Bundle Audit Committee (Open) 1 December 2022

Agenda attachments

ITEM 0 Agenda Audit Committee Open 1 December 2022.docx

1	09:30 - Chair's welcome; apologies and confirmation of quorum
2	Minutes of last meeting
	ITEM 2 Audit Committee OPEN Minutes 15 September.doc
3	Action Log
	No open actions
3.1	ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION
4	09:40 - Internal Audit Reports
	4.1. Progress Report and IA reports as follows: *4.2. Hazardous Area Response Team (HART)* *4.3. Attendance Management* *4.4. EPCR*
	ITEM 4.1 WAST_2223_Internal Audit Progress Report_December 22.pdf
	ITEM 4.2 WAST_2223_07_HART_Final Internal Audit Report_for Trust issue.pdf
	ITEM 4.3 WAST_2223_10_Attendance Management_Final Internal Audit Report_for Trust issue.pdf
	ITEM 4.4 WAST ePCR Final Audit Report 2122.pdf
5	10:10 - Audit Wales Reports
	5.1. Update Report *5.2. Equality Impact Assessment* *5.3. National Fraud Initiative in Wales* *5.4. Public Sector Readiness for Net Zero Carbon by 2030*
	ITEM 5.1 WAST Audit Committee update 112022.pdf
	ITEM 5.2 Equality_impact_assessment-english_0.pdf
	ITEM 5.3 The_National_Fraud_Initiative_in_Wales_2020_21_English_0.pdf
	ITEM 5.4 Public_Sector_Readiness_for_Net_Zero_Carbon_by_2030_Evidence_Report_English.pdf
6	10:30 - Risk Management and Board Assurance Framework
	ITEM 6 Risk Management Report AC 011222.docx
7	10:45 - Losses and Special Payments Update
	ITEM 7 Executive Summary SBAR Losses and Special Payments.docx
	ITEM 7.1 Annex 1 - Losses Special and Payments 2022-23 M1-7.pdf
8	11:00 - Audit Tracker
	Audit tracker circulated by e mail
	ITEM 8 Executive Summary AC - Internal Audit Report 011222.docx
8.1	11:10 - CONSENT ITEMS
9	Committee priorities report Quarter 3
	ITEM 9 Audit Committee Priorities December 22.docx
10	All Wales Audit Committee Chairs Highlight Report
	ITEM 10 AWACCM - Highlight Report - 13.10.2022.docx
10.1	11:15 - CLOSING ITEMS
11	Key messages for Board
12	Any other business
13	Date and time of next meeting:
	2 March 2023, 09:30

AGENDA
MEETING OF THE AUDIT COMMITTEE
Held in public on 1 December 2022 from 09:30 to 11:20
Meeting held virtually via Microsoft Teams

No.	Agenda Item	Purpose	Lead	Format	Time
OPENING ITEMS					
1.	Chair's welcome; apologies and confirmation of quorum	Information	Martin Turner	Verbal	10 Mins
2.	Minutes of last meeting	Approval	Martin Turner	Paper	
3.	Action Log – No Open actions	Review	Martin Turner	Paper	
ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION					
4.	Internal Audit (IA) reports 4.1. Progress Report and IA reports as follows: 4.2. Hazardous Area Response Team (HART) 4.3. Attendance Management 4.4. EPCR	Assurance	Osian Lloyd	Paper	30 Mins
5.	Audit Wales Reports 5.1. Update Report 5.2. Equality Impact Assessment 5.3. National Fraud Initiative in Wales 5.4. Public Sector Readiness for Net Zero Carbon by 2030	Assurance	Fflur Jones	Paper	20 Mins
6.	Risk Management and Board Assurance Framework	Assurance	Trish Mills	Paper	15 Mins
7.	Losses and Special Payments	Assurance	Chris Turley	Paper	15 Mins
8.	Audit Tracker	Assurance	Julie Boalch	Paper	10 Mins
CONSENT ITEMS					
9.	Committee priorities report Quarter 3	Information	Trish Mills	Paper	5 Mins
10.	All Wales Audit Committee Chairs Highlight Report	Information	Trish Mills	Paper	
CLOSING ITEMS					
11.	Key messages for Board	Information	Martin Turner	Verbal	5 Mins
12.	Any other business	Discussion	Martin Turner	Verbal	
13.	Date and time of next meeting: 2 March 2023, 09:30	Information	Martin Turner	Verbal	

Lead Presenters

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

WELSH AMBULANCE SERVICES NHS TRUST

UNCONFIRMED MINUTES OF THE OPEN MEETING OF THE AUDIT COMMITTEE OF THE WELSH AMBULANCE SERVICES NHS TRUST HELD ON TUESDAY 15 September 2022 VIA TEAMS

PRESENT :

Martin Turner	Non Executive Director and Chair
Paul Hollard	Non Executive Director
Ceri Jackson	Non Executive Director
Joga Singh	Non Executive Director

IN ATTENDANCE :

Andrew Doughton	Audit Wales
Estelle Hitchon	Director of Partnerships and Engagement
Fflur Jones	Audit Wales
Navin Kalia	Deputy Director of Finance and Corporate Resources
Angie Lewis	Executive Director of Workforce and OD
Osian Lloyd	Deputy Head of Internal Audit NWSSP
Trish Mills	Board Secretary
Steve Owen	Corporate Governance Officer
Urvisha Perez	Audit Wales
Duncan Robertson	Interim Assistant Director of Audit, Research and Service Improvement
Paul Seppman	Trade Union Partner
Chris Turley	Executive Director of Finance and Corporate Resources
Liam Williams	Executive Director of Quality and Nursing
Carl Window	Counter Fraud Manager

APOLOGIES:

Julie Boalch	Head of Risk and Deputy Board Secretary
Lee Brooks	Executive Director of Operations
Leanne Smith	Executive Director of Digital Services
Damon Turner	Trade Union Partner

37/22 PROCEDURAL MATTERS

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

2. The Minutes of the open session of the Audit Committee meeting held on 7 June 2022 were confirmed as a correct record subject to amending the correct title of Estelle Hitchon to Director of Partnerships and Engagement. Apologies were recorded as

stated above. The action log was considered and the one action marked as closed.

RESOLVED: That

(1) the Minutes of the meeting held on 7 June 2022 were confirmed as a correct record subject to the above.

(2) the action referred to in the action log was considered and actioned as necessary.

38/22 COMMITTEE CYCLE OF BUSINESS

1. Trish Mills presented the report explaining that it provided the Committee with its draft cycle of business for the next year which will have several developments to it going forward. The cycle had been written to align the duties of the Committee as detailed in its terms of reference. This included an update on the policy report which was being developed for each Committee and would be reviewed annually by the Audit Committee who had overall oversight.

2. Members were informed that each Board Committee will be/have been presented (already approved at the People and Culture Committee) with their own cycle of business for review and approval.

3. The cycle of business had been agreed by Internal Audit and Audit Wales with one minor amendment to the update report for Audit Wales.

Comments:

The Chair asked whether a Value for Money (VFM) audit was scheduled through any Internal Audit planning. Chris Turley explained there was nothing specifically detailed as a VFM audit but this could be something to consider in the future. He added that the Trust carried out work on value based healthcare and financial sustainability which was monitored through the Finance and Performance Committee; this work could also be linked with any VFM audit.

RESOLVED: The cycle of business was reviewed and approved as a first version.

39/22 INTERNAL AUDIT REPORTS

1. Osian Lloyd presented the progress report advising that it highlighted progress of the Team's work on the 2022/23 Internal Audit plan. He made reference to a minor typographical error in the report at section three which referred to a deferral of the decarbonisation audit which should read was at the request of IA capital estates audit. Osian Lloyd agreed to rectify this and submit an updated report for ibabs. Furthermore he stated that in terms of the Key Performance Indicators described in section five, further work was required for this audit to be delivered. The sickness and EPCR audits should be ready for the next Committee meeting.

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

Fleet Maintenance Audit review. Reasonable Assurance

The purpose of this review was to assess the application of the Fleet Management System and its impact on improving Fleet coordination, maintenance and cost control. It was noted that the Trust's vehicles were serviced more frequently than the manufacture's standard period which in itself was an impressive achievement. The review raised two high priority findings, three medium and one low. Details of these were contained within the review.

Comments:

1. Chris Turley commented that it had been a very comprehensive audit acknowledging that it covered much of the period of the pandemic whilst the Trust had continued under extreme pressure on its resources. Several of the recommendations had already been progressed and it was expected that the rest would be completed within the timelines as indicated in the report.

2. The Committee queried why a Fleet policy was not in place, albeit it was covered under the Fleet strategy. Osian Lloyd explained that the Standard Operating Procedures (SOP) in place and a user guide which outlined clear guidelines were sufficient. Chris Turley added that a policy probably would not add any value and that the SOP and user guides provided enough assurance. This had been supported by IA as part of the review.

3. An explanation was sought in terms of the signatory expenditure levels and whether one individual could authorise up to £200k. Chris Turley explained that only the CEO had a delegated authority limit of that amount under the Trust's SoD. He also added that the Trust had recently changed some of its delegated limits and this had been reflected on its Oracle system and a further check would be done now to ensure that the Fleet system remained consistent with this.

4. Was the Trust looking into providing its own in house vehicle servicing across Wales? Chris Turley advised that the Trust's ambition was to move away from a mixed economy approach and as far as possible, bring it all in house.

Major Incident review. Reasonable Assurance

Osian Lloyd advised the Committee that the purpose of this review was to evaluate the Trust's approach to its readiness for major incidents, including counter terrorism incidents. The Trust's Emergency Preparedness Resilience and Response Team has developed its incidents response plan in line with guidance issued from the National Ambulance Resilience Unit. There was one high priority finding, three medium and one low. These were illustrated in more detail within the review.

RESOLVED: That the updates were noted.

40/22 AUDIT WALES REPORTS

Audit Wales Update Report

Fflur Jones, in providing an update report advised the Committee that the 2021/22 audit of the charitable funds financial statement was due to commence in November. She made reference to the performance audit work which was summarised in the report and that a

national report on quality governance was also being worked on. The Committee noted that the structured assessment work was almost complete for this year and it will be reported to the Committee in December.

Quality Governance Report

1. Urvisha Perez explained that the report considered the Trust's governance arrangements that supported delivery of high quality safe and effective services; both from an operational and a corporate perspective. She drew the Committee's attention to the following key points from the report:

   a. Delivery of the Trust's Quality Strategy had been hindered by pressures on resources caused by the pandemic and a lack of funding for senior quality leads.
   b. The Trust's clinical audit required strengthening and there was a need to address the substantial backlog of mortality reviews.
   c. The Trust has refreshed its organisational behaviours however there was scope for improvement especially with Board member walkabouts.
   d. The Trust has a clear quality governance structure and has taken steps to improve the Quest Committee sub structures, the handling of serious adverse incidents with other joint bodies could be improved.
   e. In terms of monitoring and reporting arrangements regarding data, this has improved however there were further opportunities for the Trust to develop a system to triangulate learning themes across its quality assurance reports.

2. Overall there were eight recommendations and reference was made to the Trust's management response within the report.

Comments:

1. The Committee welcomed the report and recognised the challenges in bringing together the work which was linked to patient outcomes. They also noted that the Quest Committee would be monitoring the issues raised, particularly around clinical audit.

2. In terms of the survey conducted which considered the Trust's support for colleagues who report near misses, the Committee expressed concern that the narrative suggested the Trust was not supportive and was not necessarily reflective of the comments made by staff. Urvisha Perez pointed out that the response to the survey was relatively low and of those 30 who responded some felt there was no action taken following the reporting of incidents.

3. It was brought to the Committee's attention by Liam Williams that the Medical Examiner has advised that several legislative changes would be emerging that the Trust would need to align to. In terms of the mortality reviews, he acknowledged the backlog and updated the Committee on the work to improve this situation. He added that the Trust's reporting process on near misses was more than adequate. Furthermore in terms of patient outcome measures the move to EPCR was essential and would be looking to hasten the work particularly around care bundles.

4. Estelle Hitchon commented that further work was still required in extrapolating the data and linking experience and qualitative information with measureable data.

5. Andrew Doughton updated Members on the new legislation that was diving quality engagement, especially in relation to duty of candour and duty of quality. He suggested that the Quest Committee was probably the most relevant Committee to receive and monitor any progress reports in relation to the recommendations.

6. The Chair gave a summary of the comments noting the importance of the report particularly from a clinical audit aspect and commended the report to the Quest Committee. Trish Mills added that the Audit Committee would be updated on progress via the audit tracker.

Unscheduled Care Project Brief

1. Fflur Jones explained that the brief set out the scope for Audit Wales' work on the review which would be undertaken within the next few months. The review has been split into three separate elements; flow out of hospital, access to unscheduled care services and national leadership structures. She added that regional partnership boards would be liaised with as part of the flow out of hospital element.

2. The first element, flow out of hospital, has commenced and will look at health board processes to enable timely discharges and the social care aspect. The review will also consider how unscheduled care was managed and will look at the arrangements in place within communities to prevent admission to hospital. In terms of the national arrangements and leadership structures this work will look at how these structures were supporting improvements in the unscheduled care system at a national level.

