exposed to such events and escalate to support if required.**	17. **TRiM is facilitated by the Wellbeing Service Assistant Psychologists supervised by a Clinical Psychologist to provide appropriate professional oversight. Numbers of referrals, assessments, follow-ups and further support needs are reported to the Health and Wellbeing Steering Group**
17. 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.	18. Each Directorate has developed their own action plan to address staff surveys. NHS staff survey high level results released 19/02/24 with directorate specific data released in April 2024. **The survey was repeated in Autumn 2024, and we are awaiting the next set of results.**
18. HSE stress risk assessments	19. Undertaken by managers and advice is provided on how to use them by Occupational Health and Health and Safety teams.
19. KPIs are reported fortnightly regarding Occupational Health and Wellbeing activity	20. Received at OHW operational team meeting and reported in MIQPR.
20. Wellbeing drop-in sessions for CCC and 111 staff	21. These sessions are now part of business as usual across services and a user experience form is collating 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. **Themes of staff concerns are also collated by wellbeing staff attending WAST sites.**
21. Fast track physiotherapy to address MSK issues.	22. Regular review meetings with physiotherapy provider and monthly monitoring information received at People and Culture Business meetings and MIQPR
22. Occupational Health team inclusion in sickness and absence meetings	23. **Qualitative anecdotal feedback has been positive, and it has strengthened relationships with the OH team. More formal feedback mechanisms are in development in line with our overhaul of service feedback**.
23. Stress risk assessments	24. 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

Risk ID 558	Deterioration of staff health and wellbeing in the face of continued system pressures as a consequence of workplace experiences	Date of Review:	16/01/2025	TREND	15 (3x5)
		Date of Next Review:	16/02/2025	⬆	

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

GAPS IN CONTROLS	GAPS IN ASSURANCE
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, **along with a new policy.** 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 **REAP** status affecting the ability of staff to engage with staff health and wellbeing services. Important to recognise the consistent reports of the impact of culture on wellbeing. Attendance at all events by operational staff consistently low due to service pressures.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. People and Culture Plan 2023-2026 relevant Actions	Assistant Director for Inclusion, culture and wellbeing	Annual Plan	First **year reviewed** at 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	**Approved by Board Q3 2024/25**	**Plan has been approved by Board. The delivery period begins 2025/2026. Promotion of the plan and key deliverables will commence then.**

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:	22/01/2025	TREND	15 (3x5)
		Date of Next Review:	22/02/2025	➡	

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

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

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 **November were 20,993 and December were 25,199.** 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.

After a thorough review and assessment of Risk 594 within the Corporate Risk Register at SLT on 02/10/2024, we propose reducing the risk score from 20 to 15 (likelihood from 4 to 3) due to the following reasons:

· Mitigation/Controls have been Implemented: We have several controls measures that directly address the identified risk and are content we have exhausted all opportunities for additional controls. These controls are embedded within the corporate risk register.

· Immediate Release Protocol: The revised version of the IR protocol v1.3 has been agreed and shared at COO group and published which has included the release schedule for ambulances at the declaration of an incident as set out below:

·50% of vehicles released within 10 minutes

· 75% of vehicles released within 20 minutes

· 100% of vehicles released within 30 minutes

· Monitoring and Review: We will continue to monitor the risk within the normal governance channels (SOT/SLT/ADLT etc) to ensure that mitigations are still in place and any emerging risks are promptly identified and addressed.

22/01/25 - In light of the critical incident declared earlier this month, a review of the risk scoring is scheduled for this at SLT on 11th February in the first instance and this will be updated following conversations.

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. V1.3 has been reviewed, updated and released (August 2024).
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

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:	22/01/2025	TREND	15 (3x5)
		Date of Next Review:	22/02/2025	➡	

				Likelihood	Consequence	Score
IF a major incident or mass casualty incident is declared	**THEN** there is a risk that the Trust cannot provide its pre-determined attendance as set out in the Incident Response Plan and provide an effective, timely or safe response to patients due to vehicles not being released from hospital sites	**RESULTING IN** catastrophic harm (death) and a breach of the Trust's legal obligation as a Category 1 responder under the Civil Contingency Act 2004	**Inherent**	4	5	20
			Current	3	5	15
			Target	2	5	10

	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 30% of vehicles released within 10 minutes of an incident declaration, 50% within 20 minutes and 100% within 40 minutes.	14. WG have confirmed that they have written to HB EPRR leads. Health Board COOs approved the proposals for vehicle release as outlined.
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
Despite the controls listed, the single most limiting factor in providing a pre-determined response in line with the Incident Response Plan is the lost capacity due to hospital handover delays. In this area, WAST has no control. – link to CRR 223 on CRR.	The Trust is not assured that Hospital sites have plans in place that are trained and tested to release ambulances effectively and immediately in the event of an incident declaration.
	Following two incidents (Pembroke Dock Ferry fire on 11th February 2023 and the Swansea gas explosion on 13 March 2023), The Trust is not assured by the effectiveness of assurances given by Health Boards (responses provided following correspondence from WAST CEO – formal returns received from LHBs except BCU). Despite these two incidents being lower-level incident declarations where the pre-determined attendance was met, the experience does not add confidence to the ability to release all resources from hospitals which would support assurance. Further testing of the pre-determined attendance levels has been undertaken as part of the Manchester Arena Inquiry recommendations; This tested the Trust's ability to fulfil the PDA in North Wales and South Wales in the event of a mass casualty scenario both in hours and out of hours. This simulation concluded that in three of these four scenarios, the Trust would be unable to fulfil the PDA. A further declared major incident at Treforest Industrial Estate in December 2023 following an explosion, failed to release resources from Morriston Hospital, Wales's dedicated burns unit (formal debrief still to be conducted).

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Review of Manchester Arena Inquiry	Assistant Director of Operations	March 2025	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 JCC 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. 01/10/2024 - Progress against the 68 recommendations, directly or through partnership working, that relate to the Trust continues. The Trust has undertaken a detailed review of its provision as part of its obligation under recommendations 105 and 106 and has recently produced an evidence-based series of reports aimed at addressing the identified gaps. This has been supported further by the development of three Quality Impact Assessments that have been approved by the Clinical Quality Governance Group. The work identified 20 recommendations for which there is a financial dependency. The submission to commissioners of the Trust's reports relating to these recommendations has now occurred and the Trust awaits their considered response. The remaining recommendations continue to be progressed, and it is anticipated these will conclude within the next six months. To ensure the continued visibility of these report findings within the Trust, a corporate risk is being developed for inclusion in the Trust's risk register. This will enable the alignment of outstanding MAI recommendations with a clearly defined business-as-usual framework, ensuring

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:	22/01/2025	TREND	15 (3x5)
		Date of Next Review:	22/02/2025	➡	

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

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

			proper governance of capability gaps while awaiting financial decisions from commissioners and the implementation of necessary changes. **Jan 2025 - Progress against the 68 recommendations, directly or through partnership working, that relate to the Trust, continues. We expect to complete all recommendations that do not rely on financial investment by the end of this financial year. To ensure the continued progression and completion of the recommendations with financial dependency (18 recommendations), a corporate risk has been developed for inclusion in the Trust's Corporate Risk Register and Board Assurance Framework. As the risk progresses through the internal governance route, culminating in final approval at Trust Board in January 2025, there is an alignment of the outstanding MAI recommendations with a clearly defined business-as-usual framework, which will support the governance of capability gaps whilst awaiting financial decisions from commissioners and the implementation of necessary changes.**
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	November 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 (6th Feb 2024). Further follow up will be provided as MAI progresses. Welsh Government has been and will continue to be kept up to date on the developing case, as have the JCC.
3. Request from COO network to share Action cards related to risk	Executive Director of Operations	Q1	May24 – LB will follow up with COO network on the sharing of their action cards to WAST. March 24 – This risk was discussed at both JCC management and in the COO meeting.

Risk ID 623	Failure to comply with Data Protection Legislation	Date of Review:	21/01/2025	TREND	15 (3x5)
		Date of Next Review:	21/02/2025	➡	

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

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.

IIn addition, the Confidentiality Advisory Group (CAG), an independent body advising the Health Research Authority, **recently required** organisations across NHS Wales to demonstrate compliance with legislation via the IG Toolkit **, or risk** requests for using sensitive patient information for research purposes **being rejected–** further resulting in risk to WAST's academic partnerships and reputation, and strategic research endeavours.

CONTROLS	**ASSURANCES**
	Internal Management (1st Line of Assurance)
1. Data Protection Expertise: **2 x** FTE Data Protection and Compliance Managers (DPCM); 1 FTE Information Governance Officer, **4 x** FTE **in the** Cyber Security **team**	1. Two Data Protection and Compliance Managers were employed on a consultancy basis to provide cover and support backlog clearance (E). Both contractors have now left the organisation (funding ceased for the first in Jun-24, and the contract ended Sep-24 for the second). Two new permanent Data Protection and Compliance Managers have been recruited and are due to start employment with WAST in November 2024, bringing capacity of this skillset up to 3 x FTE.
2. **Permanent** Data Protection Officer	2. Temporary Data Protection Officer **responsibilities held by Head of ICT up to December 2024.** A full-time, permanent DPO has been recruited and the position has been filled since December 2024.
3. Data Protection and Information Governance Policies and Procedures (Incl. DPIAs and Cloud Assessments)	3. **Procedure for auditing Welsh Clinical Portal usage (by WAST staff) updated (Jun24).** 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)	**7. Summary statistics reported monthly via IGSG**
8. NIIAS **(national intelligent integrated audit solution)** for auditing access to personal information **across systems such as CAD and ePCR**	

Risk ID 623	Failure to comply with Data Protection Legislation	Date of Review:	21/01/2025	TREND	15 (3x5)
		Date of Next Review:	21/02/2025		

IF	THEN	RESULTING IN
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	the Trust will breach its legal obligations and potentially cause the personal or sensitive data to be compromised, lost, or inappropriately used.	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

9. Digital Notices / comms Ongoing (see Siren & recent Lock-screen notices)	**Regular publication of IG related comms:** Lock screen **image** issued 04/24 in relation to WhatsApp and training. This will be refreshed in 06/24. Siren notice drafted for ELT 05/24. **AI Guidance issued 01/25. Cyber & IG procurement guidance drafted for release.**
10. Proactive engagement outbound (not inbound to team)	
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. **- The third DPCM position has recently become vacant, and recruitment efforts will need to recommence in Spring 2025, however, with 2 x DPCMs in post, this is no longer considered a significant gap in control.**	1. See 21. Further Actions (1)
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.	2. 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.	3. 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)	4. Data Protection and Compliance Risks not fully realised. IGSG have approved the establishment of a sub-group to manage activities related to Information Asset Register and Ownership, however, due to vacancies and limited capacity in the IG team, this action will not be able to be progressed until January-25.
6. Currently not meeting levels of IG staff training.	3. Some data errors in ESR reporting for IG mandatory training has been identified, requiring manual effort to calculate Trust- wide compliance percentages.
7. Lack of Data Protection pre procurement controls which form part of Data Protection by Design and Default means that Departments could purchase **non-compliant** 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. **The Improvement Plan Actions were met by the Nov 24 deadline, satisfying the requirements of the CAG. This is no longer a gap in Controls / Assurance.**

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)	Leanne Smith	Q2 2024/25	Two candidates expected in post November 2024. **Action complete – 2 new DPCMs in post since November 2024. Now included in Controls.**
2. Seeking funding to recruit/upskill/resource DPO who will encourage engagement**.** Additional funding into Digital for 24/25 allowed a permanent DPO position to be created within the structure.	Jonny Sammut	Q3 2024/25	JD evaluated and translated. Awaiting approval by Recruitment Control Panel to commence recruitment. Expected Recruitment and in post Q4 24/25. **Action complete – permanent DPO in position since December 2024. Now included in Controls.**
3. Ensure compliance with the appropriate IG level training across all Directorate and Departments a. Demonstrate a regular series of comms on IG and DP **- complete** b. Regular monitoring of training compliance through IGSG **– evidence of ongoing**	Leanne Smith	Q**4** 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. **AI guidance issued 01/25. Cyber & IG procurement guidance in development. Evidence that regular comms is being published,**

Risk ID 623	Failure to comply with Data Protection Legislation	Date of Review:	21/01/2025	TREND	15 (3x5)
		Date of Next Review:	21/02/2025		

IF	THEN	RESULTING IN
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	the Trust will breach its legal obligations and potentially cause the personal or sensitive data to be compromised, lost, or inappropriately used.	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

c. Targeted training compliance reporting to line manager on individuals to ensure that 85% target is reached **by March 2025.** d. BAU on Siren training notices and specific guidance or advice			**and so action complete, and assurances added to Controls.** IG training compliance still below 85% target **required to be evidenced by March 2025.** 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 Direct contact to individuals who have been non-compliant for a significant period of time, with escalation through their line management structures as required.
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. **A risk has been drafted by members of IGSG, but action plan to be developed in collaboration with Fleet & Estates.**
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	Nov24 for IG Toolkit Improvement Action Plan (with evidence to CAG) **- complete** **Next deadline is March for 24/25 submission**	Paper to ADLT Jun24 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 Nov24. **The improvement plan actions resulting from the "standards not met" results of the 23/24 IG Toolkit submission were met ahead of the Nov24 deadline to assure CAG, however, to meet the requirements of the 24/25 IG Toolkit submission, further improvement work is required before the Mar25 deadline.**

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:	21/01/2025	TREND	12 (3x4)
		Date of Next Review:	21/04/2025		

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

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

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.

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). The JCC had 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 now looking to recruit up to the modelled 153 CHARU FTEs and connected to this focus on CHARU productivity. CHARU UHP in **December** 2024 was 8**9**%, which is the highest it has achieved, and it is now seeking to close the remaining gap through the recruitment of fully qualified paramedics. 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. A further funded 32 APPs are being recruited in 2024/25 along with 2**8** FTEs to **EMSC (clinical navigators)**. The 111-call abandonment rate **has stabilised post 111 CAS go live, as the Trust has recovered it call handler staff in post to establishment**. Ambulance Care performance is stable.

The JCC **is now becoming more established. Current areas of focus for the JCC (in relation to WAST) include: a scrutiny exercise on the Trust's MAI submission, consideration of the Future Vision for NEPTS and the Ambulance Measure Review led by Welsh Government. The Trust has received the JCC draft commissioning intentions 25/26 for 111, 999 and NEPTS. These are broadly supportive of the Trust's ambitions, but the financial pressures within NHS Wales that there is unlikely to be any investment by the JCC in 25/26 in support of the Trust's ambitions.**

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. JCC 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.	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.
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. Commissioning intentions.	7. In year progress reported each quarter to the relevant commissioning meeting and 24/25 commissioning intentions approved for 111 Wales and expected to be approved by Mar-24 JCC (approved).
8. Governance arrangements for 111 commissioning: 111 Board, 111 Commissioning Board + 111 DAG etc.	8. 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

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:	21/01/2025	TREND	12 (3x4)
		Date of Next Review:	21/04/2025		

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

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	**As part of 25/26 budget setting process in Q4 this year (18/03/25 F&P Committee)**	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. **21/01/25 ELT has considered the draft commissioning intentions and responded to the Director of Commissioning.**
2. Agree and influence JCC/Health Board of the need for significant reduction in hospital handover hours	CEO WAST	**IQPD 12/02/25**	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. **21/01/25 The Trust experienced 26,000 ambulance unit hours lost to hospital handover in December 2025, in line with its prediction, but significantly above the WG target of no waits over one hour, which equates to approximately 7,500 hours.**
3. Increased understanding of NEPTS by JCC	Executive Director of Strategy Planning and Performance	02/08/23 30/06/24 20/08/24 **21/02/25**	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. **21/01/25 Consideration of Future Vision for NEPTS at JCC meeting on 21/02/25**.
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. **21/01/25 Meeting continues to operate.**
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 163	Maintaining Effective & Strong Trade Union Partnerships	Date of Review:	16/01/2025	TREND	12 (4x3)
		Date of Next Review:	16/04/2025	➡	

IF	THEN	RESULTING IN
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	there is a risk that TU partnership relationships increase in fragility and the ability to effectively deliver change is compromised	a negative impact on colleague experience and/or services to patients

	Likelihood	Consequence	Score
Inherent	5	3	15
Current	4	3	12
Target	4	3	12

IMTP Deliverable Numbers: 1, 13, 14, 19, 22, 30, 32

EXECUTIVE OWNER	Director of People	ASSURANCE COMMITTEE	People & Culture Committee

Risk Commentary

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

Work is well underway to seek to improve partnership working through the delivery of the action plan. The engagement structures below WASPT are in place and running. The Deputy Director of People Services 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 . At a local level there are ongoing discussions on a range of organisational change issues and currently engagement and partnership working is **operating well and as a result the score has been reduced to 12 (3x4) during the quarter. However, there is a recognition that the nature of partnership working and the issues that arise mean that the level of risk fluctuates more regularly than others and will be kept under review. The Executive Owner will change from November 2024 to Director of People – same for Risk 160. It is noted that work required on financial sustainability to meet savings requirements and projects such as reviewing the skill mix has the potential to disrupt relationships and may lead to a review of the score. On a national level, TUPs have not accepted the 2025 pay offer of 2.8% and there is a risk for industrial action should the offer not be improved.**

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 TUPs 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 TUPs 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 TUPs. 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:	16/01/2025	TREND	12 (4x3)
		Date of Next Review:	16/04/2025	➡	

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	3	12
Target	4	3	12

16.

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	**Ongoing**	Plan agreed and being monitored via WASPT. **The plan is dynamic with actions being completed and additional actions added to the plan as they arise.** Draft training development underway in partnership with TUPs – list of training needs shared from TUPs. **- Completed** Principles on engagement being developed (in part from the training) and as a result the partnership statement will be updated. **eLearning courses created by WG Social Partnership Team to be added to Learn365** **Further session of partnership training to be scheduled in Q1 2025/6**
2. Continue the rollout of partnership training across WAST	Deputy Director of People	**Complete**	**One additional session is being added to capture colleagues who have not yet attended.**
3. Develop the next round of initiatives based on the output from recent sessions	Deputy Director of People	**Complete**	**Observation of partnership forums and further development work is ongoing regarding initiatives to support embedding partnership training across the organisation. Additional actions added to the action plan. WASPT updated on 27.01.25**
4. Learning and Development opportunities for TU partners e.g. shadowing, digital skills, coaching and mentoring	Deputy Director of People	31/03/25	**Captured in action plan. e.g. TU rep shadowing on cases**
5. Develop consultation guidance for managers	Deputy Director of People	31/0**6**/25	**Date pushed out due to team capacity**
6. Consider how we celebrate success and capture the positive learning	Deputy Director of People	31/01/25	
7. Delivery of Social Partnership Conference	**Deputy Director of People/ TUPs**	**31.03.25**	**Programme development underway. Scheduled for 31.03.25**
8. Task and Finish group to be established to work on mitigating the impact of EAP Band 5 post introduction and wider skill mix discussions.	**Director/Deputy Director of People**	**30.04.2025**	**Email to TUPs from Director of Strategy and Planning. Meeting schedule in train.**

Risk ID 139	Failure to deliver our Statutory Financial Duties in accordance with Legislation	Date of Review:	07/01/2025	TREND	8 (2x4)
		Date of Next Review:	07/04/2025	➡	

				Likelihood	Consequence	Score
IF the Trust does: • not achieve financial breakeven and/or • does not meet the planning framework requirements and/or • does not work within the EFL and/or • fails to meet the 95% PSPP target and/or • does not receive an agreement with commissioners on funding (linked to 458)	**THEN** there is a risk that the Trust will fail to achieve all its statutory financial obligations, and the requirements as set out within the Standing Financial Instructions (SFIs)	**RESULTING IN** potential interventions by the regulators, qualified accounts, and impact on delivery of services and reputational damage	**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: Q3 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 9 of the 2024/25 Financial Year. The score is consistent with that of **Qtr. 2 2024/25** due to a presented opening balanced financial plan for 2024/25 and the Month 9 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 **has been mitigated for 2024/25 financial year** the ability to fund / receive income may impact on the delivery of the financial plan for 2025/26. 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. JCC management meetings. Monthly meetings with DAG for NEPTS.
	8. Bi-monthly Capital CRL meetings with Trust and WG capital leads
	9. Regular P2P meetings diarised (bi-monthly)
	10. Monthly monitoring returns into Welsh Government
	Independent Assurances (3rd Line of Assurance)
	1-10 Internal audit reviews covering
	1-10 External audit reviews

Risk ID 139	Failure to deliver our Statutory Financial Duties in accordance with Legislation	Date of Review:	07/01/2025	TREND	8 (2x4)
		Date of Next Review:	07/04/2025	➡	

IF the Trust does: • not achieve financial breakeven and/or • does not meet the planning framework requirements and/or • does not work within the EFL and/or • fails to meet the 95% PSPP target and/or • does not receive an agreement with commissioners on funding (linked to 458)	**THEN** there is a risk that the Trust will fail to achieve all its statutory financial obligations, and the requirements as set out within the Standing Financial Instructions (SFIs)	**RESULTING IN** potential interventions by the regulators, qualified accounts, and impact on delivery of services and reputational damage		Likelihood	Consequence	Score
			Inherent	3	4	12
			Current	2	4	8
			Target	2	4	8

GAPS IN CONTROLS	GAPS IN ASSURANCE
1. Lack of formalised service contracts between Commissioner and WAST as a commissioned body	1. 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
2.	Rapid (111) call answering, initial triage and onward referral	223
3.	Timely, high quality clinical assessment, advice and referral	223, 224
4.	Seamless transfer of 111 callers to wide range of available pathways	223
5.	Immediate 999 call answering, and efficient and effective dispatch of the right resource	223
6.	High quality, timely, clinical triage, assessment and consultation, with personalised response	223
7.	High quality, immediate or timely on scene assessment, care and conveyance where needed	223, 100
8.	A range of 24/7 pathways available for further assessment or treatment, closer to home	223, 224
9.	A flexible, user-centred Non-Emergency Patient Transport Service with the right capacity in place to meet demand	100,139
10.	A dedicated and timely transfer & discharge service supporting HBs with their transformation agendas	223
11.	A clear vision for Ambulance care services that supports wider health and care transformation	100, 201
12.	A high quality, safe (NEPTS) service with improved patient experience	100, 139
Strategic Objective 2: Enabling our people to be the best they can be		
13.	Culture: • 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
14.	Capacity: • 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, 558, 594, 623
15.	Capability: • 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
16.	Strengthen Welsh Language compliance through strong leadership, enabling Welsh language to flourish	201
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
18.	The right fleet in the right place, enabling our staff to provide the best and safest care across Wales	139, 542, 623
19.	Develop & agree Digital Plan • Everyday essentials • Security, Safety & Cyber • Digital Pioneers • Transformation • Data, Information & Insight	163, 260, 623
Strategic Objective 4: Developing services in collaboration		
20.	Well-placed to influence system thinking / strategy development	100, 223
21.	Meet the requirements of the Wellbeing of Future Generations Act	558
22.	University Trust Status in collaboration with WG, embracing a 'democratised culture' of learning, research and innovation	160, 163, 223, 224
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
24.	Excellent clinical leadership	100, 139,160, 223, 224, 260, 594
25.	A culture of quality improvement with robust quality management systems	100, 139, 160, 201, 223, 224
26.	High quality Putting Things Right, Safeguarding and Health & Safety systems	160, 224, 558
27.	Meaningful engagement and co-production with communities	223, 224
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
31.	Generate income alongside our core commissioned functions	139, 224
32.	A Value-Based approach across the organisation which is embedded in culture	100, 139, 163
33.	Developing and implementing our plans for Environmental Sustainability and Adaptation	542

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

AGENDA ITEM No	**10**
OPEN or CLOSED	**OPEN**
No of ANNEXES	**2**

AUDIT TRACKER 2.0 – DECEMBER 2024 (Q3)

MEETING	Audit, Risk and Assurance Committee
DATE	6 March 2025
EXECUTIVE	Trish Mills, Director of Corporate Governance/Board Secretary
AUTHOR	Trish Mills, Director of Corporate Governance/Board Secretary Lisa Trounce, Head of Compliance and Assurance
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. **Quarter 3 Progress:** There continues to be good engagement with Directorates on the revised Tracker 2.0 for Quarter 3 that has resulted in 31 of a total 113 (27%) open internal audit actions being closed in quarter, this figure is down from the 37% reported in Quarter 4.

3. **Seasonal Delays:** Some audit actions have been delayed because of seasonal pressures. However, 68 of 113 open internal audit actions (60%) are planned for closure in Quarter 4 (January – March 2025).

4. **Revised Dates:** 32 (28%) of open internal audit actions have had revised dates, a slight increase from 29% in the previous quarter; With seven actions on their third revised date.

5. **ARAC Internal Audit Actions:** There are 8 internal audit actions under the Committee's purview. 6 have been closed in quarter (75%), up from 38% last quarter. The remaining two actions are both due in March 2025, with updates expected at the end of Quarter 4.

6. **Partially Complete Actions:** Two actions from the 2022/23 'Quality Governance Review' Internal Audit remain partially complete and will remain on the tracker until replaced by more up-to-date actions, as agreed with Audit Wales. In addition,

an action from the 2023/24 Workforce Planning Arrangements Internal Audit has been marked part-complete, with a revised date of March 2025.

7. There are no current **external audit actions under the purview of ARAC**.

8. **Historical Actions Review:** Discussions are ongoing to review and potentially revise or close historical actions in light of the current operating context.

9. **Tracker and reporting:** Development of Tracker 3.0 continues with Power BI support in Q4 to develop the reporting agreed by this committee in September 2023. This report seeks reconfirmation on that reporting and any amendments thereto.

RECOMMENDATION

10. 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; and

(b) Review the reporting agreed at the September meeting of this committee on Tracker 3.0 (see paragraph 27)

KEY ISSUES/IMPLICATIONS
As set out above.

REPORT APPROVAL ROUTE
Tracker presented to ADLT at a meeting on 20 January 2025.

REPORT APPENDICIES
Annex 1 – Tracker 2.0 24-25 Q3 (October-December 2024) – Finalised 270125 – For ARAC (Open Session) – ARAC Actions Only Annex 2 - Tracker 2.0 24-25 Q3 (October-December 2024) – Finalised 270125 – For ARAC (Open Session) – Copy of Full Tracker

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

SITUATION

1. This paper provides the Committee with the current position with respect to management actions for audits within the purview of the Audit, Risk and Assurance Committee (ARAC), in addition to the wider progress in quarter. A copy of the Tracker is available at **Annex 1 (filtered to the actions assigned to this Committee)** for oversight.

BACKGROUND

2. 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.

3. The Handbook includes roles and responsibilities for the various stakeholders including:

   - Points of contact in Directorates steers the audit with the Director and Assistant Directors/Deputies, ensuring these feature on the directorate agenda monthly, they update the Tracker, and escalate issues as appropriate.

   - The Assistant Directors Leadership Team (ADLT) as the forum to agree closure of actions, taking a check and challenge role on the Tracker.

   - Board Committee receive audits in their remit, and monitor management actions to address recommendations.

   - ARAC also scrutinises the progress of audits recommendations overall, escalating to the Board any issues or concerns. A copy of the **full Tracker is also reproduced at Annex 2**.

4. It is noted that the Quality, Patient Experience and Safety Committee, and the People and Culture Committee have reviewed the management actions for audits within their purview in the last few weeks.

5. The Finance and Performance Committee is scheduled to receive an update on its audit actions at the meeting planned for 18 March 2025. The Committee's AAA reports to Board will note this and there have been no escalations to Board thus far.

ASSESSMENT

Internal Audit: - Full Tracker Review (**Annex 2**)

6. There continues to be good engagement with Directorates on the revised Tracker 2.0 for Quarter 3, with the result that of the total of 113 open internal audit actions on the Tracker, 31 have been closed in quarter. This is a closure figure of 27% of all open internal audit actions (compared to 37% in the previous quarter).

Year	No. Actions Closed in Quarter (Q3)	Date Completed			
		Original Deadline	1st Revised Date	2nd Revised Date	3rd Revised Date
2022/23	8	0	2	2	4
2023/24	14	3	9	2	0
2024/25	9	9	0	0	0
Totals	**31**	**12**	**11**	**4**	**4**
% of Total Closed in Quarter		**39%**	**35%**	**13%**	**13%**

7. Seasonal pressures have delayed progress against some audit actions; However, as shown in the breakdown below, a substantial number of the remaining open actions (68 of the total 82, which equates to 83%) are planned for closure during Quarter 4 (between January and March 2025).

Year	Total No. of Remaining Open Actions (Q3)	Date Due for Closure				
		2024/25	2025/26			
		Q4	Q1	Q2	Q3	Q4
2022/23	12	11	1	0	0	0
2023/24	37	34	2	0	1	0
2024/25	33	23	5	4	0	1
Totals	**82**	**68**	**8**	**4**	**1**	**1**
% of Total Open Actions		**83%**	**10%**	**5%**	**1%**	**1%**

8. Of the 113 open internal audit actions updated during Quarter 3, 32 of these have been given proposed revised dates in quarter; which is 28% of the total (compared to 29% in the previous quarter).

9. There are no internal audit actions this quarter that have moved to a third and final date.

10. There are seven open actions on their third revised date, which is 6% of the total number of open actions (compared to 9.5% in the previous quarter). Members will recall that the responsible directors appeared at this committee in November to discuss these actions. Updates for each of these actions are as follows and it can be seen that these are expected to close in Q4:

Action Ref:	Audit Title	Executive Lead	3rd Revised Date	Q3 Update
604	Pain Management	Andy Swinburn	Mar-25	• Pharmacist Advisor now in post. Medicines Management Group established in January 2025 as a forum for to review PGD schedule. • On track to be proposed for closure in Q4.
621	(Reported within Closed Session)	Jonny Sammut	Mar-25	• On track to be proposed for closure in Q4.
624	IM&T Infrastructure	Jonny Sammut	Mar-25	• Problems encountered with the integration to House on the Hill system is ongoing to resolve the issues identified and enable action to be proposed for closure in Q4.
657	Records Management	Jonny Sammut	Mar-25	• Progress against this action delayed due to long term absence of key expert within the team. Capacity issue now resolved, and work is ongoing to enable action to be proposed for closure in Q4.
614	Senior Paramedic Role	Andy Swinburn	Mar-25	• Lessons learned paper has been prepared and will report to the next steering group. On track to be proposed for closure in Q4.
643	111 Commissioning Final Advisory Report	Rachel Marsh	Dec-24	• Confirmed as action completed – awaiting evidence to support the proposed closure. Pending supply of required evidence, action will be proposed for closure in Q4.
683	Electronic Patient Clinical Records: Clinical Compliance (ePCR)	Andy Swinburn	Mar-25	• CCIO appointed with responsibility for ePCR developments • Meeting held on 10/02/25 - LMS365 solution required but Education and Training Team do not have capacity to accommodate this request at the moment. It has been proposed that requirement be added to Education and Training Work Programme – to be discussed with Internal Audit to allow closure.

11. PCC reviewed the two actions related to Audit Actions 612 and 613 relating to Trade Union Release Time and agreed to closure based on the assurances provided and the risk mitigations in place.

12. The open actions from the Cyber-Security and the Technical Resilience audit will be received in the closed session.

Internal Audit: – ARAC Actions (**Annex 1**)

13. The internal audit recommendations within the purview of ARAC relate to the Risk Management (22/23), Risk Management (23/24), and Follow Up (23/24) internal audits.

14. Of the eight internal audit actions where the ARAC is the oversight Committee, six of these have been closed in quarter, which is 75% (compared to 38% in the previous quarter).

15. There is one remaining ARAC internal audit action, relating to Risk Management. Action 596 has been assigned a revised date of May 2025 extended from March 2025. Work has commenced on the development of risk appetite statements with the board and good progress made to date; however, it's important to give sufficient time to complete this work and set the appetite.

16. A more detailed update on the action is outlined in the table below, noting that this is proposed for closure during 2025/26 Quarter 1.

Action	Recommendation	Update
596	Following development of risk appetite matrix, develop and finalise risk appetite statement	• Risk appetite training session took place with the Board in December 2024. • Risk appetite workshop with the Board in February 2025 beginning the work on finalising the risk appetite statements.

External Audit: - Full Tracker Review (**Annex 2**)

17. Of the total 14 open external audit actions, 4 have been closed in quarter pending supply of evidence; which is 29% (compared to 28% in the previous quarter).

18. Of the remaining 10 open audit actions, 5 have been assigned revised dates in quarter, with 4 scheduled to be completed in Quarter 4.

19. There are 2 remaining actions relating to the 2022/23 Review of Quality Governance Arrangements Internal Audit which have been marked as partially complete; they are both listed under Audit Action 106.

20. The Quality Governance Review Follow Up Audit in October 2024 was reviewed by the Quality, Patient Experience and Safety Committee on 4 March 2025 and is before this committee today. A number of actions from the 2022/23 review were deemed to be still in progress, including those at action 106 referred to above. These, and their revised action plans, will be shown on the next audit tracker.

21. There is a third action marked as part-complete i.e. Audit Action 124 relating to the 2023/24 Review of Workforce Planning Arrangements Internal Audit. A third revised date of March 2025 has been applied to this outstanding action however it is likely to close this quarter as we await evidence of the action. For that reason, the director has not been requested to attend the committee today.

External Audit: – ARAC Actions

22. There are currently no external audit actions in the purview for this committee.

Management and Development of the Tracker

23. Discussions have 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 with a view to closing down or revising as many as possible going forward.

24. The current version of the tracker is now open for Directorate review for actions due between January and March 2025. These updates will then be reported to the Committee at its meeting in May 2025.

25. The Corporate Governance Team continues to work on the development of the SharePoint solution for Audit Tracker 3.0. Testing of Audit Tracker 3.0 is continuing during Quarter 4, with implementation planned during 2025/26 Quarter 1.

26. Once Tracker 3.0 is in place different reporting is anticipated for the Audit Committee and Executive Leadership Team 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.

27. Power BI support is in place in Q4 to support the development of this reporting, therefore this is an ideal opportunity for ARAC to reconfirm the reporting on the tracker approved in September 2023, which was as follows:

    (a) Number of substantial/reasonable/limited/no assurance/advisory audit reports per year.
    Gives a general overview throughout the year and over audit years

    (b) Number of audit reports per committee oversight
    Gives a general overview of the spread of oversight of audit reports and those who may not be monitoring any reports

(c) *Number of high rated recommendations with actions more than 3 months past their original date*
High rated actions should be closed off as soon as practicable due to their risk profile. This will allow for escalations.

(d) *Number of actions for limited assurance audit reports more than 3 months past their original date*
Due to the issues that will arise in a limited assurance report they should be closed off asap and before follow-up reviews. This will allow for escalations.

(e) *Number of actions that have 'met' and 'not met' the original due date*
Gives an indication of the realistic nature of the original dates leading to a change in behaviour
Provides oversight of progress over audit years.
This may be similar as the table at paragraph 6 above.

(f) *Number of individual actions that have 'not met' revised dates*
Will indicate a potential issue in meeting an action or lack of progress for some other reason. Will need to be sure this is not a double count with some of the other metrics.

RECOMMENDATION

28. 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; and

(b) Review the reporting agreed at the September 2023 meeting of this committee on Tracker 3.0 (see paragraph 27)

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	Rec. No.in Audit	Recommendation	Respons e No.in Audit	Management Response	Agreed Deadline in Report	Status - met or not met agreed	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. Reason why action is overdue and
596	22/23	Audit	Risk Management	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	Mar25			Open	**181224:** The RA training session took place. Survey and prep underway for February BDD when RAS will be finalised, at which point this action can be closed. On track to achieve revised due date Mar25. **081024**: A Risk Appetite session has been scheduled with the Board for 2nd December 2024. This session will inform the development of the risk appetite statmements during Q4. **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.
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 Met	Dec-24			Closed in Quarter	**230125: (LT) Copy of Case Tracker supplied by CW.** **200125: (LT) ADLT approved for closure pending receipt of evidence.** **171224**: (LT) Carl Window email replied to advise action was resolved recently and updated in the latest committee. Tracker developed and will be presented at Mar25 ARAC. **Proposed for Closure**
744	23/24	ARAC	Risk Management	Reasonable	Julie Boalch	Trish Mills	Medium	2.1	Risk assessment forms should be completed for all risks.	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.	Aug-24	Not Met	Dec-24			Closed in Quarter	**200125: (LT) ADLT approved closure** **181224:** SIREN notice issued 03/11/24 to direct colleagues to risk templates and support when developing or updating risks - **ACTION COMPLETE** **081024**: (AP) Complete when Siren notice is issued 011124 to remind colleagues where to access templates, information and support. This will be completed in November 2024 and as such a revised date has been applied in Q2 24/25 to December 2024.
745	23/24	ARAC	Risk Management	Reasonable	Julie Boalch	Trish Mills	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.	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).	Mar-25	Not Yet Due				Open	**181224:** LMS365 basic risk training developed and due to be uploaded in January 25. Risk Manager will undertake more detailed training once in post. Additionally, individual directorate support is in place. Training delivered to a new cohort of DOMs in November 2024.
746	23/24	ARAC	Risk Management	Reasonable	Julie Boalch	Trish Mills	Medium	3.1	All risks should be uploaded and managed on Datix.	3.1	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. 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. 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.	Jan-25	Met				Closed in Quarter	**200125: (LT) ADLT approved closure** **181224:** Progress on procurement of a new Risk Management system is underway in consultation with the Director of Digital. The evidence shows that the Clinical and Operations directorates are managing and considering their risks in 4.1 - **ACTION COMPLETE. Proposed for closure**
747	23/24	ARAC	Risk Management	Reasonable	Julie Boalch	Trish Mills	Medium	4.1	We recommend the Trust consider arrangements to support the consistency and monitor the completeness of directorate registers.	4.1	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. 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.	Oct-24	Not Met	Dec-24			Closed in Quarter	**200125: (LT) ADLT approved closure** **181224:** The Corporate Governance team have reviewed the Agendas, AAAs and dashboards provided by the Clinical and Operations directorates which evidence that risks are being prioritising for discussion at Directorate Business meetings and the flow through governance. In addition we have provided instructions to both directorates as to how to produce reports from Datix for their directorate risks - **ACTION COMPLETE. Proposed for Closure** **081024**: Work ongoing. Date extended to Dec24
748	23/24	ARAC	Risk Management	Reasonable	Julie Boalch	Trish Mills	Medium	5.1a	A summary risk report, similar to the format presented at Trust Board and Committees, should be developed and reported at directorate and service level.		1.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.	Oct-24	Not Met	Dec-24			Closed in Quarter	**200125: (LT) ADLT approved closure** **181224:** Operations Directorate are producing reports for discussion at Business Meetings evidenced in attached file. Instructions on how to draw reports from Datix have been issued to support this - **ACTION COMPLETE. Proposed for closure.** * Instructions on how to extract Risk Register Dashboards from Datix: pdf/ excel * How to find the relevant risk register in order to review it * How to add an action plan to the risk * Emails with previous reports (Datix) sent to Operations for SOT meetings
749	23/24	ARAC	Risk Management	Reasonable	Toni-Marie Norman	Trish Mills	Medium	5.1b	A summary risk report, similar to the format presented at Trust Board and Committees, should be developed and reported at directorate and service level.		2.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	Oct-24	Not Met	Dec-24			Closed in Quarter	**200125: (LT) ADLT approved closure** **171224:** TN provided a copy of the slide deck dashboard that is now reported monthly to SOT on risk compliance, total number of risks, how many risks at each level - **ACTION COMPLETE. Proposed for Closure.**

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	Rec. No.in Audit	Recommendation	Respons e No.in Audit	Management Response	Agreed Deadline in Report	Status - met or not met agreed deadline in report	1st revised date	2nd revised date	3rd revised date	Closure Status	Where a management action has not met the agreed or revised date, Director must 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.
527	22/23	FPC	Data Analysis	Reasonable	Aled Williams	Jonny Sammut	High		3.1 A programme to replace all of the Qlik reports with Power BI equivalents should be scoped and completed. Qlik should then be decommissioned and removed.		A risk-assessment will be conducted to understand the exposure to WAST of Qlik Sense being out of vendor support. This platform is not internet facing (i.e. for internal users only, not on a publicly accessible web url), and not believed to present an information security risk, but pending ICT assessment, we will devise a mitigation plan, or an options appraisal for maturity - due March	Mar 24	Not Met	Oct-24			Closed in Quarter	**200125 (LT): ADLT approved closure.** **181224: (LS)** - Email confirmation supplied by Acting Director confirming all dashboards and reports have been migrated to PowerBI, and Qlik platform is no longer in use. The server hosting the platform has been switched off and decommissioned. Email confirmation of server shut-down supplied as evidence for closure. **Action Complete. Proposed for Closure.**
567	22/23	FPC	Hazardous Area Response Team (HART)	Reasonable	Clare Langshaw/Judith Bryce	Lee Brooks	Medium		2.1 The Trust should undertake a self-assessment against the NARU key lines of enquiry review document. This could support any future "critical friend" review undertaken.		The Trust accepts this recommendation and is committed to undertaking a self-assessment aginst the NARU review document	May-23	Not Met	Mar-23	Mar-24	Jun-24	Closed in Quarter	**200125: (LT) ADLT approved closure.** **151124:** SOT content with the Peer Review process and contents of the document following the process, evidence supplied includes: Peer Review report, SOT agenda and Triple A confirming SOT content with process undertaken and SLT agenda and Minutes confirming SLT content with process. **Proposed for Closure.**
596	22/23	Audit	Risk Management	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	Mar25			Open	**181224:** The RA training session took place. Survey and prep underway for February BDD when RAS will be finalised, at which point this action can be closed. On track to achieve revised due date Mar25. **081024**: A Risk Appetite session has been scheduled with the Board for 2nd December 2024. This session will inform the development of the risk appetite statmements during Q4. **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.
604	22/23	Quest	Pain Management	Limited	Jonathan Chippendale	Andy Swinburn	High	1.2(c)	The Trust should ensure all PGDs follow the Medicines Management policy, with a review undertaken every three years as a minimum.	1.2 (c)	The PGD development and review process is resource intensive, and pharmacist input is an essential requirement. Pharmacist Advisor availability is currently limited to 4-hours per month and does not currently meet the needs of the organisation, particularly given the uplift in advanced practitioners and extended skills (enhanced analgesia) of the paramedic workforce. We will develop an options appraisal to determine a costed and effective way forward to provide additional Pharmacist Advisor capacity.	Mar-24	Not Met	May-24	Sep-24	Mar-25	Open	**201224**: Pharmacist Advisor availability now resolved as Sofia Fernandez (Lead Pharmacist) has now joined the Trust. A Medicines Management Group will be established in January 2025 as a forum for the PGD schedule and review as a standing item at every meeting to review purpose and against the policy. A AAA report of the reviewed PGDs will then be submitted to APSG. **071024**: (AP) In line with update given in July 2024, action can only be closed when the backlog of PGDs has been reviewed. Given that and that the Pharmacist begins in post mid-Q3 24/25, requested that a revised date of March 2025 be applied to permit this to take place. Revised date of March 2025 added in Q2 24/25. 080724: Revised date of September 2024 added in Q1 2024/25. When Pharmacist Advisor recruited the role holder will be reviewing the Patient Group Directives outstanding. At that point this will be an ongoing responsibility of the PA. Action to be closed when backlog of PGDs reviewed. 050724: Proposure not accepted; post holder needs to be in post before closure. Last Updated 270624: (JL) Additional support approved and agreed at EFG 27/03/24. Lead Pharmacist role is currently out for recruitment and second Head of Medicines Management role expected to be out for recruitment in next few days. Action recommended for closure. 170424: (AP) Not clear when received at ELT so revised date in Q4 of May24 added. Last updated 04.04.2024 Recommend for closure: Options presented to Executives and recruitment commenced.
612	22/23	PCC	Trade Union Release Time	Limited	Liz Rogers	Angela Lewis	High	2.1	A standardised process to formally request trade union time should be agreed and appropriate monitoring mechanisms put in place to ensure practices are applied and managed consistently. The process should also incorporate the method of approval and payment / TOIL as well as the	2.1 (c)	The comments of audit colleagues are noted and accepted. Whilst there was a template provided, reps were advised that they needed to maintain a personal record but flexibility was given on how this was to be done. The audit feedback will be shared with TU partners for information and clarification. The current	Sep-24	Not Met	Dec-24			Closed in Quarter	**200125: (LT) ADLT approved closure.** **161224**: (LR) DOMs sign off requests for TU time at a local level for TU Partners to be abstracted to attend to TU activities. Senior Representatives are spending much time on whole organisational issues but still complete a timesheet and are abstracted with sign off from the line manager. **Proposed for closure**
613	22/23	PCC	Trade Union Release Time	Limited	Liz Rogers	Angela Lewis	High	3.1	A standardised process to formally record facility time, and in sufficient detail, should be agreed and implemented.	3.1 (a)	WAST do not currently have the systems to record this information centrally and to do this manually will take more administrative support which is not good value for money. Most TU reps are based in Operations and are recorded in GRS. Only a handful are working outside of the GRS system. **Action:** We will review whether the information could be held in ESR effectively and what the maintenance of this would be and the ease of collecting it. It needs to be in one place for ease of reporting and management. If this is not a realistic option (in terms of cost), we will explore options for alternative methods of recording total time.	Nov-23	Not Met	Mar-24	Dec-24		Closed in Quarter	**200125: (LT) ADLT approved closure, pending form of words to be supplied by LR for PCC Audit Report.** **161224:** (LR) A meeting was held with TU Partners with AL and LR in Summer 2023 on recording the time spent on TU activities. At the meeting TU Partners noted a range of significant reasons why the example spreadsheet in the facilities agreement was not usable. A key issue was that it could not be accessed on iPads. Time off is recorded in GRS for all TU reps in Operations except for those in 111 which is recorded in Shift Track. These colleagues are likely to move to GRS recording in the work being undertaken on RICS in 2025. All the TU Partners involved in the audit were able to provide evidence of their detailed TU work when requested by audit albeit in different formats. The Director of People and Culture agreed that this was acceptable in the meeting with TU Partners. DOMs sign off TU Partners time at a local level. ELT have recently received a report on options regarding FT TU Partners. There is some further work to be done on this as directed by ELT. The cost of facility time is calculated by Finance on an annual basis but can be generated more frequently if required. **Proposed for Closure**
622	22/23	FPC	IM&T Infrastructure	Reasonable	Aled Williams	Jonny Sammut	Medium	1.1	WAST should schedule a physical stocktake to ensure the asset register is 100% accurate.	1.1	With the majority of corporate staff remote working since Covid it has been difficult to conduct a physical audit. Also given the range of equipment provided to staff for home working (laptop, dock and monitors) we will have to develop a new way of undertaking a physical audit.	Apr-24	Not Met	Mar-25			Open	**111224** (AIW) - planning is underway to conduct a virtual audit utilising digital toolsets which will turn over Q1 2025. Any equipment not identified by this process will be followed up with the allocated users. On track to achieve first revised date of Mar25. **270924** (AIW) - work pressures have resulted in a delay, HotH service desk go-live is now 300924. ICT are planning to utilise tools available to conduct a full audit of equipment by Q4 2024/25 080724: Revised date of March 2025 added in Q1 24/25 in line with update. 170624: ICT Update - Launch of new service desk for ICT staff will commence 01/07/2024 with a rollout of incident and problem management modules along with migration of assets into the new system CMDB. To update the asset register the Trust has invested in additional licences to allow for remote scan of equipment connecting to network and work is ongoing to reconcile this data and we will utilise this reconciliation exercise to virtually audit this equipment. We are unlikely to physically audit equipment at remote workers homes and discussions are ongoing as to the availability of non-ICT staff to undertake a physical audit of equipment located at Trust sites if this is deemed necessary. Revised date of March 2025. Work is now underway with the new system in build and is expected to go-live in Jun-24 and a review of assets will be conducted as part of this implementation. In parallel work is ongoing to undertake a physical audit of WAST sites when resources are available. However we still considering option for physical stocktake of remote workers where it does not involve a visit staff home address