Comments:

1. Liam Williams asked that the report took into account those patients who have not been able to access primary healthcare and have since deteriorated. He also asked that the report consider patient outcome measurement in terms of any individuals whose condition had deteriorated due to delays. Fflur Jones assured the Committee that these issues were part of the scope of the report.

2. Will the preventative aspect of social care feature in the report? Fflur Jones advised that social care would appear prominently in the hospital flow work and with the scheduled meetings with social services work colleagues. Primary care was also a key focus of the report; Andrew Doughton added that it would be a follow up of the previous primary care review.

3. The Committee also asked that interim updates on progress be provided at each Audit Committee meeting going forward which should include feedback from staff. Fflur advised this would be part of the routine update to the Committee.

RESOLVED: That

(1) the Committee noted the updates; and

(2) it was agreed that Quest would monitor progress on the recommendations within the quality governance report and that the Audit Committee would be updated through the audit tracker.

41/22 UPDATE ON WASTE MANAGEMENT ACTIONS FOLLOWING LIMITED REVIEW

Chris Turley gave a verbal update advising the Committee that updates on the eight key recommendations were contained in the audit tracker. Two of the recommendations have been closed and the others were on track bar one. The recommendation which was slightly off track required further work and this was being addressed. However an amended approach to managing the risk of this one may need to be agreed with IA.

RESOLVED: That the update was noted.

42/22 RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK

1. Trish Mills gave an outline of the report and drew the Committee's attention to risks that had been added, increased/decreased in score and risks that had been closed. These were contained in more detail within the report and further described in the resolutions below.

2. She added that all Board committees, Executive Management Team (EMT) and the Assistant Directors Leadership Team (ADLT) have reviewed the risks assigned to them and continue to monitor them going forward.

3. Members were reminded that the Board would receive a bespoke front page report highlighting the top rated risks.

Comments:

The Committee discussed in detail ownership of the higher rated risks acknowledging that EMT and ADLT were fully aware of the risks scoring 20 and above. Trish Mills assured the Committee that engagement with Executive Leads on their specific risks was excellent.

RESOLVED: That the Committee:

(1) Noted that the actions outlined in the avoidable harm paper presented to Trust Board in July 2022 were described as further mitigations against Risks 223 and 224;
(2) Noted the closure of Risk 303 from the Corporate Risk Register;
(3) Noted the decrease in score of Risk 199 from 20 to 15;
(4) Noted the decrease in score of Risk 311 from 16 to 12;
(5) Noted the inclusion of the new Risk 543 on the Corporate Risk Register at a score of 15; and
(6) Noted the inclusion of the new Risk 558 on the Corporate Risk Register at a score of 15;

43/22 LOSSES AND SPECIAL PAYMENTS – PAYMENTS FOR THE PERIOD 1 APRIL 2022 – 31 AUGUST 2022

1. The Committee were informed by Chris Turley that the total net losses and special payments made during this period actually amounted to a small recovery of £0.009m, after reimbursements from the WRP were factored in.

2. Chris Turley drew the Committee's attention to the Welsh Risk Pool reimbursements which amounted to £0.26m, the majority of which related to two medical negligence

claims.

3. Members' attention was also brought to annex 1 of the report which provided a summary description of individual payments.

4. Chris Turley assured the Committee that all the payments had been made within the financial delegated limits as prescribed in the Trust's Standing Financial Instructions (SFI). He further mentioned that work was ongoing to consider whether the Committee should be required to retrospectively approve these payments going forward; and how this would be expressed within SFI's, with the expectation being that these will continue to be approved in line with delegated limits within the SoD.

RESOLVED: That the losses and special payments for the period 1 April 2022 – 31 August 2022 were received and noted.

44/22 AUDIT TRACKER

1. Trish Mills explained that the report provided an update in respect of audit recommendations resulting from Internal Audit and external reviews.

2. There were 35 Internal Audit recommendations that were overdue; five were of a high priority, specifics of those and all other overdue recommendations were detailed in the report.

3. It was noted there were three recommendations overdue from the 2019/20 year; two were expected to be closed at the end of September 2022 with the remaining one due completion around June 2023.

4. The Committee were advised that two recommendations were proposed to be closed, ID 379 and 380.

5. In terms of the 12 External Audit reviews three were overdue, two were not due and seven had been completed.

Comments:

Members acknowledged the progress and looked forward to seeing the older recommendations being completed in due course.

RESOLVED: That the Committee;

(1) Noted the audit activity since the last Audit Committee in June 2022; and

(2) Considered the proposals to address each recommendation particularly those that have been further extended beyond agreed deadlines.

45/22 COVID-19 PUBLIC INQUIRY UPDATE

1. The Committee were advised that the public inquiry had commenced in December 2021 with its terms of reference being finalised on 25 June 2022

2. Trish Mills set out further details of the information contained in the terms of reference

noting there was now specific mention to advice given as part of the 111 and 999 services.

3. The inquiry has been grouped into modules with teams based across the UK to investigate each one.

4. A Pandemic Governance Group has been established which will navigate the Trust through the public inquiry preparations.

5. In terms of timelines, it was expected that the public hearings for module one would be in spring 2023; module two public hearings in summer 2023; however no date has been set for module three. Details of what each module examined as part of the inquiry was illustrated in the report.

RESOLVED: The Committee noted the update.

46/22 REPORT FROM QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE (Quest) RE CLINICAL AUDIT

1. The report, which focused on the approval of the clinical audit and outcome review plan was presented for noting.

2. Furthermore, the Quest Committee had also held a discussion of the challenges in developing the quality strategy.

47/22 COMMITTEE PRIORITIES Q2

RESOLVED: The Committee noted the update.

Date of Next Meeting: 1 December 2022

Internal Audit Progress Report

Audit Committee

December 2022

Welsh Ambulance Service 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 GIG Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services NHS Trust

Contents

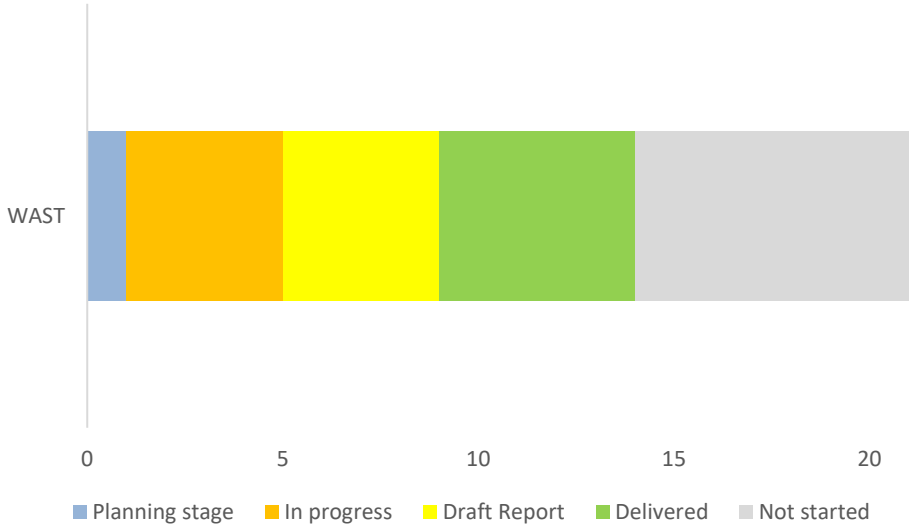
1. Introduction

The purpose of this report is to:

- highlight progress of the 2022/23 Internal Audit Plan to the Audit Committee; and
- provide an overview of other activity undertaken since the previous meeting.

2. Progress against the 2022/23 Internal Audit Plan

There are 21 reviews in the 2022/23 Internal Audit Plan, and overall progress is shown below.



Detailed progress in respect of each of the reviews in the 2022/23 Internal Audit Plan is summarised in Appendix A.

3. Proposed changes to approved plan

No further changes are proposed in respect of the 2022/23 Internal Audit Plan.

4. Engagement

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

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

We have met Executive Directors to discuss areas for review in 2023/24, and discuss the long list of reviews with the Trust before producing a draft Audit Plan for Audit Committee approval at the March 2023 meeting.

5. Key Performance Indicators

Correct on 31 October 2022

Indicator	Status	Actual	Target
Operational Audit Plan agreed for 2022/23		March	By 30 June
Audits reported over planned		3	4
Work in progress		9	
Report turnaround: time from fieldwork completion to draft reporting [10 days]		3 out of 3	80%
Report turnaround: time taken for management response to draft report [15 days]		1 out of 3	80%
Report turnaround: time from management response to issue of final report [10 days]		2 out of 2	80%

Key:

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

6. Recommendation

The Audit Committee is invited to note the above.

Appendix A: Progress against 2022/23 Internal Audit Plan

Review	Status	Rating	Key matters arising	Anticipated Audit Committee[1]
Risk management and assurance	Not started			June 2023
Health and safety (Deferred from 2021/22)	Not started			June 2023
Infection prevention and control	Draft report	Limited	IPC audits are not yet underway with audit tools yet to be finalised; Continued issues in operation and membership of the Strategic IPC group; Structure in place for approval of documents, but little evidence of ongoing performance monitoring and reporting; Arrangements for formal monitoring of the IPC Action Plan are unclear; Inconsistencies identified in roles and responsibilities within draft policies and procedures.	March 2023
Savings and efficiencies (Deferred from 2021/22)	Not started			March / June 2023
Fleet maintenance	Final report	Reasonable	Inconsistencies between the Fleetwave and Oracle authorised signatory lists; Appropriate procurement of suppliers and review of supplier lists; Estimates should be included on job cards and raised before work is undertaken; Lack of formal performance monitoring of suppliers and inhouse workshops; and Undertaking risk-based spot checks on work completed.	September 2022
Major incidents	Final report	Reasonable	Committee oversight of the Incident Response Plan; Exercising is at a low frequency, weighted towards the South East territory, and reliant on multi agency partners; There is a clear process for capturing and monitoring lessons from incidents, but lessons	September 2022

[1] May be subject to change

Review	Status	Rating	Key matters arising	Anticipated Audit Committee[1]
			from exercising are not routinely noted; Arrangements to share plans have been outlined, but we noted instances where action cards required updating; Gaps identified in Commander CPD records.	
Hazardous Area Response Team (HART)	Final report	Reasonable	Training records and materials do not fully capture detail of sub-competencies; Debriefs take place but no mechanisms to capture or monitor associated actions and learning; SOPs require updating to reflect current methods; Activity not currently captured in full and lack of reporting to oversight committee; SLA with Welsh Government in need of updating with opportunities to achieve further alignment with NARU guidance.	December 2022
Immediate Release Directions	Draft report	Reasonable	Allocators must review the resource screen prior to directing immediate release of vehicles; Escalation of declined directions to the Operational Delivery Unit; Datix incidents must be completed and reviewed in a timely manner following each declined direction; Review of declined directions to ensure the correct process has been followed; Themes and trends should be captured and lessons learned shared.	March 2023
Trade union release time	In progress			March 2023
Attendance management	Final report	Reasonable	Scope to improve analysis of underlying causes of sickness, alternative duties, and their reporting; Standardisation of sickness audits, including criteria and approach; Developing key performance indicators and data for evaluating quality and effectiveness of services; A training register has been established, but there is a need to develop monitoring and reporting arrangements.	December 2022

Review	Status	Rating	Key matters arising	Anticipated Audit Committee[1]
Clinical handover	Not started			March / June 2023
Pain management	In progress			March 2023
Strategy development	Not started			June 2023
IMTP delivery	Planning			March 2023
Cyber security	In progress			March 2023
IM&T infrastructure	Not started			June 2023
Data analysis	In progress			March 2023
Standards of Business Conduct: Declarations	Draft report	Limited	Absence of a Declaration of Interest (register, and the gifts and hospitality register requires strengthening; Completeness and accuracy of declarations of interest submissions; Non-compliance relating to the completion of gifts and hospitality forms; Lack of due diligence checks on declarations.	March 2023
Recommendations tracker	Not started			June 2023
Capital & Estates				
Decarbonisation	Draft report	N/A - An action plan of common themes across NHS Wales.	Whilst some progress has been observed with implementation of Decarbonisation Action Plans, this has been restricted by the availability of financial and staff resources. The recommendations made, relating to governance, localised strategy, monitoring and reporting and project delivery, aim to aid management in driving forward the strategies, whilst also highlighting some of the competing pressures / risks.	March 2023
Electronic Patient Clinical Record	Final report	Reasonable	The programme is progressing within budget and target delivery for a highly complex implementation involving multiple health bodies across Wales. Matters arising include: The need to	December 2022

Review	Status	Rating	Key matters arising	Anticipated Audit Committee[1]
			consider the timing and method of engagement of health bodies within lessons learnt; The need for early development plans with DHCW.	

[1] May be subject to change

Hazardous Area Response Team (HART)

Final Internal Audit Report

November 2022

Welsh Ambulance Services NHS Trust

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

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

Contents

Review reference:	WAST-2223-07
Report status:	Final
Fieldwork commencement:	6th September 2022
Fieldwork completion:	2nd November 2022
Draft report issued:	3rd November 2022/10th November 2022
Debrief meeting:	4th November 2022
Management response received:	23rd November 2022
Final report issued:	23rd November 2022
Auditors:	Osian Lloyd, Head of Internal Audit Jonathan Jones, Audit Manager
Executive sign-off:	Lee Brooks, Executive Director of Operations
Distribution:	Judith Bryce, Assistant Director of Operations, National Operations & Support Clare Langshaw, Head of EPRR and Specialist Operations Kate Blackmore, Head of Service, EMS Co-ordination Jason Fenard, Service Manager EPRR and Specialist Operations Gavin Davies, HART Locality Manager Giles Hodges, HART Training Manager
Committee:	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors

Acknowledgement

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

Executive Summary

Purpose

To review how the Trust ensures the team is appropriately trained and equipped to respond to high-risk and complex emergency situations.

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- Training records and materials do not fully capture detail of sub-competencies.
- Debriefs take place but no mechanisms to capture or monitor associated actions and learning.
- SOPs require updating to reflect current methods.
- Activity not currently captured in full and lack of reporting to oversight committee.
- SLA with Welsh Government in need of updating with opportunities to achieve further alignment with NARU guidance.

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

Report Classification

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

Assurance summary[1]

Assurance objectives		Assurance
1	HART Interoperability	Reasonable
2	Deployment processes and procedures	Reasonable
3	Training compliance	Limited
4	External agency cooperative working	Reasonable
5	Performance reporting and lessons learnt	Limited

Key matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
1	Service Level Agreement content review	1	Design	Medium
2	NARU self-assessment	1	Design	Medium
3	HART asset register	1	Design	Medium
4	HART Standard Operating Procedures	2	Operation	Medium
5	CAD data review	2	Operation	Medium
6	HART Activity Monitoring	2	Design	Medium
7	Training competencies and reporting	3	Design	High
8	Fire and rescue MOU	4	Design	Medium
9	Debriefing and lessons learnt	5	Design	Medium
10	Committee oversight	5	Design	Medium

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

1. Introduction

1.1 The Hazardous Area Response Team (HART) is made up of specially recruited personnel, who are trained and equipped to provide the Welsh Ambulance Services NHS Trust ('the Trust') with the ability to respond to high-risk and complex emergency situations. Established in 2012 and based within a dedicated facility in Bridgend, HART personnel receive specialist training to save lives and improve clinical outcomes across a number of high-risk environments, including situations involving hazardous materials, CBRN(e) events (Chemical, Biological, Radiological, Nuclear and Explosives), response to marauding terrorist attacks, working at height, in water or within confined spaces, or providing healthcare support to security operations.

1.2 HART teams work alongside police and fire and rescue services, and there is the expectation that in line with national standards of interoperability, they can be deployed nationally to support HART teams at other UK Ambulance Services on large scale or high-profile incidents.

1.3 The risks considered during the review were as follows:

i. Failure to meet national interoperability standards would impact Trust deployment and response to high-risk emergency situations.

ii. Reputational damage to the Trust where it cannot provide equipment and training to meet national standards.

2. Detailed Audit Findings

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

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	1	5	0	6
Operating Effectiveness	0	3	0	3
Total	1	7	0	9

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

Audit objective 1: The Trust Hazardous Area Response Team (HART) operates in line with UK standards of interoperability and is equipped accordingly.

2.3 The National Ambulance Resilience Unit (NARU) set out the specialist capabilities for Hazardous Area Response Teams through a set of National Standards. The Standards were last issued in 2018 and are linked to the NHS Emergency Preparedness Resilience and Response Framework, which is a contractual requirement in England.

2.4 The Standards include a requirement for specialist capabilities to be interoperable, i.e. '*they must be maintained according to strict national standards to ensure they can be combined safely to provide an effective national response to certain types of incidents*.' Whilst the Standards state that they do not apply to Ambulance Services in devolved nations, they are accepted as best practice and the Trust's HART unit seeks to ensure alignment.

2.5 The HART capability is provided and funded through a service level agreement (SLA) between the Trust and Welsh Government, which was signed in 2011. The SLA contains an outline of service summary, staffing requirements/training, funding arrangements and equipment.

2.6 The Standards sets out the tactical capabilities required of a HART service across a range of high-risk environments, including hazardous materials; chemical, biological radiological, nuclear, explosives (CBRNe); marauding terrorist firearms attack; safe working at height, in water, on unstable terrain or within confined spaces; and providing healthcare support to security operations. Review of the NARU Standards identifies that there is opportunity to refresh the SLA against its contents, in particular to capture and reflect the services and required capabilities. **See MA1**

2.7 The Standards also define nationally specified 'Safe System of Work', supplemented by guidance on components such as standard operating procedures, rescue plans, risk assessments, training and equipment. We requested and were provided with a sample of risk assessments for three capabilities (Water Operations, Unstable Terrain and ATV (All Terrain Vehicle)), and for any associated training facilities as NARU expectations are that these will be held locally by the Trust.

2.8 We obtained Job Descriptions for HART operatives and operational managers and reviewed against NARU templates and confirmed consistency subject to minor differences NARU Standards also require HART operatives be qualified paramedics. Whilst the Trust has not made this mandatory, there is a desire to move all HART staff to registrants and it has supported staff members who wish to qualify. At present there are two Technician's within the HART unit, and the makeup of the workforce is reported to Welsh Government.

2.9 NARU has also established an annual review process for NHS England Ambulance Trusts, to assess adherence to the EPRR Core Standards and interoperable capabilities. Prior to the Covid-19 pandemic, the previous Head of EPRR had held

discussions with the NARU assessment lead to explore the Trust undergoing a 'critical friend' peer review. The Trust may want to consider undertaking a self-assessment prior to any formal review being commissioned. **See MA2**

Equipment

2.10 The EPRR Core Standards includes a requirement that '*Organisations must procure and maintain interoperable equipment specified in the National Capability Matrices and National Equipment Data Sheets*.' There is also reference to use of national buying frameworks co-ordinated by NARU.

2.11 We were advised by the HART Team that the Trust retains awareness of NARU specifications, but that there have been instances where it has been deemed necessary to diverge from specifications. Examples given include the makeup of the HART vehicle fleet to take into account the geography and urban/rural mix covered by the unit, and incident ground technology (IGT) which we understand has been decommissioned by the Trust as it was operating beyond its original expected lifespan. Funding is currently being sought to allow the procurement of the next generation of IGT, should this not be obtained this would impact the unit's interoperability. We were also informed that there can be variation in standard clinical equipment, depending on sourcing from procurement. However, there is more alignment where equipment is required for the HART capabilities.

2.12 We sampled five items of equipment to identify if those held by the Trust matched the NARU Equipment Data Sheets (EDS). Exceptions were noted for two items related to safe working at height. Discussion with the lead for that equipment noted that the Trust is intending to match the equipment specified by NARU, but this is through iterative replacement as needed.

2.13 Equipment should also be subject to regular inspections by a competent assessor to ensure they are fit for purpose. Noting safe working at height equipment is subject to LOLER requirements, we were provided with a monitoring spreadsheet which records inspections undertaken by HART operatives. We identified whilst all equipment kits have had a service within the past 6 months as required, monitoring spreadsheet did not include the previous date of inspection for all kits to demonstrate regular maintenance has been undertaken. **See MA3**

2.14 Additionally, we note that the NARU annual review process includes a requirement for HART units to maintain an equipment asset register. Currently HART has a split between assets registered on NARU's PROCLUS website and local records. For some entries provided, the PROCLUS register did not include use of all fields available. See **MA3**

Conclusion:

2.15 The Trust provides a HART capability in line with the Service Level Agreement in place with Welsh Government. It also recognises and seeks to align with NARU Standards which is recognised as best practice. We have identified areas where alignment could be improved and highlight an opportunity for the Trust to

undertake a formal self-assessment against the Standards. We assign this objective **reasonable** assurance.

Audit objective 2: There are clear processes and procedures to activate and deploy HART in line with Trust needs and operational demands.

2.16 NARU guidance does not extend to provide specific criteria for incidents which prompt the deployment of HART, although there would be natural links to the capabilities the team are trained for.

2.17 Our review of the Trust's Major Incident Plan earlier this year confirmed that HART deployment is included within the pre-determined response matrix. The matrix assigns set resource levels, determined by number of casualties and anticipated incident duration.

2.18 The HART unit has a suite of Standard Operating Procedures (SOPs) to support the day-to-day operation of the service. The majority were issued in 2016, and would have been due for review in April 2020. Our review has concentrated on a small number which we reference directly below.

2.19 *Deployment Criteria* (SOP-8) outlines the assets required for certain incidents, although it allows for HART Operational Managers and Second in Command (2ic) flexibility to consider resource requirements based upon information available. The incident types outlined include chemical/tanker incidents, rail, aircraft, fire, suspect packages, public order events, amongst others. Each holds a listing of vehicle assets, minimum staffing and deployment reasoning to support these. There is also a column to link to Computer Aided Dispatch (CAD) codes, however this is not populated.

2.20 We were informed that the SOP is in need of updating, including to reflect a Vehicle Deployment Plan to support ongoing interoperability with the majority of Ambulance Trust's across the UK who have adopted this methodology. This allows for the allocation of one 'pod' to support HART specific incidents, allowing the other to provide operational support to the wider Trust, or to operate in tandem where required. The operational support also has a criteria that they should '*only be responded to calls with an achievable response time from the HART base and there should be a clear patient or staff benefit from the attendance of that POD*.' **See MA4**

2.21 There is also a SOP for *HART Dispatch* (SOP-9) which sets out how resources will be mobilised by the Clinical Contact Centres (CCC). A flow chart contained within identifies the process by which a CCC can activate HART and references the deployment criteria above. However, it requires updating to reflect available methods of activation, we were informed that HART vehicles were previously assigned to geographical areas. We were informed these can include HART self-tasking or requesting assignment through monitoring of CCC calls, or requests for support received directly from Duty Operational Managers and Senior Paramedics. **See MA4**

2.22 We were informed that the previous Head of EPRR had undertaken a review of dispatch codes within the CAD system when the HART unit had been established in 2012. This review resulted in codes being assigned a prompt '*consider specialist response*', although we note this is not HART specific and may suggest use of EMERTS or others.

2.23 Review of an extract from the CAD system indicates that 465 out of 2,460 codes contain the specialist response prompt. A review of codes has not been undertaken since, although the Trust does have a mechanism for ongoing oversight through its Clinical Prioritisation Assessment Software group, which has membership from across the Trust, but no representation from HART. **See MA5**

2.24 We were also advised that the HART base in Bridgend was selected in line with the Home Office guidance at the time, but that this has been superseded by methodology based upon population centres. North Wales remains within HART's remit, and we note there is the ability to request mutual aid from North West Ambulance Service NHS Trust if required. We note direct support would be provided by HART team from South Wales if the incident extends beyond four hours.

2.25 HART SOPs have been developed for *Joint responses within Welsh regions* (SOP-29) and arrangements to support requests for *Mutual Aid Requests* (SOP-11). We were informed that requests relating to North Wales are infrequent, but there are no mechanisms for monitoring activity levels which could prompt HART dispatch on an ongoing basis. **See MA6**

2.26 In line with NARU requirements, calls assigned to HART are logged onto the PROCLUS system by HART Operational Managers. Information being recorded includes the type of incident and number of casualties, but not the location. We understand that there are limitations on how this information can be exported and discussions with the HART team also highlighted concerns around the completeness of activity details being captured. The HART Locality Manager is currently considering approaches to address this, including comparison of entries by team.

2.27 We were able to undertake some limited analysis which suggests that activity is underreported. Analysis of data captured within the Trust's CAD system indicated incidents were attended by HART vehicles which were not included within the PROCLUS report for the period. **See MA6**

Conclusion:

2.28 There are HART SOPs which outline deployment criteria and despatch mechanisms. However these have not been updated to reflect current procedures. Improvements can also be made to accurately capture and report HART activity. We assign this objective **reasonable** assurance.

Audit objective 3: Members of the team maintain compliance with required training competencies, and that records are maintained.

2.29 The Trust's 42 HART Operatives are organised across seven teams (known as 'colour watches'). Each team is led by an Operational Manager, who is supported by a 2ic. Each watch operates to a seven-week rota, with one week dedicated for training.

2.30 NARU has issued Training Information Sheet (TIS) for each of the interoperable capabilities, which includes set frequency for re-certification (training frequency per year) and re-qualification (periodic internal or external assessment of capability) period. Review of the Trust's training programme for its HART operatives confirmed alignment with NARU.

2.31 Following each training cycle, Operatives are expected to complete a form to capture the subject of training undertaken, as well as the overall aim of the session, whether the aim was achieved and confidence level. The latter is to recognise that there can be scope for additional training even where session aims are achieved.

2.32 Each competency is broken down further to sub-competencies, the achievement of which would be demonstrated through lesson plans. We requested lesson plans relating to three capabilities and whilst they included reference to sub-competency headings, outline of lesson activities did not necessarily provide sufficient level of detail to support this. We understand that the Trust is planning to migrate to a training record facility within PROCLUS, which includes prompts for Operatives to address each sub-competency. **See MA7**

2.33 The HART Training Manager highlighted non-compliance against three training areas which related to equipment and exercising availability; '*HAZMAT Personal Protective Equipment*', '*Support to Security Operations*' and '*Polaris and Winch*'.