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624	22/23	FPC	IM&T Infrastructure	Reasonable	Wyn Morris	Jonny Sammut	Medium	3.1	The process for clearing all PRTG/system alerts should be formalised and documented. It would typically include •A shared mailbox, all alerts go to one place •Prioritisation guidelines for all calls. •Scheduled review times for technicians and managers. •Process for storing cleared alerts for periodic analysis to assist with trend /cause identification If there are too many alerts for this to be considered reasonable then the parameters for their production could be reconsidered so that a lower number of what could be considered higher priority alerts is generated.	3.1	Agreed, will look to formalise the process and provide some ownership to the defined process	Dec-23	Not Met	Jun-24	Aug-24	Mar-25	Open	**111224** (AIW) - Problems encountered with the integration to HoTH, work is ongoing to resolve in advance of the deadline. **270924** (AIW) - Service desk will launch 200924 which will see the automated creation and management of alerts. This work is therefore not yet complete and revised date requested to March 2025. Revised date to March 2025 in Q2 24/25. 080724: Revised date of August 2024 added in Q1 24/25 in line with update. 170624: ICT Update - Launch of new service desk for ICT staff will commence 01/07/2024 with a rollout of incident and problem management modules along with migration of assets into the new system CMDB. Automation of incidents form alerts is planned to be in place from mid-July. Revised date August 2024. Linked with implementation of House on the Hill ITSM software. Date moved in Q4 to June24. 20/03/2024 - This recommendation is now linked with the implementation of the new service desk software has been delayed due to contract finalisation and work associated with CAS replacement. Work is now underway with the new system in build and is expected to go-live in Jun-24 and automation of PRTG alerts is a key part of this implementation. Target date moved in quarter 3. Last Updated 06/12/23: Technical solution still to be designed but likely solution superseded by implementation of new Service Desk platform which will address this need in core requirements. Timeline June 2024. 18/12/23: Contract for new service desk software signed 15/12/23, Draft implementation plan produced with full implementation expected to take 6 months, individual modules are yet to be prioritised
625	22/23	FPC	IM&T Infrastructure	Reasonable	Tony Raine	Jonny Sammut	High	4.1	Switches should be identified within the asset register.	4.1	This work was underway prior to the audit but the member of staff is on long term sick. As our switches are configured not to respond to general network sweeps it is a manual task to collate and add this information to the CMDB.	Mar-24	Not Met	Sep-24	Mar-25		Open	**111224** (AIW) - Work ongoing and on schedule for Mar-25 **270924** (AIW) - New service desk will launch 300924 which will include a revised asset schedule that will include switches. This work is therefore not yet complete and revised date requested to March 2025. Revised date to March 2025 in Q2 24/25. 170624: ICT Update - Launch of new service desk for ICT staff will commence 01/07/2024 with a rollout of incident and problem management modules along with migration of assets into the new system CMDB. Switches will be included as assets in the new system Linked with implementation of House on the Hill ITSM software. Date moved in Q4 to Sept24. 20/03/2024 - Work completed and list produced and waiting on the implementation of the new service desk software which has been delayed due to contract finalisation and work associated with CAS replacement. Work is now underway with the new system in build and is expected to go-live in Jun-24.
655	22/23	FPC	Records Management	Reasonable	Judith Birkett	Jonny Sammut	High	3.1(a)	A formal agreement for storage of records should be developed. This should set out the responsibilities and requirements for management of health records.	3.1(a)	Additional temporary resource to be sought (from Jan-24) to conduct review of DCC stored boxes and retention schedules. A forecast of storage requirements at DCC will be created to inform a decision on if/when it will be possible to move these records into WAST-managed storage (e.g. at VPH).	Apr-24	Not Met	Sep-24	Mar-25		Open	**011024**: (AP) Revised date of March 2025 in Q2 24/25 added in line with update. **260924:** LS update - this work has not been able to be progressed due to long-term absence of a key expert within the Records Team. This pressure on team capacity is expected to remain until January and until this time focus remains on Records Requests (not management and storage) and maintaining compliance with regulatory targets. As such, propose to extend due date to March-25. **080724**: Revised date of September 2024 added in Q1 24/25. **190624**: LS Update - Due to some sickness within the small team this action has not been able to be complete. Work continues on reviewing the records held in DCC, and as per retention schedules, an instruction for disposal has been issued for some boxes. Linked with Action 657, it is believed that following a review of the storage facility in VPH, as the requirement for external storage at DCC has decreased, we may be able to transfer remaining boxes to WAST storage instead. Propose that this date is extended to September 2024, and sequenced after action 657.
656	22/23	FPC	Records Management	Reasonable	Judith Birkett	Jonny Sammut	High	3.1(b)	A formal agreement for storage of records should be developed. This should set out the responsibilities and requirements for management of health records.	3.1(b)	Should [following the review at 3.1a being evaluated] we still need space at Denbigh County Council then we will pursue an agreement with them for those storage, retention and disposal. In the meantime, we will ask for the policies and procedures the Council have in place for their receipt, retention and destruction of records and confirm that this is the way they treat our records. That should provide some assurance on the issues in the matter arising.	Sep-24	Not Met	Mar-25			Open	**011024**: (AP) Revised date of March 2025 in Q2 24/25 added in line with update. **260924**: LS update - this work has not been able to be progressed due to long-term absence of a key expert within the Records Team. This pressure on team capacity is expected to remain until January and until this time focus remains on Records Requests (not management and storage) and maintaining compliance with regulatory targets. As such, propose to extend due date to March-25.
657	22/23	FPC	Records Management	Reasonable	Leanne Smith	Jonny Sammut	Medium	4.1	Records should be moved into the new storage area.	4.1	RSAM to review suitability of the VPH storage facility and access management arrangements. If appropriate, secure transfer of the records from Pontypool to VPH will require budget approval beyond the funds available for Records Services (to be discussed with Corporate Governance & Finance).	Jan-24	Not Met	Jun-24	Aug-24	Mar-25	Open	**011024**: (AP) Revised date of March 2025 in Q2 24/25 added in line with update. **260924**: LS update - this work has not been able to be progressed due to long-term absence of a key expert within the Records Team. This pressure on team capacity is expected to remain until January and until this time focus remains on Records Requests (not management and storage) and maintaining compliance with regulatory targets. As such, propose to extend due date to March-25. **080724**: Revised date of August 2024 added in Q1 24/25. **190624**: Due to some sickness within the small team this action has not been able to be progressed. The Records & Archives Manager plans to visit VPH in person to conduct this suitability review. Completion of this action will support with Action 655. Propose that this date is extended to August 2024, and sequenced before action 655. Date changed in Q4 to June 2024 in line with update. **250324**: request for date extension to Jun-24. VPH storage facility still to be assessed for feasibility.
658	22/23	FPC	Records Management	Reasonable	Judith Birkett	Jonny Sammut	Medium	5.1	The records management improvement plan noted in MA2 should include a programme of identification and assessment of all records storage areas within the Trust.	5.1	The risk of not fully assessing storage areas in 2023-24 will be acknowledged in the risk being developed as per action 1.1. A Trust-wide request will be made to gather intel on what paper records are being stored across the organisation and where. This will inform the improvement plan of how to assure these storage areas.	Sep-24	Not Met	Mar-25			Open	**011024**: (AP) Revised date of March 2025 added in line with update. **260924**: LS update - this work has not been able to be progressed further due to long-term absence of a key expert within the Records Team. This pressure on team capacity is expected to remain until January and until this time focus remains on Records Requests (not management and storage) and maintaining compliance with regulatory targets. As such, propose to extend due date to March-25. **250324**: a risk has been developed regarding the overall compliance of records management. Further risks are in development, to capture the specifics of storage areas.
612	22/23	PCC	Senior Paramedic Role	Reasonable	Darren Panniers	Andy Swinburn	Medium	3.2	A training plan, and expected timeline for the required clinical skill enhancements should be established.	3.2	An Extended Skills Working Group has been established to deliver four new areas for skill development during 2024. The first meeting is in November 2023 with two priorities already agreed (sedation for post ROSC patients and the management of ABD). The workplan and draft terms of reference have been shared with Audit	Dec-23	Not Met	May-24	Aug-24	Dec-24	Closed in Quarter	**200125: (LT) ADLT approved for closure.** **201224**: Extended skills workshop has taken place and training programme has started. Training plans included timelines provided to AP on 12.11.2024. **Recommended for closure.**

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613	22/23	PCC	Senior Paramedic Role	Reasonable	Darren Panniers	Andy Swinburn	Low	4.1	The terms of reference should be reviewed to: •Include a defined pathway for escalation of issues; •Update membership to ensure representation from each locality; andNov •Define quoracy.	4.1	The SP steering group has changed to a quarterly meeting and the terms of reference are being updated to reflect the audit findings. An Alert/Assure/Advise report will be completed and submitted to the Senior Operations Team.	Nov-23	Not Met	Feb-24	May-24	Aug-24	Closed in Quarter	**200125: (LT) ADLT approved closure.** **201224**: Quoracy and AAA into SOT included in the ToR and approved by the group on 04.11.2024 as confirmed in email to AP. **Recommended for closure.** **021024**: (AP) CGT not accepted closure position as the ToR revisions don't include everything that is required by the management action. Quorum not included and escalation process not explicit (although says that will provide AAA to SOT). Marked date of August 2024 as red, to indicate not completed. AP engaged wtih Clinical Directorate to provide advice and request revision of ToR; Greg Lloyd is aware of position. Last updated 01102024: Recommend for closure. SOT approved ToR on 10/09/24. AAA and ToR received as evidence for closure.
614	22/23	PCC	Senior Paramedic Role	Reasonable	Greg Lloyd	Andy Swinburn	Medium	5.1	The Trust should undertake a lessons learned exercise on the development and evolution of the SP role.	5.1	A review on the evolution of the role will be completed to highlight any lessons that can be learned for future role development.	Feb-24	Not Met	May-24	Aug-24	Mar-25	Open	**201224**: Lessons learned paper has been written and will report in to the next Steering Group. On track for completion within timeframe. **071024**: (AP) Clarified with Clinical Directorate that this action is yet to be completed. Requested revised date of March 2025 to allow this to be completed. Revised date for this action of March 2025 added in Q2 24/25. **040724**: (AP) Revised date of August 2024 added in Q1 24/25. Last Updated 270624: (JL) Discussion not yet taken place due to postponed Steering Group. Request extension of revised due date to Q2 to allow for discussion at Steering Group in July. **040424** Not yet commenced. Jen Lloyd to send reminder to Greg Lloyd for discussion at Steering Group. Revised date proposed of May24 in Q4.
616	22/23	PCC	Senior Paramedic Role	Reasonable	Greg Lloyd	Andy Swinburn	Medium	5.3	Feedback from Paramedics and Technicians should be included as a standing agenda item on the SP Steering Group for consideration / action as appropriate.	5.3	Feedback through the Power BI reporting process will be included on the SP Steering Group quarterly meeting.	Jan-24	Not Met	May-24	Aug-24	Dec-24	Closed in Quarter	**200125: (LT) ADLT approved closure.** **20122024**: Evidence of standing item on agenda sent via email to AP on 12.11.2024. No forward plan for meetings as this is not typical practice for meeting on this level but this will be a standing item on all of the meetings going forward. **Recommended for closure.**
631	23/24	FPC	Estates Condition	Limited	Richard Davies Joanne Williams Edward Roberts	Chris Turley	High	7.1	The Estates Strategy should be updated to provide a funded target solution separately to eliminate "high and significant" and overall backlog maintenance profiled by year.	7.1	Agreed, a refreshed Strategic Outline Programme is required upon receiving guidance from NWSSP as detailed within recommendation 4.	Sep-24	Not Met	Mar-25			Closed in Quarter	**200125: (LT) ADLT approved closure** **131224**: (LT) Update from Estates: Closure of this action is sought as the Estates SOP is not planned to be refreshed due to the recent prioritisation of All Wales capital funding requested by Welsh Government whereby 15+ ranked capital priorities were presented. The full outcome of this process has not yet been finalised, therefore due to this and likely funding pressures for coming years, to refresh the Estates Strategy of 2021 is not recommended at present. As the service submits annual backlog data to Shared Services whereby high and significant elements are highlighted, the use of such data to reduce the backlog figures even further will continue. The service has been successful in reducing its backlog maintenance over the last 7 years, the majority of the poorer estate has been removed through disposal or refurbishment. A risk based assessment will continue and form part of the estates risk register, reported to Finance and Performance Committee, and reviewed by ARAC annually. **Proposed for closure**
635	23/24	FPC	111 Commissioning Final Advisory Report	Not Rated	Rachel Marsh	Rachel Marsh	N/A	1.1	Noting that roles and responsibilities will have changed since the national NHS 111 Wales service has been implemented, roles and responsibilities should be clearly detailed within the National Collaboration Agreement and signed by both parties (Commissioner and Trust). Opportunities should be provided for partners to reflect on their roles and functions regularly so that the Agreement can be amended to reflect any changes.	1.1	A new Joint Commissioning Committee will come into effect from 01/04/24. The Trust wants to wait and see what develops in this space rather than commit time to a document that could cease on the 31/03/24.	Apr-24	Not Met	Jun-25			Open	**270125: (LT) HB advised action complete. Awaiting supply of evidence** **300824**-Collaboration Agreement: so marked as 'no further action'. We cannot proceed with this until the JCC moves from transition to a more settled state. The 111 & Ambulance Commissioner was appointed this month, so we may expect progress on Q3, but currently paused. **260724**: Discussion w/HB; will discuss the position with the Interim Director for Commissioning and 111, to understand whether there will be a new collaboration agreement following the implementation of the JCC. AP to discuss with TM to consider whether - should there not be - this is acceptable. Potential action for discussion wtih IA. **050724**: (AP) The Trust will revisit this recommendation in June 2025 to ensure that roles and responsibilities are clear for NHS111. Revised date of June 2025 added in Q1 2024/25. CGT to discuss with SPP; to understand how the recommendation 635-645 on the basis of the new JCC arrangements can be progressed / closed. **260624**: No further action with the collaboration agreement at this juncture.
643	23/24	FPC	111 Commissioning Final Advisory Report	Not Rated	Rachel Marsh	Rachel Marsh	N/A	4.3	The Trust should obtain written confirmation of the escalation process to be followed within the current governance structure.	4.3	A letter will be collaboratively drafted and agreed between the 111 Board Chair and Trust CEO to formalise the informal escalation arrangements that do currently exist.	Jan-24	Not Met	Jun-24	Sep-24	Dec-24	Open	**101024**: (AP) Revised date applied of December 2024 in Q2 24/25. **300824** - Escalation arrangements i.e. between ourselves and commissioners: HB has drafted a letter, which is what we agreed to do, which is now with RM, but only this week. **260724**: Discussion w/HB - AP said to HB that likely still required and the new commissioning arrangements do not supersede this action (in terms of process), but AP will verify with TM that position and then feed to HB. If agreed HB will prepare the letter in order to close off the action. **050724**: Revised date of September 2024 added in Q1 24/25. CGT to discuss with SPP; to understand how the recommendation 635-645 on the basis of the new JCC arrangements cam be progressed / closed. **260624**: The JCC arrangements are not yet sufficiently developed for this to be actioned. **170424**: New date added in Q4 of June 2024.
646	23/24	FPC	Strategy Development	Reasonable	Alex Crawford James Houston	Rachel Marsh	Medium	1.1	A refresh of the Long-Term Strategy shall be considered, clearly outlining the aspects of the long-term strategy that require updating, and specifying the new developments to be included.	1.1	Aligned to the continued development of the future clinical service model taking place in Q1 to Q2, a clear recommendation shall be presented to ELT and respective groups outlining the specific requirements (if required) to refresh the Long-Term Strategy document.	Dec-24	Not Met	Mar-25			Open	**200125: (LT) 1st revised date (Mar25) agreed by ADLT** **160125: (LT) Request for due date to be extended to Mar25**
653	23/24	FPC	Strategy Development	Reasonable	Alex Crawford James Houston	Rachel Marsh	Medium	3.1 (c)	The Trust should also consider opportunities to enhance reporting to demonstrate that strategic delivery programmes are having the intended impact in terms of outcome achievement.	3.2 (c)	Aligned to the Benefits Realisation Plan, respective benefits and outcomes to be mapped and regularly monitored as part of the refreshed programme arrangements	Sep-24	Not Met	Dec-24	Mar-25		Open	**200125: (LT) 2nd revised date (Mar25) approved by ADLT** **101224**: (LT) HH email received supplying copy of CMT Programme Board Minutes 241108 when benefits realisation approach (for the CMT) was presented and agreed. Workstream LBMs have all been drafted and meeting with SRO to refine. These are scheduled to go to CMT Board on 13/02/25 for appoval. **Extend until Mar25 once aqpproved by CMT Board** **121124**: (KL for HH) A Quality & Performance Metrics sub-group established to ensure a consistent and robust approach to benefits realisation across the CMT programme. A Series of benefits realisation workshops convened, and an approach agreed, including completion of Logic Benefits Maps (LBM) for wach workstream. Benefits realisation Approach - LBM template and definitions to be be presented to CMT Board for approval (8/11) following which work will commence to develop embed across each workstream. Following approval of complete Workstream LBMs (early Q1), a Benefits realisation Plan will be developed for the overall programme, with responsibility devolved to each Workstream SRO for benefits realisation - Proof requested 13.11.24) **071024**: (AP) Update from SPP: There is work ongoing to develop benefits realisation plans for the programme, alongside a piece of work to develop CMT Quality and Performance Metrics to support the benefits realisation plan. Not met, revised date of December 2024 applied in Q2 24/25.

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655	23/24	PCC	Retention of Staff	Reasonable	Liz Rogers	Angela Lewis	Medium	1.1(b)	The 'Moving on Interview' process should be finalised and approved in accordance with Trust procedure.	1.1(b)	The team are still exploring opportunities to generate automatic triggers for managers and staff rather than relying on managers remembering to ask a colleague to complete.	Jun-24	Not Met	Sep-24	Dec-24		Closed in Quarter	**200125: (LT) ADLT approved closure** **161224: (LR)- Propose for closure -** The process is done and will officially be live on 01.01.2025 and the report has been to ELT on 12.12.2024.
657	23/24	PCC	Retention of Staff	Reasonable	Liz Rogers	Angela Lewis	Medium	1.3	The Trust should look to develop an appropriate training package to assist managers in the use of the new Moving on Interview Process.	1.3	Guidance for managers on using the process developed and signed off	Jun-24	Not Met	Sep-24	Mar-25		Closed in Quarter	**200125: (LT) ADLT approved closure** **161224 (LR) - Propose for closure** - The guidance has been produced and drop in sessions are scheduled for January 2025 when the process is live.
658	23/24	PCC	Retention of Staff	Reasonable	Liz Rogers / Peter Brown	Angela Lewis	Medium	2.1	The Trust should undertake, and report to an appropriate forum, an evaluation of the initiatives introduced to determine their impact and effectiveness in retaining staff.	2.1	An evaluation report will be developed in association with the 111 senior team. It is noted that not all initiatives are appropriate for other areas of the organisation based on role types, culture differences and different pressures.	Sep-24	Not Met	Mar-25			Open	**161224:** (LR) - Work is progressing as expected and is not due for completion yet. **231024**: (AP) Revised date to March 2025 applied in Q2, in line with update. **231024**: (AP) Update from PCC: Propose for extension – Unfortunately due to the need to move re-prioritise team resource into manage employee relations and operational HR work, it has not been possible to complete the project as originally scheduled. Resources are currently being evaluated on how to proceed effectively and it has been requested that an adjustment of March 2025 is made to the completion date. This will allow these challenges to be addressed and appropriate capacity to be assigned to focus on the desired developments. **18.09.24** - JS - During the development of the moving on conversation process, close working relationships with the 111 management team were had throughout the pilot, which enabled feedback from users to be incorporated into the final process. The form that has been developed as the final process has formally been rolled out across 111 and a rollout plan across WAST will commence in October.
663	23/24	FPC	Vehicle Replacement Programme	Reasonable	David Holmes / Andrea Davies	Chris Turley	Medium	4.1	The various aspects of the procurement strategy include: (a)enhanced narrative within the business case; & (b)evaluation and approval by appropriate parties to confirm that it remains optimal (as detailed within the business case for approval) e.g. to affirm that it best aligns procurement and contractual arrangements to obtain best value from strategic partnering.	4.1	Agreed. The current narrative describing the procurement strategy will be further detailed within future business cases to better facilitate evaluation of the procurement strategy.	Dec-24	Met				Closed in Quarter	**200125: (LT) ADLT approved closure** **191224**: (LT) AD email advising narrative in existing BJC documentation updated and expanded. BJC 2025/26 included within VP Strategy (previously referred to as SOP) for 2025/26 (year 1) onwards. As part of VP Strategy, procurement strategy reviewed and developed, and narrative included in the document. Outcome reported and approved at Fleet SOP Delivery Group Meeting 18/12/24. Proposed that action has been completed and can now be closed. **Proposed for closure.**
668	23/24	Quest	Serious Adverse Incidents - Joint Investigation Framework	Reasonable	Wendy Herbert	Liam Williams	Medium	1.1	The Trust's 'Adverse Incident and Reporting Policy' should be reviewed and updated to reflect the requirements set out within the NHS Wales policy.	1.1	The Putting Things Right Team plan was to review relevant policies following the release of the new Putting Things Right Regulations by Welsh Government in May 2024. A recent update from Welsh Government has confirmed that the release will now be Autumn 2024. At which point the review will be undertaken. The Trust has approved policies in respect of incident reporting and management and a Putting Things Right Policy which are included on the intranet site (review dates are both April 2026). Staff also have access to User Guides on the intranet site for Datix Cymru. The All-Wales Patient Safety Policy (NHS Executive) (May 2023) is also due review in March 2024 and will be updated internally when released nationally	Nov 24 On release from NHS Wales Exec	Not Met	**Dec-25**			Open	**200125: (LT) ADLT noted 1st revised date (Dec25)** **061224**: The Putting Things Right Regulations by Welsh Government are yet to be updated. The latest position provided by the Stakeholder Reference Group is for Autumn 2025. The proposal is to move deadline date to December 2025 to allow for Policy rewrite and approval post national release. The NHS Wales Executive have confirmed to the HOPE Network on 27 November 2024 that there is no anticipated revision of the National Patient Safety Incident Policy. What will close the action: Updated version of the Putting Things Right Policy (following release of the new Putting Things Right Regulations in Autumn 2025). **The element of this action related to the adoption of the updated National Patient Safety Incident Reporting and Management Policy can be closed based on the update provided above.** What will you provide as evidence for the closure: Copy of Putting Things Right Policy Is date reasonable: Dependant on release date of Putting Things Right Regulations by Welsh Government .
681	23/24	Quest	Electronic Patient Clinical Records: Clinical Compliance (ePCR)	Reasonable	Jonathan Chippendale	Andy Swinburn	Medium	1.1	To confirm accuracy of the self-certification compliance rate, management should consider capturing the method of training delivery on ESR.	1.1	For future training, the method of instruction will be captured as part of the ESR sign-off process (for example, classroom based, individual learning using the training materials, one to one instruction using the training zone in the application).	Jun-24	Not Met	Sep-24	Mar-25		Open	**20.12.2024**: Following appointment of CCIO who now holds responsibility for ePCR developments, this action should be transferred from the Clinical Directorate to Digital Services Directorate with the Responsible Officer as CCIO (Keith Dorrington). A meeting needs to be held with Audit Management Team in the new year as this and may of the ePCR deliverables are now unfit for purpose given the resources that will consumed to complete these actions. Jonathan Chippendale, Keith Dorrington, Jen Lloyd and Lisa Trounce to meet to discuss how this can be amended with likely meeting required with Auditors for KD to be able to close actions. Date of meeting tbc Q4. **021024**: (AP) Revised date of March 2025 applied in Q2 24/25, in line with update. Last updated **01102024**: Revised date of Q4 requested to enable the capture of this info. **110924**:Ffion Timmins liaising with ESR team to arrange this. Request due date to beginning of Q4. **040724**: (AP) Revised date to September 2024 added in Q1 24/25. Last updated 270624: (JL) At ePCR CRG, this item was specifically discussed. Future data will capture the method of training. Requires updates to the ESR system to accommodate. Request deadline extended to end Q2 to allow time for this change to be made. **04.04.2024** Work has yet to be commence due to meeting cycles. Will be an agenda item at the ePCR Clinical Reference Group on the 28th March (agenda to be competed on the 21st March 2024).
683	23/24	Quest	Electronic Patient Clinical Records: Clinical Compliance (ePCR)	Reasonable	Jonathan Chippendale	Andy Swinburn	Medium	1.3	Management should consider including a test in ESR to confirm competency before successfully self-certifying.	1.3	At the ePCR CRG WAST will discuss including a test to assess understanding at the completion of training.	Jun-24	Not Met	Sep-24	Dec-24	Mar-25	Open	**20.12.2024**: As above - Following appointment of CCIO who now holds responsibility for ePCR developments, this action should be transferred to the Digital Directorate with the Responsible Officer as CCIO (Keith Dorrington). A meeting needs to be held with Audit Management Team in the new year as this and may of the ePCR deliverables are now unfit for purpose given the resources that will be consumed to complete these actions. Jonathan Chippendale, Keith Dorrington, Jen Lloyd and Lisa Trounce to meet to discuss how this can be amended with likely meeting required with Auditors for KD to be able to close actions. Date of meeting tbc Q4. NB L&E Team have indicated low levels or resource to be able to support this. **021024**: (AP) Revised date of December 2024 in Q2, as requested. **011024**: Awaiting transfer to LMS 365. Revised date of Q3 requested to determine Education team capacity and to enable this transfer. **11092024**: This was discussed at ePCRCRG on 27 June 24 and agreed that training materials would transfer from learning launch pad to LMS365 with integrate competency assessment. **040724**: (AP) Revised date to September 2024 added in Q1 24/25. Last updated 270624: (JL) ePCR CRG have discussed and agreed that a self-test will be included in the training materials. This will be incorporated following migration of the training materials to the LMS365 platform. Request deadline extended to end Q2. **04.04.2024** Work has yet to be commence due to meeting cycles. Will be an agenda item at the ePCR Clinical Reference Group on the 28th March (agenda to be competed on the 21st March 2024).

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684	23/24	Quest	Electronic Patient Clinical Records: Clinical Compliance (ePCR)	Reasonable	Jonathan Chippendale	Andy Swinburn	Medium	1.4	Whilst we acknowledge there are different methods of training delivery, management should review lower viewed training modules, to confirm that the completed ePCRs are compliant with expectations in this area.	1.4	Through the ePCR Clinical Reference Group (CRG) we will review the lower viewed modules as set out in Appendix B of this report. This will build on knowledge discussed at the most recent ePCR CRG where a small audit has identified that the obstetric section is not being completed. However, we currently have only opened access to the Welsh GP Record (WGPR) for our cohort of Advanced and Senior Paramedics. The pathways section of the ePCR is not currently live and requires testing prior to going live, which explains the disparity reported in these sections of Appendix B.	Sep-24	Not Met	Dec-24	**Mar-25**		Open	**200125: (LT) ADLT noted 2nd revised date (Mar25)** **20.12.2024**: As above - Following appointment of CCIO who now holds responsibility for ePCR developments, this action should be transferred to the Digital Directorate with the Responsible Officer as CCIO (Keith Dorrington). A meeting needs to be held with Audit Management Team in the new year as this and may of the ePCR deliverables are now unfit for purpose given the resources that will consumed to complete these actions. Jonathan Chippendale, Keith Dorrington, Jen Lloyd and Lisa Trounce to meet to discuss how this can be amended with likely meeting required with Auditors for KD to be able to close actions. Date of meeting tbc Q4. **01102024**: On track for completion in Q3 and discussed at Sept ePCRCRG on 26/09. **110924**: Pathways section is now live on ePCR. The lower viewed modules will reviewed and reported back to ePCRCRG for December closure date. **040724**: (AP) Revised date to December 2024 added in Q1 24/25 to end of Q3. **270624**: (JL) Action has yet to commence in order to accommodate earlier actions. Request deadline extended to end Q3 to enable earlier actions to be completed Q2 and then for this is take place Q3. **04.04.2024** Work has yet to be commence due to meeting cycles. Will be an agenda item at the ePCR Clinical Reference Group on the 28th March (agenda to be competed on the 21st March 2024).
686	23/24	Quest	Electronic Patient Clinical Records: Clinical Compliance (ePCR)	Reasonable	Jonathan Chippendale	Andy Swinburn	High	2.2	Management should ensure the tenant structure is developed to provide data at both a team and individual level to assist in identifying training needs and drive improvement in ePCR compliance.	2.2	Reporting into CIAG, we will set up a Task and Finish Group to write the plan to deliver the dashboards against the Tenant Structure. This is a complex piece and requires input from multiple directorates. It is also dependent on the capacity within teams to deliver the dashboards, therefore the output of the T&F might be a business case jointly developed between the Digital and Clinical Directorates to outline the resources required and what this would cost to deliver.	Sep-24	Not Met	Mar-25			Open	**201224**: As above - Following appointment of CCIO who now holds responsibility for ePCR developments, this action should be transferred to the Digital Directorate with the Responsible Officer as CCIO (Keith Dorrington). A meeting needs to be held with Audit Management Team in the new year as this and may of the ePCR deliverables are now unfit for purpose given the resources that will consumed to complete these actions. Jonathan Chippendale, Keith Dorrington, Jen Lloyd and Lisa Trounce to meet to discuss how this can be amended with likely meeting required with Auditors for KD to be able to close actions. Date of meeting tbc Q4. **021024**: (AP) Revised date of March 2025 applied in Q2 24/25, as requested. **011024**: Request for revised completion date of Q4. Project Manager assigned to work with newly appointed CCIO on this to develop the business case. The ability to role this out will be entirely dependent on capacity and funding but the Task & Finish Group will work to build up the business case for how it would be done. **110924**: Project manager assigned to this with T&F group to start October 2024. Request extended deadline for end of Q4 to produce business case. **270624**: (JL) Following HI pause, leads for this work within the digital directorate have been identified. Work will commence late June 2024 to enable initial scoping to be undertaken. Request deadline extended to end Q2. **04.04.2024** Work has yet to be commence due to meeting cycles. Will be an agenda item at the ePCR Clinical Reference Group on the 28th March (agenda to be competed on the 21st March 2024).
691	23/24	FPC	ICT Contract Management	Reasonable	Robert Walker	Jonny Sammut	Medium	3.2	ICT contract management process should be applied to all ICT related contracts, with the ICT Contract Manager feeding into any management meetings within other areas.	3.2	The Contract Management [SOP] process is to be applied to all contracts listed in the contracts register.	Mar-25	Not Yet Due				Open	**111224** (AIW) - Robert Walker back in post and is now working on embedding the contract process into current and future contract. **270924** (AIW) - Appointment made to the Contract Manager role. **170624** - The contract manager has resigned from the Trust as of the 14/06/2024. Senior management will undertake necessary meeting with suppliers with priority on key and high value contracts until a replacement is recruited.
698	23/24	Quest	Seatbelt Action Plan	Reasonable	Mark Harris	Lee Brooks	Medium	3.1	Consideration should be given to undertake a higher number of internal inspections per annum to provide sufficient coverage and assurance that the Trust is compliant with required standards.	3.1	The decision to include internal inspections has been driven internally by the Operations Directorate although capacity remains a limiting factor. Whilst the audit has highlighted the need to undertake a higher number of inspections, we remain committed to four per annum with more being undertaken should capacity permit	Dec-24	Met				Closed in Quarter	**200125: (LT) ADLT noted closure.** **161224**: (TMN) The contents of evidence sent to LT include 3 quarters of Quality Assurance Inspections that are reported to SOT including the SOT highlight reports. There are also plans for a Q4 report which we will see early April 2025 however content 3 quarters of inspections sufficient to **propose closure**.
701	23/24	Quest	Clinical Audit	Reasonable	Jonathan Chippendale	Andy Swinburn	Medium	1.1	The Trust should ensure appropriate detail in relation to clinical audit is included and documented it within its organisational documents.	1.1	There are workshops scheduled (4th, 9th and 10th July 2024) to plan the next iteration of the Trust clinical strategy. The Clinical Directorate will ensure that clinical audit is given the space it needs to articulate the need for, and link to the guidelines on how to undertake an audit in the final approved document. Where update presentations are given up to, and including, board level meetings, the Clinical Directorate will ensure clinical audit is included. The clinical strategy will articulate clearly how clinical audit meets HQIP standards and will link to the clinical audit plan (for example, to the Clinical Audit section on the Trust intranet).	Mar-25	Not Yet Due	**Jun-25**			Open	**200125: (LT) ADLT noted 1st revised date (Jun25)** **011024**: The development of the Trust Clinical Plan has been proposed for delay until Q4/Q1 2025 due to capacity contraints on the team. The Assistant Director for Clinical Development has informed the Director of Paramedicine of the need for reference to this in the Clinical Plan and this will be incorporated into the Plan development. Currently on track but dependent on the timing of the first draft of the Clinical Plan. **Requested extension to end of 25-26 Q1 (Jun25).** **11092024**: To be included in Clinical Plan 2025-2030 - to be picked up by T&F group delivering Clinical Plan adn draft to be shared when it goes to QuEST. On track for end Q4. **270624**: (JL) Awaiting Clinical Strategy development days (9-10 July) to incorporate clinical audit activity.
702	23/24	Quest	Clinical Audit	Reasonable	Kevin Webb	Andy Swinburn	Medium	2.1	The Trust should link all clinical audits to either the clinical directorate risk register or Trust/Directorate priorities to support the justification for undertaking them. Where a link cannot be made, additional narrative should be included to justify the inclusion of the clinical audit within the audit plan.	2.1	Work will be undertaken to ensure relevant risks are linked to clinical audit activity; specifically, a mandatory field will be added to the proposal form to link to either a clinical risk or organisational clinical priority. This form will be submitted to CIAG for approval. The Trusts/Directorate priorities are not always clearly identifiable, but we will look to include in the 2024/25 CAP a justification linked to the IMTP/LDP.	Sep-24	Not Met	Dec-24	**Jan-25**		Open	**200125: (LT) ADLT noted 2nd revised date (Jan25) to allow time for approval of actions to support closure.** **201224**: Identified and potential risks considered as part of new Clinical Audit Prioritisation form which has been taken to CIAG. This will be included in an SBAR for the January 25 CIAG meeting. KW meeting with team on 03.01.2025 to consider the 2025/26 clinical audit plan to go to QuEST for approval in Feb 25. **To be reviewed for closure in January 25 so extension requested just to approve all actions to close the recommendation.** **021024**: (AP) Revised date of December 2024 in Q2, as requested. **011024**: Request to revise the completion date to Q3. ADCD is attending CIAT in November which will enable justification of Trust priorities. This will be discussed at the next Business Meeting for the Directorate to align to any Directorate priorities. Additional time will enable new AD to enact this recommendation and amend clinical audit reporting to link to priorities. **270624**: (JL) New actions, meeting scheduled for 29 July to look at actions and revision of forms, Some work already ongoing to draft changes to consider and to include more detail in decisions logs. Request to identify clinical priorities and risks to inform the audit plan and opportunities for clinical improvement proposed to QMG meeting in June. Further updates with actions to be completed to be provided after July meeting.

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703	23/24	Quest	Clinical Audit	Reasonable	Kevin Webb	Andy Swinburn	Medium	2.2	The development of the clinical audit plan should be formally documented to provide assurance on the appropriateness of inclusion of individual audits.	2.2	The CIAT decision log and proposal form to include more detail outlining the priority of the audit activity and the justification for inclusion in the workplan, which will also be reflected in the completed audit reports. A review of the clinical audit documentation is scheduled. This will be reported for approval to the CIAG	Sep-24	Not Met	Dec-24	Jan-25		Open	**200125: (LT) ADLT noted 2nd revised date (Jan25) to allow time for approval of actions to support closure.** **201224**: As with 702 above, more detail is included in the Clinical Audit Delivery Plan that is submitted to CIAG monthly with the proposal form to be updated and a brief SBAR to cover off the actions for January Business Directorate meeting. **Recommended for closure in Jan 25,** request extension till then to close down these actions. **021024**: (AP) Revised date of December 2024 in Q2, as requested. **011024**: As above, request to revise the completion date to Q3. Additional time will enable new AD to enact this recommendation and review CIAT documentation for CIAG. **270624**: (JL) New actions, meeting scheduled for 29 July to look at actions and revision of forms, Some work already ongoing to draft changes to consider and to include more detail in decisions logs. Request to identify clinical priorities and risks to inform the audit plan and opportunities for clinical improvement proposed to QMG meeting in June. Further updates with actions to be completed to be provided after July meeting.
704	23/24	Quest	Clinical Audit	Reasonable	Jonathan Chippendale	Andy Swinburn	Low	3.1	A review of the CIAG Members within the Terms of Reference should be undertaken to ensure Membership is appropriate.	3.1	The TOR is scheduled for review by CIAG and membership will be reviewed at this time. In addition, the stated action regarding missing meetings and follow-up will be similarly reviewed.	Jul-24	Not Met	Dec-24			Closed in Quarter	**200125: (LT) ADLT noted closure** **201224**: ToR updated and taken to CQGG meeting as AAA agenda item on 17.12.2024 where they were approved. JL to send copy of minutes to LT for evidence. **Recommended for closure.**
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 Met	Dec-24			Closed in Quarter	**230125: (LT) Copy of Case Tracker supplied by CW.** **200125: (LT) ADLT approved for closure pending receipt of evidence.** **171224**: (LT) Carl Window email replied to advise action was resolved recently and updated in the latest committee. Tracker developed and will be presented at Mar25 ARAC. **Proposed for Closure**
707	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Medium	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.	1.1	The Trust accepts this recommendation and will consider options to address volunteer development. This will be assessed during the forthcoming financial year.	Mar-25	Not Yet Due				Open	**281024**: OCP, after this will then develop volunteer structure - after which development opps will be considered. So at this point in time can't say what evidence will close this off, as need to work through. But the date will not be met.
708	23/24	PCC	Volunteers Governance	Reasonable	Jonathan Chippendale	Lee Brooks	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.	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-24	Not Yet Due	Mar-25			Open	**200125: (LT) ADLT approved 2st revised date (Mar25)** **201224**: Following appointment of CCIO who now holds responsibility for ePCR developments, this action should be transferred to the Digital Directorate with the Responsible Officer as CCIO (Keith Dorrington). A meeting needs to be held with Audit Management Team in the new year as this and may of the ePCR deliverables are now unfit for purpose given the resources that will consumed to complete these actions. Jonathan Chippendale, Keith Dorrington, Jen Lloyd and Lisa Trounce to meet to discuss how this can be amended with likely meeting required with Auditors for KD to be able to close actions. Date of meeting tbc Q4. Regarding this action, proposed indicators were discussed at CIAG feeding into APSG however upon consideration were not fit for purpose. JC has suggested better metrics might focus around chain of survival data with CMT advancement so will discuss this in meeting handing action over to Digital. **261124**: (LT) TMN email received supplying evidence from Ops: - AAA Report to confirm the action has started in relation to clinical outcomes for CFRs - Agenda to confirm the discussions took place - Screenshot within email to confirm the action is within the action log to progress. Extension until Jan25 requested. Email trail between Chip and Toni, meeting being held in November. Extend action to January 2025, can evidence following meeting. CIAG held 14.11.24, with an ask to form a group to specify the following Membership of the group Action log/tracker Notes from meeting
709	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Medium	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.	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-24	Not Yet Due	Mar-25			Open	**200125: (LT) ADLT approved 1st revised due date (Mar25). NB: Meeting between Head of Compliance & Assurance, Operations Business Managers, and Volunteer Steering Group scheduled to take place 1st week of Feb25 in advance of VSG Meeting on 12/02/25. Therefore due date extended to Mar25 (instead of Jan25 as requested by directorate).** **Jan24:** (LT) HoCA invited to attend VSG meeting on 12/02/25 to discuss and agree process to ensure relevant policies are shared with VSG members for comment. In advance of this meeting. Operations Business Managers and Volunteer Management Team have been asked to considered potential options suggested by HoCA. As meeting not scheduled to take place until February 2025, and process will take a couple of weeks, proposed extension until 31st March 2025, by which time the process will have been agreed, implemented and communicated to Policy Leads. **Dec24:** PROPOSING EXTENSION TO JAN 2025 Refreshing the VSG now; inaugeral mtg November 20th .....asked JW to contact JB/LT and add as agenda item. If one of them geos to the VSG in November that can be used as evidence. Then the AAA (from PG to ELT) is evidence of this and also AAA from VSG re the approach that will be taken. These can be used as evidence.