2.34 Review of training records from a sample of ten HART operatives across four capabilities; '*Marauding Terrorist Attack (MTA)*', '*Water Operations'*, '*Fitness Testing'* and Clinical (*Continuous Professional Development - CPD*) identified that outside of CPD, training frequencies were not achieved for these capabilities in 2021. **See MA7**

2.35 We recognise that the above reflects the impact of the pandemic and operational pressures which saw the Trust operate at REAP Level 4 (its highest level of escalation), during which training is typically cancelled due to the need to focus on operational pressures. Recognising that extended periods of REAP Level 4 could impact operatives' ability to meet re-qualification deadlines, the Executive Management Team (EMT) approved an SBAR in April 2022 which allows Trust Strategic Commanders to apply discretion and consider immediate needs, including to support completion of HART training.

2.36 The HART management team meet formally on a regular basis and receive a standing report from the HART Training Manager. The reports mainly provide narrative updates, including on general performance and issues, however there is

opportunity to develop further and enhance to improve compliance monitoring of re-certification or re-qualification. **See MA7**

Conclusion:

2.37 Due to the unprecedented pressures brought by the pandemic, compliance with NARU training frequency requirements has not been achieved. We have also identified opportunities to improve the recording and reporting of training competencies. We recognise actions are underway to address these areas, however currently would assign a **limited** assurance rating.

Audit objective 4: Documented arrangements are in place which outline HART's cooperative working with external agencies.

2.38 The HART Capability references primary functions of the team include '*to provide NHS coordination of casualty management activities by other agencies working inside the high-risk area*' and, *'to provide medical cover for other agencies operating in high-risk areas in response to an emergency.'* There will also be multi agency working where incidents or deployments could involve safe working from height, confined space rescue or inland water rescue.

2.39 The HART Management team has co-developed a briefing document with the Joint Firearms Unit (JFU). The JFU is a specialised team which operates across the three police services of Gwent, South Wales and Dyfed Powys.

2.40 The briefing sets out factors to consider to determine the involvement required by HART in an incident, such as risk assessing the need for immediate clinical care and the risk to officer safety. The document includes that if there is an immediate risk to life, or that the risk assessment does not suggest that the specialist capabilities of HART operatives is required, then the request should be directed through the Trust's normal channels.

2.41 The document includes guidance for scene management, key priorities for HART Operatives under deployment, and overview of incident and activation arrangements. The briefing should support that HART would not necessarily be engaged for all calls received requesting support. We were also informed that the JFU are encouraged to direct calls to the HART Operational Managers rather than the CCC as the managers are better placed to confirm and challenge requests.

2.42 We were informed where activated as above the HART operatives would receive briefings, either ahead of time through co-location, or ad hoc through IIMARCH (Information, intent, method, administration, risk assessment, communication, humanitarian) methodology reflecting the JESIP (Joint Emergency Service Interoperability Principles) which support multi-agency working.

2.43 Support provided to other agencies is captured through the categorisation of incidents logged on PROCLUS. Review of that data highlighted that almost half of the '*Support to Security Services*' incidents responded to in quarter one of 2022 resulted in the HART team being stood down or not required following acceptance of the call. The briefing document and use of Operational Managers to receive

requests, demonstrates the measures the Trust is taking to ensure the appropriate use of this resource.

2.44 We were also provided with a copy of a memorandum of understanding (MOU) which has been signed by representatives of all three Fire and Rescue services (FRS) across Wales. The MOU was signed in 2012 and discussion with the Service Manager, EPRR & Specialist Operations, outlined that the document contained detailed appendices linked to operational deployment arrangements, reflecting that HART was a newly commissioned service at that point.

2.45 With HART now firmly established, and good working and exercising arrangements in place with FRS, discussions had been held prior to the onset of the Covid-19 pandemic to revise the MOU to recognise and better reflect HART capabilities. A draft copy has been shared with FRS colleagues with the intention to revisit this further. **See MA8**

2.46 We also briefly discussed arrangements in place to work with Mountain and Cave rescue services. These are more informal, reflecting that activation of those services would be through external parties rather than directly by HART. Training exercises have been planned for this year with Mountain rescue teams.

Conclusion:

2.47 There is evidence of ongoing co-operative working between HART and other agencies, although this varies in formality. The Trust is taking measures to ensure the appropriate use of resource noting half of incidents responded to did not require HART resources. There is opportunity to revisit the MOU in place with the Fire and Rescue Services, a process started prior to the pandemic. Noting this we assign the objective **reasonable** assurance.

Audit objective 5: Team deployment and performance is monitored, which includes both activity and quality indicators, and lessons learnt are identified and acted upon.

2.48 Our review of Major Incidents undertaken earlier this year reflected positively on the Trust's development of an Organisational Learning SOP ('the SOP') and the processes in place to support actions from both internal and external lessons learnt. The SOP set out the process from the point a debrief request is made from an incident Commander or Senior Manager, through to the support provided by the EPRR team and the resulting report and recommendations which are monitored by the Directorate's Senior Operational Team (SOT).

2.49 There is confidence within the team that the debrief meetings held by HART operatives are to a good standard. However, we were informed that there is no formal structure supporting the process and there are no set triggers or prompts to indicate when a debrief should take place.

2.50 We were provided with a HART Debrief tool which prompts the inclusion of good points, learning points, and what could be done differently. This is consistent with the format in use by the EPRR team within the SOP process above.

2.51 We requested examples of debriefs undertaken in 2022 and were provided with six – although one related to a review of medicine (Ketamine) use rather than a wider incident. Debriefs provided related to three of the seven teams / watches in operation within HART. Their content was generally consistent, although we noted slight variation in their format. However, there was a lack of further actions or recommendations. **See MA9**

2.52 We were also informed that, prior to the Covid-19 pandemic, there had been periodic sharing of lessons learnt by individual HART teams / watches through a regular Continuous Professional Development day. Alongside the sharing of good practice this, provided a platform for discussion on areas for development and training opportunities. **See MA9**

2.53 Our recent review of Major Incidents also included an overview of the arrangements in place for national learning between category one and two responders. NARU also oversees a national safety alerts system which includes focus on the interoperable service and capabilities associated with HART.

2.54 We were provided with a listing of National Safety Notices issued between May and September 2022. 10 notices had been issued during that period, two of these being submissions from the Trust.

2.55 We sampled three of the remaining eight notices, and were provided with evidence to support action being taken relating to one of these. However, we were informed that information for the two remaining notices would have been shared through structured handovers, but that this had not been formally recorded. **See MA9**

2.56 Key Performance Indicators (KPI) for the HART unit are outlined within the SLA with Welsh Government and reported on a quarterly basis. These are also reported internally through the Operations Directorate structure to the SOT and Senior Leadership Team. We were not able to identify reporting arrangements for other HART units to allow us to compare the KPI content against that provided elsewhere, but this might be a useful exercise for the Trust to consider.

2.57 Review of the Q1 2022/23 KPI report confirmed alignment with the SLA requirements, noting there has been some minor amendments and terminology changes also no longer including a small number of workforce indicators. This included a recent change in relation to number of staff a shift has been below a certain level, with the change from six operatives which remains the NARU target. Welsh Government requested the indicator be amended to four operatives, which impacts HART's ability to deploy 'Safe System of Work' for some capabilities and would require the team to stand down from these. We were informed discussion on KPI content regularly takes place with the Welsh Government lead to ensure content is appropriate.

2.58 We have highlighted within earlier objectives recognition by the HART team that all activity is not currently being captured, and there is action underway to address this.

2.59 HART KPI and activity has previously been shared with the Finance and Performance Committee. It received the 2020/21 end of year summary report in May 2021. We have not identified further reporting of KPI or summary information. **See MA10**

Conclusion:

2.60 There is a lack of formal arrangements to capture and confirm implementation of lessons learnt, and this could be supported by a more formalised debrief process. Whilst performance reporting is evident, there is awareness and action to address gaps in capturing the full activity of the HART unit. Reporting within the Directorate is regularly occurring, however there has been a lack of recent reporting to the Trust Committee structure. We assign this objective **limited** assurance.

Appendix A: Management Action Plan

Matter arising 1: Service Level Agreement content review (Design)	Impact
The Trust is commissioned to provide a Hazardous Area Response Team through a Service Level Agreement (SLA) with Welsh Government which was agreed in September 2011. We were informed the document has not received any amendment of content since initial agreement. Review of the SLA identifies that Schedule 1 - Services includes reference to the team being trained and equipped to enter and provide clinical treatment in hazardous environments, an incident response unit capability, and an urban search and rescue capability. The Trust HART unit trains to meet the full range of capabilities outlined within the NARU Standards. Whilst the Standards state that they do not apply to Ambulance Services in devolved nations, they are accepted as best practice and the Trust's HART unit seeks to ensure alignment. Review of the NARU Standards identifies that there is opportunity to refresh the SLA against its contents, in particular to capture and reflect the services and required capabilities.	Potential risk of: • Arrangements and requirements related to HART service not fully documented.

Recommendations	Priority
1.1 The Trust should engage with Welsh Government to update the content within the SLA to recognise the HART capabilities and include reference, where appropriate, to National Standards.	Medium

Management response	Target Date	Responsible Officer
1.1 The Trust accepts this recommendation, recognising that the SLA is provided to WAST by Welsh Government who procure the services from WAST. We will therefore seek to agree the content of the SLA with Welsh Government on next annual refresh of the SLA.	March 2023	Clare Langshaw, Head of Service, EPRR

Matter arising 2: NARU self-assessment (Design)	Impact
NARU has also established an annual review process for NHS England Ambulance Trusts, to assess adherence to the EPRR Core Standards and interoperable capabilities under the heading of Key Lines of Enquiry (KLOE). This assessment combines review of evidence and site visits to assess their adherence to the EPRR Core Standards and interoperable capabilities. Prior to the Covid-19 pandemic, the previous Head of EPRR had held discussions with the NARU assessment lead to explore the Trust undergoing a 'critical friend' peer review. The Trust may want to consider undertaking a formal self-assessment prior to any formal review being commissioned.	Potential risk of: • Potential to ensure fuller alignment with interoperability requirements.

Recommendations	Priority
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.	Medium

Management response	Target Date	Responsible Officer
2.1 The Trust accepts this recommendation and is committed to undertaking a self-assessment against the NARU review document.	May 2023	Clare Langshaw, Head of Service, EPRR

Matter arising 3: Asset Register (Design)	Impact
We note that the NARU annual review process includes a requirement for HART units to maintain an equipment asset register. Currently HART has a split between assets registered on NARU's PROCLUS website and local records. PROCLUS entries provided included use of serial numbers and end of life dates, but not all fields are actively used, such as date of issue. Equipment should also be subject to regular inspections by a competent assessor to ensure they are fit for purpose. Noting safe working at height equipment is subject to LOLER requirements, we were provided with a monitoring spreadsheet which records inspections undertaken by HART operatives. We identified whilst all equipment kits have had a service within the past 6 months as required, monitoring spreadsheet did not include the previous date of inspection for all kits to demonstrate regular maintenance has been undertaken.	Potential risk of: • Gaps in completeness of equipment register.

Recommendations	Priority
3.1 The Trust should establish a single process to collating and maintaining the HART service asset register. NARU guidance indicates this must include any regulatory requirements associated with the equipment.	Medium

Management response	Target Date	Responsible Officer
3.1 The Trust accepts this recommendation and will ensure that relevant fields are updated and included on Proclus. Regular updating on Proclus will also be maintained.	April 2023	Clare Langshaw, Head of Service EPRR

Matter arising 4: HART Standard Operating Procedures (Operation)	Impact
There are a range of HART SOPs that are in place to support the day to day operation of the service. A number reviewed date to 2016 and require updating. Of those relating to deployment and dispatch: • *Deployment Criteria* (SOP-08) – to reflect the adoption of a POD Vehicle Deployment methodology and plan. • *HART Dispatch* (SOP-09) – to reflect the above and to capture all processes for the activation of HART, such as HART self-tasking, or requests for support received from Duty Operational Managers and Senior Paramedics. A broader review of all SOPs may be appropriate noting the document control sheet included an April 2020 review date.	Potential risk of: • Guidance and procedure documents do not reflect current processes.

Recommendations	Priority
4.1 HART SOPs should be reviewed to ensure they reflect current practice.	Medium

Management response	Target Date	Responsible Officer
4.1 The Trust accepts this recommendation and will ensure that current SOPS are updated to reflect current practice. Further, we will create a mechanism to monitor the review period of SOPs to ensure currency.	April 2023	Clare Langshaw, Head of Service EPRR

Matter arising 5:CAD Code Review (Operation)	Impact
CAD codes used to identify HART related calls were established following the formation of the HART unit in 2012. Review of an extract from the CAD system indicates that 465 out of 2,460 codes contain the specialist response prompt. A review of codes has not been undertaken since. There is a mechanism to support the oversight of the appropriateness of codes through a Clinical Prioritisation Assessment Software group. The group has membership from across the Trust, but not representation from HART.	Potential risk of: • Appropriateness of codes could impact on effectiveness of dispatch and deployment of service.

Recommendations	Priority
5.1 The Trust should consider undertaking a periodic review of the CAD codes assigned to prompt specialist response, or establishing a link between the group and HART for its input into ongoing reviews.	Medium

Management response	Target Date	Responsible Officer
5.1 The Trust accepts this recommendation and will undertake a review of CAD codes to ensure they are applicable to HART capabilities and also maximise the use of HART deployments. Any changes will be subject to CPAS approval and we will engage with CPAS to reflect this work on their work programme.	June 2023	Clare Langshaw, Head of Service EPRR Kate Blackmore, Head of Service, EMS Co-ordination

Matter arising 6: HART Activity monitoring (Operation)	Impact
In line with NARU requirements, calls assigned to HART are logged onto the PROCLUS system by HART Operational Managers. Information being recorded includes the type of incident and number of casualties, but not the location. We understand that there are limitations on how this information can be exported and discussions with the HART team also highlighted concerns around the completeness of activity details being captured. The HART Locality Manager is currently considering approaches to address this, including comparison of entries by team. We were able to undertake some limited analysis which suggests that activity is underreported. Analysis of data captured within the Trust's CAD system indicated incidents were attended by HART vehicles which were not included within the PROCLUS report for the period. HART SOPs have been developed for *Joint responses within Welsh regions* (SOP-29) and *Mutual Aid Requests* (SOP-11). We were informed that requests relating to North Wales are infrequent, but there are no mechanisms for monitoring activity levels which could prompt HART dispatch on an ongoing basis.	Potential risk of: • Underreporting of HART activity. • Gap in monitoring of potential activity.

Recommendations	Priority
6.1 HART management should undertake periodic comparison of data extracted from the CAD system to compare against activity reported on PROCLUS to support ongoing efforts to improve data recording on that system 6.2 The Trust should consider mechanisms to capture activity including through review of location which could generate HART deployment for assessing against any future service needs.	Medium

Management response	Target Date	Responsible Officer
6.1 The Trust accepts this recommendation and will undertake a comparison of CAD data to Proclus, with a view to improving the accuracy and system of reporting on Proclus in the future.	May 2023	Clare Langshaw, Head of Service, EPRR Kate Blackmore, Head of Service, EMS Co-ordination
6.2 The Trust accepts this recommendation and will finalise the work on capturing location of deployments in order to assess any future service needs.	May 2023	Clare Langshaw, Head of Service, EPRR

Matter arising 7: Training competencies and reporting (Design)	Impact
NARU has issued Training Information Sheet (TIS) for each of the interoperable capabilities, which includes set frequency for re-certification (training frequency per year) and re-qualification (periodic internal or external assessment of capability) period. Each competency is broken down further to sub-competencies, the achievement of which would be demonstrated through lesson plans. We requested lesson plans relating to three capabilities and whilst they included reference to sub-competency headings, outline of lesson activities did not necessarily provide sufficient level of detail to support this. We understand that the Trust is planning to migrate to a training record facility within PROCLUS, which includes prompts for Operatives to address each sub-competency. The HART management team meet formally on a regular basis and receive a standing report from the HART Training Manager. The reports mainly provide narrative updates, including on general performance and issues, however there is opportunity to develop further and enhance to improve compliance monitoring of re-certification or re-qualification. Our review of training records, and discussion with the HART Training Manager, outlined that as a result of pandemic and operational pressures training frequencies were not attained for '*Marauding Terrorist Attack'*, '*Water Operations'*, '*Support to Security Operations'*, and '*Fitness Assessments'* (bi-annual requirement not met). Training was also not undertaken for '*HAZMAT Personal Protective Equipment*' due to a changeover in the generation of PPE which was not available until 2022, and '*Polaris and Winch*' where the vehicle was unavailable.	Potential risk of: • Gap in capture, monitoring and escalation of training activity.

Recommendations	Priority
7.1 We would support the action taken to trial recording operative training on PROCLUS, and the Trust should review opportunities to incorporate any data extracts to support training performance and compliance monitoring which could be included in Training Manager update reports.	**High**

Management response	Target Date	Responsible Officer
7.1 The Trust accepts this recommendation and will ensure there is a robust system in place to capture the training compliance for teams. Where there is potential for compliance to be compromised, an early escalation system will be activated to ensure remedial action and reporting.	March 2023	Clare Langshaw, Head of Service, EPRR

Matter arising 8: Fire and Rescue MOU (Design)	Impact
We were provided with a copy of a memorandum of understanding (MOU) which has been signed by representatives of all three Fire and Rescue services (FRS) across Wales. The MOU was signed in 2012 and discussion with the Service Manager, EPRR & Specialist Operations, outlined that the document contained detailed appendices linked to operational deployment arrangements, reflecting that HART was a newly commissioned service at that point. With HART now firmly established, and good working and exercising arrangements in place with FRS, discussions had been held prior to the onset of the Covid-19 pandemic to revise the MOU to recognise and better reflect HART capabilities. A draft copy has been shared with FRS colleagues with the intention to revisit this further but is yet to be finalised.	Potential risk of: • Roles and responsibilities not aligned to current practices.

Recommendations	Priority
8.1 The Trust should make arrangements to update and finalise the MOU with Fire and Rescue services.	Medium

Management response	Target Date	Responsible Officer
8.1 The Trust accepts this recommendation and will ensure that the MOU with Fire and Rescue Services is updated appropriately.	May 2023	Clare Langshaw, Head of Service, EPRR

Matter arising 9: Debriefing process and lessons learnt (Design)	Impact
We were provided with a HART Debrief tool which prompts the inclusion of good points, learning points, and what could be done differently. This is consistent with the format in use by the EPRR team within the Trust Organisational Learning SOP. Example debriefs were provided and related to three of the seven teams / watches in operation within HART. Their content was generally consistent, although we noted slight variation in their format. However, there was a lack of further actions or recommendations. We were informed that there had been periodic sharing of lessons learnt by individual HART teams / watches through a regular Continuous Professional Development day. Alongside the sharing of good practice this, provided a platform for discussion on areas for development and training opportunities. NARU oversees a national safety alerts system which includes focus on the interoperable service and capabilities associated with HART. We sampled three notices, and were provided with evidence to support action being taken relating to one of these. We were informed that information for the two remaining notices would have been shared through structured handovers, but that this had not been formally recorded.	Potential risk of: • Gap in mechanisms for capture and implementing of lessons learnt.

Recommendations	Priority
9.1 A formal mechanism should be developed for the recording, monitoring and completion of actions related to debriefs and lessons learnt. Periodic reporting within the Directorate should be undertaken to provide assurance that these mechanisms, and the debrief process are operating as expected. 9.2 In progressing the above there could be consideration to aligning the recording of actions and responses to NARU National Safety Notices.	Medium

Management response	Target Date	Responsible Officer
9.1 The Trust accepts this recommendation and will develop a formal mechanism to record, monitor and complete actions from debriefs and lessons learnt. This mechanism will include a reporting process to Senior Operations Team (SOT) with relevant assurance to Senior Leadership Team (SLT) where appropriate.	May 2023	Clare Langshaw, Head of Service EPRR

9.2	The recording of actions and responses to NARU National Safety Notices will be incorporated into the formal reporting mechanism in 9.1	May 2023	Clare Langshaw, Head of Service EPRR

Matter arising 10: KPI Reporting & committee oversight (Design)	Impact
The Finance and Performance Committee terms of reference include '*review performance against targets and standards set by Commissioners and/or Welsh Government for the Trust and, where appropriate, against national ambulance quality indicators.*' It received the 2020/21 end of year summary report in May 2021. We have not identified further reporting of KPI or summary information.	Potential risk of: • Responsible committee not sighted on commissioned service activity.

Recommendations	Priority
10.1 HART KPI should be provided to the Finance and Performance Committee on an annual basis.	Medium

Management response	Target Date	Responsible Officer
10.1 The Trust accepts this recommendation and will provide the HART KPIs to the Finance and Performance Committee on an annual basis.	April 2023	Judith Bryce, Assistant Director of Operations

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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Attendance Management
Final Internal Audit Report

November 2022

Welsh Ambulance Services NHS Trust

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

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

EXTERNAL • QUALITY • ASSESSMENT

Contents

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Auditors:	Osian Lloyd, Head of Internal Audit Jonathan Jones, Audit Manager Mair Evans, Principal Auditor
Executive sign-off:	Angela Lewis, Director of Workforce & OD
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Committee:	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors

Acknowledgement

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

Disclaimer notice - please note

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Executive Summary

Purpose

The overall scope of the audit is to assess the effectiveness of the early intervention mechanisms the Trust has put in place to improve staff attendance.

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- Scope to improve analysis of underlying causes of sickness, alternative duties, and their reporting.
- Standardisation of sickness audits, including criteria and approach.
- Developing key performance indicators and data for evaluating quality and effectiveness of services.
- A training register has been established, but there is a need to develop monitoring and reporting arrangements.

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

Report Classification

		Trend
Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	⇔ 2020/21

Assurance summary[1]

Assurance objectives		Assurance
1	Key causes of staff sickness identified	Reasonable
2	Early intervention mechanisms adopted	Reasonable
3	Effectiveness and quality of services monitored and assessed	Limited
4	Impact of intervention mechanisms monitored	Reasonable
5	Oversight and reporting arrangements	Reasonable

Key matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
1	Collating data for alternative duties	1, 4	Operation	Low
2	Audit process and outcome reporting	1, 4	Design	Medium
3	Training register	2	Design	Medium
4	Evaluating quality and effectiveness of services	3, 4	Design	Medium
5	Sickness indicators	5	Operation	Medium
6	Project reporting	5	Design	Medium

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

1. Introduction

1.1 The Welsh Ambulance Services NHS Trust (the 'Trust') has historically been faced with managing high levels of sickness absence and in 2021 these reached the highest level to date. High levels of sickness absence can impact on resourcing, productivity and staff morale which could adversely affect the quality and safety of service delivery and patient care.

1.2 Included within the Trust's IMTP 2022-25 is an intention to reduce sickness absence levels to 10% by the end of the year one, 8% by the end of year two and 6% by the end of year three. To address this challenge, the Trust has developed an 'Improving Attendance Project Plan', to support the reduction of sickness absence levels. The plan is made up of seven workstreams and includes identifying and providing appropriate interventions alongside support mechanisms, to motivate and encourage staff to return to work at the earliest possible opportunity.

1.3 The associated risks are:

- Increased sickness absence levels could lead to diminished service delivery;
- Impact on staff morale and wellbeing from increased workloads due to reduced resourcing.

1.4 The audit excluded the specific detail of individual elements of each workstream, but will focus on the key contributors to absenteeism and the Trust's overall progress in improving attendance levels.

2. Detailed Audit Findings

The table below summarises the recommendations raised by priority rating:

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	-	4	0	4
Operating Effectiveness	-	1	1	2
Total	-	4	2	6

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

Audit objective 1: Key causes contributing to staff sicknesses have been identified.

2.1 The Trust is committed to improving the wellbeing of staff and improving the culture of the organisation, by providing proactive mechanisms to support staff in work and returning to work. The Operations Directorate, including paramedics and staff in the Clinical Contact Centres, experiences the highest impact from sickness absence. They are often faced with the challenge of working under significant system pressures and dealing with the public in emotional and traumatic environment.

2.2 There is awareness that the above represent system wide pressures, however the Trust is focussing their attention to develop tools and resources to equip managers to effectively support staff, both whilst in work and to return to work during a period of absence. There is an appetite to understand the pressures that colleagues experience and to provide compassionate guidance and proactive support for their wellbeing.

2.3 The Trust uses ESR to record and capture sickness absence. As ESR is used as a live system, the Trust produces standard sickness absence reports at same point at the end of each month to ensure standardisation and consistency.

2.4 Sickness absence reports are generated from the Business Intelligence facility within ESR. These illustrate graphically the sickness trends at a corporate and divisional level, and can be tailored to provide information at a more granular level.

2.5 We have reviewed reports provided to Senior Leadership Team, Senior Operations Team and at Executive Management Team. These show the 'top 10' sickness reasons and trends. The Trust also regularly provides sickness performance information and trends to the Chief Ambulance Services Commissioner (CASC).

2.6 We reviewed the trends from prior to the approval of the Wellbeing Improvement programmes to date (November 2021 to September 2022). The three main causes reported as contributing to staff sickness are mental health related (anxiety/stress/depression/other psychiatric illnesses), back or other musculoskeletal problems and infectious diseases / cold, cough, influenza / chest & respiratory problems.

2.7 The examples of reports referenced above contains ongoing review of performance trends. There is a myriad of reports internally generated and external reports provided by Trust commissioned Health Care providers. We have not seen that the Trust analyses all the reports on wellbeing generated internally and externally, to provide a full analysis of absence types and use of proactive services across geographical locations as well as job roles. As reports are not uniform in collection of data this makes it very difficult to collate. Through access to provider data we have undertaken some limited analysis on sickness causes.