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711	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Medium	3.1	The Trust should consider addressing the highlighted enhancements to Operations Manuals outlined above. ** Each manual includes an outline of volunteer team structure but not an outline of where volunteer responsibility sits within the Trust. The inclusion of detail relating to executive and volunteer team responsibilities would enhance the robustness of the manuals.* ** 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.' As a signed agreement there is opportunity to strengthen the wording to include an expectation to comply with Trust policies.* ** 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. It could offer greater clarity to volunteers to include a copy of the skills matrix in place of the deployment codes.* **There are triggers for non-compliance with the mandatory elements of the role, but this is not included within either manual. Inclusion of this may assist in volunteer awareness of their responsibilities and processes in place.* **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. The Trust should introduce a timescale related to the Problem Solving Process.*	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.	Feb-25	Not Yet Due				Open	**281024**: Evidence to close this off is evidence of the review of the manual against the elements of the action. Date is reasonable (as at 281024).
712	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Medium	4.1	The Trust should ensure the distribution of received guidance in relation to fundraising to the full CFR population.	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	Mar-25	Not Yet Due				Open	**20.11.24** - Directorate confirmed that agreed completion date in report remains reasonable and achievable. TFG arranged for 21.11.24. Agenda to be created with the items listed for discussion. Actions to be recorded in action and copy sent to TMN. Draft risk already in development and will be reviewed in T&F Group
713	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	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.	4.2	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.	Mar-25	Not Yet Due				Open	**20.11.24** - Directorate confirmed that agreed completion date in report remains reasonable and achievable. TFG arranged for 21.11.24. Agenda to be created with the items listed for discussion. Actions to be recorded in action and copy sent to TMN. Draft risk already in development and will be reviewed in T&F Group
714	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Medium	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.	4.3	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.	Mar-25	Not Yet Due				Open	**20.11.24** - Directorate confirmed that agreed completion date in report remains reasonable and achievable. TFG arranged for 21.11.24. Agenda to be created with the items listed for discussion. Actions to be recorded in action and copy sent to TMN. Draft risk already in development and will be reviewed in T&F Group
715	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Medium	4.4	The Trust should prioritise the completion of a Volunteer fundraising risk, including clarifying the ownership of the risk within the Trust.	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.	Mar-25	Not Yet Due				Open	**20.11.24** - Directorate confirmed that agreed completion date in report remains reasonable and achievable. TFG arranged for 21.11.24. Agenda to be created with the items listed for discussion. Actions to be recorded in action and copy sent to TMN. Draft risk already in development and will be reviewed in T&F Group
717	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Medium	5.2	Trust management should ensure that gaps in compliance with safeguarding training are addressed for both CFR and VCS roles.	5.2	The Trust will ensure that gaps in safeguarding compliance are addressed for VCS and CFRs.	Sep-24	Not Met	Nov-24	**Feb-25**		Open	**200125: (LT) ADLT approved 2nd revised date (Feb25)** **Dec24**: Extension requested until Feb 25 **Nov24**: Volunteer Team are delivering drop in sessions for safeguarding training to record internally. Toni awaiting evidence of the training records and monitoring. **041024**: (AP) Revised date of November 2024 added in Q2 24/25, in line with update given. **270924** Recommending new deadline for November24. A three stage approach is being taken to address the gaps in Safeguarding compliance. Documentation and projected timelines of the 3 stage approach will be the evidence to support this action for recommended closure.
718	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Medium	6.1	The Trust should consider mechanisms to monitor the uptake of the mentoring arrangements outlined within the CFR Operational Manual.	6.1	The Trust will consider mechanisms to monitor the uptake of the mentoring arrangements.	Nov-24	Not Met	**Jan-25**			Open	**200125: (LT) ADLT approved 1st revised date (Jan25)** **Dec24**: Extension requested until Jan25
719	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Low	7.1	The Trust should introduce a process which includes responsibility for allocation of calls or timeframes for addressing these [CFR Welfare and Activity Returns].	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.	Oct-24	Not Met	**Feb-25**			Open	**200125: (LT) ADLT approved 1st revised date (Feb25)** **Dec24**: Extension requested until Feb25. Once OCP in place, the process will be artifculated. The process doc will be used as evidence to close it, but the date is not achieable. OCP will be in place late November. Suggest revised date of Feb 2025.
720	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	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.	7.2	This process will also include the documentation of any follow up action on the CFR individual record.	Mar-25	Not Yet Due				Open	**Dec24**: Directorate confirmed agreed completion date in report remains reasonable and achievable. The new volunteer management system which will go live after the OCP has gone live will allow the Trust to do this. The date for this is achievable. Evidence for this one can be screen shots of the new sysetm and samples of follow up.
721	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Low	7.3	The Trust should consider approaches to encourage the full completion of welfare returns to include a response of thriving, surviving, or struggling.	7.3	The Trust will consider approaches to encourage the full completion of welfare returns.	Oct-24	Not Met	**Feb-25**			Open	**200125: (LT) ADLT approved 1st revised date (Feb25)** **171224**: (TMN) Sent to LT a copy of standing agenda documenting the monthly review of completion of welfare returns, including a work programme to show the pre planned agenda item for future volunteer management meetings. Awaiting confirmationf this evidence is sufficient to close action. Extension requested until Feb25.
722	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Medium	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.	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.	Oct-24	Not Met	**Jan-25**			Open	**200125: (LT) ADLT approved 1st revised date (Jan25)** **Dec24**: Directorate requested extension until Jan25. Staff within the new OCP will be responsible for ensuring the recruitment dates are updated. Redact the screen shots so that there aren't personal detalis. *Sophie to link in with admin team to get understanding of the recruitment spreadsheet. Meeting following this to determine how to evidence. Need to establish if there is a mechanism where the team go through this spreadsheet, is it part of an agenda.*

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723	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	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.	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.	Oct-24	Not Met	Jan-25			Open	**200125: (LT) ADLT approved 1st revised date (Jan25)** **Dec24**: Directorate requested extension until Jan25. Staff within the new OCP will be responsible for ensuring the recruitment dates are updated. Redact the screen shots so that there aren't personal detalis. *Sophie to link in with admin team to get understanding of the recruitment spreadsheet. Meeting following this to determine how to evidence. Need to establish if there is a mechanism where the team go through this spreadsheet, is it part of an agenda.*
724	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Medium	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.	9.1	Following the introduction of Assemble, the Trust will undertake a records stock take and address any gaps identified.	Mar-25	Not Yet Due				Open	**Dec24**: Directorate confirmed the agreed due date within the report is reaonable and remains achievable. Assemble is the new volunteer management software. Date is achievable.
725	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	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.	9.2	The Trust will introduce a system to include the completion of vehicle check lists for VCS volunteers.	Mar-25	Not Yet Due				Open	**Dec24**: Directorate confirmed that the agreed due date within the report is reasonable and remains achievable. OCP is the mitigating action for this; once in place our own staff will be doing the checks. Date is achievable.
726	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Medium	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.	10.1	The Trust will agree a consistent selection criterion for validation of checks, to include risk assessment and coverage of outliers.	Oct-24	Not Met	Mar-25			Open	**200125: (LT) ADLT approved 1st revised date (Mar25)** **Dec24**: Directorate requested extension until March 2025. Mileage claims - this will be done but once OCP in place. Revised date of March 2025, which will allow sufficient time for the new process to be developed and evidenced. A paper that geos through SOT will close this off. Revised date of March 2025.
727	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	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.	10.2a	The Trust will satisfy itself that Central and West records are subject to appropriate checks and validation.	Jul-24	Not Met	Nov-24	Jan-25		Open	**200125: (LT) ADLT approved 2nd revised date (Jan25)** **041024**: (AP) Revised date of November 2024 added in Q2 24/25, in line with update given. **270924** Recommending new deadline of Nov24 - spreadsheets are now in place to ensure appropriate checks and validation. Further evidence of this will be discussed in upcoming meetings for the moniroing of these checks. Agenda and summary notes will be provided before recommending closure of action.
728	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Medium	10.2b	There should also be periodic checks to ensure documents are saved in a shared accessible location.	10.2b	The Trust will ensure that periodic checks are undertaken to ensure documents are saved in a shared accessible location.	Oct-24	Not Met	Jan-25			Open	**200125: (LT) ADLT approved 1st revised date (Jan25)** **Dec24:** Directorate requested extension until Jan25. Jenny/Soph to confirm: Is there a shared channel? Who has access? Teams channel with spreadsheet and schedule of when these are reviewed. Are they scheduled a week prior to review? Is this discussed in any local meetings? Where is this reported? Escalation? Who to and how?
732	23/24	PCC	Disciplinary Case Management	Reasonable	Karen Jones	Angela Lewis	Medium	2.2a	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.	2.2a	Contact will be made with HEIW as the training provider to confirm evaluation process.	Sep-24	Not Met	Dec-24	Jan-25		Open	**200125: (LT) ADLT approved 2nd revised date (Jan25)** **221024** - **Propose for closure** - The evaluation is underway with HEIW, therefore believe the action has been met. **211024**: (AP) Revised date of December 2024 applied in Q2 24/25 as position is not clear. **20.09.24** - KJ - The evaluation is a planned process being undertaken by AB Health Board, this evaluation is underway and expected to be completed this Autumn. **16.08.24** - KJ - There was a planning meeting on 31.07.24 to discuss the format of the evaluation that is planned for Autumn 2024. This is evidenced in the Compassionate Practices Action Plan and via a planning group that has already been formed. However evluation is ongoing, and action to remain open until it is concluded.
736	23/24	PCC	Disciplinary Case Management	Reasonable	Karen Jones	Angela Lewis	Medium	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.	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.	Aug-24	Not Met	Dec-24	Jan-25		Open	**200125: (LT) ADLT approved 2nd revised date (Jan25) to allow time for submission of evidence required to support closure** **221024** - **Propose for closure** - This action forms part of our roles as the Senior Team within People Services and is therefore very much business as usual. The People Leader job description is sent as evidence that shows it is part of the role and the document that is discussed in these meetings mentioned below is the ER Case Tracker.
737	23/24	PCC	Disciplinary Case Management	Reasonable	Karen Jones	Angela Lewis	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.	4.2	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.	Aug-24	Not Met	Dec-24			Closed in Quarter	**200125: (LT) ADLT approved closure** **221024** - **Propose for closure** - The tracker now has the relevant information added, this is on Slide 5 of the evidence (Employee Relations - Disciplinary Cases). This is monitored on a monthly basis and updates will be provided to PCC (added to the existing standing item CUltural Themes and Trends). **211024**: (AP) Revised date of December 2024 applied in Q2 24/25 as position is not clear regarding the evidence. Clarifications on the evidence provided not resolved in the reporting period. October Update from P&C: Propose for closure - The relevant KPIs have been added to the tracker, which has been sent across as evidence. The relevant members of the team will continue to monitor on a monthly basis and updates are being provided to the People & Culture Committee via the Cultural Themes and Trends standing item, with the document from August PCC sent over.
742	23/24	PCC	Disciplinary Case Management	Reasonable	Karen Jones	Angela Lewis	Medium	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.	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.	Aug-24	Not Met	Dec-24			Closed in Quarter	**200125: (LT) ADLT Approved closure** **22.10.2024** - **Propose for closure** - Guidelines and reminders are sent to the team, including appropriate documents. This is built in to internal audit checks and two have been completed to date so far (23rd August and 21st October). The reports are sent as evidence / information. **211024**: (AP) Revised date of December 2024 applied in Q2 24/25 as evidence clarifications required. **071024**: (AP) Not accepted closure proposal; requested evidence of checks. **October Update from P&C**: Propose for closure - A reminder has been sent to the team via email and includes appropriate guidelines and docuemnts. This can be provided as evidence, and this process will continue as business as usual moving forward.
744	23/24	ARAC	Risk Management	Reasonable	Julie Boalch	Trish Mills	Medium	2.1	Risk assessment forms should be completed for all risks.	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.	Aug-24	Not Met	Dec-24			Closed in Quarter	**200125: (LT) ADLT approved closure** **181224:** SIREN notice issued 03/11/24 to direct colleagues to risk templates and support when developing or updating risks - **ACTION COMPLETE** **081024**: (AP) Complete when Siren notice is issued 011124 to remind colleagues where to access templates, information and support. This will be completed in November 2024 and as such a revised date has been applied in Q2 24/25 to December 2024.

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745	23/24	ARAC	Risk Management	Reasonable	Julie Boalch	Trish Mills	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.	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).	Mar-25	Not Yet Due				Open	**181224:** LMS365 basic risk training developed and due to be uploaded in January 25. Risk Manager will undertake more detailed training once in post. Additionally, individual directorate support is in place. Training delivered to a new cohort of DOMs in November 2024.
746	23/24	ARAC	Risk Management	Reasonable	Julie Boalch	Trish Mills	Medium	3.1	All risks should be uploaded and managed on Datix.	3.1	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. 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. 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.	Jan-25	Not Yet Due				Closed in Quarter	**200125: (LT) ADLT approved closure** **181224:** Progress on procurement of a new Risk Management system is underway in consultation with the Director of Digital. The evidence shows that the Clinical and Operations directorates are managing and considering their risks in 4.1 - **ACTION COMPLETE. Proposed for closure**
747	23/24	ARAC	Risk Management	Reasonable	Julie Boalch	Trish Mills	Medium	4.1	We recommend the Trust consider arrangements to support the consistency and monitor the completeness of directorate registers.	4.1	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. 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.	Oct-24	Not Met	Dec-24			Closed in Quarter	**200125: (LT) ADLT approved closure** **181224:** The Corporate Governance team have reviewed the Agendas, AAAs and dashboards provided by the Clinical and Operations directorates which evidence that risks are being prioritising for discussion at Directorate Business meetings and the flow through governance. In addition we have provided instructions to both directorates as to how to produce reports from Datix for their directorate risks - **ACTION COMPLETE. Proposed for Closure** **081024**: Work ongoing. Date extended to Dec24
748	23/24	ARAC	Risk Management	Reasonable	Julie Boalch	Trish Mills	Medium	5.1a	A summary risk report, similar to the format presented at Trust Board and Committees, should be developed and reported at directorate and service level.		1.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.	Oct-24	Not Met	Dec-24			Closed in Quarter	**200125: (LT) ADLT approved closure** **181224:** Operations Directorate are producing reports for discussion at Business Meetings evidenced in attached file. Instructions on how to draw reports from Datix have been issued to support this - **ACTION COMPLETE. Proposed for closure.** * Instructions on how to extract Risk Register Dashboards from Datix: pdf/ excel * How to find the relevant risk register in order to review it * How to add an action plan to the risk * Emails with previous reports (Datix) sent to Operations for SOT meetings
749	23/24	ARAC	Risk Management	Reasonable	Toni-Marie Norman	Trish Mills	Medium	5.1b	A summary risk report, similar to the format presented at Trust Board and Committees, should be developed and reported at directorate and service level.		2.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	Oct-24	Not Met	Dec-24			Closed in Quarter	**200125: (LT) ADLT approved closure** **171224:** TN provided a copy of the slide deck dashboard that is now reported monthly to SOT on risk compliance, total number of risks, how many risks at each level - **ACTION COMPLETE. Proposed for Closure.**

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	Rec. No.in Audit	Recommendation	Response No.in Audit	Management Response	Agreed Deadline in Report	Status - met or not met agreed deadline in report	1st revised date	2nd revised date	3rd revised date	Closure Status	Where a management action has not met the agreed or revised date, Director must 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
1-24/25	2024/25	FPC	Data Quality	Reasonable	Leanne Smith	Jonny Sammut	Medium	1.1	Management should ensure that policies and guidance which underpin the Trust's commitment to improving data quality are reviewed and / or developed and aligned with new legal requirements and current best practice.	1.1	The Trust's Data Quality policy was reviewed, approved and published earlier in 2024. The Records Management Policy is currently under review and due for submission for approval in November 2024, in order to support the IG Toolkit Improvement Action Plan. The Information Risk Policy is scheduled for Policy Group in December 2024. The Confidentiality and Code of Conduct policy is scheduled for Policy Group in February 2025. The Information Governance Policy is still tba.	Nov-24	Met				Closed in Quarter	**200125: (LT) ADLT approved closure** **181224: (LS)** as per the recent ADLT Policy Prioritisation exercise, Digital agreed that the relevant policies prioritised for review in the remainder 2024 and into 2025 would be: 1) Information Risk Policy (in progress, expected at Jan-25 Policy Group); 2) Information Sharing Policy (due to increasing pressures around sharing WAST data externally, work expected to commence in Q4 24-25); 3) Information Governance Policy (expected to follow shortly afterward). Email trail with Digital's priority list of policies supplied as evidence for **PROPOSE FOR CLOSURE.**
2-24/25	2024/25	FPC	Data Quality	Reasonable	Leanne Smith	Jonny Sammut	Medium	1.2	Management should ensure that current written protocols for delivering the Trust's functions and responsibilities are proactively published on the Trust's website or otherwise made available as a matter of routine.	1.2	As it is not current practice to publish any Trust policies on the public website, this recommendation is not one that can be actioned without a significant and disproportionate change to procedure in WAST. Policies are available on Siren (intranet) for all staff, and for the public / non-WAST employees a copy of any policy can be requested. There is a plan, led by the Corporate Governance Directorate, to begin reviewing the approach to policy publication in 2025/26. As such, no action will be taken specifically for data-related policies until completion of this wider review.	n/a	Met				Closed in Quarter	Status of **closure proposed** upon addition to Tracker due to the management response and indication that no action will be taken.
3-24/25	2024/25	FPC	Data Quality	Reasonable	Head of Information	Jonny Sammut	Medium	2.1	Management should consider assessing the digital literacy of all staff and developing data quality awareness training to complement the newly updated Data Quality Policy.	2.1	A full programme for assessing & improving Digital Literacy is planned for Tranche 2 (i.e. 2025-26) under the refreshed Digital Plan. In the meantime, a Data Quality awareness training module will be made available across the Trust via an existing platform (i.e. ESR, LMS365 or MetaCompliance – tbc) to minimise any additional cost.	Dec-24	Not Met	Apr-25			Open	**200125: (LT) ADLT approved 1st revised due date (Apr25)** **181224: (LS)** All content available to WAST via the MetaCompliance e-learning site was explored, but no suitable Data Quality awareness training modules were found. As such, WAST would need to develop or procure a new module. Preference would be to develop something for LMS365 (rather than introduce another system) and so **PROPOSE DATE REVISED to April-25.** **EVIDENCE REQUIRED TO SUPPORT CLOSURE**
4-24/25	2024/25	FPC	Data Quality	Reasonable	Leanne Smith	Jonny Sammut	High	3.1	Management should ensure that the Information Asset Register accurately reflects the Trust's information landscape to ensure that a singular, consistent catalogue of information assets is in place to monitor compliance and efficiency.	3.1	IGSG has already agreed to establish an Information Asset Owners Group. This sub-group will be responsible for the further development and ongoing maintenance of the Trust's Information Asset Register. Until the two vacant Data Protection Compliance Manager posts are filled (expected November 2024) there is not capacity within the IG function to help establish and run such a group.	Apr-25	Not Yet Due				Open	**EVIDENCE REQUIRED TO SUPPORT CLOSURE:** Information Asset Owners Group established as a sub-group of IGSG, and updated Information Asset Register presented back to and approved by IGSG evidenced through AAA.
5-24/25	2024/25	FPC	Data Quality	Reasonable	Head of Information	Jonny Sammut	Low	4.1	Management should consider utilising an automated data quality tool to develop automated audit processes to reduce the need for manual intervention and improving overall data accuracy and consistency.	4.1	Implementation of a new tool is a significant digital project, however, some functionality may be available in existing platforms which would offer a minimum viable product. Action is to conduct a gap analysis on automated data quality functionality within the Trust and make a recommendation to IGSG for a way forward.	Jan-25	Not Yet Due				Open	**EVIDENCE REQUIRED TO SUPPORT CLOSURE:** Gap analysis conducted, and findings reported to IGSG with recommendation – evidenced through AAA.
6-24/25	2024/25	FPC	Data Quality	Reasonable	Leanne Smith	Jonny Sammut	High	5.1	Management should ensure that reporting arrangements for Data Quality are reviewed and formalised with a clear route to ELT and the Board.	5.1	Standard Digital reporting on plans, systems and compliance, has a passage through to Finance & Performance Committee bi-monthly. In addition to this, DQ is an element of the IG reporting which goes to IGSG by exception and for broader discussion on a monthly basis. These reporting routes are articulated in both the TORs of FPC and IGSG.	Oct-24	Not Met				Closed in Quarter	**200125: (LT) ADLT approved closure** **181224: (LS)** governance and passage of reporting on data quality was discussed at the November 2024 meeting of IGSG and the group agreed overarching data quality should be handled by IGSG, reporting to Finance & Performance Committee, with specific metrics managed by the Quality & Performance Management Group. Evidence supplied in the form of the IGSG agenda and resultant AAA. **PROPOSE FOR CLOSURE.**
7-24/25	2024/25	FPC	Data Quality	Reasonable	Head of Information	Jonny Sammut	Medium	5.2	Management should ensure that the progress to address 111 CAS data quality issues and arrangements for ongoing scrutiny are appropriately reported.	5.2	An update on the 111 CAS reporting and data quality efforts will be offered in future IG Highlight reports which pass to IGSG.	Nov-24	Met				Closed in Quarter	**200125: (LT) ADLT approved closure** **181224: (LS)** An update regarding the ongoing 111 CAS reporting and data quality resolution was presented to the November meeting of IGSG via the IG Highlight Report. Updates on this project will continue monthly via this mechanism, until resolved. **PROPOSE FOR CLOSURE.** Evidence supplied via the IGSG agenda and highlight report.
8-24/25	2024/25	FPC	Data Quality	Reasonable	Leanne Smith	Jonny Sammut	Medium	5.3	Management should ensure that assurance in relation to data quality exception handling and the Incidents with Cause for Concern is appropriately reported.	5.3	Following recent investment in the Digital Directorate, two new Data Quality JDs have been submitted for evaluation to support recruitment of additional expertise into this function. Once in post, as per the TOR, DQ representation will resume in IGSG, and we expect any large-scale / system level data quality issues such as this to be brought to the group for awareness and support in a timely manner.	Mar-25	Not Yet Due				Open	**EVIDENCE REQUIRED TO SUPPORT CLOSURE:** Confirmation via the AAA that Data Quality has had representation and discussion at IGSG consistently (i.e. across Nov-Feb meetings).
9-24/25	2024/25	FPC	Data Quality	Reasonable	Leanne Smith	Jonny Sammut	Medium	5.4	Management should ensure reportable data quality KPIs are developed and are appropriately reported.	5.4	A monthly KPI report passes through IGSG, already with a placeholder for Data Quality metrics. The development of these metrics is dependent upon recruitment into the proposed new DQ posts.	Apr-25	Not Yet Due				Open	**EVIDENCE REQUIRED TO SUPPORT CLOSURE:** Evidence of Data Quality metrics presented in the monthly Information Governance KPI report, and evidence of discussion / noting of these metrics via the IGSG AAA.

10-24/25	2024/25	FPC	Data Quality	Reasonable	Head of Information	Jonny Sammut	Low	5.5	Management should consider developing a standard reporting template for data quality matters.	5.5	Following recent investment in the Digital Directorate, two new Data Quality posts are planned to be created. Capacity to build standard DQ reporting is dependent on having more than the current 0.4 FTE, and so this action is to demonstrate movement towards a more resilient Data Quality team with the development of a template form to ensure a standardised method of recording, escalating and resolving Data Quality issues as they are discovered.	Dec-24	Not Met	May-25			Open	**200125: (LT) ADLT approved 1st revised due date (May25)** **181224:** A template form is yet to be developed. The team currently consists of 0.4 FTE, and other members of the Insights & Data Services function, who support the Data Quality team have recently focused efforts on recruitment instead. In December 2024, we shortlisted over 300 applicants for 2 new Data Quality positions, interviews are currently in progress, and candidates hopefully in place by Mar-25. **PROPOSE REVISED DATE to May-25** to allow team to be recruited to deliver on this action.
11-24/25	2024/25	FPC	Overtime Controls	Reasonable	Liz Wedley	Lee Brooks	Medium	1.1	The reporting of amendments to overtime allocations should be strengthened and supported by a documented audit trail of the rationale applied.	1.1	SOT will consider and agree a formal mechanism to capture any changes to allocations in month. This will be recorded at SLT and documented through the AAA reporting process to SLT.	Dec-24	Met				Closed in Quarter	**200125: (LT) ADLT approved closure.** **181224**: (TMN) Link of evidence sent to LT to confirm if sufficient to close action. SOT is the formal mechanism for the financial savings plan quarterly SBARs which consist of overtime control information and the evidence includes SBARs and copies of the SOT highlight reports which are then reported to SLT. **Proposed for Closure (pending review of evidence)**
12-24/25	2024/25	FPC	Overtime Controls	Reasonable	Liz Wedley	Lee Brooks	Medium	1.2	Recognising the individual variances, against allocations reported at health board areas, consideration should be given to their re-mapping to a more reasonable expectation.	1.2	SOT will review and reassess the overtime allocation at Health Board levels, recognising the variable nature of all that may affect allocations.	Mar-25	Not Yet Due				Open	
13-24/26	2024/25	FPC	Overtime Controls	Reasonable	Liz Wedley	Lee Brooks	Medium	2.1	Consideration should be given to whether it would be possible to automate parts of the process, to reduce the amount of manual input by managers.	2.1	The Trust accepts this recommendation. Electronic timesheet development and implementation is a feature of the current IMTP. Scope work has begun in this financial year, however progress on implementation is expected to be in 2025/26 provided it is included in the forthcoming IMTP.	Mar-26	Not Yet Due				Open	
14-24/26	2024/25	PCC	Resourcing Policy	Limited	Siobhain Frain	Lee Brooks	High	1.1	The mapping exercise should be completed to ensure that all local arrangements or differences in application of the Policy are appropriately recorded.	1.1	Resourcing Policy allows for local arrangements, which results in variation of process across the Trust which currently is not quantified. Resourcing will complete the process mapping and documentation of all local arrangements and differences in the application of the Policy across operational HBs by function. This will be submitted via the Resourcing monthly management team meetings.	Nov-24	Not Met	Jun-25			Open	**220125: (LT) Operations Directorate requested extension until Jun25** **200125: (LT) ADLT provisionally approved 1st revised due date (to be advised by Operations Directorate)** **271224: (LT) - Due date extended until Mar25** **191224: (**SF) confirmed that this has been paused untill February 2025 due to management absence and winter pressures.
15-24/25	2024/25	PCC	Resourcing Policy	Limited	Siobhain Frain	Lee Brooks	High	1.2	The functional SOPs for each area should be completed, approved and communicated to all staff.	1.2	Resourcing will construct departmental Standard Operating Procedures to support consistent application relevant to individual functions. SOT will review and agree each of the SOPS will be published and communicated to staff and resourcing teams.	Mar-25	Not Yet Due	Sep-25			Open	**220125: (LT) Operations Directorate requested extension until Sep25** **200125: (LT) ADLT provisionally approved 1st revised due date (to be advised by Operations Directorate)**
16-24/25	2024/25	PCC	Resourcing Policy	Limited	Jonathan Edwards	Lee Brooks	High	1.3	The Resourcing Policy should be reviewed and revised (or re-drafted), approved at an appropriate forum and communicated to all staff.	1.3	The Trust accepts this recommendation, and the Resourcing Policy will be reviewed and revised. A Resourcing Policy Group, in partnership with Trade Unions, will convene to review the existing policy. Governance arrangements including SOT, SLT and ELT will ensure changes are agreed and recorded.	Oct-25	Not Yet Due				Open	
17-24/25	2024/25	PCC	Resourcing Policy	Limited	Siobhain Frain	Lee Brooks	High	2.1	Resource Managers should undertake regular review of the WT breach analysis reports, within GRS and ShiftTrack, to identify whether it is a "true" breach and these should be reported.	2.1	The requirement for review the Working Time (WT) breach analysis reports has been included as part of the Quality Control and Audit Management processes. Resource Managers will undertake a monthly review of the Working Time (WT) breach analysis reports, to identify whether it is a "true" breach and if these should be reported. Any true breaches are passed through to Heads of Service for action.	Nov-24	Not Met	Mar-25			Open	**200125: (LT) ADLT approved 1st revised due date (Mar25)** **271224:** (LT) Due date extended until Mar25 to allow time for report to be presented to SOT in Jan25 and SLT Feb25 **191224** Resource managers should undertake regular review of WTR breeches - due to the manager absence a plan has been put in place to review Q3 data (Oct-Dec) in January nationally. Report due to go to SOT end of January 2025.
18-24/25	2024/25	PCC	Resourcing Policy	Limited	Siobhain Frain	Lee Brooks	High	2.2	Resource Managers should consider whether there is a training need for Resource Co-ordinators or for wherever the WT breach originated e.g. if it was as a result of local arrangements or shift changes.	2.2	Resource managers, following the monthly audit of the WT breach analysis report, will identify any individual or system trends and issues and any remedial actions addressed through line management structures.	Nov-24	Not Met	Mar-25			Open	**200125: (LT) ADLT approved 1st revised due date (Mar25).** **271224: (LT) -** Directorate requested due date be extended until Feb25 to allow time for actions to be approved by SOT in Jan25 **191224**: ORA dropdown list and process of ops team updating
19-24/25	2024/25	PCC	Resourcing Policy	Limited	Jonathan Edwards	Lee Brooks	Medium	3.1	The process for TOIL should be reviewed, revised, agreed and communicated to provide clarity for both the Resource co-ordinators and staff.	3.1	The process for agreeing TOIL will be reviewed, revised, agreed and communicated as part of the Resourcing Policy review **(see Management Action response 1.3)**. This will provide clarity for both the Resource Co-ordinators and staff.	Oct-25	Not Yet Due				Open	
20-24/25	2024/25	PCC	Resourcing Policy	Limited	Siobhain Frain	Lee Brooks	Medium	4.1	The Trust should consider revising the GRS structure to include ORA as an abstraction report group with a dropdown list detailing the reason for the ORA.	4.1	The Trust will revise the GRS structure to include ORA Absence Group and SOT will agree associated ORA Absence types for implementation to the rostering system. This will be agreed through SOT.	Dec-24	Not Met	Mar-25			Open	**200125: (LT) ADLT approved 1st revised due date (Mar25) based on action being complete, paper going to SOT in Feb25 and to allow time for any subsequent changes that may be required post discussion.** **271224**: (LT) Propose due date be extended until Feb25 as workstream has been paused during winter pressures.
21-24/25	2024/25	PCC	Resourcing Policy	Limited	Siobhain Frain	Lee Brooks	Medium	4.2	The reasons for ORAs, if captured, should be reported and monitored.	4.2	Once ORA Absence Types are agreed by SOT and implemented into the rostering systems, a self-service reporting guide will be provided to operational teams to permit local monitoring. Formal quarterly reporting by Resourcing dept will be provided to SOT to monitor.	Jan-25	Not Yet Due	Mar-25			Open	**200125: (LT) ADLT approved 1st revised due date (Mar25) based on action being complete, paper going to SOT in Feb25 and to allow time for any subsequent changes that may be required post discussion.** **271224**: (LT) Propose due date be extended until Feb25 as workstream has been paused during winter pressures.

22-24/25	2024/25	PCC	Resourcing Policy	Limited	Siobhain Frain	Lee Brooks	Medium	5.1	The Trust should ensure that performance against all expected timeframes within the Resourcing Policy are reported and monitored.	5.1	The Trust accepts this recommendation. The KPIs listed within the report are based on the existing resourcing policy. A reporting framework will be developed as part of the Resourcing Policy Review (**see Management Action response 1.3**). There are however two areas that have been completed or superseded as per below: Action 5.1c - visibility of vacant shift. This functionality exists and is evident within the GRS system options. **This is complete.** Action 5.1 d & e. Availability and acceptance of overtime - These KPIs are no longer applicable due to the implementation of the overtime allocation SOP and Financial Savings Plan.	Oct-25	Not Yet Due				Open	
23-24/25	2024/25	FPC	Integrated Quality & Performance Management Framework	Reasonable	Hugh Bennett	Liam Williams / Rachel Marsh	High	1.1	The Quality & Performance Management Framework's work programme should be reviewed and incorporate SMART criteria to define success and provide realistic timescales for delivery. Similarly, any work programmes that are designed to support the pathfinder, e.g. Resource Service, should provide realistic timescales for delivery.	1.1	a) The current work programme has recently been reviewed, including amendments based on IA feedback during the audit. It continues to be reported into Q&PMF Steering Group each month. Timescales are considered realistic, but subject to on-going performance management.	Nov-24	Met				Closed in Quarter	**270125: (LT) HB advised action now completed. Evidence supplied: copy of Work Plan QPMF 2024-2025** **200125:** (LT) ADLT approved 1st revised date (Jan25) if required to allow time for progress to be reported / evidence to be supplied.
24-24/25	2024/25	FPC	Integrated Quality & Performance Management Framework	Reasonable	Hugh Bennett	Liam Williams / Rachel Marsh	High	1.1	The Quality & Performance Management Framework's work programme should be reviewed and incorporate SMART criteria to define success and provide realistic timescales for delivery. Similarly, any work programmes that are designed to support the pathfinder, e.g. Resource Service, should provide realistic timescales for delivery.	1.1	b) An annual review will also be undertaken, with time-out in December programmed to start to build programme for 2025/26.	Mar-25	Not Yet Due				Open	
25-24/25	2024/25	FPC	Integrated Quality & Performance Management Framework	Reasonable	Hugh Bennett	Liam Williams / Rachel Marsh	High	1.2	Regular performance reporting should provide effective oversight of progress with the delivery of the QPMF's work programme that clearly defines risks and enables prompt action to be taken where issues are escalated.	1.2	ELT to be supplied with AAA after every Q&PMF Steering Group, with the AAA including progress on the work programme.	Mar-25	Not Yet Due				Open	
26-24/25	2024/25	FPC	Integrated Quality & Performance Management Framework	Reasonable	Hugh Bennett	Liam Williams / Rachel Marsh	High	1.3	The development of the process for local frameworks should be concluded and incorporate the areas of the Trust that will require a framework to be implemented; and take account of the design and content of the frameworks through providing guidance and templates.	1.3	The Trust is not planning to develop local frameworks for every area of the Trust. The approach is proportionate. Every area is required to complete a selfassessment, governance map, cycle of quality & performance business and work programme. Timetable to be developed to ensure completion across Trust.	Dec-24	Met				Closed in Quarter	**270125: (LT) HB advised action now completed. Evidence: Timetable for completing self-assessments.** **200125:** (LT) ADLT approved 1st revised date (Jan25) if required to allow time for progress to be reported / evidence to be supplied.
27-24/25	2024/25	FPC	Integrated Quality & Performance Management Framework	Reasonable	Hugh Bennett	Liam Williams / Rachel Marsh	Medium	2.1	The Communication Plan's action plan should be revised to include additional actions pertaining to the later phases. SMART criteria should be incorpiorated to clarify the current status of actions and provide realistic timescales for delivery.	2.1	Communications Plan to be updated accordingly.	Dec-24	Met				Closed in Quarter	**270125: (LT) HB advised action completed. Evidence: QPMF Comms Plan (04) hbmoc 20241023 example** **200125: (LT)** ADLT approved 1st revised date (Jan25) if required to allow time for progress to be reported / evidence to be supplied.
28-24/25	2024/25	FPC	Integrated Quality & Performance Management Framework	Reasonable	Hugh Bennett	Liam Williams / Rachel Marsh	Medium	2.2	Following the amendments, the plan should be shared at an appropriate forum and appropriate staff engagement should be carried out to ensure that arrangements continue to be embedded.	2.2	Q&PMF Steering Group will approve the communications plan.	Dec-24	Not Yet Due	Jan-25			Open	**200125: (LT) ADLT approved 1st revised date (Jan25) to allow time for progress to be reported / evidence to be supplied.**
29-24/25	2024/25	FPC	Integrated Quality & Performance Management Framework	Reasonable	Hugh Bennett	Liam Williams / Rachel Marsh	Medium	3.1	There should be regular reporting to both the Executive Leadership Team and at committee level to ensure there is effective oversight of the Quality & Performance Management Framework.	3.1	Production of AAA after each Q&PMF Steering Group and onward supply to ELT. It has been agreed by ARAC that one further update will be provided this financial year and thereafter 6 monthly reports to FPC.	Nov-24	Not Met				Closed in Quarter	**270125: (LT) HB advised action complete and confirmed reporting will continue for a further 5mths as indicated. Evidence supplied: Copy of AAA Highlight Report - QPMF Steering Group hb 20250127** **200125: (LT)** ADLT approved 1st revised date (Jan25) if required to allow time for progress to be reported / evidence to be supplied.
30-24/25	2024/25	FPC	Integrated Quality & Performance Management Framework	Reasonable	Hugh Bennett	Liam Williams / Rachel Marsh	Medium	3.2	Attendance and key decisions arising from the QPMF Steering Group meetings should be appropriately recorded.	3.2	The AAA does record attendance, but production of the AAA to date has been intermittent. See 3.1 above.	Mar-25	Not Yet Due				Open	
31-24/25	2024/25	FPC	Integrated Quality & Performance Management Framework	Reasonable	Rachel Marsh	Liam Williams / Rachel Marsh	Medium	3.3	Both the Framework and the Steering Group's terms of reference should be updated to clarify arrangements or reflect any amendments.	3.3	The ToR has been through several iterations and updates and is considered up to date, however, there is a F2F Q&PMF workshop planned for Dec-24, which will provide a further opportunity for review. Going forward the review will be at least annually.	Mar-25	Not Yet Due				Open	
32-24/25	2024/25	PCC	Exposure to Fumes	Reasonable	Nicola White	Liam Williams	Medium	1.1	The Trust should formally communicate to staff that the manner by which the diesel heaters can be re-started should the shoreline trip.	1.1	The Trust has undertaken previous communications to inform staff of this issue. Further action will be taken to seek systematic improvement and will ensure that clear guidance on restarting diesel heaters after shoreline trips is communicated cross all relevant staff to promote operational safety and efficiency. A review of former safety notices will be undertaken, and a further formal safety notrice will be issued to relevant staff groups.	Dec-24	Not Met	Jan-25			Open	**200125: (LT) ADLT approved 1st revised due date (Jan25) to allow time for progress to be reported / evidence to be supplied.**
33-24/25	2024/25	PCC	Exposure to Fumes	Reasonable	Jo Kelso	Liam Williams	Medium	1.1	The Trust should formally communicate to staff that the manner by which the diesel heaters can be re-started should the shoreline trip.	1.1	Training has been reviewed: information on shoreline use is now included in induction training and Trust driving courses for new entrants and staff moving into EMS from Ambulance Care too.	**Already Complete**	Met	Jan-25			Open	**200125: (LT) Action reported as already completed. ADLT approved 1st revised due date (Jan25) to allow time for evidence to be supplied.**

34-24/25	2024/25	PCC	Exposure to Fumes	Reasonable	Jo Kelso	Liam Williams	Medium	1.1	The Trust should formally communicate to staff that the manner by which the diesel heaters can be re-started should the shoreline trip.	1.1	Information will be provided in the 5-yearly High Speed Driving Assessment from FY 2025/26.	**Already Complete**	Met	Jan-25			Open	**200125: (LT) Action reported as already completed. ADLT approved 1st revised due date (Jan25) to allow time for evidence to be supplied.**
35-24/25	2024/25	PCC	Exposure to Fumes	Reasonable	Nicola White	Liam Williams	Medium	1.1	The Trust should formally communicate to staff that the manner by which the diesel heaters can be re-started should the shoreline trip.	1.1	Information will also be produced through the Workforce Education & Development Learn365 platform on the use of shorelines to ensure the topic is incorporated in training and education sessions.	Mar-25	Not Yet Due				Open	
36-24/25	2024/25	PCC	Exposure to Fumes	Reasonable	Nicola White	Liam Williams	Medium	2.1	The Trust should have a risk assessment work programme in place to ensure that all EDs are risk assessed on a regular basis.	2.1	The Trust is committed to reviewing sites as per the frequency deemed appropriate following risk assessment undertaken by a Health & Safety professional. Following introduction of additional control measures for Winter 2024, the Trust will develop a work programme for risk assessment review for all EDs ensuring assessments are conducted annually.	Jan-25	Not Yet Due				Open	
37-24/25	2024/25	PCC	Exposure to Fumes	Reasonable	Nicola White	Liam Williams	Medium	2.2	For transparency, and good practice, the Trust should invite Trade Union Partners to attend when undertaking the onsite ED Risk Assessments.	2.2	Scheduled dates for the assessments (as per 2.1) will be made available for Trade Union Partners to attend ED risk assessments ensuring transparent and collaborative practices	Jan-25	Not Yet Due				Open	
38-24/25	2024/25	PCC	Exposure to Fumes	Reasonable	Nicola White	Liam Williams	Medium	3.1	The Trust need to reiterate to staff the importance to following guidance to ensure their safety and lower their exposure to diesel fumes.	3.1	Mandatory safety notice to be distributed to all operational staff on the updated controls for fume mitigation and the importance of implementing them during delays at EDs, along with evidence that it has been read and understood.	Jan-25	Not Yet Due				Open	
39-24/25	2024/25	PCC	Exposure to Fumes	Reasonable	Sonia Thompson	Liam Williams	Medium	3.1	The Trust need to reiterate to staff the importance to following guidance to ensure their safety and lower their exposure to diesel fumes.	3.1	Mandatory safety notice to be distributed to all operational staff on the updated controls for fume mitigation and the importance of implementing them during delays at EDs, along with evidence that it has been read and understood. The action will be presented at SOT (Senior Operations Team) and a feedback mechanism will be discussed and created to monitor the situation.	Jan-25	Not Yet Due				Open	
40-24/25	2024/25	PCC	Exposure to Fumes	Reasonable	Aled Williams	Liam Williams	Medium	4.1	The development of the data vault should be completed to ensure the relevant data is recorded from the earliest possible stage.	4.1	The Trust has completed the data vault to capture accurate and comprehensive data on potential incidents where fume exposure could have occurred, ensuring transparency and informed decision making. Now the digital architecture is complete, further development is required to capture broader data sources (e.g. risk assessments). The Trust will finalise the development of the data vault system to centralise and track staff exposure data effectively.	Mar-25	Not Yet Due				Open	
41-24/25	2024/25	PCC	Exposure to Fumes	Reasonable	Nicola White	Liam Williams	Medium	4.2	To ensure completeness of such, the Trust should ensure that the systems currently used are designed to routinely capture the information required.	4.2	Where possible, any relevant data source will be automated for transfer into the Data Vault.	Mar-25	Not Yet Due				Open	
42-24/25	2024/25	PCC	Exposure to Fumes	Reasonable	Nicola White	Liam Williams	Medium	5.1	The designated deadline to issue Health & Safety Committee papers, prior to the meeting date, should be adhered to. This will allow the Trade Unions to have sufficient time to review and discuss key matters within the papers and avoid meetings being cancelled.	5.1	The Trust has reviewed the Committee terms of reference and undertaken an organisational development workshop with Committee members. Going forward, there will be enforced adherence to deadlines for issuing Health & Safety Committee papers to ensure timely review by Trade Union members preventing meeting cancellations.	Jan-25	Not Yet Due				Open	

Points of Contact, Directors and Owners of Audit Actions - Do Not Amend Any Column With a Red Header
When proposing a revised 1st, 2nd or 3rd date, include the rationale for the movement and any progress on the action to date

Trust Ref No.	Audit Wales or HIW Report	Year	Committee Assigned to	Report Title	Responsible Officer	Director	Priority Level	Rec. No in Audit	Recommendation	Response no. in Audit	Management Response	Agreed Deadline in Report	Status	1st revised date	2nd revised date	3rd revised date	Status	Where a management action has not met the agreed or revised date, Director must inlcude here: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. **Please add most recent update first**
106	Audit Wales	22/23	QUEST	Review of Quality Governance Arrangments	Jonathan Turnbull-Ross/ Wendy Herbert /Hugh Bennett	Liam Williams			R8 We found that the QuEST Committee is well served with quality information, but there are opportunities for improvement. The Trust should: develop a system to triangulate learning themes (d) work with health bodies so that there are systems to determine the outcomes for patients who have received emergency ambulance services. This should particularly seek to understand the consequence and harm resulting from service failures such as long ambulance waits.		d) The Trust will continue to share information and intelligence with partners that detail the consequences of system failures. Whilst particularly evident where experience or outcome is poor and results in complaint or adverse incident. The Trust will pursue patient outcome data through development of the ePCR over 2022/23.	Mar-23	Not Met	Dec-23	Mar-24	Jul-24	Partially complete	**October 2024: Based on the Quality Governance Review Follow Up report, Audit Wales has noted that this audit action should remain open. New management responses/actions will be developed, at which point this action will be closed and superseded by a new action in relation to the Follow Up Audit (but will remain on this Tracker for the formal record).** **250424**: Date changed in Q4 to July 2024 in lnie with AW timelines for conclusion of related follow up audit. **150424**: This will remain open until AW confirm as part of the current quality governance audit that it can close. Date will change in quarter (from March 2024 to new date). Update 14032024 from Duncan Robertson: The Health Informatics team are currently working with DHCW to enable a flow of data relating to out of hospital cardiac arrest. This it to test the systems and processes. When complete, this learning will be applied to other presentations for analysis. TM will engage with Audit Wales on a potential revised approach for this action. **201223**: Given the comment below Board Secretary suggests a 'check in' date of 31 March 2024. Audit Wales will be doing a further review at that time and may wish to reframe this recommendation. **11.12.23** Update from Duncan Robertson: The WAST and DHCW data-sharing agreement is with the ICO and Welsh Government as part of a consultation. This will provide the legal basis to share data. No completion date has been provided, therefore the December target date will not be met. It is completely outside of WASTs gift to propose a completion date The Putting Things Right Team are strengthening the Putting Things Right Quarterly Reports to include themes, patterns and trends. REVISED DATE OF DECEMBER 2023 **21.11.23**: Update 121023: Work Ongoing and will take a period to complete. Conversations continue with DHCW and the Ambulance Data Set (ADS) lead in England to define the ePCR definitions. Work is also continuing with DHCW to establish data sharing to enable joining up of patient records to report on outcome data. no timeline as yet and meeting with DHCW continue to clarify some of the definitions following discussions with the lead for the
106	Audit Wales	22/23	QUEST	Review of Quality Governance Arrangments	Jonathan Turnbull-Ross/ Wendy Herbert/ Hugh Bennett	Liam Williams			R8 We found that the QuESt Committee is well served with quality information, but there are opportunities for improvement. The Trust should: (e)develop patient outcome measures to support its existing quality measures.		e) The Trust is often limited by data accessibility where the patient journey extends beyond the organisational boundary. The Trust will pursue patient outcome data through development of the ePCR over 2022/23, which will enable 'joining up' of patient records. Furthermore, the Trust will further consider accessibility and governance matters for wider adoption of Patient Reported Outcome Measures, and Patient Reported Experience Measures.	Mar-23	Not Met	Mar-24	Jul-24		Partially complete	**October 2024: Based on the Quality Governance Review Follow Up report, Audit Wales has noted that this audit action should remain open. New management responses/actions will be developed, at which point this action will be closed and superseded by a new action in relation to the Follow Up Audit (but will remain on this Tracker for the formal record).** **250424**: Date changed in Q4 to July 2024 in lnie with AW timelines for conclusion of related follow up audit. **150424**: This will remain open until AW confirm as part of the current quality governance audit that it can close. Date will change in quarter (from March 2024 to new date). Update 14032024 from Duncan Robertson: The Health Informatics team are currently working with DHCW to enable a flow of data relating to out of hospital cardiac arrest. This it to test the systems and processes. When complete, this learning will be applied to other presentations for analysis. TM will engage with Audit Wales on a potential revised approach for this action. **201223**: Given the comment below Board Secretary suggests a 'check in' date of 31 March 2024. Audit Wales will be doing a further review at that time and may wish to reframe this recommendation. **11.12.23** DEVELOPMENT OF EPCR: Update will be provided by Duncan Robertson via update of item d) PATIENT REPORTED OUTCOME MEASURES: The Trust has defined standardised data to measure. Minimum dataset of approximately 600 definitions to agree with DHCW. Currently linking with England to assess available datasets and definitions. Data sharing agreements currently sit with DHCW and Welsh Government for approval. Instruction letters shared and awaiting response. (Leanne Hawker liaising with Alex Crawford on completion date) PATIENT REPORTED EXPERIENCE MEASURES: Data survey and narrative for generalised PREMs has been standardised and feeds into the MIQPR. A bespoke PREM is being developed in relation to Pain Management and Learning Disability (should be completed by end January 2024) REVISED DATE OF MARCH 2024 **121023**: PREMS live, but in development. PLICS is due to come on stream in Mar-24. PROMS is in development and dependent on DCHW. Business Care Process and Project Management Pathway are relevant considerations.
124	Audit Wales	23/24	PCC	Review of Workforce Planning Arrangements	Hugh Bennett	Angela Lewis		2.1(a)	Workforce information systems We found that there is scope for the Trust to make better use of its workforce information by ensuring data is consistent, joined up and up to date. The Trust should work to ensure that (medium priority): • Systems that hold workforce information including Electronic Staff Record (ESR), Global Rostering System (GRS) and finance systems interconnect, where possible.	2.1(a)	Alongside this we are working on Integrated Planning Nexus via the Planning and Strategy team which enables our understanding of the interconnection between workforce, fleet, estate etc. *Excel version*	Mar-24	Not Met	Oct-24	Dec-24	**Mar-25**	Partially complete	**200125: (LT) ADLT noted 3rd revised due date (Mar25)** **271224:** (LT) Propose date be extended to Mar25 to enable report to be presented to ELT in Jan25 and Trust's position to be clarified. **16.12.2024** - LR/HB - Nexus has partially been progressed (the replacement for 'megasheet') but this is not an organisational priority and the Trust has subsequently embarked on a very large transformation programme, consequently, we have paused Nexus development to accommodate this. However, we have done a series of fleet calculations (using 'megasheet' as a baseline) to estimate fleet requirements for the next two years, on potential areas of workforce growth e.g. APPs etc. The ITPG continues to meet weekly (informal) and monthly (formal) and fleet and estate are standing items on the monthly agenda. Also, a report is due at ELT in January, with workforce planning assumptions for next year, which will include fleet and estate considerations. A very high bar is set with Nexus and would be an ideally, but not delivering does not preclude us from planning around fleet and estate. **211024**: (AP) Revised date of December 2024 applied in Q2 24/25 as position not clear. **22.08.24** - JK - THe Nexus part of the recommendation has been completed, however, confirmation has not been given as to whether the joining up of the suggested systems will be achieveable for the Trust. Further consideration is taking place. **26.06.24** - JK - Further development has taken place for the PowerBI solution, however it is not yet QA'd for release but it is being used within the ITPG. It will be refined during July 2024 with an ELT specific summary produced highlighting KPIs and any relevant sensitivity analysis. **17.05.24** - JK - Manually generated monthly report created as the forerunner of the PowerBI Monthly Workforce Dashboard - work progressing on this solution with its delivery scheduled for June 2024. **21.03.24** - LR - The Workforce Transformation and Planning Team now produce a highlight report on key workforce information. Propose an extension to this action as the work on Nexus will be longer than expected. To date the following has been undertaken. Date moved in Q4 to October 2024. Project team established. Initial mapping completed. Currently developing what the end product will look like to work backwards to the requirements Complex exercise meaning timelines are difficult to estimate. Investment in connecting GRS, ESR and Oracle would be needed to build interfaces therefore Nexus is the solution for the time being.
126	Audit Wales	23/24	PCC	Review of Workforce Planning Arrangements	Dee Udeze-Chibuzor / Liz Rogers	Angela Lewis	Medium	3.1	Evaluating workforce planning training We found that the Trust is strengthening workforce planning capability through training initiatives, but it will need to evaluate these to ensure they are having the desired impact. The Trust should develop an evaluation framework to measure the success of its training programme (medium priority).	3.1	We will implement an evaluation process to baseline where managers are pre and post training and post 3 months to measure improvement.	Jun-24	Not Met	Aug-24	Dec-24	**Mar-25**		**200125: (LT) ADLT noted 3rd revised due date (Mar25** **16.12.2024** - LR - The team have developed and delivered the workforce planning training, take up of this has been limited across the organisation. The evaluation is to be completed in January, therefore an **request to extend until March 2025.** **211024**: (AP) Revised date of December 2024 applied in Q2 24/25 as position not clear. **22.08.24** - JK - The Workforce Planning training has been moved onto Learn 365 and development is ongoing to include an evaluation and feedback facility in the future. Evidence has been provided of the training up and running on Learn 365. **04.07.24** - AP - Added revised date of August 2024 in Q1 2024/25 in line with narrative provided. **17.05.24** - JK - Workforce Planning training is being rolled out pan Trust. However, to allow the sufficient time for all areas to receive this training and commence an evaluation, it was requested that the deadline be moved to August 2024.