2.8 **Mental Health related (anxiety/stress/depression/other psychiatric illnesses)**

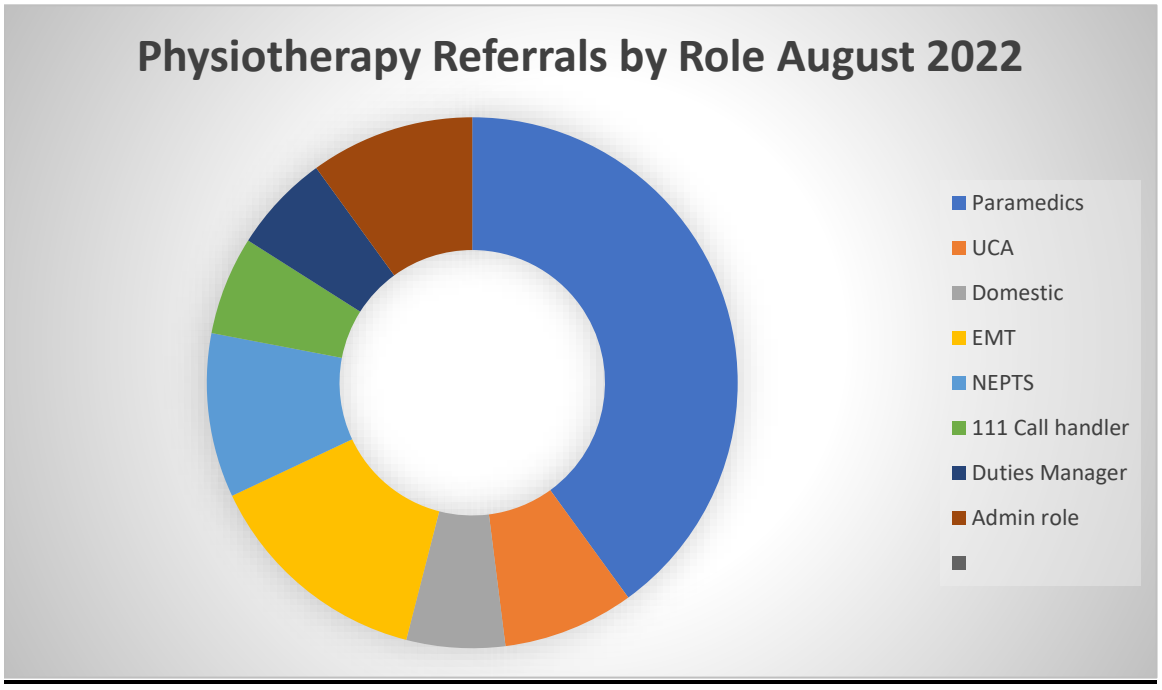
Mental health is reported as the main type of sickness absence within the Trust and include reference to significant system pressures and dealing with the public in emotional and traumatic environment cited above. Reports and graphs produced by the Health Assured Employee Assistance Programme show that the highest category received related to mental health enquiries (391 in total with 249 registered under the subcategory of anxiety), during the year between August 2021 and July 2022.

2.9 **Other musculoskeletal problems and back problems**

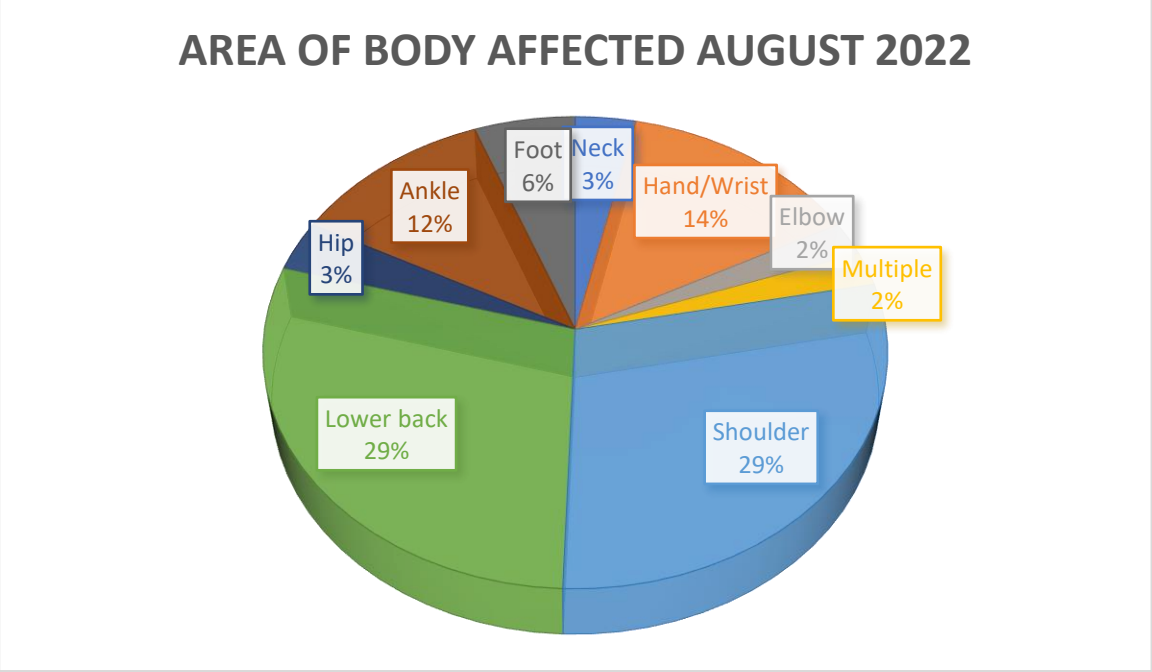
The Trust reports musculoskeletal injury as the second largest cause of sickness.

The information provided by the supplier, *fitBack* physiotherapy, provided a visual interpretation to show the main job role affected. Accounting for most referrals are the Paramedics, Emergency Medicine Technicians, and those involved in non-emergency patient transport, which can all involve physical movement of patients.

The graph below illustrates the main type of injury treated which is shoulder and back, which also corresponds with the nature of the patient facing roles referred to above.



2.10



2.11 **Infectious diseases - cough, cold, flu, covid**

There is not a specific code to record COVID, one of the highest reasons for absence in recent years, on ESR. We understand that it could be classified under a number of different absence types on the system. The Trust has a dedicated COVID wellbeing site which provides current guidance information, and has set up a long COVID group to provide ongoing support and guidance.

2.12 In addition to collating sickness absence trends, the Trust also collects information on staff who have undertaken alternative duties to facilitate an earlier return to work or to remain in work. The information is gathered locally, and the Trust has concerns on the accuracy of information and methods used to measure or determine the impact of providing alternative duties for supporting staff to work.

2.13 The Trust is aware that there can be some confusion on the distinction between alternative duties provided for staff to return to work and alternative duties provided for other operational reasons. Reporting does also not make the distinction between new or ongoing returns. One of the suppliers (*fitBack*) does give some indication on how many of their referrals are on alternative duties, in work and off sick. The Trust is keen to establish a more robust method to gather information on alternative duties including measuring effectiveness. **(Matters arising 1)**

2.14 We queried processes in place to support the validation of sickness information. Prior to the pandemic, the Trust had established a sickness audit process, supported by a compliance tool kit and template documents to capture findings and recommendations. No current criteria to prompt audits has been provided and we were informed during the pandemic these audits were only carried out at the request of managers.

2.15 Details of the audit's carried out in 2022 included a sample of ten staff selected from each of Hywel Dda, Cwm Taf and Powys Health Board areas, to test return to work interview had been completed and identify if a trigger point had been reached. Deep dive audits have also been undertaken at Central and West and South East Clinical Contact Centres (CCC). These reviewed use of prompts for escalation, use of redeployment and outlined areas where managers would benefit from further support. There was reference to a review undertaken at the North Wales CCC which had identified good local overview of processes and no gaps in escalation had been identified. We noted no consistent format with variance in the approach, findings and resulting recommendations of those reviewed. **(Matters arising 2)**.

Conclusion:

2.16 The Trust has the systems in place for capturing information to inform managing attendance at work. However, there is opportunity to refine and improve analysis and reporting of root causes and to include measuring the impact of providing alternative duties to facilitate staff in work. Also, the completion of internal sickness absence audits is ad hoc, with no set criteria or format. We have provided an assurance rating of **reasonable**.

Audit objective 2: Early intervention mechanisms have been adopted to promote and support staff wellbeing.

2.17 The Trust approved its Health and Wellbeing Strategy ('the strategy') in 2020. The strategy '*seeks to understand the health of the Trust's workforce, work together to ensure a fit for purpose range of interventions and promote proactive innovations to increase resilience right from first application to retirement and beyond for the Trust's people and their families and support networks*.' Contained within the strategy are a number of objectives including assessing the health and wellbeing of the workforce, proactively promoting health and wellbeing offers, and providing preventative health and wellbeing services and training for everyone at each stage of their WAST career path. In December 2021 the Trust approved the establishment of an Improving Attendance Project combining existing actions under development, with new interventions across dedicated thematic workstreams.

2.18 The workstreams within the Improving Attendance Project include:

- Work Stream 1 Wellbeing Support delivered to meet needs of employees;
- Work Stream 2 Data and information available to stakeholders;
- Work Stream 3 Management Support
- Work Stream 4 Workforce Engagement / Ownership
- Work Stream 5 Long Term Absence Support including COVID
- Work Stream 6 Pilot Projects (including launching/embedding new behaviours, alternative rostering arrangements, communications and engagement opportunities).

We note the Improving Attendance Project Plan and its supporting workstreams can be seen to be in alignment with the objectives of the strategy outlined above.

2.19 We have concentrated our review on workstreams and proactive mechanisms for the key causes of sickness identified within objective one.

2.20 **Mental Health**

The top cause of staff sickness relates to mental health issues and the Trust has engaged with Health Assured to provide its Employee Assistance Programme, which includes external confidential counselling services. As detailed above, the main cause is anxiety due to the nature and environment that public facing operations experience on a day-to-day basis.

2.21 The Trust is promoting the services via intranet, induction, and training courses to stakeholders, managers and employees. The Occupational Health team is also carrying a programme of site visits to contact centres and emergency departments to promote wellbeing, and ensure that all staff have equal access to services. The Trust is aware that Operational staff do not have access to the intranet via laptops so are promoting the wellbeing app on mobile phones to support staff.

2.22 The Trust also provides internal support for mental health wellbeing which include Trauma Risk Management programme (TRiM) and Thrive: Mental Wellbeing. TRiM is a peer support system, and the Trust has secured funding from Welsh Government to train TRiM practitioners and managers. Access to the service can be through self-referral, manager request or through Occupational Health.

2.23 TRiM addresses the various stressors on mental health such as traumatic incidents, moral impact and work life balance etc, concentrating on recognising the stressor and talking. Thrive also deals with mental wellbeing through interactive programmes, triage, relaxation, meditation and goal setting to proactively support mental health wellbeing. The Trust has also provided several Thrive webinars which support suicide prevention, alcohol, and mental health awareness.

2.24 The Trust also provide links to other mental health support including Mind Blue Light, NHS England Wellbeing Apps, Samaritans, DAN 24/7, Community Advice and Listening Line and Silver Cloud.

2.25 **Back and other musculoskeletal problems**

The Trust is offering physiotherapy services and preventative approaches include induction courses covering wellbeing information including manual handling training. The Trust has also carried out presentations to inform staff how to prevent or help back ailments e.g. November 2021 Joy of Movement look after your back presentation.

2.26 The Trust has invested in offering physiotherapy services for some time, but has recently changed provider. We were informed the new provider, *fitBack,* offers more flexibility in capturing feedback and reporting. Management information provided by *fitBack* (refer to table 2.09 & 2.10) shows that main job role affected

is those with patient facing roles which account for 50% of referrals, and the main injuries are split equally between back problems and shoulder problems, followed by ankle, knee and hand or wrist.

2.27 **Infectious diseases, cold, cough, Flu-Influenza**

The Trust finds this category of sickness absence the most challenging to provide a proactive service to support staff wellbeing. The Trust has a dedicated COVID wellbeing site which provides current guidance information, and has set up a long COVID group to provide ongoing support and guidance.

2.28 The Trust promotes Infection Prevention and Control arrangements through a dedicated sharepoint page on the intranet. This directs staff to the latest guidance and policies. and the Trust is also providing Flu and COVID vaccinations across various sites geographically to ensure equal distribution/access.

2.29 One of the key proactive approaches supported by the Trust is training managers to support staff to return to work and support attendance. A training programme has been developed which includes the following:

- Management Attendance Core Training;
- Management Attendance Foundation Training; and
- Management Attendance Train the Trainer Course.

2.30 The Trust has also created several 'bitesized' courses which are more digestible and cover topics such as review prompts and discretion, managing short term sickness absence, and reasonable adjustments and the Disability Discrimination Act.

2.31 Trust has also provided action cards, to assist managers with effectively managing planned absences, short term sickness, long term sickness and sickness and annual leave. Presentations have also been given to promote the role of the Occupational Health Service to provide wellbeing support

2.32 The Trust maintains a register for some training events, however does not demonstrate that all managers have attended wider training events and workshop to ensure those which require support have accessed all available resources. We note training figures are currently not reported. We are informed there is intention to implement a monitoring system to assist in identifying managers yet to attend. **(Matters arising 3)**.

2.33 The Trust has previously developed a *Sickness Action Plan* in 2017-18, and an *Improving Attendance at Work Action Plan* in 2018-19. In comparing plan content against the current Improving Attendance workstreams, we noted the change in focus with the inclusion of a wider range of wellbeing services and training to support more proactive approaches from managers.

Conclusion:

2.34 The Trust is enthusiastically providing a programme of wellbeing support that is of a proactive nature and is in the initial stages of a promotional campaign. We've

also highlighted opportunity to improve monitoring of training attendance. We have sufficient evidence to support a **reasonable** assurance rating.