Trust Ref No	Audit Wales or HIW Report	Year	Committee Assigned to	Report Title	Responsible Officer	Director	Priority Level	Rec. No in Audit	Recommendation	Respons e no. in Audit	Management Response	Agreed Deadline in Report	Status	1st revised date	2nd revised date	3rd revised date	Status	Where a management action has not met the agreed or revised date, Director must inlcude here: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. **Please add most recent update first**
127	Audit Wales	23/24	PCC	Review of Workforce Planning Arrangements	Dee Udeze-Chibuzor / Liz Rogers	Angela Lewis	Medium	4.1	Recruitment support We found that only the emergency ambulance services department has dedicated support from the central management team for recruitment activity, due to capacity issues. While the central team can provide support on a case-by-case basis, the Trust should review opportunities to increase the corporate support offered to other departments across the organisation (medium priority).	4.1	The recruitment team focus primarily on EMS but do offer support where needed to other services. This would need to be agreed by ELT and the Directorates as resource would need to be moved into the team from elsewhere. Report to be produced and shared with ELT.	May-24	Not Met	Sep-24	Dec-24	Sep-25		**200125: (LT) ADLT noted 3rd revised due date (Sep25)** **16.12.2024** - LR - The centralisation of recruitment has also been highlighted in the Service Review. A business case will be produced to centralise recruitment for ELT to consider. Support is ongoing for EMS and advice provided where capacity allows for other parts of the organisation. This will need to be an OCP as it will impact on roles across the organisation and is also impacted by the budget settlement. Therefore **request to extend to September 2025.** **211024**: (AP) Revised date of December 2024 applied in Q2 24/25 as position not clear. **05.07.24** - AP - Revised date of end of Q2 added in Q1 24/25, and to discuss closure evidence required with Directorate. **21.05.24** - JK - additional Fixed Term support secured in the function.
129	Audit Wales	23/24	PCC	Review of Workforce Planning Arrangements	Liz Rogers / Hugh Bennett	Angela Lewis	Medium	6.1	Benchmarking The Trust does not routinely benchmark its workforce performance metrics with other health bodies in Wales. Its performance benchmarking with other ambulance trusts is infrequent. The Trust should introduce regular workforce benchmarking with similar organisations and use this to inform relevant groups and committees on its performance and efficiency and to identify and share good practice (medium priority	6.1	Recommendation accepted for high level measures and will be based on what other organisations share / make available. Benchmarks need to be with ambulance sector rather than Health Boards	Jun-24	Not Met	Sep-24	Dec-24	Mar-25		**200125: (LT) ADLT noted 3rd revised due date (Mar25)** **16.12.2024** - LR - Comparison data is difficult to gather as there are no single sources of data and the data also tends to be relatively historic. Currently looking at what options are available to gather data quickly and effectively as connections are made. Therefore an ask for this to be **extended to March 2025.** **211024**: (AP) Revised date of December 2024 applied in Q2 24/25 as position not clear. **16.09.24** - HB - The 2023 EMS Demand & Capacity Review was reported to F&P Committee in a closed session on 16.07.24. **22.08.24** - JK - The Trust now have the ability to access on occassion the AACE HRD Network, which will allow us to see a shared spreadsheet with all Ambulance Services in England. As a pan Wales Trust, we do not have the ability to benchmark against another ambulance service in Wales but it will give the ability to benchmark against appropriate Trusts in England. **05.07.24** - AP - Revised date of end of Q2 added in Q1 24/25, and to discuss closure evidence required with Directorate. **26.06.24** - JK - the AACE HRD Network could be positioned to assist the Trust with this. **26.06.24** - HB - the Trust has recently received the final 2023 EMS Demand & Capacity Review, which benchmarks the Trust's performance on a range of metrics. This will be reported to F&P Committee on 16.07.2024.
139	HIW	23/24	Quest	National Review of Patient Flow – a journey through the stroke pathway	Andy Swinburn	Liam Williams Andy Swinburn		32(b)	WAST must consider its current response times for patients awaiting interhospital transfers for urgent thrombectomy treatment which are classified as 'Red'. This is to ensure a thrombectomy can be completed within the six-hour timescale from the onset of symptoms.	32(b)	WAST will review this process in due course and ascertain its success and determine if any further actions are required	Jun-24	Not Met	Sep-24	Dec-24	Mar-25		**160124: (LT) ADLT noted 3rd revised due date (Mar25)** **021024**: (AP) Revised date in Q2 24/25 applied to December 2024, as requested. Last updated 01102024: Request to review due date to Q3 to enable a full quarter of data collection for review of the new process. The data is being collected and can be demonstrated through Power BI but additional time would enable leads to review a full quarter data set for discussion and to develop response to recommendation. **110724**: Action: 1) Review the process agreed with the Health Boards, and ascertain its success / determine if any actions required. It is noted that The process we agreed in 2022 was for the trauma desk to take the transfer requests for thrombectomy. From 30th July 2024 a new process is being introduced for all transfers in WAST (including thrombectomy), this is a new protocol called Medical Transfer Protocol Suite (MTPS) and will specifically handle transfer requests. Evidence: 1) The communication to the Health Board is evidence of the agreed process (the Commissioning Policy). The new MTPS is going live on the 30 July 2024, which includes the provision of thrombectomy transfers which are categorised as Red calls. The process was agreed in 2022 however the new MTPS process begins in mid-2024, therefore a review cannot be undertaken until later in 2024. **150724**: Due to position with new system going live in July 2024, revised date added in Q1 24/25 to September 2024. Last updated 28062024: (JL) The process for requesting an interhospital transfer for patients requiring thrombectomy has been reenforced, confirming that the clinician requesting this transfer should utilise the dedicated number (not 999) where they will speak to a clinician, their request for transfer will be process as a red response and this has been communicated as required.
150		23/24	FPC	Reasonable	Chris Turley	Chris Turley	Medium	R1	The Trust should strengthen its approach to identifying and delivering recurrent savings. This will enable it to reduce its reliance on nonrecurrent savings in areas such as vacancy management and place its financial savings plans on a more sustainable footing. **(Paragraph 12)**	R1	There will always be an element of non-recurring savings in relation to the theme of corporate vacancy management savings due to historic time to advertise, recruit and appoint when posts become vacant. Recommendations from the servcies review will be assessed and, where possible, any recurrent efficiences via organisational structural changes will be implemented. 2024/25 currently has a split of 56.7% recurrent and 43.3% non-recurrent savings, with any in yeara over delivery being helpfully in recurring as opposed to non0recurrent schemes. The 2024/25 Financial Plan savings target will aim for a minimum of c65% recurrent themes.	Mar-25	Not Yet Due					
151		23/24	FPC	Reasonable	Carl Kneeshaw / Rachel Marsh	Chris Turley	Medium	R2	The Trust should ensure it takes forward work to address gaps in staff skill sets in respect of the identification and delivery of savings and efficiency opportunities. **(Paragraph 14)**	R2	The outcome of the recent Administrative & Corporate Services Review highlighted need for additional training and investment in colleagues, which is currently being actioned via ADLT-owned Action Plan, and the upcoming finalisation of the Service Review is also expected to highlight areas of under or over resourced service ensuring most appropriate investment of resource in the right areas. Specifically focussing on the income generation and commercialisatoin agenda, included in the 2024/25 financial plan is c.£0.250m to directly support this. This will include recruitment of dedicated resources to drive this forward, including the investment in a Head of Commercial post alongside Commercial structure to enhance specialist knowledge. This project and recruitment is underway.	Jun-25	Not Yet Due					
152		23/24	FPC	Reasonable	Chris Turley	Chris Turley	Medium	R3	The Trust should ensure that its savings reports to Board and F&PC, are consistent or provide a clear explanation of the differences between the reported savings performance. This will aid understanding, reduce confusion, and maintain the credibility of the Trust's savings reporting. **(Paragraph 16).**	R3	Finance Reports from M03 2024/25 to Trust Board and F&PC include further detailed analysis reporting of savings which includes split of recurrent and non-recurrent themes. WAST Monthly Monitoring Returns (MMR) submitted to WG also flow through committees and board. Further classification included in the proforma to be completed now include further breakdowns (i.e. Income Generation) so this allows clearer reconciliation for 2024/25 and beyond.	Aug-25	Not Yet Due					

Trust Ref No	Audit Wales or HIW Report	Year	Committee Assigned to	Report Title	Responsible Officer	Director	Priority Level	Rec. No in Audit	Recommendation	Respons e no. in Audit	Management Response	Agreed Deadline in Report	Status	1st revised date	2nd revised date	3rd revised date	Status	Where a management action has not met the agreed or revised date, Director must inlcude here: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. **Please add most recent update first**
153		23/24	FPC	Reasonable	Carl Kneeshaw	Chris Turley	Medium	R4	The Trust should ensure that it fully implements the learning from its recent gateway review of its Financial Sustainability Programme. This will ensure that it further strengthens its savings arrangements and maximises its savings opportunities. (**Paragraph 19)**	R4	The Gateway Review provided opportunity to self-assess the successes and challenges of the Financial Sustainability Programme at the end of Financial Year 2023/24. With this self-assessment are 11 key lessons, all of which are reviewed on an ongoing basis, and many of which underpin the FSP's 2024/25 objectives. Overall, the FSP has implemented a number of recommendations to date, including improved communication and engagement, and enhanced investment in a financially sustainable future, including a commercial structure in-house. Those recommendations not yet implemented will either be done before the end of the 2024/25 financial year, or will look to be included in the operational plan of the incoming Head of Commercial role. Attached as an appendix is the full list of lessons learnt, including an update as to current position as of August 30th, 2024. We will look to provide regular updates as we progress throughout the year,via both the Finance and Performance Committee, Strategic Transformation Board, and Audit, Risk and Assurance Committee as part of wider set of recommendations.	Jun-25	Met					

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

AGENDA ITEM No	**11**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**0**

2024/25 ANNUAL ACCOUNTS UPDATE

MEETING	Audit, Risk and Assurance Committee
DATE	6 March 2025
EXECUTIVE	Chris Turley, Executive Director of Finance and Corporate Resources
AUTHOR	Jessica Price, Head of Financial Accounting
CONTACT	Jessica.Price3@wales.nhs.uk

EXECUTIVE SUMMARY

This report provides the Committee an update on planning undertaken, progress made and any issues arising with both the preparation and external audit of the 2024/25 Annual Accounts.

KEY ISSUES/IMPLICATIONS

Key highlights for the Committee to note are as follows: -

- Audit Wales (AW) propose an average fee increase of 1.7% for 2025/26 due to unavoidable inflationary pressures.
- At the time of writing, Welsh Government (WG) are yet to provide the final year-end timetable, but the draft year-end timetable proposes audit certification deadline of 30th June 2025 compared to 15th July 2024 certification for 2023/24.
- At the time of writing, AW have provided the draft Outline Audit Plan 2025 and have advised the Detailed Audit Plan 2025 will be provided in readiness for the May ARAC meeting.
- '*Audit enquiries of those charged with governance and management*' is yet to be received from AW and will therefore be circulated at a later date.

REPORT APPROVAL ROUTE
Audit, Risk and Assurance Committee 6th March 2025.

REPORT APPENDICES
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	Y
Environmental/Sustainability	NA	Legal Implications	Y
Estate	NA	Patient Safety/Safeguarding	NA
Ethical Matters	NA	Risks (Inc. Reputational)	Y
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
2024/25 ANNUAL ACCOUNTS PLANNING UPDATE

SITUATION

1. The purpose of this paper is to make the Committee aware of the current position in relation to the planning for the upcoming Annual Accounts and audit for 2024/25.

BACKGROUND/ASSESSMENT

Audit Fee

2. AW propose an average fee increase of 1.7% for the 2025/26 audit, in comparison to the increase of 6.4% seen in 2024/25. The increase is due to unavoidable inflationary pressures.

Year end timetable & Audit

3. At the time of writing, WG are yet to provide final confirmation of year end submission dates via the Manual for Accounts, therefore the below key dates are based on the draft timetable issued by WG. The final timetable is not anticipated to be significantly different:

Key Dates	
ELT to review draft Remuneration Report	30th April 2025
Submit Unaudited accounts, Pooled Budgets and All FRs including FR6,(except FR10) MS A to C and F-H inclusive	2nd May 2025 (noon)
Audit commences	6th May 2025 (Tuesday)
NHS Bodies to submit Accountability Report (Statement of Accountable Officer Responsibilities, Statement of Directors responsibilities in respect of the accounts, Annual Governance Statement) (At this stage the statements are not signed and the AGS is in draft).	9th May 2025 (noon)
NHS Bodies to submit (from Finance) Remuneration Report TMS2 and FR10	9th May 2025 (noon)
Closure meeting with External Auditors	TBC
Audit, Risk & Assurance Committee meeting initial accounts approval	24th June 2025
Trust Board meeting to formally approve and sign accounts	26th June 2025
Audit Wales to submit final audited accounts to the Welsh Government including:- Audited accounts All TFRs TMS 1 A to C and F-H inclusive Audited accounts, Annual Report Sections including; Accountability Report (Statement of Accountable Officer Responsibilities, Statement of Directors responsibilities in respect of the accounts AGW Report and Certificate, Performance Report, Annual Governance Statement, Remuneration Report) and Financial Statements (audited accounts)	30th June 2025 (noon)

4. AW have recently advised of their intention to carry out an interim audit. Conversations between the Finance team and AW to determine the dates of the interim audit and the areas to be covered are ongoing at present.

5. The '*Audit enquiries of those charges with governance and management*' is yet to be received from AW. The Trust's planned response to this will require consideration and approval by Committee members, therefore this will be circulated at a later date.

RECOMMENDED: That the Committee notes the contents of this report.

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

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

2024-25 ANNUAL FILINGS SCHEDULE

MEETING	Audit, Risk and Assurance Committee (ARAC)
DATE	06 March 2025
EXECUTIVE	Trish Mills, Director of Corporate Governance/Board Secretary
AUTHOR	Alex Payne, Corporate Governance Manager Julie Boalch, Assistant Director of Corporate Governance and Risk
CONTACT	Email: Trish.Mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. The Annual Filings Task and Finish Group (the "Group") was re-established in December 2024 to ensure that the Trust meets the Annual Report and Accounts 2024-25 disclosure and reporting requirements as set out in the draft Manual for Accounts (MfA) published by Welsh Government (WG).

2. The terms of reference were approved by the Assistant Directors Leadership Team (ADLT) on 20 January 2025 and the expected submission dates noted. The Chair of the ADLT is also the Chair of the Group, and as such is aware of the proposed schedule. The schedule will be formally received by the ADLT at its meeting on the 03 March 2025.

3. The Trust Annual Report includes the Performance Report (Part 1) and the Accountability Report (Part 2). The MfA indicates that the overarching structure of the Annual Report for 2024-25 has not changed; however, the final MfA is yet to be received.

4. In 2023-24 the Trust prepared and published its first Duty of Quality Annual Report. It is not yet clear whether the reporting requirements for the Duty of Quality Annual Report for 2024-25 will differ from 2023-24.

5. A timetable for the Annual Filings has been developed and is set out below. The timetable has been drafted based on the draft MfA, so the schedule is subject to change as the final MfA is yet to be received. The committee should note that the deadline / certification date for the 2024-25 filing is the 30 June 2025; which is earlier than the 2022-23 and 2023-24 filing. The Finance Team will maintain a work programme for the production of the accounts.

RECOMMENDATION

6. **The Audit, Risk and Assurance Committee is requested to approve:**

6.1 The Annual Filings 2024-25 schedule;

6.2 The circulation of the draft reports for review and comment by email as set out in the table in paragraph 13.

KEY ISSUES/IMPLICATIONS
Given the tight timeframes within which the annual report must be prepared, and the contributions from multiple sources, a structured approach will be adopted to allow for oversight and escalation.

REPORT APPROVAL ROUTE
03 March 2025: ADLT – Review of Annual Filings Timetable

REPORT APPENDICES
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)	n/a	Financial Implications	n/a
Environmental/Sustainability	n/a	Legal Implications	Y
Estate	n/a	Patient Safety/Safeguarding	n/a
Ethical Matters	n/a	Risks (Inc. Reputational)	Y
Health Improvement	n/a	Socio Economic Duty	n/a
Health and Safety	n/a	TU Partner Consultation	n/a

SITUATION

7. The Annual Filings Task and Finish Group (the "Group") was re-established in December 2024 to ensure that the Trust meets the Annual Report and Accounts 2024-25 disclosure and reporting requirements as set out in the Manual for Accounts (MfA) published by Welsh Government (WG).

BACKGROUND

8. The Welsh Government draft MfA 2024-25 requires the Trust to submit as a single PDF document, a three-part Annual Report and Accounts. The Annual Report includes the Performance Report (Part 1) and Accountability Report (Part 2).

ASSESSMENT

9. The Annual Report requires contributions from a number of individuals including performance and planning, partnerships and engagement, corporate governance, finance, people and culture, and others. The MfA indicates that the overarching structure of the Annual Report for 2024-25 has not changed; however, the final MfA is yet to be received.

10. In 2023-24 the Trust prepared and published its first Duty of Quality Annual Report. It is not yet clear whether the reporting requirements for the Duty of Quality Annual Report for 2024-25 will differ from 2023-24.

11. Whilst the Performance Report is drafted by the Performance Team, there is close coordination with those drafting the Accountability Report. Where governance information that would otherwise appear in the Accountability Report would flow better by appearing in the Performance Report, close cross-referencing is required to ensure duplication is reduced, messaging is consistent, and the data set is the same.

12. The development of the Financial Accounts will have an established timetable, and whilst it is not intended that the Group will manage this work, finance colleagues are part of the Group to ensure a coordinated approach, synchronicity of dates, management of contributions to the Accountability Report, and the publishing of the final single PDF Annual Report and Accounts.

13. The below timetable has been developed to include key submission dates to Welsh Government, Audit Wales, Trust Board, and the Audit, Risk and Assurance Committee based on the draft MfA detail / reporting dates. The ARAC is asked to note that the certification date for the 2024-25 filing is the 30 June 2025; which is earlier than the 2022-23 and 2023-24 filing.

2024/25 DRAFT ANNUAL FILINGS TIMETABLE

HIGH LEVEL DEADLINES	ACTION	DETAIL	EXECUTIVE LEAD
02/05/2025	Submission Deadline	Draft 24/25 Unaudited Accounts	Chris Turley
09/05/2025	Submission Deadline	Draft Annual Report	Trish Mills
30/06/2025	Submission Deadline	Final Annual Report & Accounts to Audit Wales	Chris/Trish

DEADLINE	ACTION	DETAIL	EXECUTIVE LEAD
26/02/2025	DL for ADLT Paper	DL for submission of paper for ADLT	Julie Boalch
03/03/2025	ADLT Meeting Date	Paper received with filings schedule	Julie Boalch
25/02/2025	DL for AC Paper	DL for submission of paper for AC	Trish Mills
06/03/2025	**Audit Committee Meeting**	Receipt of paper at AC setting out the annual filings timetable for approval	Trish Mills
03/03/2025-14/03/2025	Commissioning of AR/PR	Review of narrative ownership and commissioning	Trish Mills
03/03/2025-31/03/2025	**DRAFTING**	Drafting by stakeholders	Trish Mills
01/04/2025	Submission to CGT	Submission of draft narrative of the AR/PR	Trish Mills
03/04/2025	Submission to Board Secretary for Review	Annual Report - for review by Board Secretary no later than the 03 April	Trish Mills
17/04/2025	Email circulation to ADLT	Circulate to ADLT for their awareness	Trish Mills
17/04/2025	DL for ELT paper - Draft AR	Draft AR to ELT for receipt / comment	Trish Mills
16-17/04/2025	Email circulation to ELT	Circulate to ELT for remote comment, then to be received at ELT on 23/04/2025	Trish Mills
23/04/2025	**ELT Meeting**	Receipt of draft AR	Trish Mills
24/04-28/04	Review of AR/PR	Review of AR/PR by RM/TM/HB/AP & Final Edits	Trish Mills
29/04/2025	**Email Circulation**	Draft RemReport to RemCom	Trish Mills
29/04/2025	**Email Circulation**	Draft AR to AC for awareness and comment	Trish Mills
29/04/2025	**Email Circulation**	Draft ARA to Board - for awareness	Trish Mills
02/05/2025	**Submission Deadline**	Draft Unaudited Accounts to WG/Audit Wales	Chris Turley
06/05/2025 (18:00)	DL for comments by Audit Com.	DL for responses by Audit Committee	Trish Mills
06/05-09/05	Final Review / Updates of Draft ARA	Final draft/review, ahead of submission on the 09/05/2025	Trish Mills
09/05/2025 (12:00)	**Submission Deadline**	Draft Annual Report to WG/Audit Wales	Trish Mills
09/05/2025	**Submit ARA for Translation**	Submit to in house translation	Trish Mills
06/06/2025	DL for papers for ELT	DL for papers for ELT	Trish Mills
11/06/2025	Submission of final AR to ELT	Final 24/25 ARA submitted to ELT (potential receipt via email)	Chris/Trish
18/06/2025	Submission DL	Final 24/25 ARA submitted for Audit Committee	Chris/Trish
24/06/2025	**Meeting of Audit Committee**	Audit Committee to scrutinise/endorse final 22/23 ARA [1 hour]	Chris/Trish
19/06/2025	Submission DL	Final ARA Submitted for Trust Board	Chris/Trish
26/06/2025	**Meeting of Trust Board**	Trust Board - Approval/sign-off of audited ARA [30 mins]	Chris/Trish
30/06/2025	Submission DL	AUDIT WALES TO SUBMIT FINAL AUDITED ARA	Chris/Trish

14. Given the proposed certification schedule proposed by Audit Wales is the 30 June 2025, the Corporate Governance Team has planned for the Annual Report and Accounts for 2024-25 to be received by the ARAC on Tuesday 24 June 2025, after which they will be approved by the Trust Board at an extraordinary meeting on the 26 June 2025.

15. This approval process was considered when the 2024-25 calendar dates were drafted, however a recent adjustment has meant that the meeting of the ARAC on the 24 June 2025 will receive ordinary business and there is therefore no need to hold an extraordinary meeting for the Annual Report and Accounts separate to the usual meeting of the committee in June.

16. The ARAC is asked to note the following: -

    16.1 A supplementary timetable will be developed by the Group to manage contributions from colleagues towards the various sections of the Annual Report, its layout and Welsh translation (which will be completed in-house by the Welsh Language Translator).

    16.2 The draft Annual Report, signed off in accordance with the above timetable, will not include a finalised public facing document. This will not delay any review of the draft by Welsh Government or Audit Wales as it is not a statutory requirement.

16.3 Due to the scheduling of trust board and committee meetings, it is proposed that some draft documents will be provided to members by email circulation towards the end of April 2025 for review and comment; as was the case for the 2023-24 filing.

16.4 The timetable has been drafted based on the *draft* MfA, and the schedule is subject to change based on the final dates confirmed by the WG. If changes are made it is anticipated they will affect the final filing deadlines, as opposed to the earlier draft submission deadlines. Any significant changes will be brought to the attention of the committee.

16.5 The placement of the Annual General Meeting (AGM) for 2025 is unclear because the final schedule is yet to be confirmed. It is possible that it will take place later than the 31 July (as required by Standing Orders) and in line with the 2023 and 2024 AGM dates.

16.6 The committee will be updated in due course once guidance is received from Welsh Government with the final MfA; however, a tentative date for the 2025 AGM has been included for the Thursday 31 July 2025, should that be achievable.

RECOMMENDATION:

17. The ARAC is asked to approve:

17.1 The Annual Filings 2025-25 schedule;
17.2 The circulation of the draft reports for review and comment by email as set out in the table in paragraph 13.

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

AGENDA ITEM No	**13**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**7**

INTEGRATED GOVERNANCE PROGRAMME: THE DYNAMIC INTEGRATED SYSTEM OF GOVERNANCE AND OVERSIGHT

MEETING	Audit, Risk and Assurance Committee
DATE	06 March 2025
EXECUTIVE	Trish Mills, Director of Governance / Board Secretary
AUTHOR	Trish Mills, Director of Governance / Board Secretary and Julie Boalch, Assistant Director of Corporate Governance & Risk
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. The Trust is undertaking an ambitious integrated governance programme aimed at enhancing governance structures from floor to board.

2. The integrated governance programme aims to streamline and unify the mechanics and dynamics of governance across the Trust. A set of simplified governance principles that can be applied to the existing, maturing, and emerging elements of WAST's governance, accountability, risk and assurance frameworks is central to the programme. This will support openness and transparency, efficiency, and accountability at all levels from 'floor to board'

3. It is important to recognise that consistency of approach in our governance structures, provision of clear guidance, and standardisation of templates is important. However, there will always be circumstances where we need to be flexible to the needs of the organisation, and to forums which may have more external attention and/or reporting requirements, or needs of pace or urgency. This requires a vibrant approach, and we have reflected this in the tagline of the programme as the 'Dynamic Integrated System of Governance and Oversight' (DISGO).

4. This paper provides the committee with an update on the progress of the programme, particularly focusing on the mapping of the Trust's governance framework, tiering principles, and the next steps.

5. The corporate governance framework map can be accessed via this link - Miro Board IGP. Members are encouraged to view and navigate the map via the link and may be prompted to open a free Miro account. Alternatively, a macro view of the entire framework is included at Annex 1 with the various arms set out as separate attachments (Annexures 1a to 1e).

6. The framework provides the following categorisation for the governance forums:

   - Assurance arm – the board and its committees (Annex 1a)
   - Advisory arm – WASPT as the board's only advisory group in the Standing Orders (Annex 1b)
   - Organisational governance arm – the governance forums that report to the Executive Leadership Team, their sub-committees and task and finish groups (Annex 1c)
   - Strategy development and delivery arm – the Strategic Transformation Board and its sub-committee and working groups (Annex 1d)
   - Directorate governance forums – the structures established by directors in their directorates (Annex 1e)

7. These six arms ensure a collaborative approach across the Trust, support the establishment of robust monitoring and assurance processes, enable clear escalation routes for issues that require a resolution, and provide for assurance reporting as part of individual director's accountability responsibilities to the board.

8. Tiering principles and standards have been developed for the organisational governance forums, including which forums should prepare formal minutes, and which should report only on a AAA. During 2025/26, the Corporate Governance team will roll out more support for all tiers (see next steps below).

9. The paper outlines the next steps to progress the programme, which will be scoped and delivered over the next two years and monitored through the Corporate Governance Team's Local Directorate Plan.

RECOMMENDATION

10. Members are asked to:
    a) Receive assurance on the integrated mapping of governance forums at Annex 1 and Annexures 1a to 1e.
    b) Consider the tiering principles at Annex 2.
    c) Note the next steps for the programme.

KEY ISSUES/IMPLICATIONS
11. The key issues and implications are set out in the Executive Summary above.

REPORT APPROVAL ROUTE
• Assistant Directors Leadership Team - 25 November 2024. • Executive Leadership Team - 12 December 2024 • Non-Executive Directors – 16 December 2024 (email circulation)

REPORT APPENDICES
Annex 1 – Macro view of governance framework mapping. **Annex 1a -** Assurance arm – the board and its committees. **Annex 1b** - Advisory arm – WASPT as the board's only advisory group in the Standing Orders. **Annex 1c -** Organisational governance arm – the governance forums that report to ELT, their sub-committees and task and finish groups. **Annex 1d -** Strategy development and delivery arm – the Strategic Transformation Board **Annex 1e -** Directorate governance forums – the structures established by directors in their directorates. **Annex 2** – Tiering principles for Organisational Governance Arm.

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

INTEGRATED GOVERNANCE PROGRAMME:
THE DYNAMIC INTEGRATED SYSTEM OF GOVERNANCE AND OVERSIGHT

SITUATION

1. This paper updates the committee on the progress of the integrated governance programme, specifically the mapping of the Trust's governance framework. This begins to put some shape on the enormity of the framework as it currently stands, and to develop standards for its operation and implementation across the Trust.

BACKGROUND

2. Board and committee governance has been significantly improved over the past 2-3 years as evidenced through positive Structured Assessments and a good programme of committee effectiveness reviews. The Corporate Governance team will now turn its attention to enhancing governance structures at levels beneath the board and replicating that the principles of good governance developed for the board.

3. The integrated governance programme was an IMTP deliverable for 2024/25 and has seen the following outputs designed and delivered:

   - Mapping of governance structures floor to board as a single source of truth.
   - Development of a legislative universe with a compliance prioritisation audit commenced.
   - Digitised Corporate Governance Standard Operating Procedure.

   The benefits and next steps for the programme are outlined in the paper and will be delivered over the next 2-3 years.

ASSESSMENT

4. The ways in which our board and its committees are governed is clearly set out in the Standing Orders and committee terms of reference. The Audit Wales Structured Assessments in recent years have assured the board and external stakeholders that these are well led and effective.

5. This, coupled with a recent Organisational Change Process (OCP) in the Corporate Governance Directorate presents an opportunity to now put more focus on the governance frameworks that sit below the board and committee assurance arm of our governance framework. This has not been holistically mapped before and no single set of standards or guidance applied consistently to ensure quality.

<u>Integrated Governance - Mapping</u>

6. The first step in the programme was the mapping of the governance forums currently in place. This was done through discussions with directors and their

teams, knowledge gleaned through reporting to the board and ELT, and through the Corporate Governance team's participation in these forums. The desired outcome of this programme is to:

- Gain a sense of the governance forums currently in place.
- Act as the single source of truth for governance forums going forward, and guide advice from the Corporate Governance team on the establishment of future forums.
- Enable us to propose tiering principles for consistency.
- Easily see where forums may appear over-burdened.
- Identify where there are forums in place which are not reporting to a primary forum.
- Identify duplications (although more work is to be done there as we delve into and review the terms of reference for each group).
- Be the blueprint upon which the Quality and Performance Management Framework (QPMF) mapping is conducted.
- Provide assurance to ELT and to ARAC that governance forums are identified, and a programme of work has been agreed to support lean and efficient processes and governance in these various 'arms.'

7. The corporate governance framework mapping can be accessed Miro Board IGP . Members are encouraged to view and navigate the map via the Miro link and may be prompted to open a free Miro account. Alternatively, a macro view of the entire framework is at Annex 1. Please note the detail on Annex 1 is not readable given its size. It is included only to provide an overview of the structures, the details of which are in Annexures 1a to 1e.

8. The framework provides the following categorisation for the governance forums:

- **Assurance arm** – the board and its committees (Annex 1a)
- **Advisory arm** – WASPT as the board's only advisory group in the Standing Orders (Annex 1b)
- **Organisational governance arm** – the governance forums that report to ELT, their sub-committees and task and finish groups (Annex 1c)
- **Strategy development and delivery arm** – the Strategic Transformation Board and its sub-committee and working groups (Annex 1d)
- **Directorate governance forums** – the structures established by directors in their directorates (Annex 1e)

9. For additional assurance, where there has been a recent internal audit, Audit Wales or external report related to the governance forum that is noted on the mapping.

10. Whilst the entire map has been produced here for completeness, the focus for this programme in 2024/25 is not on the assurance and advisory arms, as these are well established and set out in our Standing Orders.

11. Instead, the programme centres around the organisational, strategic development and delivery, and directorate governance forums as key components in our broader governance framework, linking day-to-day management activities with the strategic oversight provided by the board and its committees. Together, the six arms of the framework ensure a collaborative approach across the Trust, support the establishment of robust monitoring and assurance processes, enable clear escalation routes for issues that require a resolution, and provide for assurance reporting as part of individual director's accountability responsibilities to the board.

12. There is a broader piece of work being undertaken by the Quality and Performance Management Steering Group to identify the forums and meetings where quality and performance is managed from floor to board. The integrated governance mapping will provide a baseline for that work.

Organisational Governance Arm

13. The ELT is the sole primary committee in the operational governance arm, with eight sub-committees regularly reporting and escalating on a AAA report. These are:

- ADLT
- National Health and Safety Committee
- Information Governance Steering Group
- Pandemic Governance Group
- Clinical Quality Governance Group
- Quality and Performance Management Steering Group
- Capital Management Board
- Equality, Diversity, and Inclusion Steering Group

14. It is important to note that there is further work to do to ensure that the terms of reference of all related groups are appropriate, that they cascade elements of the primary group's remit and that they are effective.

Strategic Development and Delivery Arm

15. This arm establishes the Strategic Transformation Board (STB) as the primary strategic forum. The STB governance structures were recently refreshed to delineate between the transformation work under the clinical transformation model, and the enabling and business as usual elements of the Integrated Medium Term Plan (IMTP).

16. The standards for operating these governance forums have been established by the Transformation Office and the Corporate Governance team will continue to work closely with them to ensure alignment where appropriate.

Directorate Governance Arm

17. Each directorate has a governance structure to suit its size and portfolio. What is consistent across many is a senior leadership team forum and a wider directorate business meeting.

18. Some of these directorate forums will be those where quality and performance is monitored, and for others there will be a 'spider web' of other meetings where this is considered in more detail.

Integrated Governance - Tiering

19. The organisational governance forums have been tiered 1-4 and high level standards developed to guide their operation as set out in Annex 2, such as which forums should prepare formal minutes, and which should report only on a AAA. During 2025/26, the Corporate Governance team will roll out more support for all tiers (see next steps below).

20. Standards for operating directorate level forums have not been developed at this stage. More work is required to understand what directorates need and to learn from exemplars in the structures. At this stage this is a lower priority to the organisation governance forums. As a minimum all directorates should have a forum that looks at their Local Directorate Plan (LDP) and any IMTP related elements where appropriate, any audits or audit recommendations, local and directorate risks as well as any corporate risks, and policy within their portfolio.

Integrated Governance – Next Steps

21. The integrated governance programme aims to streamline and unify the mechanics and dynamics of governance across the Trust. A set of simplified governance principles that can be applied to the existing, maturing and emerging elements of WAST's governance, accountability, risk and assurance frameworks is central to the programme. This will support openness and transparency, efficiency, and accountability at all levels from 'floor to board.'

22. There is still much to do to ensure those mechanics and dynamics are operating in an aligned and streamlined way, with the first step of this 2-3 year project being the mapping, with other work underway and planned which includes.

- Finalise tiering principles for operational governance arm.
- Communications plan
- New front cover and SBAR templates (completed – stakeholder engagement underway - due for roll out by 1 April 2025)
- AI for governance: report writing, minutes, AAA, actions and decisions logs

- Writing and presentation guidance (completed – stakeholder engagement underway - due for roll out by 1 April 2025)
- Minute taking guidance (completed – stakeholder engagement underway - due for roll out by 1 April 2025)
- Consultation on the principles of good governance and their application
- Alignment of nomenclature of governance forums
- Alignment of terms of reference for organisational governance arm
- Benchmarking with sector colleagues
- Establish terms of reference repository on Siren and update currency
- Effectiveness (lite) toolkit for operational governance
- Roll out board governance SOP (lite) for operational governance (cradle to grave process)
- Meeting etiquette policy
- Standardise secretariat templates (completed and on Siren but with further communication and education of these planned via LMS365)
- Accountability, assurance and governance handbook
- Support, education and training – focus on secretariat and chair
- Legislative universe prioritisation for compliance review plan
- With the digital team, determine direction of travel for housing of meeting artifacts
- Develop version control rules on Miro
- Focus on directorate governance arm
- Align governance principles on strategic development and delivery arm

23. We have worked closely with both Audit Wales and Internal Audit who are supportive of our approach and the mapping has been shared with them.

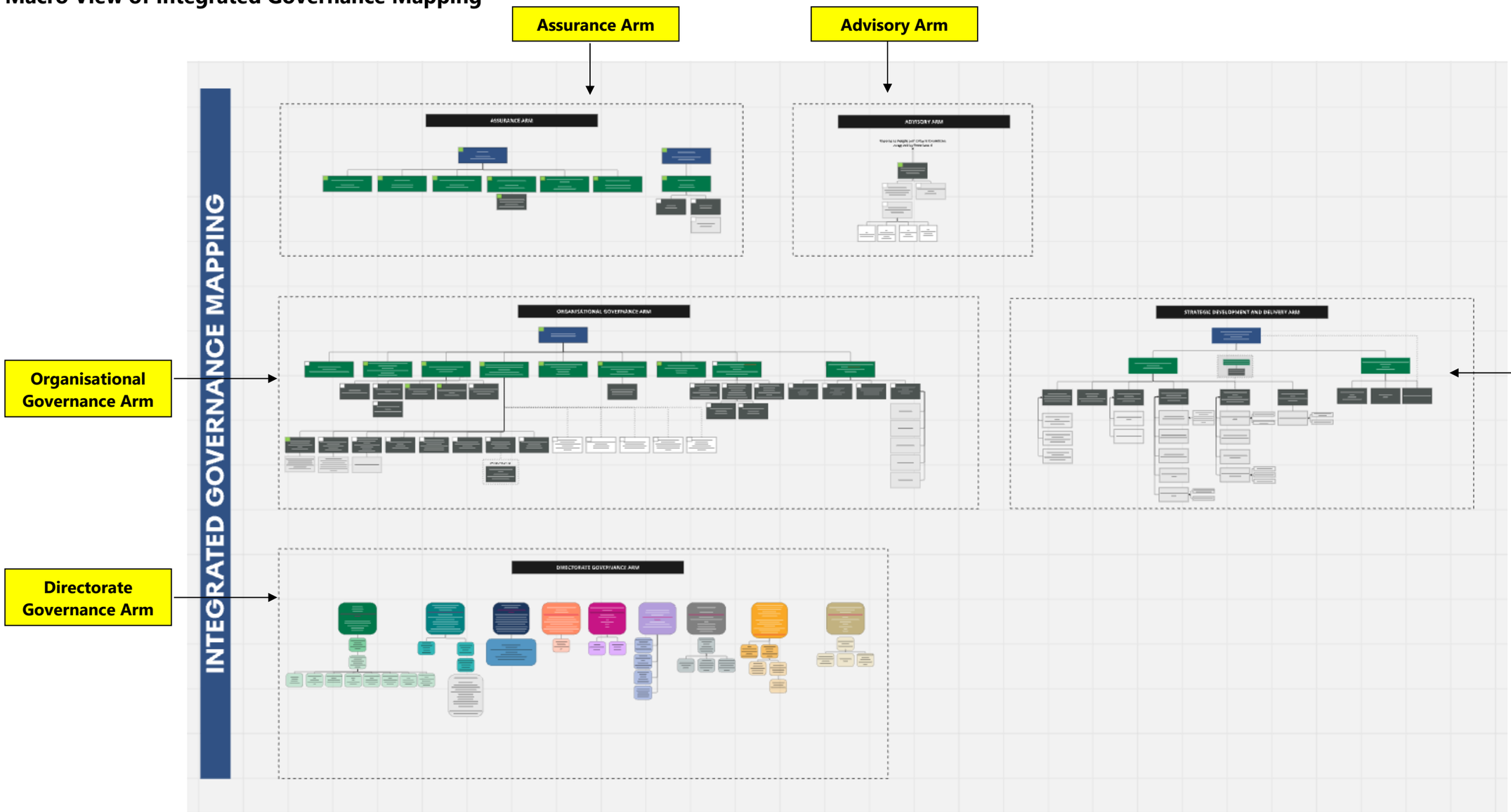
24. Committee will receive a further update report in Q3 2025/26 on the integrated governance programme, including outline of the handbook.

RECOMMENDATION

25. Members are asked to consider and discuss the contents of the report and:
    a) Receive assurance on the integrated mapping of governance forums at Annex 1 and Annexures 1a to 1e.
    b) Consider the tiering principles at Annex 2.
    c) Note the next steps for the programme.

NB: This extract is not decipherable given its size but gives a macro overview of the governance framework. Members are requested to refer to annexures 1a to 1e for the detailed arms

Annex 1
Macro View of Integrated Governance Mapping



Annex 2 – Organisational Governance Tiering Principles

TIER 1 (ELT)

Primary Executive decision-making Body (subject to individual delegations)
Supports CEO in leadership and management of the Trust
Wide-ranging remit in TOR
Key artifacts: TOR; minutes; forward planner; actions & decisions log

TIER 2

Established by a T1 committee
Chair is a member of the T1 committee
Operates with a delegated portion of the T1 committee's remit and authority
Undertakes detailed exploration of specific areas
Provides focused assurance to primary T1 committee
Enables swift escalation of issues to the T1 committee via a AAA
Key artifacts: TOR; work programme; minutes only for areas of potential exposure or where audit or regulators require a clear trail; AAA to T1 Committee; work programme; forward planner; actions & decisions Log

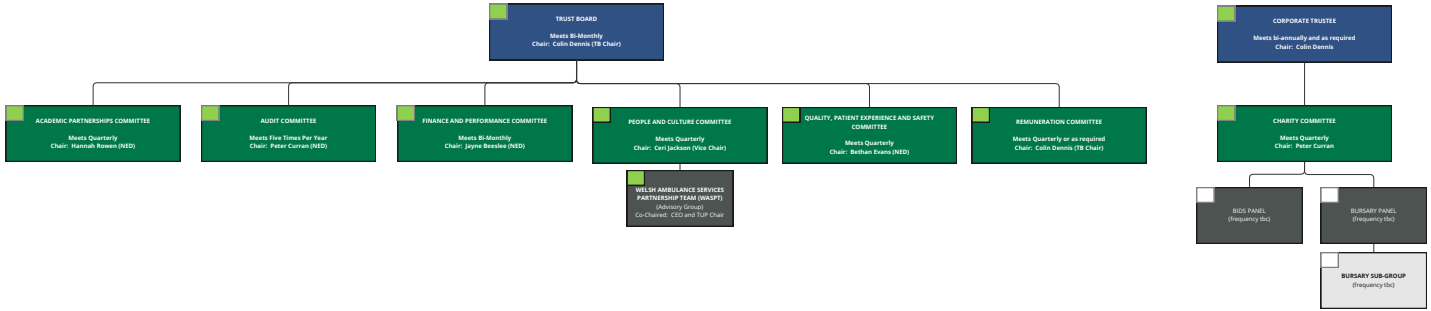
TIER 3

Established by a T2 committee
Chair is a member of the T2 committee
Operates with a delegated portion of the T1 committee's remit and authority
Undertakes further detailed exploration of specific areas in the T2 committee's TOR
Key artifacts: TOR; work programme; AAA to T2 committee; forward planner; actions & decisions log

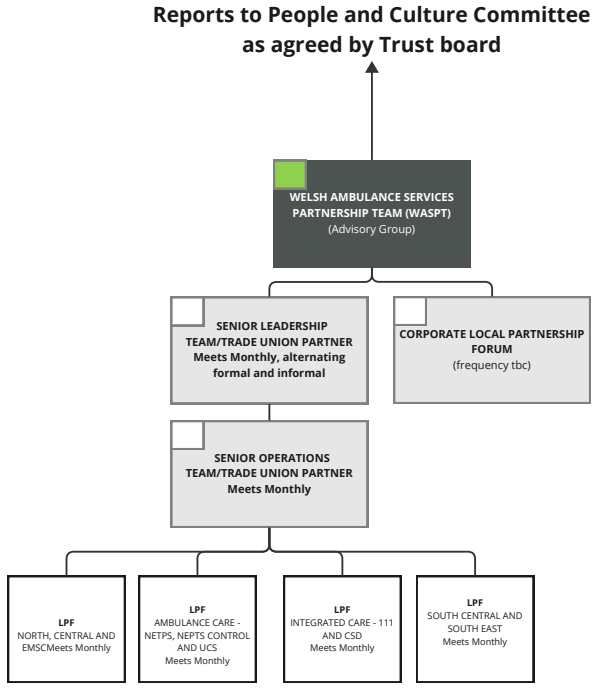
TIER 4

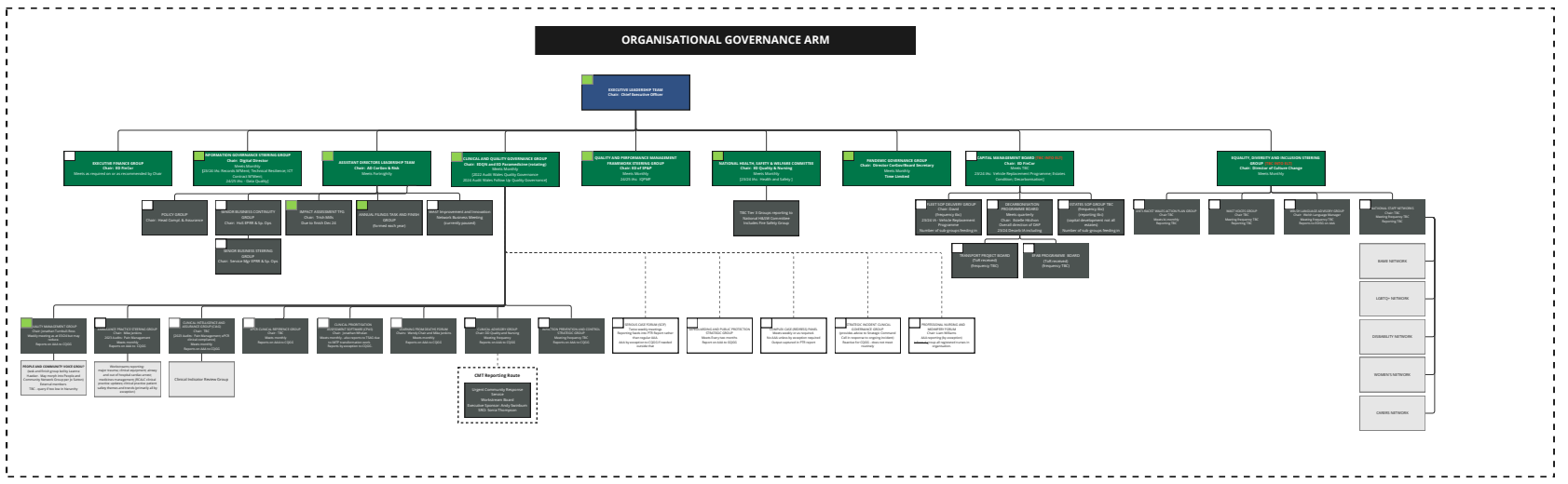
Established by a T3 committee
Chair is a member of the T3 committee
Usually time limited working group or task and finish group
Operates with a narrow scope, often for work that requires pace and subject matter expertise
Key artifacts: TOR; work programme; AAA to T3 committee; forward planner; actions and decisions log; closure report

ASSURANCE ARM

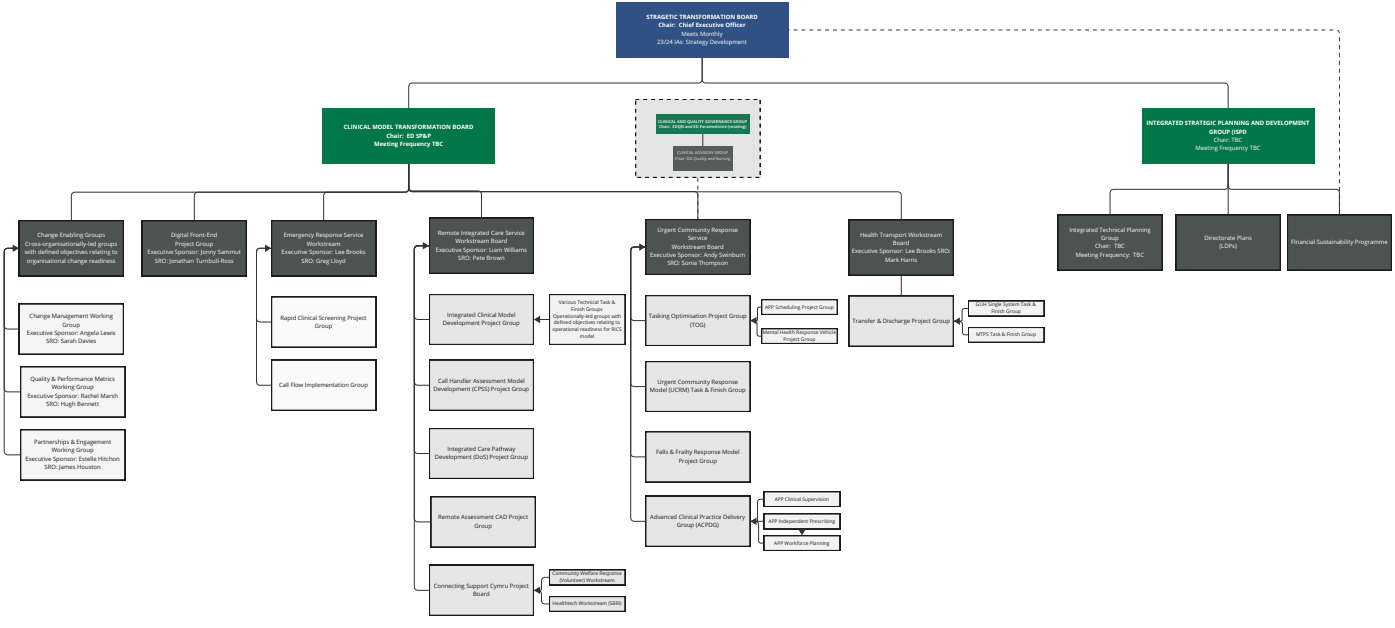


ADVISORY ARM

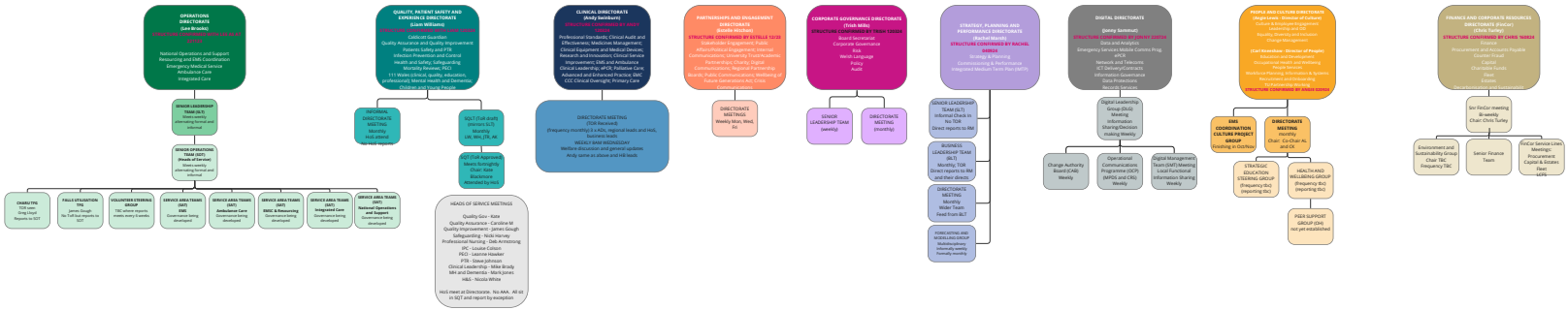



ORGANISATIONAL GOVERNANCE ARM
EXECUTIVE LEADERSHIP TEAM
Chair: Chief Executive Officer
EXECUTIVE FINANCE GROUP
Chair: XX Vector
Meets as required on an as recommended by Chair
INFORMATION GOVERNANCE STEERING GROUP
Chair: Digital Director
Meets Monthly
(23/24 Dec Records/SENnet, Technical Resilience, ICT Disaster Recovery)
24/25 Jan - SENnet Briefing
ASSISTANT DIRECTORS LEADERSHIP TEAM
Chair: AD Carlton & Hub
Meets Fortnightly
CLINICAL AND QUALITY GOVERNANCE GROUP
Chair: EDCH and ED Paramedicine (rotating)
Meets Monthly
(2022 Audit Wales Quality Governance)
2024 Audit Wales Follow Up Quality Governance)
QUALITY AND PERFORMANCE MANAGEMENT FRAMEWORK (QPMF) GROUP
Chair: Head of Staff
Meets Monthly
24/25 Jan - QPMF
NATIONAL HEALTH, SAFETY & WELFARE COMMITTEE
Chair: AD Quality & Nursing
Meets Monthly
(23/24 Inc. Health and Safety.)
PANDEMIC GOVERNANCE GROUP
Chair: Director Carlton/Board Secretary
Meets Monthly
Now Limited
CAPITAL MANAGEMENT BOARD (TBC 24/25 Q1)
Chair: Director of Finance
Meets Monthly
23/24 Dec Vehicle Replacement Programme: Estates, Condition, Decarbonisation)
EQUALITY, DIVERSITY AND INCLUSION STEERING GROUP
Chair: Director of Culture Change
Meets Monthly
POLICY GROUP
Chair: Head Compl. & Assurance
SENIOR BUSINESS CONTINUITY GROUP
Chair: Hall EPRR & Sp. Ops
IMPACT ASSESSMENT TTG
Chair: Trish Mills
Due to finish Dec 23
REGIONAL FUNDED TASK AND FINISH GROUP
(formed each year)
SENIOR BUSINESS STEERING GROUP
Chair: Service Mgr EPRR & Sp. Ops
QUALITY improvement and Innovation Network Business Meeting
(currently paused)
TBC Tier 3 Groups reporting to National HSEQM Committee
Includes Fire Safety Group
FLEET TOP DELIVERY GROUP
Chair: Head of Fleet
23/24 Dr. Vehicle Replacement Programme
Number of sub groups feeding in:
DECARBONISATION TASKFORCE WORKING GROUP
Chair: Estate Workers
Overall direction of SMP
23/24 Decarb Workstreams
ESTATES SUB GROUP TBC
(frequency tbc)
Chair: Estates Workers
Capital development (not all estates)
Number of sub groups feeding in:
ANTI-RACIST INVESTIGATION PLAN GROUP
Chair: TBC
Meets bi-monthly
Reporting TBC
WAST USERS GROUP
Chair: TBC
Meeting Frequency TBC
Reporting TBC
WELSH LANGUAGE ADVISORY GROUP
Chair: Director of Culture Change
Meeting Frequency TBC
Reports to EDICG on ASA
LESBIAN, GAY NETWORK
Chair: TBC
Meeting Frequency TBC
Reporting TBC
TRANSPORT PROJECT BOARD
(Sub-involved)
(Frequency TBC)
EPMS PROGRAMME BOARD
(Sub-involved)
(Frequency TBC)
Clinical Audit Group (CAG)
Chair: Lisa Lewis/Clinical Effect
Meeting Frequency as at 23/24 but may change
Reports to/ Ask to CQSC
PEOPLE AND COMMUNITY VOICE GROUP
Chair: Director of Culture Change
Quarterly - May morph into People and Community Network Group per Jo Turton's paper
TBC - Query if this has to be Quarterly
Workstreams reporting:
•Improvement of ambulance response in urban, rural and all hospital conflux areas
•Addiction management (ACAS), clinical pathways and alternative conveyance
•Safety themes and trends (primarily all by exception)
Clinical Indicator Review Group
PRESCRIBED CLINICAL REFERENCE GROUP
Chair: TBC
Meeting Frequency TBC
Reports on Ask to CQSC
CLINICAL ADVISORY GROUP
Chair: Medical Director/Deputy
Meeting Frequency TBC
Reports on Ask to CQSC
CLINICAL PRIORITISATION DEVELOPMENT SOFTWARE (CPDS)
Chair: Head of Clinical Operations
Meets Monthly - assurance from CPDS Ltd re NHP transformation work)
Reports by exception to CQSC
CLINICAL PRIORITISATION AND CONTROL GROUP
Chair: Head of Clinical Operations
Meeting Frequency TBC
Reports on Ask to CQSC
Cohort to be established and reviewed in Q1 of 24/25
24/25 Audit - Non-Management of EA clinical complaints)
Chair: TBC
Reports on Ask to CQSC
Individuals from Stroke Forum, Heart Forum and Maternity Forum
Reports on Ask to CQSC
SERIOUS CASE REVIEW GROUP
Purpose: Review of serious cases and action plan
Chair: Ingrid Mills
Ask & by exception to CQSC/if needed outside this
LEARNING AND PUBLIC PROTECTION GROUP
Meets Every two months
Report on Ask to CQSC
MENTAL CASE (MCARD) PANEL
Chair: Head of Clinical Operations
Quarterly assessment
Ask to escalate by exception required
Output captured in TTS report
PAEDIATRIC ACCIDENT CLINICAL GOVERNANCE GROUP
Quarterly assessment
Ask to escalate by exception required
Reports to CQSC - does not meet monthly
PROFESSIONAL NURSING AND MIDWIFERY FORUM
Chair: Director of Nursing
Ask to escalate by exception
Lines of reglement/control/accountability
Urgent Community Response Service
Workstream Board
Executive Sponsor: Andy Swinbourn
SRO: Sara Thompson
CMT Reporting Route
BAME NETWORK
LGBTQ+ NETWORK
DISABILITY NETWORK
WOMEN'S NETWORK
CARERS NETWORK

STRATEGIC DEVELOPMENT AND DELIVERY ARM



DIRECTORATE GOVERNANCE ARM



Annex 2 – Organisational governance tiering principles

TIER 1 (ELT)

Primary Executive decision-making Body (subject to individual delegations)
Supports CEO in leadership and management of the Trust
Wide-ranging remit in TOR
Key artifacts: TOR; minutes; forward planner; actions & decisions log

TIER 2

Established by a T1 committee
Chair is a member of the T1 committee
Operates with a delegated portion of the T1 committee's remit and authority
Undertakes detailed exploration of specific areas
Provides focused assurance to primary T1 committee
Enables swift escalation of issues to the T1 committee via a AAA
Key artifacts: TOR; work programme; minutes only for areas of potential exposure or where audit or regulators require a clear trail; AAA to T1 Committee; work programme; forward planner; actions & decisions Log

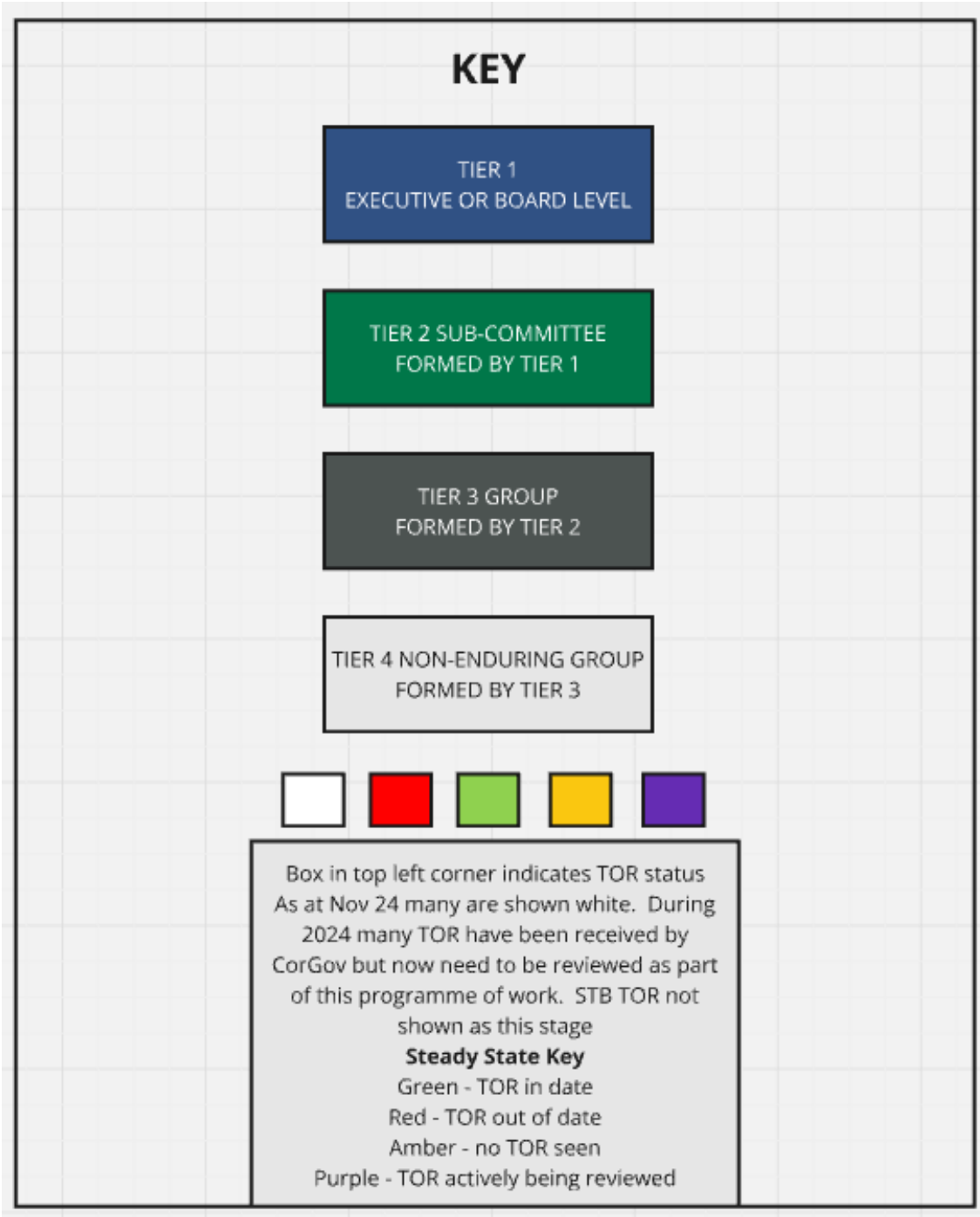
TIER 3

Established by a T2 committee
Chair is a member of the T2 committee
Operates with a delegated portion of the T1 committee's remit and authority
Undertakes further detailed exploration of specific areas in the T2 committee's TOR
Key artifacts: TOR; work programme; AAA to T2 committee; forward planner; actions & decisions log

TIER 4

Established by a T3 committee
Chair is a member of the T3 committee
Usually time limited working group or task and finish group
Operates with a narrow scope, often for work that requires pace and subject matter expertise
Key artifacts: TOR; work programme; AAA to T3 committee; forward planner; actions and decisions log; closure report

KEY



Box in top left corner indicates TOR status
As at Nov 24 many are shown white. During 2024 many TOR have been received by CorGov but now need to be reviewed as part of this programme of work. STB TOR not shown as this stage

Steady State Key

Green - TOR in date
Red - TOR out of date
Amber - no TOR seen
Purple - TOR actively being reviewed

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

AGENDA ITEM No	**14**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**1**

TRUST POLICY REPORT

MEETING	Audit, Risk and Assurance Committee (ARAC)
DATE	6 March 2025
EXECUTIVE	Trish Mills, Director of Corporate Governance/Board Secretary
AUTHOR	Lisa Trounce, Head of Compliance and Assurance / Policy Group Chair
CONTACT	Lisa.Trounce@wales.nhs.uk

EXECUTIVE SUMMARY

1. The purpose of the report is to provide an update to the Committee on the status of the Trust's policy work programme to bring key policies up to date.

2. A work programme for 2023/24 was established following the Covid-19 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. A further work plan was agreed for 2024/25.

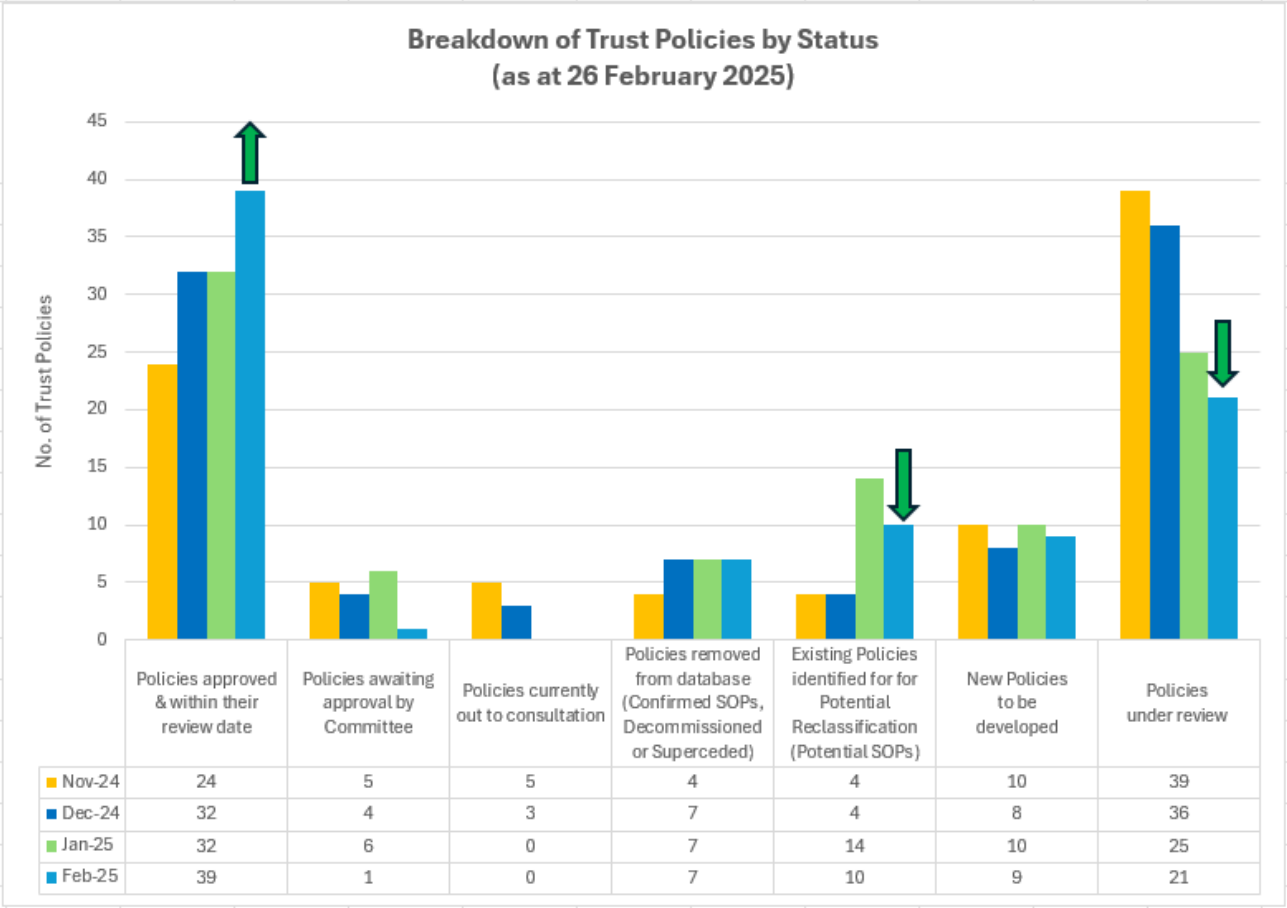
3. Whilst the work plans have been held flexibly from the outset to take account of resourcing demands, internal and external pressures, and the competing portfolios of Directorate Policy Leads; it is pleasing to report that a significant amount of work has taken place to refresh existing policies and develop new ones, with reports submitted to the Committee by exception as agreed.

4. A breakdown of all policies within the Trust and their status regarding the stages of review/approval is described in the table and graph below:

Status	Number
Policies approved and within their review date	39
Policies due to be approved by end of March 2024	1
Policies currently out to consultation	0
Policies removed from database (**see note overleaf*)	7
Policies identified as Potential Standard Operating Procedures	10
New Policies to be developed	9
NHS All Wales Policies	30
Other Policies: 1x Welsh Government Policy and 1x NMC Policy	2
Policies still to be reviewed	21
Total Number of Policies	**127**

**Approved for reclassification to Standard Operating Procedures, Decommissioned or Superseded.*

5. The graph below shows the decrease in the number of Trust-owned policies which require review, and the increase in those approved and now within their review date.



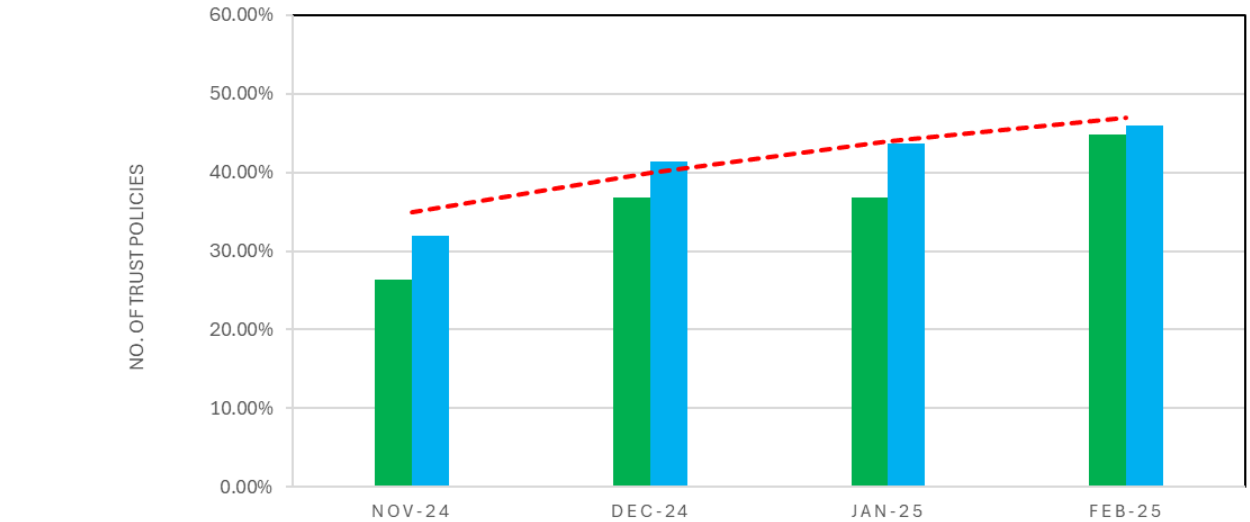
	Policies approved & within their review date	Policies awaiting approval by Committee	Policies currently out to consultation	Policies removed from database (Confirmed SOPs, Decommissioned or Superceded)	Existing Policies identified for for Potential Reclassification (Potential SOPs)	New Policies to be developed	Policies under review
Nov-24	24	5	5	4	4	10	39
Dec-24	32	4	3	7	4	8	36
Jan-25	32	6	0	7	14	10	25
Feb-25	39	1	0	7	10	9	21

6. Assurance against the progress of the policy work programmes is provided routinely following each Policy Group meeting via the Alert, Advice, Assure (AAA) reports. These reports were previously presented to the Executive Leadership Team (ELT); However, in view of the improved compliance, since December 2024 Policy Group has reported to the Assistant Directors Leadership Team (ADLT).

7. The work undertaken to date shows that 46% of Trust owned policies are within their review date compared to 14% overall reported to Committee in July 2023 and at the time the initial 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.

8. Of the 30 NHS All Wales NHS Policies that the Trust has adopted, 7 of these are within their review date - equating to 23% overall. These figures and policy reviews are out of the Trust's control as the programme of policy review work sits with NHS Wales. Similarly, the 2 policies which sit with Welsh Government and the Nursing and Midwifery Council (NMC) are also outside the Trust's control but continue to be monitored.

9. A performance trajectory has been mapped to ensure at least 95% of Trust-owned policies are within review date compliance by the end of March 2026. The graph below shows an improved trajectory; However, as a result of seasonal pressures and other priority work streams, in February 2025 planned % compliance fell just short of the projected target. we are confident of being able to regain momentum with effect from March 2025 onwards.



	Nov-24	Dec-24	Jan-25	Feb-25
Current % Compliance	26.37%	36.78%	36.78%	44.83%
Planned % Compliance	31.87%	41.38%	43.68%	45.98%
Projected % Compliance	35.00%	40.00%	44.00%	47.00%

10. Acknowledging that several work streams have moved on since the initial prioritisation exercise was undertaken in 2023, progress against the 2024/25 Policy Work Programme is contained at **Annex 1**.

11. As well as indicating those policies that have been updated and approved since the previous report in October 2024, it also details the policies scheduled to be presented to Policy Group in March 2025, and identifies the 32 policies that are expected to be carried forward for review or development during 2025/26.

12. During March 2025, we will be engaging with Directorates to agree the 2025/26 Policy Work Programme, against which compliance will be assessed and included within the routine monthly reports to the ADLT with effect from April 2025.

RECOMMENDATION:

13. **Members are asked to:**
    a) **Receive assurance on the progress to bring the Trust's Policies up to date.**
    b) **Endorse the future work plans for the remainder of this work.**

KEY ISSUES/IMPLICATIONS
14. The key issues are set out in the Executive Summary above.

REPORT APPROVAL ROUTE
15. Progress against the work plans was reported to ADLT via the monthly, Policy Group AAA following each Policy Group meeting.

REPORT ANNEXES
16. Annex 1 – 2025/26 Policy Work Programme.

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

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Key:	
	Policies approved since last report (Oct24)
	Policies scheduled for Policy Group in 2024/25 Q4
	Policies awaiting approval during 2024/25 Q4
	Policies c/f to 2025/26 Policy Work Programme

Annex 1: Update on 2024/25 Policy Work Programme

Policy Title	Priority Number 1 High 10 Low 2023/24	Priority Number 1 High 10 Low 2025/26	Directorate	Policy Lead	Current Status
Violence & Aggression Policy	1	1	Quality, Safety & Patient Experience	Nicola White	Initially proposed for reclassification to a SOP but decision then made to review policy this year. Scheduled for Policy Group in March 2025
Return to Practice Policy [previously Educational Programmes Policy]	1	1	People Services	Martin Mulholland	In Development - Presented to Policy Group in October 2024 where revised approach agreed and is now in progress
Retirement Policy	1	1	People Services	Sara Williams	Awaiting guidance to be issued on All Wales basis
Policy For the Development, Review and Approval of Policies	1	1	Corporate Governance	Lisa Trounce	c/f to 2025/26 Policy Work Programme Q1 to align with implementation of new system
Equality, Diversity and Inclusion Policy	1	1	People Services	Kat Cobley	Approved by PCC in February 2025
Estates, Environmental and Facilities Management Policy	1	1	Finance & Corporate Resources	Susan Woodham	Presented to Policy Group in October 2024 – policy required further work which is underway.
CCTV Policy	2	1	Digital	Kelly Holding	Scheduled for Policy Group in March 2025
Assessment, Failure Referral and Appeals Policy	2	1	People Services	Martin Mulholland	Scheduled for Policy Group in March 2025
Bank Worker Policy	7	1	People Services	Michelle Morse	Approved by PCC in February 2025
Driving at Work Policy	1	N/A	People Services	Andrew Morgan	Approved by PCC in December 2024
Equality Impact Assessment (EqIA) Policy	1	N/A	People Services	Kat Cobley	Approved by QuEST in February 2025

Policy Title	Priority Number 1 High 10 Low 2023/24	Priority Number 1 High 10 Low 2025/26	Directorate	Policy Lead	Current Status
Occupational Immunisation and Screening Policy	1	N/A	People Services	Kim Crichton	NEW - Approved by PCC in February 2025
Recruitment and Selection Policy	1	N/A	People Services	Charlie Bosher	Approved by PCC in February 2025
Management Of Allegations Policy: When an Allegation or Concern Is Raised About an Employee or Volunteer	2	2	Quality, Safety & Patient Experience	Gwenan Jones-Parry	Scheduled for Policy Group in March 2025
Fuel Card Policy	9	2	Finance & Corporate Resources	Gavin Lane	In development - c/f to 2025/26 Policy Work Programme Q1 to allow time for updated policy to go to Senior Operations Team for review
Information Risk Policy	10	2	Digital	Kelly Holding	For approval by FPC in March 2025
People Development Policy	NEW	2	People Services	Jo Kelso	Scheduled for Policy Group in March 2025
Infection, Prevention and Control: Sharps Policy	2	N/A	Quality, Safety & Patient Experience	Louise Colson	Approved by QuEST in November 2024
Occupational Health Policy	2	N/A	People Services	Kim Crichton	Approved by PCC in February 2025
Alternatives to Conveyance Policy	3	3	Clinical	Bryn Thomas	Scheduled for Policy Group in March 2025
Safer Handling Policy	3	3	Quality, Safety & Patient Experience	Graham Stockford	Request for Policy Reclassification (to a SOP) considered by Policy Group in November 2024 – legal advice to be sought. Scheduled for Policy Group in March 2025.
Lone Worker Policy	3	3	Quality, Safety & Patient Experience	Nicola White	Initially proposed for reclassification to a SOP but decision then made to review policy this year. Scheduled for Policy Group in March 2025

Policy Title	Priority Number 1 High 10 Low 2023/24	Priority Number 1 High 10 Low 2025/26	Directorate	Policy Lead	Current Status
Colleague Experience / Wellbeing Policy	3	3	People Services	Lynda Bugonovic	New – c/f to 2025/26 Policy Work Programme (policy or guidance? – to be determined)
Freedom of Information Policy	3	3	Corporate Governance	Lisa Trounce	c/f to 2025/026 Policy Work Programme to align with planned Policy Transformation
Bring Your Own Device (BYOD) Policy	NEW	3	Digital	James Rowland	In development - c/f to 2025/26 Policy Work Programme to allow time for queries raised to be resolved
Vehicle Disposal Policy	8	3	Finance & Corporate Resources	Gavin Lane	Scheduled for Policy Group in March 2025
Tyres and Wheels Policy	10	3	Finance & Corporate Resources	Gavin Lane	Scheduled for Policy Group in March 2025 (Potential SOP)
Vehicle Telematics Policy	10	3	Finance & Corporate Resources	Gavin Lane	Scheduled for Policy Group in March 2025
Working Time Regulations Policy	5	4	People Services	Sara Williams / Emma Morgan	Low risk - c/f to 2025/26 Policy Work Programme
Information Sharing Policy	6	4	Digital	Kelly Holding	c/f to 2025/26 Policy Work Programme
Information Governance Policy	6	4	Digital	Kelly Holding	c/f to 2025/26 Policy Work Programme
Maternity Policy	3	5	People Services	Sophie James	Low risk - c/f to 2025/26 Policy Work Programme
Paternity Policy	3	5	People Services	Sophie James	Low risk - c/f to 2025/26 Policy Work Programme
Shared Parental Leave Policy	3	5	People Services	Sophie James	Low risk - c/f to 2025/26 Policy Work Programme
Trust Mobile Phone Policy	9	5	Digital	Aled Williams / Tony Raine	Scheduled for Policy Group in March 2025

Policy Title	Priority Number 1 High 10 Low 2023/24	Priority Number 1 High 10 Low 2025/26	Directorate	Policy Lead	Current Status
Safeguarding Children and Adults at Risk of Harm Policy	5	5	Quality, Safety & Patient Experience	Gwenan Jones-Parry	Approved by QuEST in February 2025
Violence Against Women, Domestic Abuse and Sexual Violence 'Ask & Act' Policy	5	N/A	Quality, Safety & Patient Experience	Rhiannon Thomas	Approved by QuEST in February 2025
Management of Compensation Claims Policy	6	6	Quality, Safety & Patient Experience	Trish Gaskell	c/f to 2025/26 Policy Work Programme
Redeployment Policy	7	6	People Services	Emma Morgan	In development – c/f to 2025/26 Policy Work Programme
Electronic Patient Care Record (EPCR) Policy	7	N/A	Digital	Keith Dorrington	Scheduled for Policy Group in March 2025
Managing Families and Relatives Working Together Policy	9	7	People Services	Amanda Jones	In development – c/f to 2025/26 Policy Work Programme
Access Control Policy	8	8	Digital	Kelly Holding	c/f to 2025/26 Policy Work Programme
Adverse Weather Conditions Policy	8	8	People Services	Bethan Davies	Scheduled for Policy Group in April 2025
Work Experience Policy	8	8	People Services	Sara Minahan	Request for Policy Reclassification (to a SOP) c/f to 2025/26 Policy Work Programme
Bursary Scheme Policy	10	8	People Services	Sarah Davies	No legislative impacts - c/f to 2025/26 Policy Work Programme
Records Management Policy	8	N/A	Digital	Judith Birkett	Approved by FPC in November 2024
Information Classification Policy	9	9	Digital	Aled Williams	Scheduled for Policy Group in June 2025
Mobile Computing Policy	9	9	Digital	Aled Williams / James Rowlands	Drafted – nb: most aspects now covered under Information Security Policy. c/f to 2025/26 Policy Work Programme

Policy Title	Priority Number 1 High 10 Low 2023/24	Priority Number 1 High 10 Low 2025/26	Directorate	Policy Lead	Current Status
Relocation Expenses Policy	2	10	People Services	Jan Cross Anna Stein	To be superceded by All Wales Policy which is awaited therefore policy to remain extant until replaced.
Confidentiality And Code of Conduct	10	10	Digital	Kelly Holding	In development – Scheduled for Policy Group in April 2025
Study Leave Policy	4	TBC	People Services	Mubo Farukanmi	c/f to 2025/26 Policy Work Programme
Transfer Policy	N/A	TBC	People Services	Jeff Morris (Operations)	Scheduled for Policy Group in March 2025
Access to Personal Information Policy	7	TBC	Digital	Judith Birkett	Scheduled for Policy Group in March 2025
Children In Special Circumstances Policy & Procedure	TBC	TBC	Medical & Clinical	Ed O'Brien	Under review – possibly to be decommissioned. Scheduled for Policy Group in June 2025
High Risk Record Policy	TBC	TBC	Operations	Gill Pleming / James Gough	Scheduled for Policy Group in March 2025
MPDS Quality Assurance Policy	TBC	TBC	Operations	Andrew Garner	c/f to 2025/26 Policy Work Programme
Quality Assurance Framework for the Clinical Desk	TBC	TBC	Operations	TBC	c/f to 2025/26 Policy Work Programme
Resourcing Policy	TBC	TBC	Operations	Siobhain Frain	c/f to 2025/26 Policy Work Programme to align with Resourcing Policy Internal Audit actions.
Business Continuity Management Policy	N/A	TBC	Operations	Mathew Jones	In development – Scheduled for Policy Group in March 2025
Welsh Language Policy	N/A	N/A	Corporate Governance	Melfyn Hughes	Approved by PCC in November 2024

Policy Title	Priority Number 1 High 10 Low 2023/24	Priority Number 1 High 10 Low 2025/26	Directorate	Policy Lead	Current Status
Airway Policy	N/A	N/A	Clinical	Mike Jenkins	Approved by QuEST in December 2024
Transgender Policy	NEW	TBC	People Services	Kat Cobley	No legal requirement to have this policy but considered good practice. c/f to 2025/26 Policy Work Programme.
PREVENT Policy	NEW	TBC	Quality, Safety & Patient Experience	Vicky Maxwell	New policy – in development. Scheduled for Policy Group in April 2025

QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE
HIGHLIGHT REPORT TO AUDIT COMMITTEE

This report provides the Audit Committee with key escalation and discussion point at the last Committee meeting.

Audit Committee Meeting Date	06 March 2025
Committee Meeting Date	04 February 2025
Chair	Bethan Evans

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of escalation)

1. No alerts for the Audit Committee.

ADVISE

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

2. No areas to advise for the Audit Committee.

ASSURE

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

3. This committee's terms of reference at paragraph 3.16 provides that it will: "*Approve the annual clinical audit plan that meets the standards set for the NHS in Wales; review the outcomes of* ***clinical audits*** *in line with the clinical audit plan and provide assurance to the Audit Committee in this respect*".

4. The Trust's annual **Clinical Audit Plan 2025/26**, which allows the planning and prioritisation of clinical audits across the financial year was approved for 2025/26 at this meeting. Further audit topics will be considered for inclusion as new guidelines and medicines are introduced and changes to clinical practice are implemented. As such, it is not always possible to predict all the topics that require evaluation and therefore this is a dynamic document which will be updated quarterly. The committee will monitor the plan and outcomes on a quarterly basis.

5. The **Audit Wales Quality Governance Follow Up Review report** was received and presented by Audit Wales. Progress in implementing recommendations from the 2022 Quality Governance Review was acknowledged, noting that some recommendations were not fully complete. The responses to both the re-opened 2022 and 2024 recommendations were reviewed, with the specificity on evidence to close the actions welcomed.

6. Overall, the discussions against this review highlighted the Trust's commitment to continuous improvement, the importance of realistic timelines for management actions, and the need for better data sharing and collaboration with system partners to enhance quality governance. It is understood that this Audit Wales report is before the Audit, Risk and Assurance Committee at its meeting in March 2025.

RISKS

N/A

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

AGENDA ITEM No	**16**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**1**

LOSSES AND SPECIAL PAYMENTS - PAYMENTS FOR THE PERIOD FROM 1ST APRIL 2024 TO 31st JANUARY 2025

MEETING	Audit Committee
DATE	6th March 2025
EXECUTIVE	Chris Turley, Executive Director of Finance and Corporate Resources
AUTHOR	Jessica Price, Head of Financial Accounting
CONTACT	Jessica.Price3@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 ten months from 1st April 2024 to 31st January 2025 (**Annex 1**)

KEY ISSUES/IMPLICATIONS

Total net Losses and Special Payments made were as follows: -

- period 1st April 2024 to 31st January 2025 £0.501m

REPORT APPROVAL ROUTE

Audit Committee 6th March 2025 – no action required for information under SFI's only

REPORT APPENDICES
Annex 1 – Summary and details of payments made for the ten months to 31st January 2025

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

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

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 JANUARY 2025

SITUATION

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

BACKGROUND

2. This report presents to the Committee details of Losses and Special Payments made during the ten months from 1st April 2024 to 31st January 2025 (**Annex 1**)

ASSESSMENT

3. Total net Losses and Special Payments made during the period 1st April 2024 to 31st January 2025 amounted to £0.501 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 ten months to 31st January 2025 payments made exceeded reimbursements received by £0.501m.

5. During October you will note Damages payments amounted to £0.126m along with the Claimants Solicitors costs amounting to £0.058m. The vast majority of payments in both areas relate to the liability for WAST in relation to 1 medical negligence claim, which is a claim with 50:50 liability between WAST and Betsi Cadwaladr UHB, in which the patient died.

6. During November you will note Damages payment amounted to £0.225m, of which £0.150m relates to the settlement of 1 medical negligence case in which the patient died.

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 10 months to 31st January 2025:

	£
April 2024	44,627.36
May 2024	23,895.81
June 2024	-901,844.23
July 2024	492,152.45
August 2024	41,959.47
September 2024	113,626.00
October 2024	206,422.27
November 2024	328,023.64
December 2024	50,002.72
January 2025	101,792.29
February 2025	0.00
March 2025	0.00
	£500,657.78

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	13,000.00	58,404.00	26,750.00	34,705.00	0.00	0.00	0.00	£168,125.80
Counsel fees	10,137.50	7,366.66	6,846.66	-1,100.00	945.00	6,540.00	2,500.00	14,246.70	0.00	0.00	0.00	0.00	£47,482.52
CRU	0.00	0.00	833.00	1,335.00	688.00	2,289.00	-833.00	0.00	0.00	766.00	0.00	0.00	£5,078.00
Damages	22,500.00	0.00	-36,079.00	376,710.00	49,125.00	46,069.00	126,254.00	224,926.00	75,896.33	27,200.00	0.00	0.00	£912,601.33
Defence Costs	45.92	967.74	14,442.55	25,512.80	7,202.55	5,355.43	5,565.50	17,521.78	30,514.40	21,706.81	0.00	0.00	£128,835.48
Expert Witness	398.91	1,500.00	3,233.57	390.00	360.00	15,610.00	0.00	0.00	0.00	0.00	0.00	0.00	£21,492.48
Vehicle Repairs	11,545.03	13,521.41	73,806.43	30,444.65	36,735.27	24,762.57	53,260.17	44,121.16	39,974.65	53,544.48	0.00	0.00	£381,715.82
WRP Refund	0.00	0.00	-975,394.24	0.00	-53,138.35	0.00	-39,628.40	0.00	-131,087.66	-1,425.00	0.00	0.00	-£1,200,673.65
Property Repairs	0.00	540.00	1,200.00	32,860.00	42.00	0.00	900.00	458.00	0.00	0.00	0.00	0.00	£36,000.00
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**	**£41,959.47**	**£113,626.00**	**£206,422.27**	**£328,023.64**	**£50,002.72**	**£101,792.29**	**£0.00**	**£0.00**	**£500,657.78**

Welsh Ambulance Services University NHS Trust
Losses and Special Payments

Summary of payments for the ten months to 31st Jan 2025:

Key
MN - Medical Negligence
PI - Personal Injury
DP - Damage to Property

	£	
DP cases <£1000	25,180.56	71 CASES
PI cases < £1,000	4,361.00	8 CASES
Redress cases <£1000	2,750.00	5 CASES
24RT4MN0012	14.35	
23RT4MN0004	66.00	
25RT4MN0023	80.49	
25RT4MN0025	114.80	
25RT4MN0021	117.20	
24RT4MN0015	129.31	
25RT4MN0024	140.63	
23RT4MN0011	390.00	
25RT4MN0022	534.44	
24RT4MN0008	750.00	
25RT4MN0020	900.00	
25RT4MN0026	910.00	
18RT4MN0016	1,000.00	
25RT4MN0017	1,260.00	
24RT4MN0011	1,500.00	
22RT4MN0017	2,275.00	
25RT4MN0016	2,820.00	
23RT4MN0021	2,850.00	
22RT4MN0016	5,128.00	
21RT4MN0009	5,200.00	
25RT4MN0001	6,510.00	
20RT4MN0018	13,981.67	
16RT4MN0009	25,000.00	
20RT4MN0008	28,951.67	
22RT4MN0018	33,884.20	
22RT4MN0011	40,000.00	
24RT4MN0013	49,700.00	
24RT4MN0009	60,933.00	
22RT4MN0001	153,182.91	
22RT4MN0002	177,314.20	
18RT4MN0012	182,275.00	
22RT4PI0006	1,424.00	
24RT4PI0026	1,834.00	
21RT4PI0021	1,850.00	
19RT4PI0032	2,000.00	
24RT4PI0057	2,626.00	
24RT4PI0006	5,009.50	
19RT4PI0037	5,849.85	
22RT4PI0020	7,500.00	
19RT4PI0009	15,250.80	
22RT4PI0003	18,854.00	
22RT4PI0046	22,301.85	
24RT4PI0043	22,376.00	
22RT4PI0022	23,400.00	
21RT4PI0026	25,945.40	
22RT4PI0038	27,052.83	
21RT4PI0006	51,500.00	
13RT4PI0035	54,945.00	
24RT4GND020	1,375.00	
23RT4GND022	1,600.00	
24RT4GND019	1,620.00	
23RT4GND012	1,600.00	
22RT4GND037	2,400.00	
22RT4GND012	2,800.00	
24RT4GND018	3,300.00	
22RT4GND005	3,800.00	
23RT4GND026	3,920.00	
24RT4GND036	6,569.00	
24RT4GND026	24,750.00	
25RT4EGD003	1,000.00	
25RT4EGD006	1,000.00	
25RT4EGD008	1,000.00	
25RT4EGD013	1,000.00	
25RT4EGD014	1,000.00	
25RT4EGD027	1,000.00	
25RT4EGD034	1,000.00	
25RT4EGD039	1,000.00	
25RT4DPD082	1,014.22	
25RT4DPD135	1,049.28	
25RT4DPD128	1,053.15	
24RT4DPD034	1,067.66	
25RT4EGD001	1,100.00	
25RT4DPD001	1,138.42	
25RT4DPD177	1,181.73	
22RT4DPD085	1,200.00	
25RT4DPD157	1,204.00	
25RT4DPD043	1,247.20	
25RT4EGD019	1,250.00	
25RT4EGD026	1,250.00	
25RT4DPD049	1,300.00	
25RT4DPD138	1,328.64	
24RT4DPD068	1,366.97	
25RT4DPD170	1,391.12	
25RT4EGD009	1,400.00	
25RT4DPD076	1,426.08	
25RT4DPD124	1,430.06	
25RT4EGD045	1,461.45	
25RT4DPD087	1,462.43	
24RT4DPD017	1,500.00	
25RT4EGD017	1,500.00	
25RT4EGD018	1,500.00	
25RT4EGD033	1,500.00	
25RT4EGD036	1,500.00	
25RT4DPD050	1,560.43	
25RT4DPD035	1,622.58	
25RT4DPD051	1,626.30	
25RT4DPD117	1,645.93	
25RT4DPD095	1,676.03	
25RT4DPD126	1,692.10	
25RT4DPD149	1,730.15	
25RT4DPD132	1,789.12	
25RT4DPD077	1,814.89	
25RT4DPD034	1,837.08	
25RT4DPD101	1,878.48	
25RT4DPD063	1,922.30	
25RT4DPD160	1,969.92	
25RT4DPD169	1,986.44	
25RT4DPD014	2,000.00	
25RT4DPD123	2,000.00	
25RT4EGD041	2,000.00	
25RT4DPD098	2,112.95	
25RT4DPD090	2,118.96	
25RT4DPD110	2,180.73	
25RT4DPD074	2,236.08	
25RT4EGD032	2,250.00	
25RT4DPD036	2,287.04	
25RT4DPD125	2,350.60	
25RT4DPD178	2,373.89	
25RT4DPD150	2,394.00	
25RT4DPD114	2,414.75	
25RT4DPD096	2,474.24	
25RT4DPD144	2,568.24	
25RT4DPD155	2,594.31	
25RT4DPD078	2,749.85	
25RT4DPD004	2,770.56	
25RT4DPD059	2,969.88	
25RT4DPD051	3,000.00	
25RT4DPD179	3,031.05	
25RT4DPD176	3,056.20	
25RT4DPD069	3,073.49	
25RT4DPD081	3,074.17	
25RT4DPD159	3,108.26	
25RT4DPD180	3,115.57	
25RT4DPD119	3,205.02	
25RT4EGD037	3,250.00	
25RT4EGD038	3,300.00	
25RT4DPD007	3,358.60	
25RT4DPD093	3,390.52	
25RT4EGD044	3,450.00	
25RT4DPD085	3,477.70	
25RT4DPD075	3,502.68	
25RT4DPD039	3,573.10	
25RT4DPD148	3,634.40	
25RT4DPD023	3,660.49	
25RT4EGD016	3,740.18	
25RT4DPD172	3,864.75	
25RT4DPD088	3,870.00	
25RT4DPD092	3,996.80	
25RT4DPD156	4,078.49	
25RT4DPD129	4,439.36	
25RT4DPD154	4,487.95	
25RT4EGD028	4,500.00	
25RT4DPD079	4,548.00	
25RT4DPD173	4,835.00	
25RT4DPD106	4,872.33	
25RT4DPD052	4,886.26	
25RT4DPD146	4,963.96	
25RT4DPD133	5,043.75	
25RT4EGD004	5,500.00	
25RT4DPD082	5,972.05	
25RT4DPD022	6,018.55	
25RT4DPD024	6,104.85	
25RT4DPD064	6,180.54	
25RT4DPD053	6,524.78	
25RT4DPD165	6,779.78	
25RT4DPD021	7,576.41	
25RT4DPD060	7,925.65	
24RT4EGD028	8,080.32	
25RT4DPD166	8,640.55	
25RT4DPD038	9,505.54	
25RT4DPD071	10,000.00	
25RT4DPD163	10,022.16	
25RT4DPD161	12,357.37	
25RT4DPD168	12,950.02	
25RT4DPD102	15,166.21	
25RT4DPD112	21,162.45	
25RT4DPD057	31,560.00	
25RT4DPD097	38,798.43	
20RT4MN0019	76,776.28	WRP Refund
20RT4MN0011	892,874.96	WRP Refund
21RT4PI0035	743.00	WRP Refund
20RT4PI0007	12,058.08	WRP Refund
22RT4PI0019	48,764.36	WRP Refund
20RT4PI0008	53,138.35	WRP Refund
24RT4GND008	300.00	WRP Refund
24RT4GND007	500.00	WRP Refund
24RT4GND010	600.00	WRP Refund
24RT4GND009	1,000.00	WRP Refund
24RT4GND025	4,012.00	WRP Refund
23RT4GND036	5,000.00	WRP Refund
21RT4GND012	16,426.40	WRP Refund
21RT4GND023	21,802.00	WRP Refund
22RT4DPD013	7,231.05	Case won
15RT4MN0010	1,425.00	WRP Refund
TOTAL	3,904,637.28	