Audit objective 3: Assessments are made to understand the effectiveness and quality of the early intervention mechanisms and staff wellbeing services provided.

2.35 The proactive intervention mechanisms the Trust has put in place are in the early stages of development, as such the arrangements for measuring their effectiveness are also in their infancy.

2.36 The Trust faces a challenge on the collection of data to capture the impact of initiatives. It does not hold information on staff that were able to continue working effectively because of the interventions and services provided, nor on staff returning to work sooner than perhaps they would have without these.

2.37 Workstream 4 of the Improving Attendance project relates to 'Workforce Engagement/Ownership'. Actions include development of a workshop and questionnaire, to be followed by focus groups to consider feedback received. Once complete there is intention to develop interventions and build these into the continuing project plan. Timescales for this workstream will need to be reassessed as the questionnaire was yet to be issued at time of fieldwork. **(Matters arising 4)**.

2.38 The Trust has completed 23 site visits to South Wales hospitals recording over 257 attendees, and 49 listed as attending the three site visits in North Wales. From August 2022 the Trust has offered seven REACT (Recognise, Engage, Actively Listen, Check risk, and Talk about specific action) sessions with a total of 53 attendees. 'Understanding stress, trauma and burnout' sessions have also been offered virtually, with 66 listed as attending.

2.39 The Trust has also recently commissioned Swansea University to carry out a staff survey, the results of which are expected in November 2022. We note the previous NHS Wales wide staff survey was undertaken in November 2020 with '*more focus on staff wellbeing*' reported as a key improvement theme. As reported to the People and Culture Committee in September 2022 (Pan-Wales Staff & Wellbeing Deep Dive report) '*the situation in managing wellbeing remains challenging*.'

2.40 Performance information collated internally includes the numbers of Occupational Health referrals received and the reason for these, along with attendance, cancellation and did not attend numbers. The service also maintains records of staff immunisation, medicals and clearance timescales. However, the reports we were provided with did not include analysis on geographical location, service area or role. **(Matters arising 4)**.

2.41 We were informed that there is consideration being given to early feedback prompts to capture user feedback of service effectiveness. This includes the Occupational Health service considering implementing an electronic method to

assess satisfaction and effectiveness by use of emoji's following each user interaction/call logged.

2.42 The Trust receives regular management information from service providers, but does not combine this intelligence to provide an overall snapshot on their effectiveness to support and improve attendance at work. **(Matters arising 4)**

2.43 *fitBack* report on the number of physiotherapy referrals received, including by type of injury and by role, whether off work, on alternative duties or in work and recovery status. It also includes a satisfaction survey but lacks detail on geographical location.

2.44 Reports provided by Thrive show an increase in the total number of referrals relating to anxiety and depression. This information only provides an aggregated position and illustrates severity of anxiety and depression, and further analysis would be more meaningful.

2.45 The Health Assured Mental Health report contains more statistics, including the type of referral, service area and customer satisfaction. User feedback includes scoring for pre and post service use on work engagement and workplace distress. Users have the option of including their service area, however most returns are registered under a generic Trust heading, indication of geographical area and role could assist in undertaking future analysis.

2.46 We have highlighted the Trust has undertaken sickness audits, but review of the outcomes provided did not identify if they include feedback of any employee use of services. Inclusion of a prompt may assist in capture of direct experience regarding their effectiveness. (**Matters arising 2)**

Conclusion:

2.47 The Trust has not been able to fully assess the effectiveness of the proactive services provided, with challenges identifying staff that were able to continue working because of the interventions and staff possibly returning to work sooner without them. There is a workstream to support gathering staff feedback and in turn develop further indicators, however this remains at an early stage. We have provided an assurance rating of **limited.**

Audit objective 4: Indicators have been established to measure the impact of intervention mechanisms to improve attendance.

2.48 The previous objective has identified there could be opportunities to develop or enhance the indicators for intervention mechanisms, at present the key indicator that the Trust currently collates is the number of referrals.

2.49 The Trust has noticed an increase in referrals since the new services have been introduced and consider that the increase is as a result in confidence in the service, including its confidential nature, and from its efforts in actively promoting services. This increase in referrals suggests the need for support is increasing and

we note there are positive signs in terms of increases in recoveries, which could suggest the intervention mechanisms are having an effect.

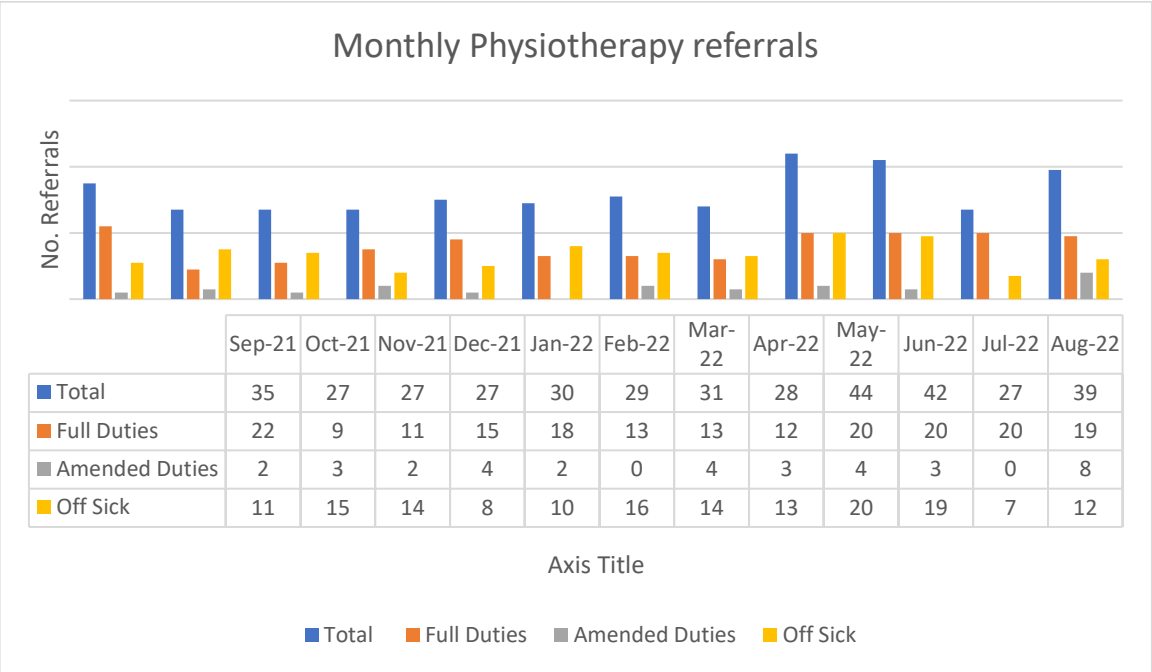
2.50 The Occupational Health service maintain a record of the reasons for referrals to best understand the needs of the employees. We note the majority of referrals were for wellbeing (30% of total referrals), followed by health condition effecting work performance (16%) and long-term sickness absence (13%) for the period January 2022 – August 2022.

2.51 Health Assured provide monthly management information on the number of referrals received and by year. It reported a total 783 calls received in the year July 2021 to August 2022, as noted previously the majority related to mental health referrals with anxiety as the highest subcategory. The provider reported that February 2022 was the peak period with 110 calls, and that 42.9% of those out of work at the start of therapy had returned at the end of the sessions.

2.52 The referrals for Thrive have been increasing which indicates that symptomatic causes still exist and there is a need to continue increasing support. There are positive signs with recoveries for depression and anxiety increasing which reflects positively on the interventions put in place. We note that the Thrive report captures the top 3 positive and negative stressors.

2.53 *fitBack* has received a total 739 referrals since the beginning of its contract in July 2021, and there were 210 open cases at the end of August 2022. On average it takes 65 days from the point the referral is made to discharge. The table below shows the number of referrals received on a monthly basis along with their status in work.

2.54



	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
Total	35	27	27	27	30	29	31	28	44	42	27	39
Full Duties	22	9	11	15	18	13	13	12	20	20	20	19
Amended Duties	2	3	2	4	2	0	4	3	4	3	0	8
Off Sick	11	15	14	8	10	16	14	13	20	19	7	12

2.55 The monthly management information from *fitBack* includes analysis on the types of appointments held, i.e. face to face vs guided self-management appointments.

There is also detail on discharges. For example, 29 employees were discharged in August 2022:

- 23 were discharged on full duties - of these 5 had been off work at the point of referral and 1 was on amended duties;
- three were discharged on amended duties, with a phased return to work in place - all had been off sick at the point of referral;
- one case was closed as it wasn't appropriate for physio; and
- two cases were closed due to being unable to contact the employee.

2.56 The management information reports are a snapshot of users of the service and in some cases whilst the reports gave indication of the service provided. There is opportunity for the Trust to work with the providers to gain a more uniform reporting to illustrate the effectiveness of services. **(Matters arising 4)**

2.57 The Trust's overall sickness absence rate is also a direct indicator to measure the effectiveness of the Improving Attendance project and its workstreams. Overall rates for the Trust, and the Operations Directorate, feature within reporting provided to EMT. Performance and forecast trajectory are included for a rolling 12-month period. At the time of Improving Attendance project initial approval in December 2021 the Trust sickness rate was 12.44%, at the close of fieldwork the August 2022 rate was reported as 8.72%.

2.58 Analysis contained within the EMT reports includes comparison of long-term and short-term rates, alongside a figure for average working days lost per full time equivalent employee. Whilst the overall rate, long term and short term figures are presented over 12 month periods, the average working days lost figure is only reported for the current month, and not presented over a similar extended timescale. Prior to June 2022 EMT reports were accompanied by a large range of indicators. We note the most recent Improving Attendance reporting is more streamlined in terms of indicators included. (**Matters arising 5)**

2.59 Alternative duties analysis is also included within the Improving Attendance reporting provided to EMT. This sets out number of staff undertaking alternative duties across categories linked to reason (health, employee relations, return to work) and this is presented as a monthly snapshot. Comparison on an ongoing basis may indicate if the Trust is successfully supporting more staff in returning to work sooner.

Conclusion:

2.60 The Trust receives management information from service providers in different formats. A number of indicators, such as referral and the overall absence rate are available, but there is scope to consider further refinement of these. We have provided an assurance rating of **reasonable**.

Audit objective 5: Adequate reporting mechanisms are in place to monitor and manage attendance levels, both locally and at Board level.

2.61 In December 2021, EMT approved an SBAR which set out the proposed plan to improve attendance across the Trust. The paper outlined that those existing actions under development would be combined with new interventions and, through combining these across dedicated thematic workstreams, would result in a more structured sustainable approach. The benefits of workstreams were set out, including their ability to provide a 'holistic' view, ability to create virtual project teams to deliver actions or new projects, and easily track action progress. .

2.62 The Trust Board approved the approach to improving attendance at its March 2022 meeting. The paper included outline of the project and supporting workstreams. It also referenced the improvement target set within the IMTP to reduce sickness absence levels to 10% by the end of the year one, 8% by the end of year two and 6% by the end of year three.

2.63 The project has a 'Managing Attendance improvement summary plan', which includes the workstreams, overall objectives, actions, responsible lead, target dates, RAG rating and outline of any comments or corrective action. The summary plan is supported by a Gantt chart, which sets out individual action progress.

2.64 The group managing the workstream has an informal reporting structure reflecting the Trust's desire to implement changes at pace. The project has no dedicated administrative support and so minutes or action notes are not available, leaving no formal record of topics discussed or actions taken. We were informed that project meetings take place on a regular basis and leads are able to update the plan for their areas of responsibility. The project plan does not list each workstream as having a formal lead, however we could identify actions assigned to individuals or teams with a small number of exceptions. **(Matters arising 6)**

2.65 The plan is updated ahead of presentation to the People and Culture Committee. Review of the July version, presented to the September Committee meeting, noted a small number of actions on hold or with no start/finish dates RAG rated green. Additionally, a small number of indicators under Workstream Engagement/Ownership (WS4) were rated green, despite not starting and being reliant on the completion of proceeding action. **(Matters arising 6)**

2.66 The project has provided regular updates to EMT, initially through narrative progress reports, more recently within a redesigned presentation deck format. The more recent format does include updates on the status of the project but only in highlight or bullet point form. **(Matters arising 6)**

2.67 We also reviewed reporting to the People and Culture Committee which has received presentation of the Managing Attendance improvement plan alongside overall performance information as contained within the deck provided to EMT.

2.68 Our review has concentrated on workstreams associated with Wellbeing Support (WS1), Data and Information (WS2), Management Support (WS3), and Workforce Engagement/Ownership (WS4). We have identified a number of opportunities to further support this work and wider monitoring and reporting, including further

analysis on absences, tools to understand and manage root causes, and indicators to capture quality and effectiveness of initiatives put in place.

Conclusion:

2.68 The Trust has a clear reporting structure to support monitoring of sickness information including progress on the Improving Attendance project. There are some opportunities to, ensure the plan is kept up to date, maintain records of key decisions, and enhance reporting. Noting this we have provided an assurance rating of **reasonable**.