Welsh Ambulance Services University NHS Trust
Oct-24

Case Reference	Details	Amount (£)
22RT4PI0006	COUNSEL FEES	500.00
22RT4PI0038	COUNSEL FEES	900.00
24RT4PI0043	COUNSEL FEES	1,100.00
24RT4PI0043	COURT FEES	303.00
22RT4MN0001	EXPERT WITNESS	1,300.00
25RT4DP0102	TP VEHICLE REPAIRS	15,166.21
25RT4DP0103	DAMAGE TO PROPERTY	900.00
25RT4EG0029	TRANSCRIPTION FEES	70.00
25RT4EG0030	TRANSCRIPTION FEES	40.00
25RT4EG0031	TRANSCRIPTION FEES	92.50
25RT4EG0031	TRANSCRIPTION FEES	10.00
25RT4DP0104	TP VEHICLE REPAIRS	455.50
25RT4DP0105	TP VEHICLE REPAIRS	1,878.48
25RT4EG0032	PROFESSIONAL FEES	2,250.00
25RT4DP0106	TP VEHICLE REPAIRS	4,873.33
25RT4DP0101	TP VEHICLE REPAIRS	83.40
25RT4DP0101	TP VEHICLE REPAIRS	- 83.40
25RT4DP0107	TP VEHICLE REPAIRS	294.55
25RT4DP0107	TP VEHICLE REPAIRS	- 294.55
25RT4DP0080	TP VEHICLE REPAIRS	1,145.29
25RT4DP0080	TP VEHICLE REPAIRS	- 1,145.29
25RT4DP0108	TP VEHICLE REPAIRS	250.00
25RT4DP0109	TP VEHICLE REPAIRS	735.00
25RT4DP0109	TP VEHICLE REPAIRS	- 735.00
25RT4DP0110	TP VEHICLE REPAIRS	2,180.73
25RT4EG0033	PROFESSIONAL FEES	1,500.00
25RT4DP0111	TP VEHICLE REPAIRS	1,011.75
25RT4DP0111	TP VEHICLE REPAIRS	- 1,011.75
25RT4DP0112	TP VEHICLE REPAIRS	6,588.84
25RT4DP0112	TP VEHICLE REPAIRS	14,151.59
25RT4DP0113	TP VEHICLE REPAIRS	50.49
25RT4DP0114	TP VEHICLE REPAIRS	2,414.75
25RT4DP0115	TP VEHICLE REPAIRS	29.51
25RT4DP0115	TP VEHICLE REPAIRS	- 29.51
25RT4DP0116	TP VEHICLE REPAIRS	4,737.15
25RT4DP0116	TP VEHICLE REPAIRS	- 4,737.15
25RT4DP0117	TP VEHICLE REPAIRS	1,645.93
25RT4DP0118	TP VEHICLE REPAIRS	771.79
25RT4DP0119	TP VEHICLE REPAIRS	3,205.02
25RT4DP0120	TP VEHICLE REPAIRS	337.74
25RT4DP0118	TP VEHICLE REPAIRS	- 710.23
25RT4DP0121	TP VEHICLE REPAIRS	121.05
25RT4DP0121	TP VEHICLE REPAIRS	- 121.05
22RT4PI0003	GENERAL DAMAGES SETTLEMENT	10,000.00
22RT4PI0003	PROFFESSIONAL FEES	8,354.00
24RT4PI0026	GENERAL DAMAGES SETTLEMENT	1,834.00

20RT4MN0018	CRU Returned	- 833.00
22RT4MN0002	GENERAL DAMAGES SETTLEMENT	100,000.00
22RT4MN0002	SOLICITORS FEES	50,000.00
23RT4MN0021	SOLICITORS FEES	50.00
24RT4MN0009	GENERAL DAMAGES SETTLEMENT	10,000.00
23RT4GN0026	GENERAL DAMAGES SETTLEMENT	3,920.00
24RT4GN0031	GENERAL DAMAGES SETTLEMENT	500.00
21RT4GN0023	WRP REFUND RECEIVED	- 21,802.00
24RT4GN0010	WRP REFUND RECEIVED	- 600.00
24RT4GN0008	WRP REFUND RECEIVED	- 300.00
21RT4GN0012	WRP REFUND RECEIVED	- 16,426.40
24RT4GN0007	WRP REFUND RECEIVED	- 500.00
Totals		**206,422.27**

Welsh Ambulance Services University NHS Trust
Nov-24

Case Reference	Details	Amount (£)
21RT4PI0026	COUNSEL FEES	3,500.00
22RT4PI0046	PROFESSIONAL FEES	4,050.00
22RT4PI0046	COUNSEL FEES	500.00
24RT4PI0043	COUNSEL FEES	700.00
24RT4PI0043	COUNSEL FEES	150.00
21RT4MN0009	COUNSEL FEES	670.00
22RT4MN0002	TRANSCRIIPTION COSTS	1,174.20
22RT4MN0018	COUNSEL FEES	8,726.70
25RT4MN0020	EXPERT WITNESS	900.00
25RT4MN0021	TRANSCRIPTION COSTS	63.14
25RT4MN0022	TRANSCRIPTION COSTS	34.44
25RT4MN0022	EXPERT WITNESS	500.00
25RT4DP0122	TP VEHICLE REPAIRS	300.00
25RT4DP0123	TP VEHICLE REPAIRS	2,000.00
25RT4DP0124	TP VEHICLE REPAIRS	1,430.06
25RT4DP0125	TP VEHICLE REPAIRS	2,159.80
25RT4DP0125	TP VEHICLE REPAIRS	190.80
25RT4DP0126	TP VEHICLE REPAIRS	1,692.10
25RT4DP0127	DAMAGE TO PROPERTY	108.00
25RT4DP0128	TP VEHICLE REPAIRS	1,053.15
25RT4DP0129	TP VEHICLE REPAIRS	4,439.36
25RT4DP0130	TP VEHICLE REPAIRS	3,115.57
25RT4EG0034	PROFESSIONAL FEES	1,000.00
25RT4EG0035	PROFESSIONAL FEES	750.00
25RT4EG0036	PROFESSIONAL FEES	1,500.00
25RT4DP0131	TP VEHICLE REPAIRS	440.29
25RT4DP0132	TP VEHICLE REPAIRS	1,789.12
25RT4DP0133	TP VEHICLE REPAIRS	4,743.75
25RT4DP0134	TP VEHICLE REPAIRS	352.80
25RT4EG0037	PROFESSIONAL FEES	3,250.00
25RT4DP0135	TP VEHICLE REPAIRS	1,049.28
25RT4DP0136	TP VEHICLE REPAIRS	185.11
25RT4DP0137	TP VEHICLE REPAIRS	500.00
25RT4DP0138	TP VEHICLE REPAIRS	1,328.64
25RT4DP0139	DAMAGE TO PROPERTY	350.00
25RT4DP0140	TP VEHICLE REPAIRS	370.97
25RT4DP0141	TP VEHICLE REPAIRS	268.04
25RT4DP0141	TP VEHICLE REPAIRS	- 268.04
25RT4DP0142	TP VEHICLE REPAIRS	3,686.10
25RT4DP0142	TP VEHICLE REPAIRS	- 3,686.10
25RT4DP0143	TP VEHICLE REPAIRS	450.00
25RT4DP0144	TP VEHICLE REPAIRS	2,568.24
25RT4DP0145	TP VEHICLE REPAIRS	679.38
25RT4DP0146	TP VEHICLE REPAIRS	4,963.96
25RT4EG0038	PROFESSIONAL FEES	3,300.00
25RT4DP0147	TP VEHICLE REPAIRS	440.23

25RT4DP0148	TP VEHICLE REPAIRS	3,634.40
24RT4DP0052	TP VEHICLE REPAIRS	16,388.35
24RT4DP0052	TP VEHICLE REPAIRS	- 16,388.35
24RT4DP0084	TP VEHICLE REPAIRS	8,400.00
24RT4DP0084	TP VEHICLE REPAIRS	- 8,400.00
25RT4DP0149	TP VEHICLE REPAIRS	1,730.15
25RT4DP0150	TP VEHICLE REPAIRS	2,394.00
25RT4DP0151	TP VEHICLE REPAIRS	120.00
25RT4EG0039	PROFESSIONAL FEES	1,000.00
25RT4DP0152	TP VEHICLE REPAIRS	147.78
25RT4DP0152	TP VEHICLE REPAIRS	- 147.78
25RT4DP0080	TP VEHICLE REPAIRS	5,228.51
25RT4DP0080	TP VEHICLE REPAIRS	- 5,228.51
24RT4PI0057	GENERAL DAMAGE SETTLEMENT	2,626.00
16RT4MN0009	GENERAL DAMAGES SETTLEMEMT	25,000.00
18RT4MN0012	GENERAL DAMAGES SETTLEMEMT	150,000.00
22RT4MN0018	GENERAL DAMAGES SETTLEMEMT	6,500.00
22RT4MN0018	SOLICITORS FEES	15,000.00
24RT4MN0013	GENERAL DAMAGES SETTLEMENT	40,000.00
24RT4MN0013	SOLICITORS FEES	10,000.00
24RT4GN0026	PROFESSION FEES	1,750.00
24RT4GN0038	GENERAL DAMAGES SETTLEMENT	800.00
Totals		**328,023.64**

Welsh Ambulance Services University NHS Trust
Dec-24

Case Reference	Details	Amount (£)
19RT4PI0037	TRANSCRIPTION COSTS	1,489.85
21RT4PI0026	COURT FEES	166.00
21RT4PI0026	COURT FEES	119.00
22RT4PI0046	PROFESSIONAL FEES	450.00
24RT4PI0043	COURT FEES	303.00
18RT4MN0016	EXPERT WITNESS	1,300.00
20RT4MN0008	EXPERT WITNESS	1,750.00
20RT4MN0008	PROFESSIONAL FEES	1,656.67
20RT4MN0008	PROFESSIONAL FEES	16,200.00
20RT4MN0008	EXPERT WITNESS	1,220.00
22RT4MN0002	EXPERT WITNESS	390.00
25RT4MN0017	PROFESSIONAL FEES	1,250.00
25RT4MN0023	TRANSCRIIPTION COSTS	80.49
25RT4MN0024	TRANSCRIIPTION COSTS	140.63
25RT4MN0025	TRANSCRIIPTION COSTS	114.80
25RT4MN0026	EXPERT WITNESS	910.00
25RT4DP0154	TP VEHICLE REPAIRS	4,487.95
25RT4EG0040	PROFESSIONAL FEES	551.96
25RT4EG0041	PROFESSIONAL FEES	2,000.00
25RT4DP0155	TP VEHICLE REPAIRS	2,594.11
25RT4DP0156	TP VEHICLE REPAIRS	4,078.49
25RT4DP0157	TP VEHICLE REPAIRS	1,204.00
25RT4DP0158	TP VEHICLE REPAIRS	147.39
25RT4DP0159	TP VEHICLE REPAIRS	3,108.26
25RT4DP0160	TP VEHICLE REPAIRS	1,969.92
25RT4DP0161	TP VEHICLE REPAIRS	12,357.37
25RT4DP0163	TP VEHICLE REPAIRS	10,022.16
25RT4DP0112	COURT FEES	303.00
25RT4DP0112	COURT FEES	119.00
25RT4DP0133	TP VEHICLE REPAIRS	300.00
24RT4DP0074	TP VEHICLE REPAIRS	- 295.00
22RT4PI0038	GENERAL DAMAGES SETTLEMENT	26,152.83
22RT4PI0046	GENERAL DAMAGES SETTLEMENT	10,000.00
24RT4PI0006	GENERAL DAMAGES SETTLEMENT	4,243.50
24RT4PI0043	GENERAL DAMAGES SETTLEMENT	12,000.00
24RT4PI0043	CLAIMANTS SOLICITORS FEES	8,105.00
22RT4MN0002	CLAIMANTS SOLICITORS FEES	25,000.00
23RT4GN0012	PROFESSIONAL FEES	1,600.00
24RT4GN0026	GENERAL DAMAGES SETTLEMENT	23,000.00
24RT4GN0039	GENERAL DAMAGES SETTLEMENT	500.00
20RT4PI0007	WRP REFUND RECEIVED	- 12,058.08
22RT4PI0019	WRP REFUND RECEIVED	- 46,264.36
20RT4MN0018	WRP REFUND RECEIVED	- 65,253.22

24RT4GN0025	WRP REFUND RECEIVED	- 4,012.00
23RT4GN0022	WRP REFUND RECEIVED	- 2,500.00
24RT4GN0009	WRP REFUND RECEIVED	- 1,000.00
Totals		**50,002.72**

Welsh Ambulance Services University NHS Trust
Jan-25

Case Reference	Details	Amount (£)
21RT4PI0026	TRANSCRIPTION COSTS	160.40
22RT4PI0006	COUNSEL FEES	350.00
22RT4PI0046	EXPERT WITNESS	1,350.00
24RT4PI0043	REFUND	- 285.00
24RT4PI0063	COUNSEL FEES	500.00
20RT4MN0008	COUNSEL FEES	3,225.00
21RT4MN0009	COUNSEL FEES	230.00
22RT4MN0016	COUNSEL FEES	770.00
22RT4MN0018	COUNSEL FEES	440.00
23RT4MN0021	EXPERT WITNESS	2,800.00
24RT4MN0008	COUNSEL FEES	750.00
24RT4MN0015	TRANSCRIPTION FEES	129.15
25RT4MN0021	TRANSCRIPTION FEES	54.06
25RT4EG0042	PROFESSIONAL FEES	600.00
25RT4DP0165	TP VEHICLE REPAIRS	6,779.78
25TR4EG0043	TRANSCRIPTION COSTS	71.75
25RT4EG0044	PROFESSIONAL FEES	3,450.00
25RT4DP0166	TP VEHICLE REPAIRS	100.00
25RT4DP0167	TP VEHICLE REPAIRS	518.40
25RT4DP0168	TP VEHICLE REPAIRS	12,950.02
25RT4DP0169	TP VEHICLE REPAIRS	1,986.44
25RT4DP0170	TP VEHICLE REPAIRS	1,391.12
25RT4DP0171	TP VEHICLE REPAIRS	435.55
25RT4DP0172	TP VEHICLE REPAIRS	3,864.75
25RT4DP0173	TP VEHICLE REPAIRS	4,835.00
25RT4DP0023	TP VEHICLE REPAIRS	500.00
25RT4DP0014	TP VEHICLE REPAIRS	2,000.00
25RT4EG0045	PROFESSIONAL FEES	1,461.45
25RT4EG0028	PROFESSIONAL FEES	3,250.00
25RT4DP0166	TP VEHICLE REPAIRS	8,540.55
25RT4DP0169	TP VEHICLE REPAIRS	3,334.28
25RT4DP0169	TP VEHICLE REPAIRS	- 3,334.28
25RT4DP0174	TP VEHICLE REPAIRS	1,400.00
25RT4DP0174	TP VEHICLE REPAIRS	- 1,400.00
25RT4DP0175	TP VEHICLE REPAIRS	14,408.26
25RT4DP0175	TP VEHICLE REPAIRS	- 14,408.26
25RT4DP0174	TP VEHICLE REPAIRS	205.94
25RT4DP0174	TP VEHICLE REPAIRS	- 205.94
25RT4DP0176	TP VEHICLE REPAIRS	3,056.20
25RT4DP0177	TP VEHICLE REPAIRS	1,181.73
25RT4EG0016	PROFESSIONAL FEES	3,700.00
25RT4DP0178	TP VEHICLE REPAIRS	2,373.89
25RT4DP0179	TP VEHICLE REPAIRS	3,031.05
21RT4PI0026	GENERAL DAMAGES SETTLEMENT	22,000.00
24RT4PI0006	CRU	766.00

22RT4GN0032	EXPERT WITNESS	2,800.00
22RT4GN0037	EXPERT WITNESS	2,400.00
18RT4MN0016	EXPERT WITNESS (CORRECTION FRC	- 1,300.00
15RT4MN0010	WRP REFUND 05.08.24	- 1,425.00
Totals		**101,792.29**

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

AGENDA ITEM No	**17**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**01**

Committee Induction

MEETING	Audit, Risk and Assurance Committee
DATE	06 March 2025
EXECUTIVE	Trish Mills, Director of Corporate Governance/Board Secretary
AUTHOR	Alex Payne, Corporate Governance Manager
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. The Trust's induction process for new committee members is essential to ensuring they understand their roles, responsibilities, and the Trust's governance structure. This paper outlines a structured induction programme that builds on existing informal arrangements, providing comprehensive support for new members, including those on the Audit, Risk, and Assurance Committee (ARAC).

2. Given ARAC's role in governance, risk management, and internal control, additional induction elements are included for its members. These include briefings on risk and assurance frameworks, internal and audit programmes, financial governance, and counter-fraud measures. A dedicated session with Audit Wales will also be offered, given the changes to committee composition in-year.

3. The proposed induction programme is set out, with the template committee induction document which will be adapted for each committee ahead of implementation. The committee is asked to provide feedback on the proposed framework, endorse the ARAC-specific arrangements, and support its implementation by the Corporate Governance Team.

RECOMMENDATION:

4. **The committee receives and provides feedback on the proposed committee induction programme, endorses the ARAC specific induction arrangements, and notes that the Corporate Governance Team will implement the arrangements as proposed.**

KEY ISSUES/IMPLICATIONS
Not applicable.

REPORT APPROVAL ROUTE
Not applicable.

REPORT APPENDICES
Annex 1: Committee induction PowerPoint

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	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

SITUATION

5. The induction process for new committee members within the Trust is critical to ensuring they quickly understand their roles, responsibilities, and Trust's board and committee structure. This package of support serves to provide the required induction and support for new committee members (including those as prescribed by the committee terms of reference and Trade Union partners).

6. Given the specific role of the Audit, Risk and Assurance Committee (ARAC), its members require a tailored induction that reflects its unique role in assuring the board on the effectiveness of the Trust's governance, risk management, and internal control arrangements. This paper outlines the proposed general induction process while highlighting the additional requirements for ARAC members.

BACKGROUND

7. Effective governance within the Trust relies on well-informed and engaged committee members. New members must be equipped with an understanding of the Trust's corporate governance framework, which includes the board and committee structure, the role of the committee, its core business and other relevant information.

8. The Trust already has informal arrangements in place for new members of committees, which includes a one to one meeting with the Director of Corporate Governance/Board Secretary or Corporate Governance Manager, access to meeting papers and signposting to key committee artefacts – such as the terms of reference. The intention is that this builds on and formalises the existing arrangements.

9. It is a priority for the ARAC in 2024/25 to 'Monitor the development of the Committee specific induction programme'. This report and proposed package of support serves to progress this priority. It is noted that the Corporate Governance Team have held a joint Board and Committee Chairs and Trade Union induction sessions in June and September 2024; this served as retrospective induction for some individuals.

ASSESSMENT

General Committee Member Induction

10. The proposed general induction programme includes:
    10.1 A welcome pack in PowerPoint format with links to key documents/artefacts (e.g., Trust strategy, committee terms of reference, recent meeting papers, AAA reports and minutes), and a high-level overview of the Trust's corporate governance framework.

10.2 This document will signpost to the Trust's governing documents - its Standing Orders - which includes the respective terms of reference for each group. This will provide clarity on the committee's scope and responsibilities.

10.3 A one to one induction meeting with the Corporate Governance Manager (CGM), at which the welcome pack will be reviewed and the role of the committee explained (should the inductee be unfamiliar with the Trust's corporate governance arrangements).

10.4 At the meeting with the CGM the member will be given details of the committee's remit, membership and cycle of business; as well as the Trust's Standards of Business Conduct Policy - with respect to the importance of declaring and managing interests, and Trust meeting etiquette policy.

10.5 Access to the Trust's board pack software iBabs, through which all of the open and closed meeting papers are accessed, will be given by the CGM. The member will be shown how to use the system and the supporting secretariat processes will be explained.

10.6 Finally, other induction meetings will be arranged by the Corporate Governance Team as required. It is proposed that the new member should meet with the committee Chair before attendance at their first meeting, if possible. This is especially important should the individual be new to the Trust.

Audit, Risk and Assurance Committee Specific Activities

11. For ARAC members, additional induction elements are necessary to sufficiently induct members to the role and operations of the committee, given its unique role. The additional support that will be provided is as follows. It is noted that the activity in paragraphs 11.1-11.3 will be offered *to* all new members; but is a requirement for all new committee Non-Executive Directors.

11.1 An overview of the risk management and assurance frameworks in the Trust, via a meeting with the Director of Corporate Governance and the Assistant Director of Corporate Governance and Risk.

11.2 A session with the internal and external auditors (respectively) to understand the current and planned audit programme and priorities. The Trust's Audit Handbook will be provided prior to this session.

11.3 A one to one session with the Executive Director of Finance and Corporate Resources, as the Executive Lead for the committee. This will include a briefing on financial governance and counter-fraud measures in the Trust.

11.4 *An immediate action for <u>all current</u> ARAC members:*
In response to the recent change in composition of the committee it has been agreed with Audit Wales that a one-off session will be held for all interested members, to provide an overview of the Audit Wales programme and planned activity.

12. The template committee induction document is presented in Annex 1. It will be updated to reflect any changes to the role/remit and attendance for each committee going into 2025/26 and for each inductee, with any changes required made following the cyclical effectiveness review activity.

RECOMMENDATION:

13. **That the committee receives and provides feedback on the proposed committee induction programme, endorses the ARAC specific induction arrangements, and notes that the Corporate Governance Team will implement the arrangements as proposed.**

Welsh Ambulance Services University NHS Trust

Committee Member Induction: NAME

GIG CYMRU NHS WALES

Ymddiriedolaeth Brifysgol GIG
Gwasanaethau Ambiwlans Cymru

Welsh Ambulance Services
University NHS Trust

COMMITTEE INDUCTION

COMMITTEE NAME

Overview

- Corporate governance
- Roles of the board, the committees and of advisory group WASPT
- Trust Board: Membership
- Trust governing documents
- Board and committee information /structure
- Role of committees and role of WASPT
- Roles
- Committee membership, cycle of business and board pack software
- Meeting etiquette and ‘Top 10 Tips’

Using this document

Where this icon is visible in this document it indicates that there is a supporting hyperlink attached to the icon, which when clicked on will take you to the content which is referred to on the slide.

You must click ‘Ctrl’ on your keyboard and then select the icon for it to redirect you to the webpage.

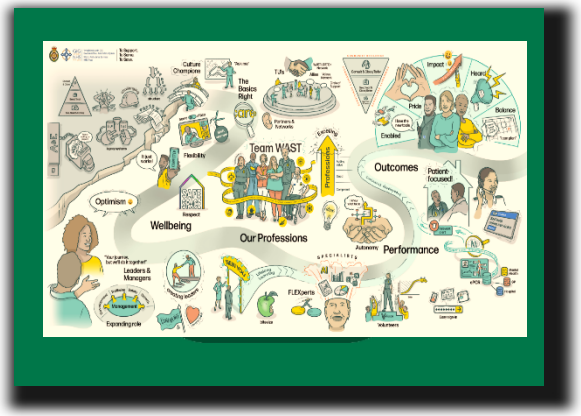
Corporate Governance

Corporate governance at WAST ensures **effective**, **ethical**, and **responsible** operations through:

- strong **leadership**
- clear **responsibilities** and **accountabilities**
- high **standards** of care and ethics
- a positive and inclusive **culture**, and
- robust **controls** and **processes**.

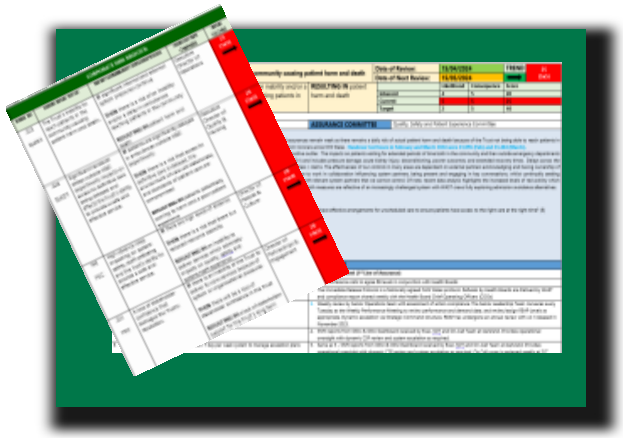
Role of the Board

Strategy, Vision, Purpose



Culture

Quality



Risk

Delivery of Strategy and Performance

TRUST BOARD: Membership, Voting and Appointment

Non-Executive Directors

Executive Directors

Directors

Trade Union Partners

Trust Governing Documents, Annual Reports & Publications

Home › About Us › Publications

Listen

Publications

Strategies and Plans

2023-2024

- Integrated Medium Term Plan (IMTP) 2024-2027
- Appendix 1 - Challenges and Opportunities Shaping our IMTP
- Appendix 2 - WAST Service Transformation deliverables
- Appendix 4 - WAST Financial plan 2024-2025
- Decarbonisation Action Plan V4 - June 2023 update
- Integrated Medium Term Plan (IMTP) Public Summary 2023-2026
- Integrated Medium Term Plan (IMTP) 2023-2026
- People and Culture Plan 2023-2026
- Strategic Equality Plan for 2024-2028
- Digital Plan 2024-2029
- Strategic Workforce Plan 2024-2(

Pre 2023

- **Long Term Strategic Framewor**
- Clinical Strategy 2020-2025
- Decarbonisation Action Plan V3 -
- Digital Strategy 2020
- Environmental Policy Statement
- Environment Strategy 2020-2025
- Health and Wellbeing Strategy 2(
- IMTP Summary Poster 2022 - 202
- IMTP 2022- 2025
- People and Culture Strategy 201
- Public Health Plan 2019-2022
- Risk Management and Board Ass
- Roster Review Stakeholder Briefir
- Roster Review Stakeholder Letter

Annual Reports

2023-2024

- Annual Report and Accounts 2023-2024
- Duty of Quality Annual Report 2023-24.pdf
- Welsh Language Standards Annual Report 2023-2024.pdf

2022-2023

- Equality Annual Report 2022-2023
- Welsh Language Standards Annual Report 2022-2023
- WAST Signed and Certified Annual Report and Accounts 2022-2023
- WAST Signed Annual Report and Accounts inc Disclaimer 2022-2023
- Charity Annual Report and Accounts 2022-2023
- Sustainability Report 2022-2023

2021-2022

- Annual Report Part 1 - Performance Report 2021-2022
- Annual Report Part 2 - Accountability Report 2021-2022
- Annual Report Part 3 - Financial Accounts 2021-2022
- Annual Report and Annual Accounts 2021-2022
- Annual Report Highlights 2021-2022
- Charity Annual Report Accounts 2021-2022
- Welsh Language Standards Annual Report 2021-2022

Trust Standing Orders

- WAST Standing Orders - Main Document v.8 approved 30052024
- WAST Standing Orders - Schedule 1 Scheme of Reservation & Delegation of Powers v.8 approved 25072024
- WAST Standing Orders - Schedule 2 Key Guidance Instructions and other related documents v.5 approved 270122
- WAST Standing Orders - Schedule 2.1 Standing Financial Instructions v.6 approved 280923
- WAST Standing Orders - Schedule 3 Board Committees v.5 approved 270122
- WAST Standing Orders - Schedule 3 - 3.1 - Academic Partnerships Committee TOR 24-25 Approved 30052024
- WAST Standing Orders - Schedule 3.2 - Audit Committee TOR 24-25 Approved by Trust Board 30052024
- WAST Standing Orders Schedule 3 - 3.3, Charity Committee Terms of Reference 2024-25 - Approved by Trust Board 30052024
- WAST Standing Orders Schedule 3 - 3.4, Finance and Performance Committee Terms of Reference 2024-25 - Approved by Trust Board 30052024
- WAST Standing Orders Schedule 3 - 3.5, People and Culture Committee Terms of Reference 2024-25 - Approved by Trust Board 30052024
- WAST Standing Orders Schedule 3 - 3.6, QUEST Committee Terms of Reference 2024-25 - Approved by Trust Board 30052024 and Updated 18092024
- WAST Standing Orders Schedule 3 - 3.7, Remuneration Committee Terms of Reference 2024-25 - Approved by Trust Board 30052024

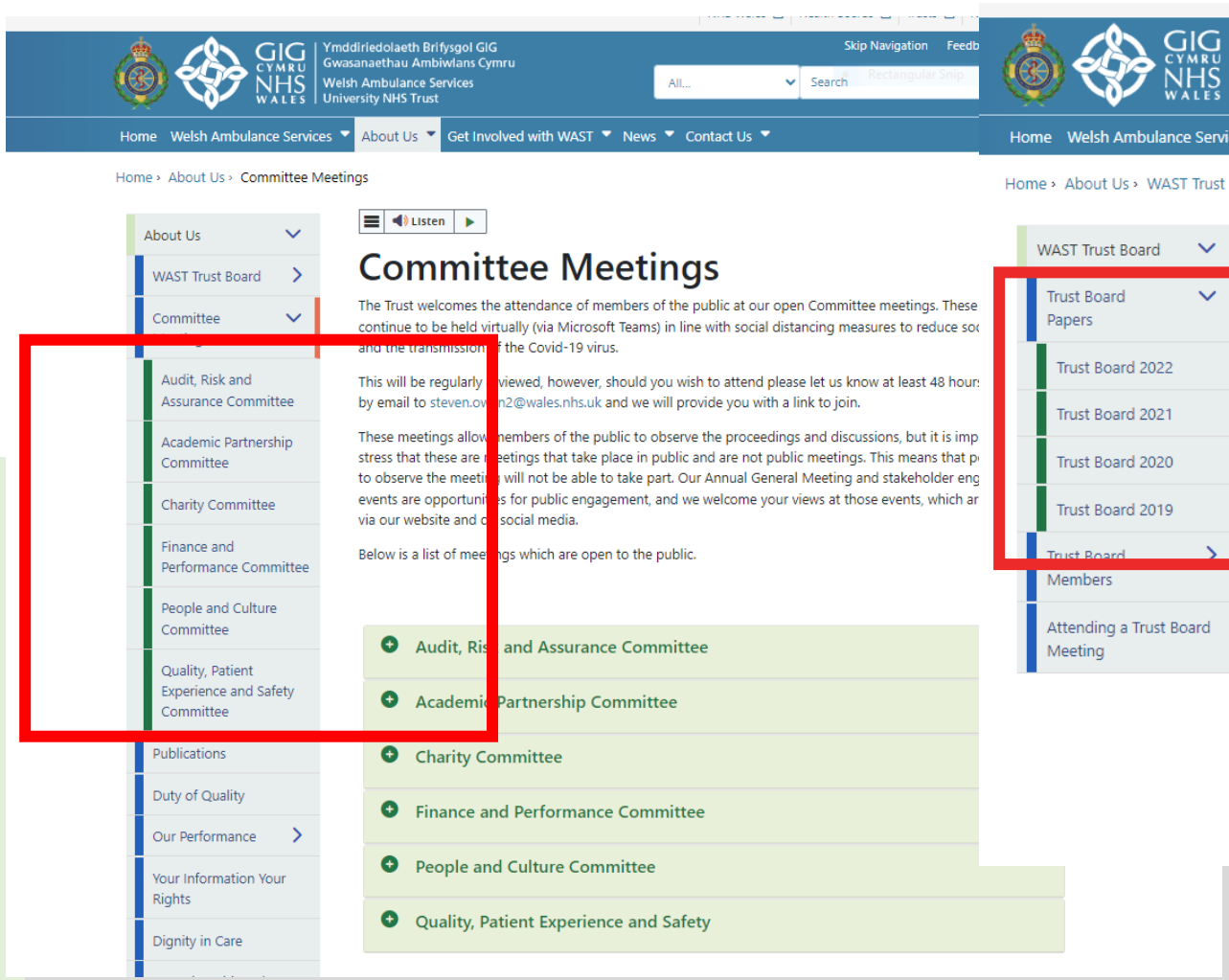
Related Policies

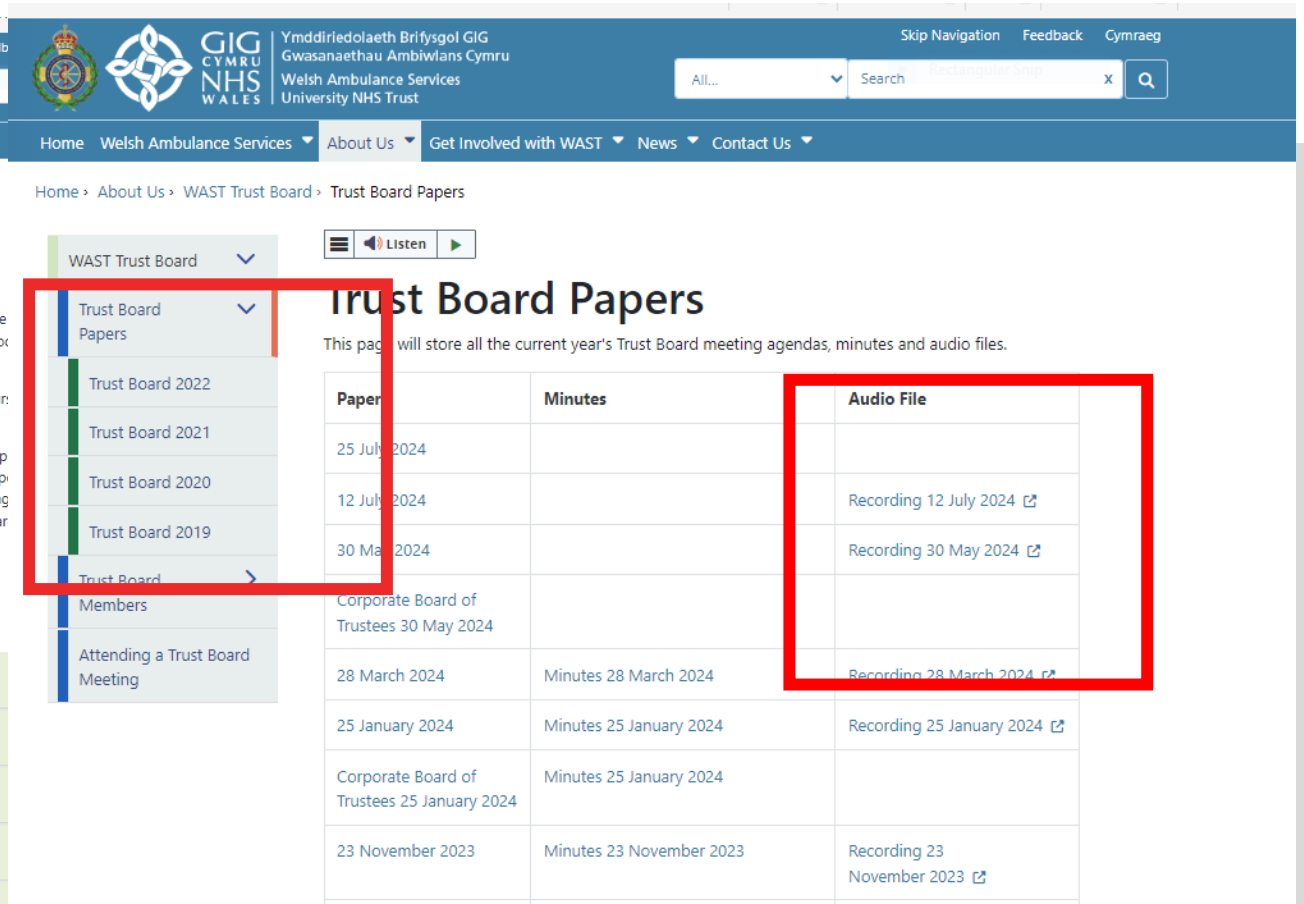
- Standards of Business Conduct Policy

For older documents please send a request to was.communications@wales.nhs.uk.

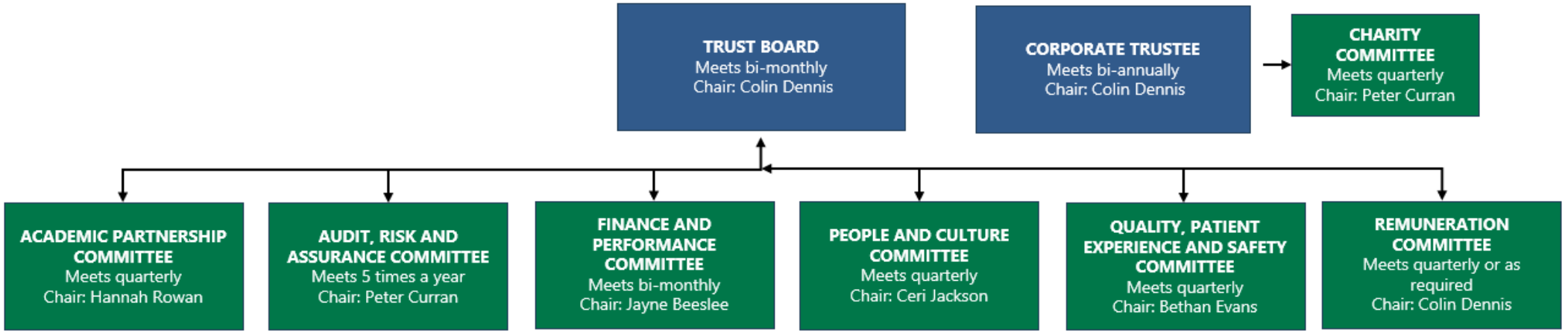
Information on expenditure over £25,000 is available on request by emailing: WAST.AR@wales.nhs.uk

Board and Committee Information





Committee Structure



Role of the Board Committees

WAST BOARD COMMITTEE REMITS – 2024/25

Quality, Patient Experience and Safety Committee

- Duty of Quality and Duty of Candour
- KPIs in remit
- Clinical & quality plans
- Health and Care Quality Standards
- Quality Impact Assessment
- Mental health
- Infection prevention and control
- Safeguarding
- Continual quality improvements
- Learning
- Mortality reviews
- Putting Things Right
- Clinical negligence & personal injury
- Clinical effectiveness
- Clinical audit
- Citizens voice & patient experience
- Clinical and quality governance
- Risks, audits, policies in remit

People and Culture Committee

- People & Culture plan and metrics
- KPIs in remit
- Trust Behaviours
- Health and wellbeing
- Staff & volunteer experience
- Speaking up safely
- Equality, diversity, and inclusion
- Recruitment and retention
- Trade Union relationships
- Leadership & development
- Succession plans
- Welsh language
- Health and safety
- Health and Care Standards in remit
- Registration and revalidation
- Partnerships and engagement
- Risks, audits, policies in remit

Advisory Group (WASPT) reports to this Committee with onward reporting to Board via the AAA

Finance and Performance Committee

- Long term strategic direction
- Long term financial direction
- Capital and revenue monitoring
- Financial sustainability
- Business cases and PIRs
- Compliance with statutory duties
- IMTP endorsement and delivery
- Value based healthcare
- Performance against targets set by Commissioners and Welsh Gov.
- Quality &Performance Management Framework (QPMF) outcomes
- Trust wide KPIs (MIQPR)
- Recovery plans for performance
- Demand and capacity
- Estates
- Fleet
- Environment and sustainability
- Digital systems
- Digital plan direction
- Information governance
- Information security
- Major Incident Plan and Business Continuity Plan
- Cyber resilience & security
- Risks, audits, policies in remit

Audit, Risk and Assurance Committee

- Governance and assurance
- Effective systems of good governance, risk management and internal control
- Board Assurance Framework
- Annual Report
- Audited financial accounts
- Standing Orders and SFIs
- Accounting policies
- Assurance processes
- Policies for reg. compliance
- Schedule of losses & special payments
- Single tender actions
- Internal audit (inc annual plan; reports; HOIA Opinion)
- Audit Wales (inc annual plan; ISA260; structured assessment; reports;
- QPMF implementation
- Audit management responses
- Local Counter Fraud Service
- Standards of business conduct
- Whistleblowing processes
- Patient's property
- Policies in remit

Remuneration Committee

- Contractual arrangements for staff
- Appointment, termination, remuneration, terms of service and appraisal for Chief Executive; Executive Directors (including interim); Very Senior Managers
- Redundancy, VERs, Settlement settlements

Academic Partnerships Committee

- Strategic collaboration with education providers and commercial partners
- Collaboration with partners in health, social care, local authority and third sector
- Partnership arrangements
- University Trust Status
- Plans to build capacity of whole workforce
- Research governance framework
- Risks, audits, policies in remit

Charity Committee (Corporate Trustees)

- Charity strategic direction
- Charitable funds monitoring including systems and processes
- Review by Audit Wales of accounts
  Fundraising
- Bursary Panel
- Promote the charity
- Annual Report and Financial Accounts
- Approve expenditure over £5,000
- Bids Panel
- Risks, audits, policies in remit

OVERSEE — **SUPPORT** — **CHALLENGE** — **ESCALATE**

COMMITTEES: Membership, Voting and Appointment

3.3.5 The membership of any such Committees - including the designation of Chair; definition of member roles and powers and terms and conditions of appointment (including remuneration and reimbursement) - will usually be determined by the Board, based on the recommendation of the Trust Chair, and subject to any specific requirements, directions or regulations made by the Welsh Ministers. Depending on the Committee's defined role and remit, membership may be drawn from the Board, its staff (subject to the conditions set in Standing Order 3.4.6) or others not employed by the Trust.

VOTING

Voting Membership of the Committees

- Non-Executive Directors;
- Quorum requirement for each (at least 2).

Executive Lead or Leads for the Committee

- Aligned to their portfolio

Non-Voting Membership of the Committees

- Prescribed attendees;
- Trade Union Partners.

APPOINTMENT TO COMMITTEES

Non-Executive Directors

- Decision of the Board, based on recommendation of the Trust Chair and any subject specific requirements, directions or regulations made by the Welsh Ministers.

Prescribed Attendees:

- Decision of the Board, based on recommendation from the Committee and as prescribed by the group's Terms of Reference, and dependent on the role and remit of the Committee.

Trade Union Partners

- Number of Trade Union Partners for each Committee is prescribed within the Terms of Reference for that group.
- Staffside meeting advises of individual members to attend.

Role of WASPT

Overarching Purpose:

- ❑ Forum for senior leaders, trade union partners, and professional organizations to improve services for Wales
- ❑ Principal partnership forum for national priorities and strategies
- ❑ Mechanism for consultation, negotiation, and communication between staff organizations and management

Delegated Responsibility:

- ❑ Establish regular dialogue on **strategic issues** affecting the workforce
- ❑ Input into **organisational strategy** and **service development**
- ❑ Address **implications of service reviews** and **NHS organisational changes**
- ❑ Discuss services, activity and financial performance, **WASPT's role in improving performance and value for money**
- ❑ **Communicate key decisions** from the board and senior management
- ❑ Develop appropriate **facilities arrangements**
- ❑ **Resolve escalations** from sub-groups

Membership:

- ❑ Joint alternating Chairs (CEO and TUP Chair)
- ❑ 8 management members
- ❑ 12 Trade Union Partners (3 from each of GMB, RCN, Unison and Unite)

Reporting:

- ❑ To People and Culture Committee on a AAA report and with copies of approved minutes

Roles

NEDs and Executive Directors steer the board towards efficiency, transparency, and quality in healthcare delivery. Key responsibilities:

- Oversight and accountability
- Strategic direction
- Culture and behaviours
- Risk management
- Promoting high standards of governance
- Stakeholder engagement

Executive Directors and Directors steer the daily management and operational decision making. Key responsibilities:

- Leadership and management
- Financial oversight
- Quality and safety assurance
- Compliance and regulation
- Stakeholder relations and communication
- Innovation and improvement

Roles

Director of Corporate Governance/Board Secretary

The **Director of Corporate Governance/Board Secretary** is the independent and principal advisor to the Board. They are non-voting, and their primary role is to ensure the establishment and maintenance of, and compliance with, strong governance frameworks and to ensure the Board acts fairly, with integrity and without prejudice or discrimination in all its dealings. The Board Secretary promotes and helps sustain good governance by:

- Keeping under review legislative, regulatory and governance developments that impact on the Trust's activities and ensuring that the Board is appropriately briefed on them.
- Winning the confidence of the Board – acting as 'wise counsel' providing a confidential sounding Board to the Chair, Chief Executive, and individual Board members on all aspects of Board business including issues of concern.
- Guiding the Board in the responsible and effective conduct of its role, providing, where appropriate, a discreet, challenging, and independent voice in relation to Board deliberations and decision making.
- Ensuring that in all its dealings, the Board acts fairly, with integrity, and without prejudice or discrimination, and within the terms of its establishment order and standing orders.
- Contributing to the development of an organisational culture that embodies NHS values and standards of behaviour.

Roles

Trade Union Partners - No limitation on information and no exclusions to their attendance

- Embedding partnership working whilst bringing a **staff perspective to strategic discussions**;
- **Scrutinising proposals**, providing constructive challenge and support where appropriate;
- Focusing on the creation of a **working safely environment** being fostered at the Board and Board Committees for the wellbeing and welfare of staff;
- **Facilitating interface and communication** between the Board/Committees and staff;
- Bringing **staff governance issues** to the attention of the Board and Committees;
- Acting as the focal point for all staff, **reflecting their needs and aspirations**;
- **Supporting communication of the work of the Board** and promote opportunities for staff to be involved in the decision-making process.

Prescribed Attendees - No limitation on information and no exclusions to their attendance. They provide **subject specific knowledge** and expertise and should fully participate in meetings. Attendees may also be **reporting to the Committee** and therefore be **accountable to the Committee for the delivery of work** (for example, Auditors). There are also regular attendees, e.g. those in the Corporate Governance Team, who are not prescribed by the terms of reference but attend all meetings.

Committee Membership: Committee Name

Name	Role	Membership Status
		Chair & Non-Executive Director
		Non-Executive Director
		Non-Executive Director
		Non-Executive Director
		Prescribed Attendee
		Prescribed Attendee
		Prescribed Attendee
		Prescribed Attendee
		Prescribed Attendee
		Prescribed Attendee
		Prescribed Attendee
		Prescribed Attendee
		Prescribed Attendee
		Regular Attendee
		Regular Attendee
		Regular Attendee (Corporate Governance Team)
		Regular Attendee (Corporate Governance Team)
		Regular Attendee (Corporate Governance Team)

Committee Cycle of Business and Monitoring: Update and provide files

PAPER	PRE or POST-C'EE FORUM	FREQUENCY	Q1	Q2	Q3	Q4	LEAD	PURPOSE	COMMENT/COMPLIANCE
ACADEMIC PARTNERSHIPS COMMITTEE - CYCLE OF BUSINESS 2024/25									
TERMS OF REFERENCE NOTED IN RED TEXT									
3.1 Promote and support the exploration of opportunities with higher and further education, wider education providers and commercial partners across and beyond Wales to: a) develop collaborative activities in relation to clinical and non-clinical services, research, and development, teaching and education, innovation and improvement, and commercial opportunities; and b) influence programme design									
3.2 Promote and support collaboration with key partners in health, social care, local authorities, and the third sector, as well as patients and patient representative groups, developing opportunities for widening access and increasing participation in health and social care education amongst local communities									
Ongoing and continuous support from Committee (inc Research Champion updates)	N/A	Ad Hoc					All members	N/A	Committee member visits and reporting of outcomes
Spotlight On e.g. Partnerships, Innovation, Research, Education ~~Partnerships~~	N/A	Ad Hoc					Relevant Director	Assurance	
3.3 Ensure appropriate arrangements are in place with partner organisations that establishes role, responsibilities and expectations, and supports the achievement of the highest standards of health, clinical care, research, innovation and health care education. Depending on the nature of the projects the risk to the parties should be understood and the appropriate mitigated action taken.									
Review partnership agreements	TBC	Ad Hoc					Relevant Director	Assurance	Scrutiny that overarching agreements with academic partners, where they exist, are appropriate
3.4 Oversee and contribute to the development of submissions to Welsh Government for University Trust Status and ensure the ongoing maintenance of that status and compliance with any conditions from Welsh Government									
Initial UTS application and any renewals	EMT and Board	Ad Hoc					DPE	Endorsement	See Note 2
Review compliance reporting	EMT and Board	Annually					DPE	Assurance	
3.5 Review and agree programmes of work aligned to University Trust Status, ensuring that they: a) explore and identify opportunities for the development of the whole workforce; b) are appropriately resourced, and where possible maximise the benefits of shared resources and expertise, and availability of grants; c) are clear where Board level scrutiny will take place, whether that is that this Committee or another Board Committee, to avoid duplication and support coalescence of Board oversight									
3.6 Monitor plans to build capacity for the whole workforce whether they be in a clinical, professional, or corporate role, to participate in research; that opportunities to do so are being promoted; and that the workforce is encouraged to be professionally inquisitive									
Agree Committee (and UTS) Priorities in IMTP	STB and Board	Annually					Relevant Director	Endorsement	See Note 2. Review priorities against (a) to (c) in 3.5 and against 3.6.
Monitor IMTP priorities as appropriate	STB and Board	Quarterly					DPE	Assurance	See Note 5
Exception reporting on UTS priorities	TBC	Ad Hoc					Relevant Director	Assurance	F&P Committee has overall oversight of IMTP, however where priority is off track or rebaselined Director may report here
Deep dive on priority (and other) elements	TBC	Ad Hoc					Relevant Director	Assurance/Information	See Note 4
3.7 Oversee implementation of the research governance framework in accordance with the Health and Care Research Wales Research Governance Framework									
Initial and ongoing review of framework	CQGG	Ad Hoc					ADR		
Research KPIs	CQGG	Ad Hoc					ADR		
Spotlight On Research	CQGG	Ad Hoc					ADR		
Research and Innovation Annual Report	CQGG	Annually					ADR		
3.8 The Committee will monitor the principal risks relevant to its remit. It will consider the controls and mitigations of related risks and provide assurance tot he B									
Board Assurance Framework	ELT	Each meeting					DC(		
Corporate Risk Register	ELT	Each meeting					DC(		
3.9The Committee will receive and gain assurance from internal and external audits in their remit. It will also monitor management actions to address recommend									
Audit Recommendation Tracker	ADLT	Each meeting					DC(		
Audits within purview of Committee	Audit/ELT	Ad Hoc					DC(		
GOVERNANCE									
Committee effectiveness review annual report	Audit/Board	Annually					DC(		
Review of Terms of Reference	Audit/Board	Annually					DC(		
Committee Cycle of Business review	N/A	Annually					DC(		
Committee Cycle of Business monitor	N/A	Each meeting					DC(		
Committee Review of Annual Priorities	N/A	Quarterly					Cha		
SUB-GROUPS									
Sub-groups or task and finish group AAA	N/A	Ad Hoc					Rele		
PROMPTS									
External Reports	N/A	Ad Hoc					TBC		

DPE = Director of Partnerships and Engagement
ADR&I = Assistant Director of Research and Innovation
DCG/BS = Director of Corporate Governance/Board Secretary

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PAPER	PRE or POST-C'EE FORUM	FREQUENCY	Q1	Q2	Q3	Q4	LEAD	PURPOSE	COMMENT/COMPLIANCE
ACADEMIC PARTNERSHIPS COMMITTEE - CYCLE OF BUSINESS 2024/25									
TERMS OF REFERENCE NOTED IN RED TEXT									
(Ongoing and continuous support from Committee (inc Research Champion updates)	N/A	Ad Hoc					All members	N/A	Q1: Research Champion update programmed.
Spotlight On e.g. Partnerships, Innovation, Research, Education ~~Partnerships~~	N/A	Ad Hoc					Relevant Director	Assurance	Q2: Digital Innovation; Digial Innovation (drones) deferred to Q3 and rec'd in closed. Q4: Staff Story programmed.
Review partnership agreements	TBC	Ad Hoc					Relevant Director	Assurance	
Initial UTS application and any renewals [See Note 2]	EMT and Board	Ad Hoc					DPE	Endorsement	Q2: UTS Benefits Realisation item programmed; Q3: UTS benefits realisation follow up. Q4: UTS benefits realisation update programmed.
Review compliance reporting	EMT and Board	Annually					DPE	Assurance	
Agree Committee (and UTS) Priorities in IMTP	STB and Board	Annually					Relevant Director	Endorsement	
Monitor IMTP priorities as appropriate [See Note 5]	STB and Board	Quarterly					DPE	Assurance	Q1: IMTP 24-27 Priorities follow up programmed; Q2: agreed not required.
Exception reporting on UTS priorities	TBC	Ad Hoc					Relevant Director	Assurance	
Deep dive on priority (and other) elements [See Note 4]	TBC	Ad Hoc					Relevant Director	Assurance/Information	Q3: Revised Priorities 24/25 discussion programmed.
Initial and ongoing review of research governance framework [See Note 3]	CQGG	Ad Hoc		→			ADR&I	Assurance	Q1: RGF (regular update) and approach to org-wide assurance; Q2: Agreed to be rec'd at every other mtg - Q1& Q3.
Research KPIs [See Note 3]	CQGG	Ad Hoc					ADR&I	Assurance	Q3: Updated position may be included in RGF paper.
Spotlight On Research [See Note 3]	CQGG	Ad Hoc					ADR&I	Assurance	
Research and Innovation Annual Report [See Note 3]	CQGG	Annually		→	→	→	ADR&I	Assurance	Q2 deferral to later in the year. Agreed to receive in Q4. Q4: Not ready for January 2025; defer to Q1 25/26.
Board Assurance Framework	ELT	Each meeting					DCG/BS	Assurance	*TBC risks in the purview of the Committee (including UTS, research, innovation, academic partners)*
Corporate Risk Register	ELT	Each meeting					DCG/BS	Assurance	*TBC risks in the purview of the Committee (including UTS, research, innovation, academic partners)*
Audit Recommendation Tracker	ADLT	Each meeting					DCG/BS	Assurance	Q1& Q2: n/a
Audits within purview of Committee	Audit/ELT	Ad Hoc					DCG/BS	Assurance	Q1& Q2: n/a
GOVERNANCE									
Committee effectiveness review annual report	Audit/Board	Annually					DCG/BS	Approval	Q4: Committee effectiveness review discussion; howeve ToR and final Annual Report to follow via Chair's Action.
Review of Terms of Reference	Audit/Board	Annually					DCG/BS	Approval	Q4: Committee effectiveness review discussion; howeve ToR and final Annual Report to follow via Chair's Action.
Committee Cycle of Business review	N/A	Annually					DCG/BS	Approval	
Committee Cycle of Business monitor	N/A	Each meeting					DCG/BS	Assurance	
Committee Review of Annual Priorities	N/A	Quarterly					Chair	Review	Q3: Revised Priorities 24/25 discussion programmed.
SUB-GROUPS									
Sub-groups or task and finish group AAA	N/A	Ad Hoc					Relevant Director	Assurance	Task and Finish Group established in April 2023 reporting. Q1: APC TFG Closure Report programmed.
PROMPTS									
External Reports	N/A	Ad Hoc					TBC	TBC	

DPE = Director of Partnerships and Engagement
ADR&I = Assistant Director of Research and Innovation
DCG/BS = Director of Corporate Governance/Board Secretary

Key: Pre-agenda setting
- Cycled for each meeting
- Ad hoc item - prompt for agenda setting
- Reporting developing

Key: Post-agenda setting
- Presented as cycled
- Ah hoc / item considered - not programmed
- → Item deferred
- Reporting developing

Standards of Business Conduct: Declaring Interests

Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru Welsh Ambulance Services NHS Trust

GIG CYMRU NHS WALES

Standards of Business Conduct Policy

Policy Number:	035	**Version No:**	3.0	**Supersedes:**	V2.2 2018
Date of Approval:	27 July 2023	**Review Date:**	2 years following approval	**Impact Assessments Completed:**	EqIA Welsh Language
Classification of Document:	Corporate	**Policy**		**Approved by:**	Trust Board
Brief Summary of Document:	The Standards of Business Conduct policy describes the standards and public service values which underpin the work of the Welsh Ambulance Services NHS Trust (WAST). In particular it sets out the specific arrangements for the appropriate declarations of interest, and the acceptance/refusal of offers of gifts, hospitality, and sponsorship.				
Scope:	This policy applies to WAST Non-Executive Directors and employees. For the purpose of this policy the term 'employees' encompasses individuals who are not direct employees of WAST and includes consultants, agency workers, specialist contractors, those who have an honorary contract with WAST, secondees who carry out work for WAST but are not directly employed by it, NHS Wales trainees on placement with WAST, jointly appointed staff and volunteers.				
To be read in conjunction with:	Nolan Principles Code of Conduct for NHS Managers UK Corporate Governance Code Standards for members of NHS boards and CCG governing bodies in England Working Time Policy				
Owning Committee	Audit Committee				
Policy Lead: **Trade Union Lead:**	Trish Mills Damon Turner	**Job Title:**	Board Secretary Trade Union Representative		
Executive Director:	Trish Mills	**Job Title:**	Board Secretary		

8. What are Conflicts of Interest?

8.1 A conflict of interest is a set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of carrying out their role is, or could be, impaired or influenced by another interest they hold.

8.2 A conflict of interest may be:

(a) Actual: there is a relevant and material conflict *now* between one or more interests of the member of staff;
or
(b) Potential: there is the possibility of a material conflict *in the future* between one or more interests of a staff member.

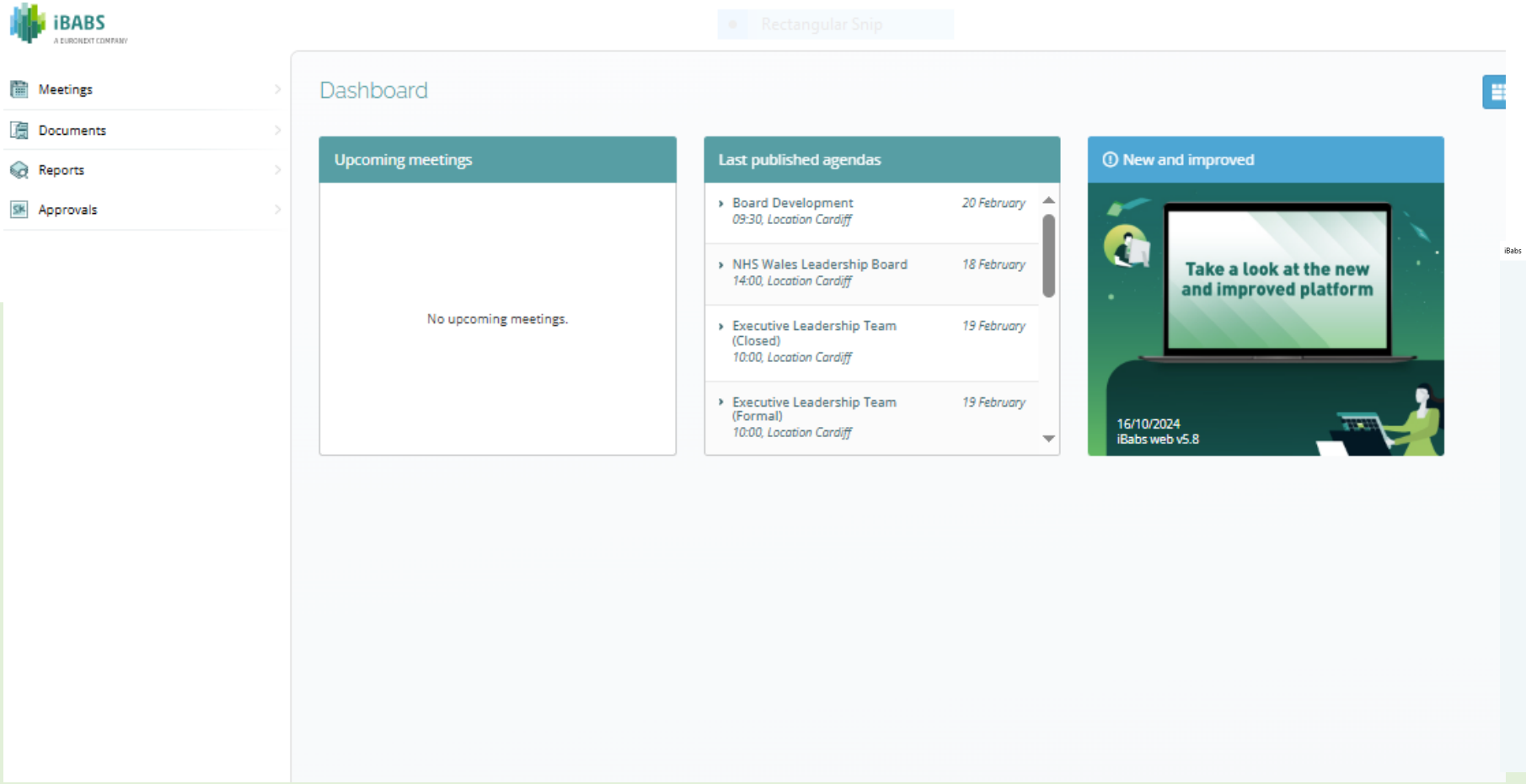
8.3 Staff are expected to act at all times with the utmost integrity and objec best interests of the organisation in performing their duties, and to where there may be a potential conflict of interest. Staff must not use t personal advantage or seek to gain preferential treatment.

8.4 Staff are required to declare any actual or potential interests which may conflicting with that overriding requirement.

Officer Category	Frequency of Mode of Declaration
(a) Members of the Trust Board	• On appointment • Annually in March • In formal meetings where an interest is material • In relation to individual procurement exercises or contracts • When potential conflicts are identified Declarations will be held centrally by the Board Secretary and placed on a register of declarations of interest.
(b) Decision Making Officers	• On appointment • Annually in March • In formal meetings where an interest is material • In relation to individual procurement exercises or contracts • When potential conflicts are identified • When moving to a new role Declarations will be held centrally by the Board Secretary from March 2024 and placed on a register of declarations of interest. The Board Secretary will provide line managers of decision makers with copies of centrally held declarations.
(c) All other staff	• On appointment • Annually (even if a nil declaration is made) • When potential conflicts are identified • When moving to a new role Declarations are held by line managers and will be made available for inspection on request by the Board Secretary, Internal Audit and Audit Wales

Board pack Software: iBabs

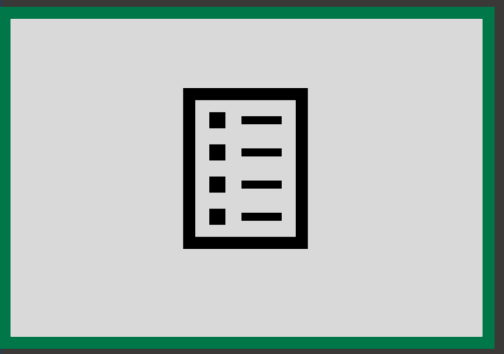
Site Name: ambulancewales



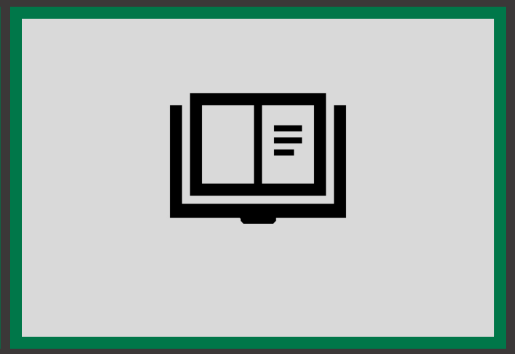
iBABS
A EURONEXT COMPANY

Meeting Etiquette Policy

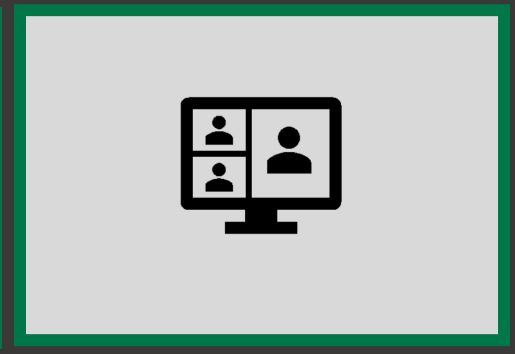
TOP TEN TIPS FOR BOARD AND COMMITTEE MEETINGS



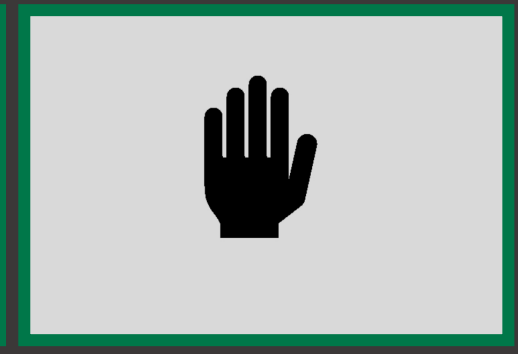
Know the scope



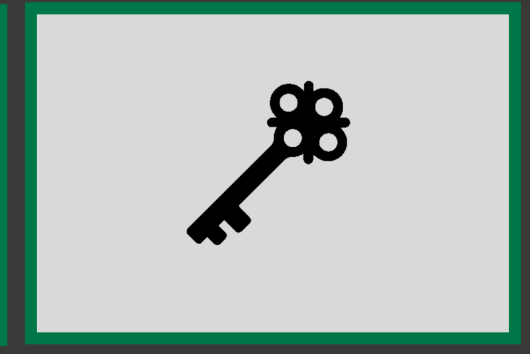
Prepare



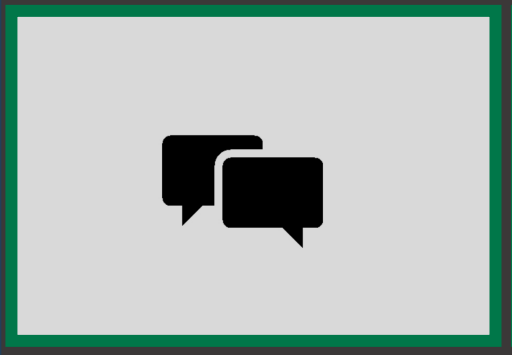
Attend regularly



Actively participate

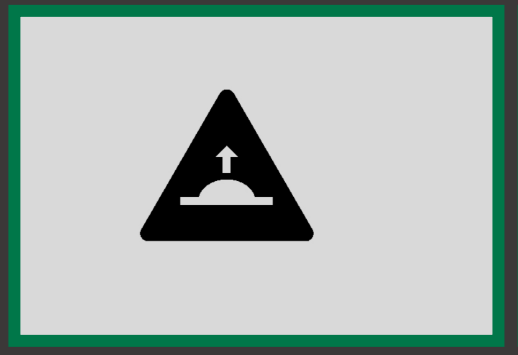


Confidentiality

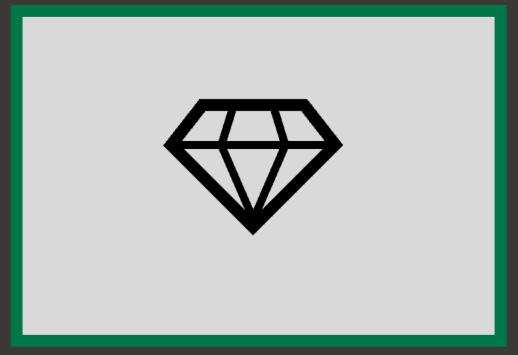


Support for partnership working

Etiquette



Avoid surprises



Nolan Principles

Declare all interests

Questions?

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

AGENDA ITEM No	**18**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**01**

AMENDMENTS TO STANDING ORDERS AND NON-COMPLIANCE REPORT

MEETING	Audit, Risk and Assurance Committee (ARAC)
DATE	06 March 2025
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. The Trust's Standing Orders (SOs) must be kept under review to ensure they remain current and that their practical application in the Trust is clear and communicated. Additionally, Welsh Government reviews the SOs and Standing Financial Instructions on a regular basis, communicating any changes thereto.

2. This paper sets out amendments to the Standing Orders Main Document and the Scheme of Reservation and Delegations of Powers (SoRD) for endorsement. These changes include the amendments required by Welsh Government following its annual review. There are no changes proposed to the Standing Financial Instructions at this stage.

3. Periodically reviewing the SoRD is essential to clarify its practical implementation and address any anomalies or inefficiencies. The changes presented include those required by Welsh Government following its annual review, and amendments to the SoRD to ensure that the responsible officers and delegations are cited correctly within Tables A (Delegated Matters). The SoRD file with amendments has been included as Annex 1. The changes to the Main Document have been detailed within the paper.

4. Additionally, it is necessary for the committee to be made aware of non-compliance with the Standing Orders. It is for the committee to formally consider the matter and make proposals to the board on any action to be taken. This paper presents two matters of non-compliance with the Standing Orders; the second of which relates to a decision sought by Chair's Action in February 2025.

Changes to the Standing Orders: Main Document

5. The changes to made to the Standing Orders Main Document have been provided by Welsh Government as part of its annual review. They relate to the publication of papers ahead of a board meeting – in provisions 7.4.3 and 7.4.7.

6. The change requires that papers must be published at least *five clear days* before a formal board meeting, as opposed to seven calendar days. Additionally, the unclear reference to the publication of 'the public part of the agenda' has been removed.

7. Additionally, an adjustment has been made to the cross-referencing within provision 3.3.5 where the paragraph refers to Standing Order 3.4.6, where it should have read 3.3.6. Also, references to the Audit Committee have been changed to reflect the change to the committee's name in 2024 to the Audit, Risk and Assurance Committee.

Changes to the Standing Orders: Scheme of Reservation and Delegation

8. The SoRD is set out in two parts. The first part is the Schedule of Matters Reserved to the Board which is prescribed by Welsh Government; the second part is the Scheme of Delegation to Executive Directors, Directors and Officers.

9. This second part contains Table A – delegated matters, and Table B – delegated financial limits. As with the Standing Orders Main Document, the references to the Audit Committee have been changed to reflect the change to the committee's name in 2024 to the Audit, Risk and Assurance Committee.

10. Within the Delegation of Powers to Committees and Others and Table A, the references to the Deputy Director of Finance have been amended to 'the relevant Assistant Director of Finance' as the former position no longer reflects the structure within the Finance and Corporate Resources Directors. Secondly, the responsible officer for Violence and Aggression has been amended to the Executive Director of Quality and Nursing, as opposed to the Director of People and Culture.

11. Finally, the references to the Director of People and Culture have been updated to state either the Director of People or the Director of Culture Change, in line with the current leadership arrangements in the People and Culture Directorate. These amendments are throughout Table A of the SoRD.

Non-Compliance with Standing Orders

12. The Trust Board has been made aware of both following matters of non-compliance given the placement of the ARAC meetings. This additional narrative serves to provide an update on the mitigations agreed when they were previously reported.

Annual General Meeting Minutes

12.1. In respect of the AGM minutes, Standing Order 7.2.7 requires that "A record of the meeting shall be submitted to the next ordinary meeting of the Board for agreement". It was identified in Autumn 2024 that this had not been the case for the 2023 AGM minutes (which were taken to the 2024 AGM for approval). This oversight was corrected for the 2024 AGM, and the minutes were approved by the board in November 2024.

Digital Expenditure Contract Award

12.2. In early February 2025 the board were notified, via the request for a decision by Chair's Action, that the contract award process with respect to the procurement of replacement iPads for frontline staff and rostering cloud-based solution did not comply with Standing Orders.

12.3. Whilst the procurement process was followed in line with Standing Orders, the contract was awarded without the required sign-off by the board (as the financial limit exceeded the Chief Executive's delegated financial limit). As such retrospective approval was sought from the board.

12.4. The Contract Award Recommendation Report (CARR) completed by NWSSP Shared Services following the procurement/tender process is usually sent to the Executive Director of Finance and Corporate Resources and on this occasion, it was not, which led to the non-compliance.

12.5. When the request for Chair's Action was issued the Trust confirmed how it would strengthen internal processes to ensure future compliance with Standing Orders and prevent recurrence. It was advised that colleagues would: -

12.5.1. Reiterate to NWSSP the importance of sending the CARR to the Executive Director of Finance and Corporate Services, who acts as a vital internal control in contract awards and compliance with delegated limits; and

12.5.2. Reinforce the process under Standing Orders to senior teams in the Trust.

12.6. Since the request was issued of the board in February, both of the actions cited in paragraph 12 have been completed. Finance and Corporate Resources colleagues have reiterated the process required in line with Standing Orders with colleagues in NWSSP, and a Siren Notice has been prepared to communicate the constitutional position to relevant colleagues regarding contract awards over £500,000 in value.

13. **RECOMMENDATION:**

12.1 The Audit, Risk and Assurance Committee is asked to review and endorse the amendments to the Standing Orders Main Document and the Scheme of Reservation and Delegation of Powers for approval by the Trust Board in March; and

12.2 Note the position with non-compliance against Standing Orders and mitigating actions taken regarding the non-compliance of Standing Orders reported to the Board in February 2025 regarding the approval of a contract award.

KEY ISSUES/IMPLICATIONS
n/a
REPORT APPROVAL ROUTE
n/a

REPORT APPENDICES
Annex 1: WAST Standing Orders - Schedule 1 Scheme of Reservation and Delegation of Powers v.9 for ARAC 06032025

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	Y
Environmental/Sustainability	N/A	Legal Implications	Y
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

Schedule 1

SCHEME OF RESERVATION AND DELEGATION OF POWERS

This Schedule forms part of, and shall have effect as if incorporated in the NHS Trust Standing Orders

Introduction

As set out in Standing Order 2, the Board - subject to any directions that may be made by the Welsh Ministers - shall make appropriate arrangements for certain functions to be carried out on its behalf so that the day to day business of the Trust may be carried out effectively, and in a manner that secures the achievement of the organisation's aims and objectives. The Board may delegate functions to:

(i) A Committee, e.g., Quality and Safety Committee;

(ii) A sub-Committee e.g., a locality based Quality and Safety Committee taking forward matters within a defined area. Any such delegation would, subject to the Board's authority, usually be via a main Committee of the Board; and

(iii) Officers of the Trust (who may, subject to the Board's authority, delegate further to other officers and, where appropriate, other third parties, e.g. shared/support services, through a formal scheme of delegation)

and in doing so, must set out clearly the terms and conditions upon which any delegation is being made. These terms and conditions must include a requirement that the Board is notified of any matters that may affect the operation and/or reputation of the Trust. The Board's determination of those matters that it will retain, and those that will be delegated to others are set out in the following:

- Schedule of matters reserved to the Board;
- Scheme of delegation to Committees and others; and
- Scheme of delegation to officers.

all of which form part of the Trust's Standing Orders.

DECIDING WHAT TO RETAIN AND WHAT TO DELEGATE: GUIDING PRINCIPLES

The Board will take full account of the following principles when determining those matters that it reserves, and those which it will delegate to others to carry out on its behalf:

- ***Everything is retained by the Board unless it is specifically delegated in accordance with the requirements set out in SOs or SFIs***

- ***The Board must retain that which it is required to retain (whether by statute or as determined by the Welsh Ministers) as well as that which it considers is essential to enable it to fulfil its role in setting the organisation's direction, equipping the organisation to deliver and ensuring achievement of its aims and objectives through effective performance management***

- ***Any decision made by the Board to delegate functions must be based upon an assessment of the capacity and capability of those to whom it is delegating responsibility***

- ***The Board must ensure that those to whom it has delegated powers (whether a Committee, partnership or individuals) remain equipped to deliver on those responsibilities through an ongoing programme of personal, professional and organisational development***

- ***The Board must take appropriate action to assure itself that all matters delegated are effectively carried out***

- ***The framework of delegation will be kept under active review and, where appropriate, will be revised to take account of organisational developments, review findings or other changes***

- ***Except where explicitly set out, the Board retains the right to decide upon any matter for which it has statutory responsibility, even if that matter has been delegated to others***

- ***The Board may delegate authority to act, but retains overall responsibility and accountability***

- ***When delegating powers, the Board will determine whether (and***

the extent to which) those to whom it is delegating will, in turn, have powers to further delegate those functions to others.

HANDLING ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS: WHO DOES WHAT

The Board

The Board will formally agree, review and, where appropriate revise schedules of reservation and delegation of powers in accordance with the guiding principles set out earlier.

The Chief Executive

The Chief Executive will propose a Scheme of Delegation to Officers, setting out the functions they will perform personally and which functions will be delegated to other officers. The Board must formally agree this scheme.

In preparing the scheme of delegation to officers, the Chief Executive will take account of:

- The guiding principles set out earlier (including any specific statutory responsibilities designated to individual roles)
- Their personal responsibility and accountability to the Chief Executive, NHS Wales in relation to their role as designated Accountable Officer
- Associated arrangements for the delegation of financial authority to equip officers to deliver on their delegated responsibilities (and set out in SFIs).

The Chief Executive may re-assume any of the powers they have delegated to others at any time.

The Board Secretary

The Board Secretary will support the Board in its handling of reservations and delegations by ensuring that:

- A proposed schedule of matters reserved for decision by the Board is presented to the Board for its formal agreement;
- Effective arrangements are in place for the delegation of Trust functions within the organisation and to others, as appropriate; and

- Arrangements for reservation and delegation are kept under review and presented to the Board for revision, as appropriate.

The Audit, Risk and Assurance Committee

The Audit, Risk and Assurance Committee will provide assurance to the Board of the effectiveness of its arrangements for handling reservations and delegations.

Individuals to who powers have been delegated

Individuals will be personally responsible for:

- Equipping themselves to deliver on any matter delegated to them, through the conduct of appropriate training and development activity; and
- Exercising any powers delegated to them in a manner that accords with the Trust's values and standards of behaviour.

Where an individual does not feel that they are equipped to deliver on a matter delegated to them, they must notify the Board Secretary of their concern as soon as possible in so that an appropriate and timely decision may be made on the matter.

In the absence of an officer to whom powers have been delegated, those powers will be exercised by the individual to whom that officer reports, unless the Board has set out alternative arrangements.

If the Chief Executive is absent their nominated Deputy may exercise those powers delegated to the Chief Executive on their behalf. However, the guiding principles governing delegations will still apply, and so the Board may determine that it will reassume certain powers delegated to the Chief Executive or reallocate powers, e.g., to a Committee or another officer.

SCOPE OF THESE ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS

The Scheme of Delegation to officers referred to here shows only the "top level" of delegation within the Trust. The Scheme is to be used in conjunction with the system of control and other established procedures within the Trust.

SCHEDULE OF MATTERS RESERVED TO THE BOARD[1]

NO.	BOARD /COMMITTEE	AREA	DECISIONS RESERVED
1	Board	General	The Board may determine any matter for which it has statutory or delegated authority, in accordance with SOs.
2	Board	General	The Board must determine any matter that will be reserved to the whole Board.
3	Board	General	Approve the Trust's Governance Framework
4	Board	Operating Arrangements	Approve, vary and amend: ▪ SOs; ▪ SFIs; ▪ Schedule of matters reserved to the Trust; ▪ Scheme of delegation to Committees and others; and ▪ Scheme of delegation to officers. In accordance with any directions set by the Welsh Ministers.
5	Board	Operating Arrangements	Ratify any urgent decisions taken by the Chair and the Chief Executive in accordance with Standing Order requirements.

[1] Any decision to reserve a matter, and the manner in which that retained responsibility is carried out will be in accordance with any regulatory and/or Welsh Government requirements.

NO.	BOARD /COMMITTEE	AREA	DECISIONS RESERVED
6	Audit, Risk and Assurance Committee	Operating Arrangements	Formal consideration of report of Board Secretary on any non-compliance with Standing Orders, making proposals to the Board on any action to be taken.
7	Board	Operating Arrangements	Receive report and proposals regarding any non-compliance with Standing Orders, and where required ratify in public session any action required in response to failure to comply with SOs.
8	Board	Operating Arrangements	Authorise use of the Trust's official seal.
9	Board	Operating Arrangements	Approve the Trust's Values and Standards of Behaviour framework.
10	Chair on behalf of Board/Joint Committee, Vice-Chair on behalf of Joint Committee Board if Chair is declaring interest	Organisation Structure and Staffing	Require, receive, and determine action in response to the declaration of Board members' interests, in accordance with advice received, e.g. From Audit, Risk and Assurance Committee or Board Secretary
11	Board	Strategy Planning	Determine the Trust's strategic aims, objectives, and priorities
12	Board	Strategy Planning	Approve the Trust's key strategies and programmes related to: ▪ The development and delivery of patient and population centred health and care/clinical services ▪ Improving quality and patient safety outcomes ▪ Workforce and Organisational Development ▪ Infrastructure, including IM &T, Estates and Capital (including major capital investment and disposal plans) ▪

NO.	BOARD /COMMITTEE	AREA	DECISIONS RESERVED
13	Board	Strategy Planning	Approve the Trust's Integrated Medium Term Plan, including the balanced Medium Term Financial Plan
14	Board	Strategy Planning	Approve the Trust's budget and financial framework (including overall distribution and unbudgeted expenditure)
15	Board	Operating Arrangements	Approve the Trust's framework and strategy for performance management.
16	Board	Strategy and Planning	Approve the Trust's framework and strategy for risk management and assurance.
17	Board	Operating Arrangements	Ratify policies for dealing with raising concerns, complaints, and incidents in accordance with the Putting Things Right and health and safety requirements.
18	Board	Operating Arrangements	Agree the arrangements for ensuring the adoption of standards of governance and performance (including the quality and safety of healthcare, and the patient experience) to be met by the Trust, including standards/ requirements determined by Welsh Government, regulators, professional bodies/others, e.g. National Institute of Health and Care Excellence (NICE).
19	Board	Strategy and Planning	Approve the Trust's patient, public, staff, partnership and stakeholder engagement and co-production strategies.
20	Board	Operating Arrangements	Approve the introduction or discontinuance of any significant activity or operation. Any activity or operation shall be regarded as significant if the Board determines it so based upon its contribution/impact on the achievement of the Trust's aims, objectives and priorities.
21	Remuneration Committee. (For Chief Executive, Committee to consist	Organisation Structure and Staffing	Appointment of the Chief Executive and Executive Directors (officer members of the Board)

NO.	BOARD /COMMITTEE	AREA	DECISIONS RESERVED
	of Chair and non-Officer Members. For all others officer members as above and to include Chief Executive)		
22	Remuneration Committee	Organisation Structure and Staffing	Approve the appointment, appraisal, discipline and dismissal of any other Board level appointments and other senior employees, in accordance with Ministerial instructions e.g. the Board Secretary.
23	Remuneration Committee	Organisation Structure and Staffing	Termination of appointment and suspension of officer members in accordance with the provisions of Regulations
24	Remuneration Committee	Organisation Structure and Staffing	Consider appraisal of officer members of the Board
25	Remuneration Committee	Organisation Structure and Staffing	Consider and approve redundancy and Early Release Applications, noting that where the settlement is £50,000 or above subsequent agreement of Welsh Government is required.
26	Board	Organisation Structure and Staffing	Approve, [arrange the] review, and revise the Trust's top level organisation structure and corporate policies
27	Board	Organisation Structure and Staffing	Appoint, [arrange the] review, revise and dismiss Trust Committees directly accountable to the Board
28	Board	Organisation Structure	Appoint, equip, review and (where appropriate) dismiss the Chair and members of any

NO.	BOARD /COMMITTEE	AREA	DECISIONS RESERVED
		and Staffing	Committee or Group set up by the Board
29	Board	Organisation Structure and Staffing	Appoint, equip, review and (where appropriate) dismiss individuals appointed to represent the Board on outside bodies and groups
30	Board	Organisation Structure and Staffing	Approve the standing orders and terms of reference and reporting arrangements of all Committees and groups established by the Board
31	Audit, Risk and Assurance -Committee	Operating Arrangements	Approve arrangements relating to the discharge of the Trust's responsibility as a bailee for patients' property
32	Board Except where Chapter 6 specifies appropriate to delegate to a committee, Chief Executive or Officers	Operating Arrangements	Approve individual compensation payments in line with the provisions of Annex 4 to Chapter 6 of the Welsh Government Manual for Accounts
33	Board Except where Chapter 6 specifies appropriate to delegate to a committee, Chief Executive or Officers	Operating Arrangements	Approve individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and officers

NO.	BOARD /COMMITTEE	AREA	DECISIONS RESERVED
34	Board	Operating Arrangements	Approve proposals for action on litigation on behalf of the Trust
35	Board	Organisation Structure and Staffing	Approve the arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee of funds held on trust in accordance with the provision of Paragraph 20 of the Standing Financial Instructions.
36	Board	Strategy and Planning	Approve individual contracts (other than NHS contracts) above the limit delegated to the Chief Executive set out in the Standing Financial Instructions[2]
37	Board	Performance and Assurance	Approve the Trust's audit and assurance arrangements
38	Board	Performance and Assurance	Receive reports from the Trust's Executive on progress and performance in the delivery of the Trust's strategic aims, objectives and priorities and approve action required, including improvement plans, as appropriate.
39	Board	Performance and Assurance	Receive reports from the Trusts Committees, groups and other internal sources on the Trust's performance and approve action required, including improvement plans, as appropriate
40	Board	Performance and Assurance	Receive reports on the Trust's performance produced by external regulators and inspectors (including, e.g., Audit Wales etc.) that raise significant issue or concerns impacting on the Trust's ability to achieve its aims and objectives and approve action required, including improvement plans, taking account of the advice of Trust Committees (as appropriate)
41	Board	Performance and Assurance	Receive the annual opinion of the Trust's Chief Internal Auditor and approve action required, including improvement plans
42	Board	Performance and Assurance	Receive the annual management report from the Auditor General for Wales and approve action required, including improvement plans

2 In this respect individual contracts refers to individual awards

NO.	BOARD /COMMITTEE	AREA	DECISIONS RESERVED
43	Board	Performance and Assurance	Receive assurance regarding the Trust's performance against the Health and Care Standards for Wales and the arrangements for approving required action, including improvement plans.
44	Board	Reporting	Approve the Trust's Reporting Arrangements, including reports on activity and performance to citizens, partners and stakeholders and nationally to the Welsh Government where required.
45	Board	Reporting	Receive, approve and ensure the publication of Trust reports, including its Annual Report and annual financial accounts in accordance with directions and guidance issued.

ADDITIONAL AREAS OF RESPONSIBILITY DELEGATED TO CHAIR, VICE CHAIR AND INDEPENDENT MEMBERS			
1.	Chair		In accordance with statutory and Welsh Government requirements
2.	Vice Chair		In accordance with statutory and Welsh Government requirements
3.	Champion/ Nominated Lead		In accordance with statutory and Welsh Government requirements

DELEGATION OF POWERS TO COMMITTEES AND OTHERS[3]

Standing Order 2 provides that the Board may delegate powers to Committees and others. In doing so, the Board has formally determined:

- The composition, terms of reference and reporting requirements in respect of any such Committees; and
- The governance arrangements, terms and conditions and reporting requirements in respect of any delegation to others

in accordance with any regulatory requirements and any directions set by the Welsh Ministers.

The Board has delegated a range of its powers to the following Committees and others:

- Audit, Risk and Assurance Committee
- Quality Patient Experience and Safety Committee
- Remuneration Committee
- Finance and Performance Committee
- People and Culture Committee
- Charity Committee
- Academic Partnerships Committee

The scope of the powers delegated, together with the requirements set by the Board in relation to the exercise of those powers are as set out in i) Committee terms of reference, and ii) Formal arrangements for the delegation of powers to others. Collectively, these documents form the Trust's Scheme of Delegation to Committees. The Committee terms of reference appear in Schedule 3 to these Standing Orders.

[3] As defined in Standing Orders.

In the event the Chief Executive Officer is absent they will appoint a Deputy Chief Executive Officer to take on full responsibility of the Chief Executive Officer. If the Deputy Chief Executive is the Director of Finance and Corporate Resources then the Director of Finance and Corporate Resources responsibilities is delegated to the ~~Deputy~~ relevant Assistant Director of Finance.

SCHEME OF DELEGATION TO EXECUTIVE DIRECTORS, DIRECTORS AND OFFICERS

The Trust SOs and SFIs specify certain key responsibilities of the Chief Executive, the Director of Finance and Corporate Resources and other officers. The Chief Executive's Job Description, together with their Accountable Officer Memorandum sets out their specific responsibilities, and the individual job descriptions determined for Executive Director level posts also define in detail the specific responsibilities assigned to those post holders.

These documents, together with the schedule of additional delegations below and the associated financial delegations set out in the SFIs form the basis of the Trust's Scheme of Delegation to Officers.

Table A – Delegated Matters

Note for Table A, where a delegation is made to more than one post holder:

- '/' signifies that either post holder may act individually, or they may act jointly.
- 'and' signifies they must act jointly

Delegated Matter	Responsible Officer/Committee	Delegated To
1. Audit arrangements		
1.1. Ensure that there is an adequate provision of internal and external audit services	Audit, Risk and Assurance Committee	Director of Corporate Governance/Board Secretary
1.2. Implement recommendations	Chief Executive	Relevant Director
1.3. Ensure the financial accounts of the Trust are audited annually	Chief Executive	Executive Director of Finance and Corporate Resources

Delegated Matter	Responsible Officer/Committee	Delegated To
2. Authorisation of new drugs	Chief Executive	Executive Director of Paramedicine and Associate Medical Director
3. Bank/OPG Accounts/Cash (Excluding Charitable Funds (Funds Held on Trust Accounts)) Refer to SFIs for banking arrangements	Chief Executive	Executive Director of Finance & Corporate Resources
4. Capital investment (Refer to SFIs)		
4.1. Programme		
(a) Preparation of Capital Investment for submission to Board	Chief Executive	Executive Director of Finance & Corporate Resources and Director of Strategy, Planning & Performance
(b) Financial monitoring and reporting on all capital scheme expenditure including variations to contract	Chief Executive	Executive Director of Finance & Corporate Resources
(c) Variation to capital programme (up to delegated limits)	Chief Executive	Executive Director of Finance & Corporate Resources and Director of Strategy, Planning & Performance
4.2. Leases – granting and termination of leases subject to the limits set out in Table B	Chief Executive	Executive Director of Finance & Corporate Resources
5. Clinical		
5.1. Clinical governance arrangements	Chief Executive	Executive Director of Quality & Nursing and Executive Director of Paramedicine
5.2. Clinical leadership	Chief Executive	Executive Director of Quality & Nursing and Executive Director of Paramedicine
5.3. Programmes of clinical education	Chief Executive	Director of People ~~and Culture~~ with Executive Director of Quality & Nursing and Executive Director of Paramedicine
5.4. Clinical staffing rotas	Chief Executive	Executive Director of Operations

Delegated Matter	Responsible Officer/Committee	Delegated To
5.5. Clinical trials and research projects (authorisation of) In accordance with JRCALC guidelines	Chief Executive	Executive Director of Paramedicine unless specified as Associate Medical Director
5.6. Responsible officer for medical revalidation	Chief Executive	Associate Medical Director
5.7. Clinical Audit To ensure there is a programme in place	Chief Executive	Executive Director of Paramedicine
6. Clinical Practice and Registration		
6.1. Compliance with statutory and regulatory arrangements relating to professional practice and/or breaches of clinical standards		
(a) Nursing	Chief Executive	Executive Director of Quality and Nursing
(b) Medical	Chief Executive	Associate Medical Director
(c) Paramedicine and affiliated roles	Chief Executive	Executive Director of Paramedicine
(d) Community First Responders	Chief Executive	Executive Director of Paramedicine
7. Complaints/concerns (patients and relatives) – Putting Things Right/the NHS (Concerns, Complaints and Redress Arrangements (Wales)) Regs 2011	Chief Executive	Executive Director of Quality & Nursing
8. Confidential information		
8.1. Monitoring of the Trust's compliance with the Caldicott report on protecting patient confidentiality in the NHS	Chief Executive	Executive Director of Quality and Nursing
8.2. Freedom of Information Act compliance code	Chief Executive	Director of Corporate Governance/Board Secretary
9. Data Protection Act and General Data Protection Regulations		
9.1. Monitoring of Trust's compliance	Chief Executive	Director of Digital Services

Delegated Matter	Responsible Officer/Committee	Delegated To
9.2. Senior Information Risk Owner (SIRO)	Chief Executive	Director of Digital Services
10. Declarations of interest		
10.1. Maintaining a register	Chief Executive	Director of Corporate Governance/Board Secretary
11. Disposal and condemnations		
11.1. Items obsolete, redundant, irreparable or cannot be repaired cost effectively	Chief Executive	Executive Director of Finance & Corporate Resources
11.2. Develop arrangements for the sale of assets	Chief Executive	Executive Director of Finance & Corporate Resources
11.3. Disposal of protected property (as defined in the terms of authorisation)	Chief Executive	Executive Director of Finance & Corporate Resources
12. Environmental Regulations		
12.1. Monitoring of compliance and ensuring compliance with environmental regulations, for example those relating to clean air and waste disposal	Chief Executive	Executive Director of Finance and Corporate Resources
13. External Borrowing		
13.1. Advise Trust Board of the requirements to repay / draw down Public Dividend Capital	Executive Director of Finance & Corporate Resources	~~Deputy Director of Finance and Corporate Resources~~ (the relevant) Assistant Director of Finance
13.2. Approve a list of employees authorised to make short term borrowings on behalf of the Trust	Trust Board	Chief Executive and Executive Director of Finance & Corporate Resources
13.3. Application for draw down of Public Dividend Capital, overdrafts, and other forms of external borrowing	Chief Executive	Executive Director of Finance & Corporate Resources
14. Financial Planning/Budgetary Responsibility		

Delegated Matter	Responsible Officer/Committee	Delegated To
14.1. Develop and submit to Trust Board a financial plan in accordance with priorities and objectives as set out in the IMTP	Chief Executive	Executive Director of Finance & Corporate Resources
14.2. Budgetary responsibility	Chief Executive	Executive Director of Finance & Corporate Resources
14.3. Prior to the start of the financial year, prepare and submit to Trust Board for approval balanced budgets that delivers the financial plan as contained within the IMTP	Chief Executive	Executive Director of Finance & Corporate Resources
14.4. Monitoring and report to Trust Board on performance against the financial plan	Chief Executive	Executive Director of Finance & Corporate Resources
14.5. Devise and maintain systems of budgetary control	Chief Executive	Executive Director of Finance & Corporate Resources
14.6. Monitor performance against budget	Chief Executive	Executive Director of Finance & Corporate Resources
14.7. Delegate budgets to budget holders	Chief Executive	Executive Director of Finance & Corporate Resources
14.8. Ensure adequate training is delivered to budget holders to facilitate their management of allocated budget	Chief Executive	Executive Director of Finance & Corporate Resources
14.9. Submit in accordance with the independent regulators' requirements for financial monitoring returns	Chief Executive	Executive Director of Finance & Corporate Resources
14.10. Identify and implement cost improvements and income generating activities in line with the business plan	Chief Executive	All budget holders
14.11. Preparation of		
(a) Annual accounts	Executive Director of Finance & Corporate Resources	(the relevant) Assistant Director of Finance~~Deputy Director of Finance and Corporate Resources~~
(b) Annual report	Chief Executive	Director of Corporate Governance/Board Secretary

Delegated Matter	Responsible Officer/Committee	Delegated To
14.12. Budget Responsibilities. Ensure that:		
(a) No overspend or reduction of income that cannot be met from virement is incurred without prior consent of Board	Chief Executive and Executive Director of Finance & Corporate Resources	(the relevant) Assistant Director of Finance~~Deputy Director of Finance and Corporate Resources~~
(b) Approved budget is not used for any other than specified purpose subject to rules of virement	Chief Executive and Executive Director of Finance & Corporate Resources	(the relevant) Assistant Director of Finance~~Deputy Director of Finance and Corporate Resources~~
(c) No permanent employees are appointed without the approval of the Chief Executive other than those provided for within available resources and workforce establishment	Chief Executive and Executive Director of Finance & Corporate Resources	(the relevant) Assistant Director of Finance~~Deputy Director of Finance and Corporate Resources~~
14.13. Authorisation of Virement The Chief Executive, Executive Director of Finance & Corporate Resources and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.	Chief Executive	Executive Director of Finance & Corporate Resources
Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement		
15. Financial Procedures and Systems Development and maintenance of systems and procedures	Chief Executive	Executive Director of Finance & Corporate Resources
16. Fire Precautions Ensure that the Fire Precautions and prevention policies and procedures are adequate, and that fire safety and integrity of the estate is intact.	Chief Executive	Executive Director of Finance & Corporate Resources

Delegated Matter	Responsible Officer/Committee	Delegated To
17. Fixed Assets		
17.1. Maintenance of asset register including asset identification and monitoring	Chief Executive	Executive Director of Finance & Corporate Resources
17.2. Ensuring arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with NHS Infrastructure Investment Guidance	Chief Executive	Executive Director of Finance & Corporate Resources
17.3. Calculate and pay capital charges in accordance with the requirements of the Independent Regulator	Chief Executive	Executive Director of Finance & Corporate Resources
17.4. Responsibility for security of Trust's assets including notifying discrepancies to the Executive Director of Finance and Corporate Services, and reporting losses in accordance with Trust's procedures	Chief Executive	All Staff
18. Fraud (see also 26 and 36) Monitor and ensure compliance with Welsh Government Directions on fraud and corruption including the appointment of the Local Counter Fraud Specialist.	Chief Executive	Executive Director of Finance & Corporate Resources
19. Funds Held on Trust Charitable Funds Charitable Funds held are managed and scrutinised appropriately	Charitable Funds Committee	Executive Director of Finance & Corporate Resources
20. Gifts and Hospitality		
20.1. Maintaining the gifts and hospitality register	Chief Executive	Director of Corporate Governance/Board Secretary
20.2. Process for declaring gifts and hospitality	Chief Executive	Director of Corporate Governance/Board Secretary
21. Health and Safety Monitor and ensure statutory compliance with all legislation and Health and Safety requirements including control of Substances Hazardous to	Chief Executive	Executive Director of Quality & Nursing

Delegated Matter	Responsible Officer/Committee	Delegated To
Health Regulations		
22. Infectious Diseases and Notifiable Outbreaks	Chief Executive	Executive Director of Quality & Nursing
23. Integrated Medium Term Plan (IMTP)		
23.1. Develop and present to Trust Board for approval an IMTP that sets out the Trust Strategies and objectives and meets Welsh Government requirement	Chief Executive	Executive Director of Strategy, Planning & Performance
24. IT Systems		
24.1. Ensuring integrity of system e.g. security, privacy, accuracy, completeness, and storage	Chief Executive	Director of Digital Services
24.2. Maintain & replacement of i) business critical systems ii) All other systems	Chief Executive	Director of Digital Services
24.3. Disaster recovery systems	Chief Executive	Director of Digital Services
24.4. Developing Business Critical Systems in accordance with the Trust's IM&T Strategy	Chief Executive	Director of Digital Services
24.5. Developing new systems to ensure they are developed in a controlled manner and thoroughly tested	Chief Executive	Director of Digital Services
24.6. Seeking third party assurances regarding Business Critical Systems operated externally	Chief Executive	Director of Digital Services
25. Losses, Write Offs and Compensation		
25.1. Prepare procedures for recording accounting and reporting to Audit, Risk and Assurance Committee for losses and special payments, including clinical negligence and personal injury claims	Chief Executive	Executive Director of Finance & Corporate Resources

Delegated Matter	Responsible Officer/Committee	Delegated To
25.2. Ex-gratia payments	Chief Executive	Executive Director of Finance & Corporate Resources and relevant Director
26. Patients' Property (in conjunction with financial advice) Ensuring patients and guardians are informed about patients' monies and property procedures	Chief Executive	Executive Director of Operations
27. Patient Services Agreements Negotiation, agreement, and monitoring of external non-clinical patient transport contracts	Chief Executive	Executive Director of Finance & Corporate Resources/Executive Director of Operations
28. Procuring Goods and Services		
28.1. Maintenance of a list of managers authorised to place requisitions/orders and accept goods in accordance with Table B	Chief Executive	Executive Director of Finance & Corporate Resources
28.2. Obtain the best value for money when requisitioning goods/services	Chief Executive	Executive Director of Finance & Corporate Resources
28.3. Prompt payment to suppliers (pspp)	Chief Executive	Executive Director of Finance & Corporate Resources
28.4. Financial limits for ordering/requisitioning goods and services Refer to Table B for delegated limits	Chief Executive	Executive Director of Finance & Corporate Resources
29. Quotation, Tendering and Contract Procedures		
29.1. Services:		
(a) Best value for money is demonstrated for all services provided under contract or in-house	Chief Executive	Executive Director of Finance & Corporate Resources
(b) Nominate officers to oversee and manage the contract on behalf of the Trust	Chief Executive	Heads of Department

Delegated Matter	Responsible Officer/Committee	Delegated To
29.2. Competitive Tenders:		
(a) Authorisation to go to tender[4]	Chief Executive	Relevant Director
(b) Maintain a register to show each set of competitive tender invitations despatched	Chief Executive	Executive Director of Finance & Corporate Resources
(c) Receipt and custody of tenders prior to opening	Chief Executive	Executive Director of Finance & Corporate Resources
(d) Opening tenders	Chief Executive	Relevant Director
(e) Decide if late tenders should be considered	Chief Executive	Executive Director of Finance & Corporate Resources/Board Secretary
(f) Ensure that appropriate checks are carried out as to the technical and financial capability of the firms invited to tender or quote	Chief Executive	Executive Director of Finance & Corporate Resources
29.3. Quotations[4] Authorisation to seek quotations	Chief Executive	Relevant Director
29.4. Waiving the requirement to request[5]		
(a) Tenders – subject to Standing Financial Instructions (reporting to Audit, Risk and Assurance Committee)	Chief Executive	Executive Director of Finance & Corporate Resources
(b) Quotes – subject to Standing Financial Instructions	Chief Executive	Executive Director of Finance & Corporate Resources

4 Individual awards of contract post tender and quotation are authorised in line with the delegations in Table B
5 See SFI 11.13.2 which provides the Executive Director of Finance and Corporate Resources approves applications for single tender waiver (STWs) up to £25,000, and the Chief Executive and Executive Director of Finance and Corporate Resources approve applications exceeding £25,000. It also provides that Procurement Services must be consulted prior to any such application being submitted for approval

Delegated Matter	Responsible Officer/Committee	Delegated To
30. Reporting of Non-Urgent Incidents to the Police	Chief Executive	Relevant Director
31. Risk Management		
31.1. Ensuring the Trust has a Risk Management Strategy and a programme of risk management	Chief Executive	Director of Corporate Governance/Board Secretary
31.2. Developing systems for the management and reporting of risks and incidents	Chief Executive	Director of Corporate Governance/Board Secretary (risk) and Executive Director of Quality & Nursing (incidents)
32. Seal The keeping of a register of seal and safekeeping of the seal	Chief Executive	Director of Corporate Governance/Board Secretary
33. Signing of Documents		
33.1. Legal Proceedings/Advice		
(a) Engage Trust's solicitors/legal advisor	Chief Executive	Relevant Director
(b) Documents connected with legal proceedings[6]	Chief Executive	Relevant Director
33.2. Documents which are required to be executed as a Deed[7]	Chief Executive	Relevant Director and Director of Corporate Governance/Board Secretary
33.3. Other Agreements/Contracts not required to be executed as a Deed	Chief Executive	Relevant Director
33.4. Agreements/Contracts where award approved by Board	Chief Executive	N/A
33.5. Lease Agreements[8]	Chief Executive	Director of Finance and Corporate Resources and Director of Corporate

6 May include but not be limited to consent orders, defences, and settlement agreements)
7 Refer to Governance Practice Note 001 for use of Trust Seal
8 Copies of all leases are to be kept once signed by the Estates Manager for property related leases and by the Board Secretary for all other leases/contracts

Delegated Matter	Responsible Officer/Committee	Delegated To
		Governance/Board Secretary
34. Security Management Provide an oversight and assurance within the context of security management within NHS Wales; working in conjunction with the following leads on specific functional areas of security management:		
34.1. Finance, fraud etc.	Chief Executive	Director of Finance & Corporate Resources
34.2. Estates, premises security etc.	Chief Executive	Director of Finance and Corporate Resources
34.3. ICT	Chief Executive	Director of Digital Services
34.4. Information/data security/records management	Chief Executive	Director of Digital Services
34.5. Violence and aggression	Chief Executive	~~Director of People and Culture~~Executive Director of Quality and Nursing
34.6. Patient Confidentiality	Chief Executive	Caldicott Guardian (Executive Director of Quality and Nursing)
35. Setting of Fees and Charges (Income)		
35.1. Income generation	Chief Executive	Executive Director of Finance & Corporate Resources
35.2. Non-patient care income (e.g., research)	Chief Executive	Executive Director of Finance & Corporate Resources
36. Stores and Receipt of Goods		
36.1. Responsibility for systems of control over stores and receipt of goods, issues and returns	Chief Executive	Relevant Director
36.2. Stocktaking arrangements	Executive Director of Finance & Corporate Resources	(the relevant) Assistant Director of Finance~~Deputy Director of Finance and Corporate Resources~~
36.3. Responsibility for controls of pharmaceutical supplies	Executive Director of	Heads of Department as appropriate

Delegated Matter	Responsible Officer/Committee	Delegated To
	Paramedicine	
37. Workforce and Pay		
37.1. Nomination of officers to enter into staff contracts of employment	Chief Executive	Director of People ~~and Culture9~~
37.2. Develop Workforce policies and strategies for approval by the Board including but not limited to training and industrial relations	Chief Executive	Director of People and Director of Culture Change
37.3. Renewal of Fixed Term Contract	Chief Executive	Director of People ~~and Culture~~
37.4. The granting of additional increments to staff upon initial appointment within the parameters of existing agreements	Chief Executive	Director of People ~~and Culture~~
37.5. Establishments		
(a) Additional staff to the agreed establishment with specifically allocated finance	Chief Executive	Executive Director of Finance & Corporate Resources/ Director of People ~~and Culture~~
(b) Additional staff to the agreed establishment without specifically allocated finance	Chief Executive	Executive Director of Finance & Corporate Resources/ Director of People ~~and Culture~~
(c) Self-financing changes to the establishment	Chief Executive	Relevant Director
(d) Self-financing changes to an establishment which involves movement between pay and other types of expenditure	Chief Executive	Executive Director of Finance & Corporate Resources
37.6. Pay Preparation of proposals for the Trust Board for the setting of remuneration and conditions of service for those staff not covered by Agenda for Change	Chief Executive	Director of People ~~and Culture~~
37.7. Annual Leave		

~~9 This delegation will be to the Director of People when that role is filled (estimated October 2024)~~

Delegated Matter	Responsible Officer/Committee	Delegated To
(a) Approval of annual leave	Chief Executive	Relevant Directors
(b) Annual leave - approval of carry forward up to maximum of 5 days (and pro rata for part time staff)	Chief Executive	Relevant Directors
(c) Annual leave – approval of carry forward over 5 days (and pro rata for part time staff) (to occur in exceptional circumstances only)	Chief Executive	Director of People ~~and Culture~~/ Executive Director of Finance & Corporate Resources
37.8. Special Leave To be applied in accordance with Trust Policy. Departure from policy will be as follows:		
(a) Compassionate leave	Chief Executive	Director of People ~~and Culture~~
(b) Special leave arrangements for domestic/personal/family reasons: • Paternity leave • Carers leave • Adoption leave	Chief Executive	Director of People ~~and Culture~~
(c) Special leave – this includes: • Jury service • Armed services • School governor To be applied in accordance with Trust Policy	Chief Executive	Director of People ~~and Culture~~
(d) Leave without pay	Chief Executive	Director of People ~~and Culture~~
(e) Time off in lieu	~~Executive~~ Director of People ~~and Culture~~	Line/Departmental Manager
(f) Maternity leave – paid and unpaid	~~Executive~~ Director of	Automatic approval within approved guidance

Delegated Matter	Responsible Officer/Committee	Delegated To
	People ~~and Culture~~	
37.9. Sick Leave		
(a) Extension of sick leave on pay due to: • Delays in process • Exceptional circumstances	Chief Executive	Director of People ~~and Culture~~
(b) Return to work part-time on full pay to assist recovery	Chief Executive	Heads of Department/Heads of Service in conjunction with People Services Business Partners
37.10. Study Leave	Chief Executive	Director of People ~~and Culture~~
37.11. Removal expenses, excess rent and house purchases in accordance with Table B	Chief Executive	Director of People ~~and Culture~~
37.12. Authorised – car users leased car	Chief Executive	Executive Director of Finance & Corporate Resources
37.13. Approval of secondary employment (also subject to a declaration of interest)	Chief Executive	Director of People ~~and Culture~~
37.14. Putting proposal to Remuneration Committee in respect of Redundancy/ Severance/ VERS/ Settlement Payments within Trust limits and, where necessary, subject to WG approval	Chief Executive	Director of People ~~and Culture~~/ Executive Director of Finance & Corporate Resources
37.15. Disciplinary procedures (excluding Executive Directors)	Chief Executive	To be applied in accordance with the Trust's disciplinary procedure
37.16. Booking of bank staff		
(a) Nursing	Chief Executive	Executive Director of Quality & Nursing
(b) Clinical (excluding nursing)	Chief Executive	Executive Director of Operations/ Executive Director of Paramedicine
(c) Other	Chief Executive	Relevant Director
37.17. Booking of agency and locum staff		

Delegated Matter	Responsible Officer/Committee	Delegated To
(a) Nursing	Chief Executive	Executive Director of Operations
(b) Medical	Chief Executive	Executive Director of Paramedicine
(c) Paramedicine and affiliated roles	Chief Executive	Executive Director of Operations
(d) Other	Chief Executive	Relevant Director

Table B – Delegated Financial Limits

NB Thresholds are inclusive of VAT irrespective of recovery arrangements with the exception of procurement thresholds which are provided net of VAT.

NB Limits are based on the lifetime value of the individual contract award, not an annual or financial year value

Category	Welsh Govt Delegated Limit - Approval Required[10]	Trust Board	Chief Executive	Exec Director Finance & Corporate Resources	Director of People and Culture	Exec Director Quality and Nursing	Exec Directors / Directors	Heads of service/ Heads of Dept	Budget Holders	Notes[11]
1. LOSSES										
1.1. Losses of Cash due to**:**										
(a) Theft, fraud, arson, sabotage, neglect of duty or gross carelessness	50,000	Over 50,000[12]	50,000	10,000						See Annex 1 to Chapter 6 of Welsh Govt Manual for Accounts (WGMFA)
(b) Overpayment of salaries, wages, fees & allowances	50,000	Over 50,000[8]	50,000	10,000						See Annex 1 to Chapter 6 of WGMFA
(c) Other causes, including un-vouched or completely vouched payments, overpayments other	50,000	Over 50,000[8]	50,000	10,000						See Annex 1 to Chapter 6 of WGMFA

10 NHS Wales health bodies do not have unlimited powers to make special payments or to write-off losses. They must obtain the written approval of the Welsh Government HSCEY Finance Director before writing-off a loss or making, or undertaking to make, any special payment that exceeds their delegated limit. The limits are listed in this column.

11 These notes are intended to guide the reader. They must be read in conjunction with the SO/SoRD/SFIs and those related to losses and special payments with respect to the Welsh Government Manual of Accounts, as well as any relevant Governance Practice Notes.

12 Does not negate the need for WG Approval which is also required

Category	Welsh Govt Delegated Limit - Approval Required[10]	Trust Board	Chief Executive	Exec Director Finance & Corporate Resources	Director of People and Culture	Exec Director Quality and Nursing	Exec Directors / Directors	Heads of service/ Heads of Dept	Budget Holders	Notes[11]
than those included under 1b; physical losses of cash and cash equivalents e.g. postage stamps due to fire (other than arson), accident and similar cause										
1.2. Fruitless Payments, including abandoned capital schemes	250,000	Over 250,000[8]	250,000				100,000	50,000	10,000	A "fruitless payment" is a payment for which liability ought not to have been incurred, or where the demand for the goods and service in question could have been cancelled in time to avoid liability. See further info at annex 1 to Chapter 6 of WGMFA
1.3. Bad Debts and Claims Abandoned										See Annex 1 to Chapter 6 of WGMFA
(a) Private patients	50,000	Over 50,000[8]	50,000	10,000						
(b) Overseas visitors	50,000	Over 50,000[8]	50,000	10,000						
(c) Causes other than (a) and (b) above	50,000	Over 50,000[8]	50,000	10,000						
1.4. Damage to buildings, their fittings, furniture and equipment and loss of equipment and property in stores and in use due to:										
(a) Culpable causes, e.g., theft, arson or sabotage whether proved or suspected, neglect of duty or gross carelessness	50,000	Over 50,000[8]	50,000	10,000						
(b) Other causes	50,000	Over	50,000	10,000						May include losses by fire (other than

Category	Welsh Govt Delegated Limit - Approval Required[10]	Trust Board	Chief Executive	Exec Director Finance & Corporate Resources	Director of People and Culture	Exec Director Quality and Nursing	Exec Directors / Directors	Heads of service/ Heads of Dept	Budget Holders	Notes[11]
		50,000[8]								arson); losses by weather damage or by accident beyond the control of any responsible person; losses due to deterioration. See Annex 1 to Chapter 6 of WGMFA for further info
2. SPECIAL PAYMENTS										
2.1. Compensation payments under legal obligation	N/A	Board to be made aware of payment over 25K	Over 100,000	100,000	25,000	25,000				Payments fall into this category only if a clear liability exists as a result of a Court Order or a legally binding arbitration award. This category can include compensation for injuries to persons, damage to property and unfair dismissal. Payments into court, and out of court settlements, are not payments made under legal obligation.
2.2. Extra contractual payments to contractors	50,000	Over 50,000[8]	50,000	10,000						An extra contractual payment is one which, although not legally due under the original contract or subsequent amendments, appears to be an obligation which the Courts may uphold. Such an obligation will usually be attributable to action or inaction by a health body in relation to the contract. See Annex 2 to Chapter 6 of WGMFA for further info
2.3. Ex gratia payment										Ex gratia payments are payments which a health body is not obliged to make or for which there is no statutory cover or legal liability. An example is a payment to compensate for financial loss resulting from an act or failure of the

Category	Welsh Govt Delegated Limit - Approval Required[10]	Trust Board	Chief Executive	Exec Director Finance & Corporate Resources	Director of People and Culture	Exec Director Quality and Nursing	Exec Directors / Directors	Heads of service/ Heads of Dept	Budget Holders	Notes[11]
										body or its servants which does not give rise to a legal liability or the payment of compensation claims or damages. See Annex 2 to Chapter 6 of WGMFA for further info
(a) To patients and staff for loss of personal effects	50,000	Over 50,000[8]	50,000	10,000	10,000					
(b) For clinical negligence (negotiated settlements following legal advice) where the guidance relating to such payment has been applied	1,000,000	Over 500,000[8]	500,000			100,000		50,000	10,000	Delegations are inclusive of plaintiff's costs. Many clinical negligence and personal injury cases are settled out of Court and are, therefore, classified as ex gratia payments. Provided the relevant guidance has been followed and appropriate legal advice has been obtained, in cases involving negligence the delegated limits are much higher than those which apply to other ex gratia payments
(c) For personal injury claims where legal advice obtained, and relevant guidance has been applied	1,000,000	Over 500,000[8]	500,000			100,000		50,000	10,000	Delegations are inclusive of plaintiff's costs. Many clinical negligence and personal injury cases are settled out of Court and are, therefore, classified as ex gratia payments. Provided the relevant guidance has been followed and appropriate legal advice has been obtained, in cases involving negligence the delegated limits are much higher than those which apply to other ex gratia payments

Category	Welsh Govt Delegated Limit - Approval Required[10]	Trust Board	Chief Executive	Exec Director Finance & Corporate Resources	Director of People and Culture	Exec Director Quality and Nursing	Exec Directors / Directors	Heads of service/ Heads of Dept	Budget Holders	Notes[11]
(d) Other clinical negligence and personal injury claims including Putting Things Right arrangements	50,000	Over 50,000[8]	50,000			10,000				
(e) Other[13] Except cases for maladministration where there was no financial loss by claimant	50,000	RemCom Over 50,000[8]	50,000		10,000					Other ex-gratia payments include: Voluntary Early Release Scheme payments which must be approved by RemCom regardless of value (SoR 25). Special severance payments when staff leave public service employment should be exceptional. They are usually novel contentious and potentially repercussive, and **ALL must be referred to WG for approval, even if they are within delegated limits** which must be approved by RemCom regardless of value (SoR 25) Settlements on termination of employment. Most payments to staff on termination of their employment will be contractual, but ex gratia payments will sometimes arise (for example to settle a claim against the health body for breach of contract). Only payments made in excess of that which is paid under contractual obligation should be recorded as ex-gratia in the losses and special payments register. *These payments may be made by Chief Executive (up to £50K) and Executive

13 ALL special severance payments (novel, contentious and potentially repercussive) of whatever value must be referred to WG for approval, even if they are within delegated limits

Category	Welsh Govt Delegated Limit - Approval Required[10]	Trust Board	Chief Executive	Exec Director Finance & Corporate Resources	Director of People and Culture	Exec Director Quality and Nursing	Exec Directors / Directors	Heads of service/ Heads of Dept	Budget Holders	Notes[11]
										Director of People (up to £10K) and reported to the next RemCom. They are also included in the report to AC on losses and special payments.
(f) Maladministration where there was no financial loss by claimant	N/A	Over 50,000	50,000	10,000						In most cases of maladministration there is unlikely to be any legal obligation to pay compensation, and any payment would, as a result, be ex gratia. Such payments may arise: • as a result of a recommendation by the Public Services Ombudsman Wales (PSOW). • in cases, not involving the PSOW, where NHS Wales health bodies consider that the effect of official failure may justify a payment
(g) Patient referrals outside UK and EEA guidelines	N/A	Over 50,000	50,000	10,000						
2.4. Extra statutory and extra regulatory Payments	N/A	Over 50,000	50,000	10,000						These are payments considered to be within the broad intention of a statute or statutory regulation, but which go beyond a strict interpretation of its terms. In some cases, WG will advise to classify the payments as extra statutory. In all other cases WG must be informed and will advise whether the payments may be treated as extra statutory See Annex 2 of WGMOA for more info.

Category	Welsh Govt Delegated Limit - Approval Required[10]	Trust Board	Chief Executive	Exec Director Finance & Corporate Resources	Director of People and Culture	Exec Director Quality and Nursing	Exec Directors / Directors	Heads of service/ Heads of Dept	Budget Holders	Notes[11]
3. REQUISITIONING GOODS AND SERVICES AND APPROVING PAYMENT **NB: To ensure processes are efficient, timely and appropriately delegated, the Chief Executive with the endorsement of the Director of Finance and Corporate Resources will approve requisitions above £500K (or £200K for management consultants at 3.6 below) arising out of an award approved by the Board in accordance with the Scheme of Matters Reserved to the Board and after satisfying themselves that the requisition is aligned to the approval provided by the Board.**										
3.1. Agency staff and private providers	N/A	See note above	500,000	200,000	200,000	200,000	200,000	50,000 (100,000 for Assistant Director of Operations, Ambulance Care for private providers only)	10,000	Any agency staff, including medical locums. No other managers can authorise use of agency staff.
3.2. Building and engineering works (non-capital)	N/A	See note above	500,000	100,000	100,000	100,000	100,000	50,000	10,000	
3.3. Call off orders (annual value)	N/A	See note above	500,000	100,000	100,000	100,000	100,000	50,000	10,000	High cost medical consumables, provisions, routine supplies, excluding locums or agency staff
3.4. Capital expenditure (subject to annual programme being approved by Trust Board)	N/A	See note above	500,000	100,000	100,000	100,000	100,000	50,000	10,000	The Board to approve cases outside discretionary allowances. Capital programme agreed annually by Board.
3.5. Information Technology	N/A	See note above	500,000	100,000	100,000	100,000	100,000	50,000	10,000	Major IT systems, software purchase, PC and printer purchase, networking, computer consumables. Includes software or hardware maintenance contracts

Category	Welsh Govt Delegated Limit - Approval Required[10]	Trust Board	Chief Executive	Exec Director Finance & Corporate Resources	Director of People and Culture	Exec Director Quality and Nursing	Exec Directors / Directors	Heads of service/ Heads of Dept	Budget Holders	Notes[11]
3.6. Management consultants (including professional services)	N/A	See note above	200,000	10,000	10,000	10,000	10,000			
3.7. Periodic payments (invoice value)	N/A	See note above	500,000 *750,000 for utilities/ fuel	100,000 *750,000 for utilities/ fuel	100,000	100,000	100,000	50,000	10,000	*In relation to Gas, Electricity, Council tax, Telephone, Water and Fleet Fuel invoices, due to the high level of expenditure on a recurring basis, payments up to a value not exceeding £750,000 can be authorised by the Director of Finance or the Chief Executive. For the provision of clarity, payments of PIBS (Personal Injury Benefit Scheme) invoices do not require authorisation on the basis that these quarterly payments are a reimbursement of pension payments made that have already been authorised.
3.8. Removal expenses	N/A	N/A			8,000					Allowance of £6,000 per relevant staff member
3.9. Services (including maintenance contracts) over lifetime of contract	N/A	See note above	500,000	100,000	100,000	100,000	100,000	50,000	10,000	Routine maintenance contracts, clinical services (e.g. MRI), legal services, audit, clinical waste etc.
3.10. All other requisitions	N/A	See note above	500,000	100,000	100,000	100,000	100,000	50,000	10,000	
4. QUOTATIONS AND TENDERS										
4.1. Authorisation of awards of tenders and competitive quotations	N/A	Over 500,000	500,000	100,000	100,000	100,000	100,000	50,000	10,000	Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully

Category	Welsh Govt Delegated Limit - Approval Required[10]	Trust Board	Chief Executive	Exec Director Finance & Corporate Resources	Director of People and Culture	Exec Director Quality and Nursing	Exec Directors / Directors	Heads of service/ Heads of Dept	Budget Holders	Notes[11]
										complied with, formal authorisation and awarding of a contract may be decided by these staff to the value of the contract. Detail provided here on quotations and tenders for ease of reference, but staff must refer to SFIs for further detail: Quotations- a minimum of 3 written quotations for goods/services must be sought where the anticipated value is likely to be above £5,000. Competitive Tenders- a minimum of 3 written competitive tenders for goods/services must be sought where the anticipated value is likely to be above £25,000. Tenders for Supplies and Services above the limit set EU Procurement matters for works above set limits must be sought in compliance with EC Directives (Updated Jan 2008) (OJEU Regulations) as appropriate. All Tenders and Quotations must be sought, registered, and opened via the SSP. These levels of authorisation may be varied or changed and need to be read in conjunction with the Trust Board's Scheme of Delegation Formal authorisation must be put in writing. In the case of authorisation by the Trust Board this shall be recorded in their minutes. Where there is urgency board approval may be by way of

Category	Welsh Govt Delegated Limit - Approval Required[10]	Trust Board	Chief Executive	Exec Director Finance & Corporate Resources	Director of People and Culture	Exec Director Quality and Nursing	Exec Directors / Directors	Heads of service/ Heads of Dept	Budget Holders	Notes[11]
										Chair's Action in line with the SOs. Exceptions and Instances where formal tendering need not be applied will require authorisation in the form of a request to waive SFIs (pre numbered document from SSP) and authorisation in advance from the Director of Finance or ~~Deputy Director~~the relevant Assistant Director of Finance (or in their absence the Board Secretary)
5. VIREMENT	N/A	Over 100,000	100,000	25,000						Trust must still meet financial targets and the total Trust budget must remain underspent
6. LEASE AGREEMENTS	**	Over 500,000	500,000	100,000 (with Board Secretary)						**See Schedule 1 to SFIs Copies of all leases are to be kept once signed by the Estates Manager for property related leases and by the Board Secretary for all other leases/contracts
7. BUSINESS CASES SEEKING EXTERNAL FUNDING	N/A	Over 500,000	500,000	100,000	100,000	100,000	100,000	50,000	10,000	Any individual awards of contract that flow from approval of a business case must be approved in line with this Scheme of Reservation and Delegation

Category	Welsh Govt Delegated Limit - Approval Required	Board of Trustees/Trust Board	Charity Committee	Bids Panel	Bursary Panel					Notes
8. CHARITABLE FUNDS	N/A	N/A	Over 5,000	5,000	N/A					

Unless otherwise stated, sub-delegations to others are permitted. It is for individual Directors to ensure that a system of sub-delegations are in place for their respective directorates.

This scheme only relates to matters delegated by the Board to the Chief Executive and their Executive Directors, together with certain other specific matters referred to in SFIs. Each Executive Director is responsible for delegation within their department. They shall produce a scheme of delegation for matters within their department, which shall also set out how departmental budget and procedures for approval of expenditure are delegated.

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AGENDA ITEM No	**20**
OPEN or CLOSED	**Open**
No of ANNEXES	**01**

COMMITTEE PRIORITES AND CYCLE MONITORING REPORT

MEETING	Audit, Risk and Assurance Committee
DATE	06 March 2025
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 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.

RECOMMENDATION: -

2. **The Committee is asked to: -**

a) **To note the update on the Cycle of Business Monitoring Report for the Committee and the position against its annual priorities.**

KEY ISSUES/IMPLICATIONS

No issues to raise.

REPORT APPROVAL ROUTE

Not applicable.

REPORT APPENDICES

Annex 1 – Audit Committee Cycle of Business Monitoring Report.

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

COMMITTEE PRIORITIES FOR 2024/25 AND CYCLE MONITORING REPORT

SITUATION

3. 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.

4. 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

5. During the course of the effectiveness reviews, it was agreed that it is good practice for Committees to set priorities for the forthcoming year. The Committee's priorities, which are set out below, were agreed by the Trust Board in May 2024 and will be tracked quarterly.

6. The Committee's cycle of business was approved by the Committee in April 2024. The agenda is set with reference to that cycle, together with the forward planner, action log and highest rated principal risks.

7. The monitoring report is at Annex 1. 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.

8. 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

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

Priority	Progress
• Monitor the development of the Committee specific induction programme.	- A substantive update is programmed for receipt at the March 2025 meeting of the committee, where the wider committee induction approach will be set out. - Additionally, it is noted that a joint Board and Committee Chairs and Trade Union retrospective induction took place on 12 June. Additionally, a committee member governance overview drop took place in August with another planned for September.
• Carry-over from 2023/24: Oversight of the development and implementation of the Quality & Performance Management Framework	<u>2024/2025 Update:</u> - At the November 2024 meeting of the committee, it received a position update on the progress against the Quality and Performance Management Framework (QPMF), with the related internal audit report. - In November the committee confirmed its assurance on the implementation of the QPMF and noted that oversight of the ongoing effectiveness of the Framework will be overseen by the Finance and Performance Committee (FPC). - It is noted that a refresh of the QPMF will be taken to the FPC and Trust Board in March 2025 for review and approval. Members of the Audit, Risk and Assurance Committee will therefore have sight of this development via these mechanisms. - Earlier updates by the committee noted that receipt of updates regarding the Quality and Performance Management Framework (QPMF) have been built into the Committee's Cycle of Business, twice a year (quarter one and quarter three). This preceded the agreement of the committee to transfer oversight to the FPC, however.

	- At the September 2024 meeting it was anticipated that oversight of the QPMF will move to the Finance and Performance Committee, in line with the respective Committee Terms of Reference, when the internal audit was presented to this ARAC meeting. <u>2023/24 Update:</u> - 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.

RECOMMENDATION: -

10. The Committee is asked to

a) To note the update on the Cycle of Business Monitoring Report for the Committee and the position against its annual priorities.

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. Q4: Programmed receipt of the 24/25 Annual Audit Report (FJ confirmed).
Structured Assessment	ELT and Board	Annually							Audit Wales	Assurance	
Other Non-Core Reports	ELT and Board	Various							Audit Wales	Assurance	
Losses & Special Payments/Single Tender Waivers											
Quarterly lossess and special payments report	N/A	Quarterly							EDOF	Approval	
Tender update report and single tender waiver request (closed)	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. Programmed for Q2 but deferred to Q3.
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	Q4:As at ASM on 17122024 unclear if any to take forward.
Financial procedures	TBC	Ad Hoc							EDOF	Approval	Q4:As at ASM on 17122024 unclear if any to take forward.
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	Q4: To be received with the Chair's comment on effectiveness, at the beginning of the meeting.
All Wales Audit Committee Chair's Meeting Report	AWACC	Bi-annually							Chair	Review	Added 19.09.23
PROMPTS											
External Reports	n/a	As required							TBC	TBC	

Two Q1 meetings. Q1a is a governance meeting to take the Committee annual reports and other items as noted

EDOF - Executive Director of Finance and Corporate Resources

BS - Board Secretary

Key: Pre-agenda setting

- Cycled for each meeting
- Ad hoc item - prompt for agenda setting
- Reporting developing

Key: Post-agenda setting

- Presented as cycled
- Ah hoc / item considered - not programmed
- → Item deferred
- Reporting developing

1	**Losses and special payments**	Whilst SFIs provide for approval of these, the payments are in effect already made when they are presented to the AC. All payments are made within SFI delegated limits. Further work with DOFs and Finance Academy at the next version of the SFIs to look at whether ACs should retrospectively approve such payments.
2	**Whistleblowing**	Staff can currently raise concerns through the traditional routes of line management and escalation set out in the All Wales Procedure for Raising Concerns, and through the sensitive issues function in Datix. A new Speaking Up Safely framework is in development by the Director of People and Culture with oversight of the implementation with the People and Culture Committee in 2023/24. The whistleblowing process and arrangements for special investigations to come to Audit Committee. Propose regular verbal updates from the Chair of the People and Culture Committee in the interim. 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 (NHSCFA) have entered into a service agreement under section 83 of the Government of Wales Act 2006, to ensure that appropriate provision is in place to tackle all matters connected to Fraud, Bribery and Corruption. It is the role of the LCFS to ensure regular engagement and reporting to senior members surrounding the work completed within this field, with the audit committee being recognised as an appropriate recipient to the status and developments of the service. Service strands of hold to account, prevent and deter, inform and involve, and strategic governance
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.

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AGENDA ITEM No	**21**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**2**

IMPACT ASSESSMENTS

MEETING	Audit, Risk and Assurance Committee (ARAC)
DATE	06 March 2025
EXECUTIVE	Trish Mills, Director of Corporate Governance and Board Secretary
AUTHOR	Trish Mills, Director of Corporate Governance and Board Secretary
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. The Impact Assessment Task and Finish Group has produced an impact assessment signposting document to aid colleagues with the circumstances under which respective impact assessments are required.

2. The benefit of this is not only compliance with legislation and Standing Orders, but an impact assessment provides an opportunity to set out any efficiency gains and positive impact on our services, as well as identifying where there may be negative consequences which could be mitigated. Attached Annex 1 is the impact assessment signpost document.

3. The Closure Report and signposting document were received by Assistant Directors' Leadership Team (ADLT) on 20 January 2025 and by the Executive Leadership Team (ELT) on the 12 February 2025 and the following was agreed:

   - Closure of the group was noted
   - Signposting document was agreed
   - The recommendation to reconvene was agreed with the caveat that this may need to be a dynamic document to emerging legislative requirements for example if there is a need for WBFGA Ways of Working assessments

RECOMMENDATION

4. **That the committee note the output of the Impact Assessment Task and Finish Group, and the preparation of the Impact Assessment Signposting Document and supporting flowchart, for use across the Trust.**

KEY ISSUES/IMPLICATIONS
As set out above.

REPORT APPROVAL ROUTE
20 January 2025 – ADLT 12 February 2025 – ELT

REPORT APPENDICES
Annex 1: Impact assessment signpost document. Annex 2: Impact Assessment Flowchart.

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	Yes
Estate	N/A	Patient Safety/Safeguarding	N/A
Ethical Matters	N/A	Risks (Inc. Reputational)	N/A
Health Improvement	N/A	Socio Economic Duty	N/A
Health and Safety	N/A	TU Partner Consultation	N/A

Corporate Governance Directorate Official Notice

21 February 2025

Impact Assessments

Impact assessments are required in the following circumstances:

- Strategic decisions and policies: These require an Equality Impact Assessment (EqIA); and
- Projects, programmes, procurement etc: These require situational specific impact assessments.

STRATEGIC DECISIONS AND POLICIES REQUIRING AN EQIA

What is a strategic decision? There is no one definition that relates to impact assessments, however the Equality Act 2010 says that decisions of a strategic nature will be those which affect how WAST, as a public body, fulfils its intended statutory purpose over a significant period of time. It does not include routine day-to-day decisions. Such decisions are usually delegated to senior management or the Trust Board.

If you are seeking approval for a strategic decision, or developing a policy for approval, an Equality Impact Assessment (EqIA) must be done. An EqIA ensures that all significant decisions are made with an informed awareness of their potential impacts on protected characteristics, especially concerning equality. Because of this they should be done at the start of your project/policy to inform its development.

The EqIA should be included with documents presented to decision-makers, ensuring it is completed before any decisions are finalised.

Strategic decisions *may* also require a Quality Impact Assessment (QIA) however, unlike the EqIA, not all strategic decision will need a QIA (see below). When considering completion of an EqIA or QIA, it is important to review the available data and existing information flows that might help demonstrate how the impact would be measured and variation identified.

The overriding requirement for decisions of a strategic nature under the Health and Social Care (Quality and Engagement) Act 2020 is that such decisions are made through the lens of improving the quality of health services and outcomes for the population. Linking the rationale for such decision to the Health and Care Quality Standards may suffice, and where a QIA is required, this will be on the advice of the clinical executive leadership or senior quality leads.

Ref: 002/2025
Approved by: Trish Mills,
Director of Corporate Governance
and Board Secretary

These are examples of when you will need an EqIA

- Long term strategy
- Directorate/speciality specific plans such as the Digital Plan, or the Strategic Workforce Plan
- Integrated Medium Term Plan (IMTP) and related financial plans
- OCPs and similar plans that affect our people
- Policies
- Service change and development of public services
- Major business cases of a strategic nature
- Closure of stations or offices/places of work
- Major procurement and commissioning decisions

Some of the above may need more than just an EqIA. For example, a clinical model transformation may also need a QIA, and a major procurement may also need a Data Protection Impact Assessment or an Environmental Impact Assessment.

If in doubt, or for further details on EqIAs, please consult the Equality, Diversity and Inclusion tab on the People Services Siren page here Equity, Diversity & Inclusion or contact the team by email on amb_inclusion@wales.nhs.uk.

OTHER IMPACT ASSESSMENTS

Some decisions you require may less strategic and more operational or situational or programme specific in nature. However, you may still need to do an impact assessment. The following are the most likely you should consider:

Quality Impact Assessment (QIA)
The Health and Social Care (Quality and Engagement) Wales Act 2020 requires us to must manage our functions to enhance the quality of healthcare services. Adhering to the statutory guidance and Health and Care Quality Standards, decision-making should be quality-focused, strategically aligned, and verifiable through an audit process.

For major clinical changes or alterations to service models, a comprehensive QIA is essential. In other instances, conducting just the screening part of a QIA or clear demonstration of adherence to the Health and Care Quality Standards may suffice.

Decisions that might require a QIA are typically identified through clinical or quality pathways. Senior quality leads or clinical and quality executive leads provide guidance on whether a full QIA or a simpler screening QIA is needed.

If in doubt, or for further details on QIAs, please consult the Quality, Safety and Patient Experience Siren page here Quality Impact Assessment Guidelines and Template or contact the team email on Amb_qualitymanagementgroup@wales.nhs.uk.

Data Protection Impact Assessment (DPIA)
The DPIA Screening Checklist must be completed for any new projects or changes to processes involving personal data.

Environmental Impact Assessment (EIA)
There are specific requirements to do an EIA in the following circumstances:

- A Sustainability Risk Assessment is required for tenders above £25K with NWSSP. This is an internal process with

The Checklist is a high-level screening test to screen for any flags which indicate that you need to do a full DPIA to look at the risk in more detail and to ensure legal compliance. The checklist must be conducted before initiating any processing activities.

If in doubt, or for further details on DPIAs, please consult with the Digital Team Siren page at Data Protection Impact Assessments (DPIA) or email the team at AMB_infoGovernance@wales.nhs.uk.

NWSSP and is not approved by them or WAST, nor is any feedback received from NWSSP.

- A Sustainability Impact Assessment is required for large-scale new builds and major refurbishments, complying with building regulations and local authority requirements.
- A WAST specific EIA is required where there are environmental impact assessments for WAST of large-scale projects or procurements not covered by the above.

If in doubt, or for further details on EIAs, please consult the Finance and Corporate Resources Siren page at Finance and Corporate Resources or email the team on amb_estates_helpdesk@wales.nhs.uk.

Cyber Assessment Framework (CAF)

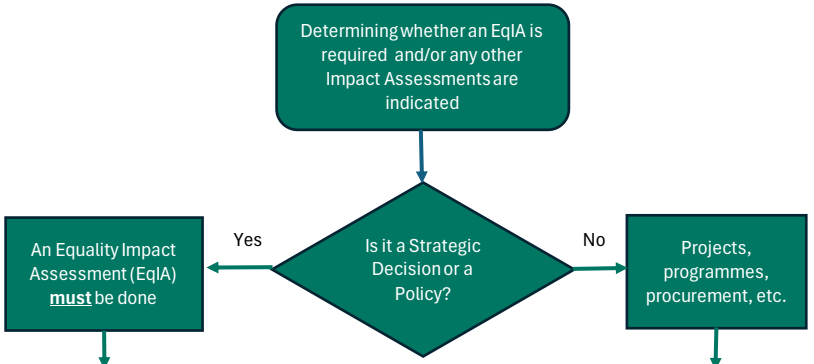
The CAF must be completed for all projects that involve new critical digital systems whether on premise or in the cloud. This provides a comprehensive and systematic approach to assessing cyber risk and resilience of a digital system.

A cloud security assessment must be completed for any digital systems that are cloud-based.

A supplier due diligence questionnaire is required to be completed at procurement stage for any suppliers who will providing digital services, systems or products.

If in doubt or for further details please contact amb_cybersecurityteam@wales.nhs.uk.

IMPACT ASSESSMENTS



An EqIA will be required for:

- Long-term Strategy
- Directorate/speciality specific plans, e.g. Digital Plan, or the Strategic Workforce Plan
- IMTP and related financial plans
- OCPs and similar plans that affect our people
- Policies
- Service change and development of public services
- Major business cases of a strategic nature
- Closure of stations or offices/places of work
- Major procurement and commissioning decisions

Example 1:
Clinical Model Transformation may also require a Quality Impact Assessment (QIA)

Example 2:
Major Procurement may also need a Data Protection Impact Assessment (DPIA) or an Environmental Impact Assessment (EIA)

Quality Impact Assessment (QIA)	For major clinical changes or alterations to service models, a comprehensive QIA is essential. In other instances, the screening part of a QIA or clear demonstration to the Health and Care Quality Standards may suffice. Decisions requiring a QIA are typically through clinical or quality pathways. For further information please consult the QSPE Siren Page here Quality Impact Assessment Guidelines and Template or contact the team email on Amb_qualitymanagementgroup@wales.nhs.uk.
Data Protection Impact Assessment (DPIA)	The **DPIA Screening Checklist** must be completed for any new projects or changes to processes involving personal data to identify whether a full DPIA is required to look at the risk in more detail and ensure legal compliance. The checklist must be conducted **before** initiating any processing activities. For further information on DPIAs, please consult with the Digital Team Siren page at Data Protection Impact Assessments (DPIA) or email the team at AMB_infoGovernance@wales.nhs.uk.
Environmental Impact Assessment (EIA)	EIAs are required in the following circumstances: 1) A **Sustainability Risk Assessment** is required for tenders above £25K with NWSSP (This is an internal process with NWSSP); 2) A **Sustainability Impact Assessment** is required for large-scale new builds and major refurbishments, complying with building regulations and local authority requirements; and 3) A WAST specific EIA is required where there are EIAs for WAST of large-scale projects or procurement. For further information, please consult the Finance and Corporate Resources Siren page at or email the team on amb_estates_helpdesk@wales.nhs.uk.
Cyber Assessment Framework (CAF)	The **CAF** must be completed for all projects that involve new critical digital systems whether on premise or in the cloud. This provides a comprehensive and systematyic approach to assessing cyber risk and resilience of a digital system. A **cloud security assessment** must be completed for any digital systems that are cloud-based. A supplier due diligence questionnaire must be completed at procurement stage for any suppliers providing digital services, systems or products. For further information If in doubt or for further details please contact amb_cybersecurityteam@wales.nhs.uk.