Appendix A: Management Action Plan

Matter arising 1: Collating data for alternative duties (Operation)	Impact
In addition to collating sickness absence trends, the Trust also collects information on staff who have undertaken alternative duties to facilitate an earlier return to work or to remain in work. The information is gathered locally, and the Trust has concerns on the accuracy of information and methods used to measure or determine the impact of providing alternative duties for supporting staff to work. The Trust is aware that there can be some confusion on the distinction between alternative duties provided for staff to return to work and alternative duties provided for other operational reasons, with no agreed definition in place to assist in collating information. Analysis on alternative duties is included within the Improving Attendance reporting provided to EMT, however this is currently a monthly snapshot with no ongoing or trend comparison provided.	Potential risk of: • Inaccurate data • Inability to measure effectiveness

Recommendations	Priority
1.1 We recommend that the Trust agree a set definition of what constitutes alternative duties. Following this the Trust should continue to investigate methods of gathering information including the measurement of the effectiveness of providing alternative duties for staff to return to work after a sickness absence. 1.2 We also suggest that the Trust considers developing longer term comparisons of alternative duties reporting to indicate where they support more staff in returning to work sooner.	Low

Management response	Target Date	Responsible Officer
1.1 Accepted – we will add to the Managing Attendance action plan and define alternative duties. From the GRS (rostering system) perspective we may have limited capacity to change in the system due to system parameters, therefore manual intervention may be needed	31st March 2023	Liz Rogers, Deputy Director of Workforce and OD / Siobhain Frain, Resource Services Manager
1.2 Accepted – will need to be a longer timeline for comparison data.	31st December 2023	Liz Rogers, Deputy Director of Workforce and OD

Matters arising 2: Audit process and outcome reporting (Design)	Impact
Prior to the pandemic, the Trust had established a sickness audit process, supported by a compliance toolkit and template documents to capture findings and recommendations. No current criteria to prompt audits has been provided and we were informed during the pandemic these audits were only carried out at the request of managers. Details provided on the audits undertaken in 2022 identified a lack of consistency in format, with varying detail in outlining the approach, findings and resulting recommendations. Review of the above did not identify the inclusion of prompts or opportunities for gaining feedback on any services or training accessed, to assess their usefulness in supporting the early return to work of employees.	Potential risk of: • Lack of consistency in audit process and reporting.

Recommendations	Priority
2.1 We recommend that the Trust review and reinstate the process and compliance toolkit for sickness audits to ensure consistency of approach and reporting. 2.2 The Trust should of incorporate gaining user or manager feedback on the effectiveness of proactive mechanisms as part of the sickness audit process.	Medium

Management response	Target Date	Responsible Officer
2.1 Accepted - We will review the compliance toolkit to establish fitness of purpose and if it is felt that it will add value to the organisation, managers and teams we will reinstate. There is a caveat on the impact of additional paperwork and processes on managers	30th September 2023	Liz Rogers, Deputy Director of Workforce and OD
2.2 Accepted – manager feedback process is already in place. We will look to replicate for colleagues who are the subject of the process	30th September 2023	Liz Rogers, Deputy Director of Workforce and OD

Matter arising 3: Training Register (Design)	Impact
The Trust has developed several training events to inform and support managers on providing supportive attendance management. A training programme has been developed for all managers and supervisors under the headings of Core, Foundation and Train the Trainer and attendance is recorded for these based upon ESR supervisor status. Through development of a fuller register of training event attendance the Trust may be in a position to identify if there is correlation between high sickness areas and training attended. We note training figures are currently not reported. We are informed there is intention to implement a monitoring system to assist in identifying managers yet to attend key training courses.	Potential risk of: • Lack of knowledge on Management Attendance procedures • Increased absence rates

Recommendations	Priority
3.1 The Trust should consider expanding the recording of training attendance beyond the key programme to include the wider range of events and workshops. This could support analysis of training impact on sickness levels. 3.2 The Trust should consider methods for monitoring attendance at key training courses, and ensure regular inclusion of attendance figures within future reporting.	Medium

Management response	Target Date	Responsible Officer
3.1 Accepted – no Learning Management System means this will be manual	31st December 2022	Liz Rogers, Deputy Director of Workforce and OD
3.2 Accepted in part – attendance is monitored and lists of attendees are maintained. Attendance figures are reported to EMT and PCC on an add hoc basis. A more regular rhythm will be introduced. It should be noted that there is a push on current training and this will change to mop up newly appointed managers as they take up the role at that point the type and frequency of reporting will need to be reviewed	31st December 2022	Liz Rogers, Deputy Director of Workforce and OD

Matter arising 4: Evaluation of quality and effectiveness of services (Design)	Impact
The Trust provided employees with a range of support services and resources for mental health and physical wellbeing, provided through Occupational Health and external providers. We have noted some limitations with the data collected internally noting that whilst Occupational Health reports referrals, there is a lack of analysis across location, service area or role. Review of management reports submitted to the Trust by external providers noted that they vary in detail against feedback from users on the services accessed/received. We note that the Improving Attendance Workstream 4 'Workforce Engagement/Ownership' include actions related to capturing feedback and developing interventions to support the ongoing development of the project. Timescales for this workstream will need to be reassessed as the questionnaire was yet to be issued at time of fieldwork.	Potential risk of: • Insufficient data for decision making • Increased absences

Recommendations	Priority
4.1 We recommend that the Trust investigate means to measure the quality and effectiveness of proactive mechanisms put in place to manage sickness absence. Also, the Trust should consider if management information provided by internal and external providers could be standardised with set key performance indicators for ease of comparisons and collection of data.	Medium

Management response	Target Date	Responsible Officer
4.1 Accepted – we will investigation options for evaluation of quality and effectiveness	31st December 2023	Liz Rogers, Deputy Director of Workforce and OD

Matter arising 5: Sickness indicators (Operation)	Impact
Analysis contained within the EMT reports includes comparison of long-term and short-term rates, alongside a figure for average working days lost per full time equivalent employee. Whilst the overall rate, long term and short term figures are presented over 12 month periods, this is not the case for the average working days lost figure.	Potential risk of: • Gap in analysis of absence length.

Recommendations	Priority
5.1 We recommend that the Trust include additional detail within its sickness reporting to capture if there are reductions in number of working days lost.	Medium

Management response	Target Date	Responsible Officer
5.1 Accepted – a graph of the days lost month to month will be developed	1st April 2023	Liz Rogers, Deputy Director of Workforce and OD

Matter arising 6: Project reporting (Design)	Impact
The group managing the workstream has an informal reporting structure and we note there is no dedicated administrative support. Minutes or action notes are not available leaving no formal record of topics discussed or actions taken. We were informed that project meetings take place on a regular basis and leads are able to update the plan for their areas of responsibility. We noted the July 2022 version of the plan a small number of actions on hold or with no start/finish dates RAG rated green. Additionally, a small number of indicators under Workstream Engagement/Ownership (WS4) were rated green despite being reliant on the completion of proceeding action and not yet commenced. The project has an Improving Attendance improvement summary plan which includes the workstreams, overall objective, action, responsible lead, target dates, RAG rating and outline of any comments or corrective action. The summary plan is supported by a Gantt chart which sets out individual action progress. Full outline of the plan is shared at People and Culture Committee but reporting to Executive Management Team has included narrative or in highlight form.	Potential risk of: • Gap in reporting

Recommendations	Priority
6.1 We recommend that the Trust ensure key changes are shared at an appropriate forum (ADLT or EMT) on a regular basis. 6.2 The Improving Management plan should be reviewed to ensure all actions have an assigned lead, start/finish date, and are appropriately RAG rated.	Medium

Management response	Target Date	Responsible Officer
6.1 Accepted – will direct via ADLT	31st March 2023	Liz Rogers, Deputy Director of Workforce and OD
6.2 Accepted	31st December 2022	Liz Rogers, Deputy Director of Workforce and OD

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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Electronic Patient Clinical Records - ePCR

Final Internal Audit Report

November 2022

Welsh Ambulance Services NHS Trust

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

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

Contents

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Report status:	Final Report
Fieldwork commencement:	28th July 2022
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Debrief meeting:	18th August 2022
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Final report issued:	21st November 2022
Auditors:	NWSSP Audit & Assurance: Specialist Services Unit
Executive sign-off:	Brendan Lloyd, Senior Responsible Owner for the Electronic Patient Clinical Records (ePCR) Programme, Executive Medical Director
Distribution:	Leanne Smith, Interim Director of Digital
	Chris Turley, Director of Finance
	Duncan Robertson, Project Executive, Interim Assistant Director of Research, Audit & Service Improvement
	Alexander Crawford, Assistant Director of Planning & Transformation
	Aled Williams, Head of ICT
	Wyn Morris ICT Programme Manager
Committee:	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors

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

Executive Summary

Purpose

The audit was undertaken to review the delivery and management arrangements in place to progress the implementation of the electronic patient clinical record system (ePCR). The solutions will provide access to appropriate medical information to inform on-scene decisions. A key objective was to enable appropriate and timely replacement of the Trust's Digital Pen.

Overall Audit Opinion and Overview

The programme was progressing within budget and target delivery for a highly complex implementation involving multiple health bodies across Wales.

Cost

The Full Business Case was endorsed by Welsh Government in December 2020 in the sum of £2.541m with targeted delivery for 31st March 2023. The approved budget was revised to £2.445m in July 2022 to align with revised national priorities of the Digital Priorities Investment Fund and expenditure to date.

The programme is currently anticipated to be delivered within the agreed budget allocation.

Time

A target deadline of 31st March 2022 was agreed with Welsh Government to coincide with the end of contractual support for the Digital Pen.

The programme suffered a significant lag in recruiting resources, in part due to the impact of Covid. However, the core elements of the programme were delivered by their target date of 31st March 2022. The efforts of a smaller team to deliver the programme in this context have therefore been significant. Further elements, such as the Welsh GP Records System interface (which are currently being developed) are targeted for delivery by 31st March 2023 (in accordance with the approved business case).

The significant matters arising at the programme include:

- The need to consider the timing and method of engagement of health bodies within lessons learnt; and
- The need for early development plans with DHCW.

The audit did not find any high priority issues arising at the programme, and many instances of good practice.

Considering the above, a **reasonable** assurance has been determined at this interim stage of the management and implementation of ePCR programme.

Report Classification

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary [1]

	Assurance objectives	Assurance
1	Governance arrangements	Reasonable
2	Monitoring and reporting	Reasonable
3	Contractual arrangements	Substantial
4	Approvals	Reasonable
5	Programme management	Reasonable

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

Key Matters Arising		Assurance Objective	Control Design or Operation	Recommendation Priority
1	Management should update governance arrangements to reflect current operational arrangements.	*1*	Design	Medium
2	Management should consider the timing and method of engagement of health bodies within lessons learnt.	1,4	Design	Medium
3	Management should ensure that quantified, measurable and achievable targets are set for benefits realisation.	*2*	Operation	Medium
4	There is a need to learn lessons, notably relating to early engagement with DHCW and associated co-ordination with the contractor, and sufficient lead time to engage a programme team.	*4*	Operation	Medium
5	The time and cost implications of variations should be reported against remaining contingency	*5*	Design	Medium
6	The approval roles of the Programme and Project Boards should be specified.	*5*	Design	Medium
7	Time implications of change control, designating client or contractor liability should be included at both change authorisations and the change control register.	*5*	Design	Medium

1. Introduction

1.1 The Electronic Patient Clinical Records (ePCR) Programme is intended to deliver a digital patient records solution for the Welsh Ambulance Services NHS Trust. This will also include new access to appropriate medical information to inform on-scene decisions. A focussed version will be provided to Community First Responders, and the system will facilitate data interrogation and audit.

1.2 The Full Business Case was endorsed by Welsh Government on 15th December 2020 in the sum of £2.541m (incl. VAT). The solution involves both an external procurement, and tailored interfaces with other systems.

1.3 The business case envisaged implementation of core scope by March 2022, and full implementation by March 2023.

1.4 A core system has been procured from a third party supplier with interface to NHS Wales systems, as facilitated by the Trust, working with the supplier and Digital Health and Care Wales (DHCW).

1.5 Further product development aims to add further enhancements (not included within the business case) as part ongoing system operation. These are not considered here, being outside the scope of the current audit.

1.6 The audit has not included an assessment of the proposed technical solution.

1.7 The potential risks considered in the review were as follows:

- the programme may not be delivered as approved;
- the Trust may breach Welsh Government Funding stipulations, Standing Orders or Standing Financial Instructions; and
- Best Value may not be achieved.

2. Detailed Audit Findings

Programme Performance: Summary of the achievement of the programme's key delivery objectives (time, cost and quality) to date.

2.1 The Programme Definition Document notes that the Programme Board has the mandate of driving the wider programme, outputs and benefits (e.g. considering workforce or clinical implications), while the Project Board is concerned solely with implementing the technical solution. This audit includes consideration of how terms of reference delineate responsibilities between the two boards.

2.2 The chosen ePCR system is one already operated commercially by the supplier. However, this has required tailoring of the application software and interfaces with Welsh NHS information systems. Accordingly, Digital Health and Care Wales have been actively involved with the supply contractor to ensure effective specification and implementation of these interfaces. There has been an associated need to ensure appropriate workforce training to ensure that health staff are informed as to system access and capabilities.

2.3 At this interim audit, when assessing progress against the original delivery objectives, the following was evidenced:

Time

2.4 The Full Business Case (FBC) aimed to deliver core elements of the system by 31st March 2022, and remaining elements by 31st March 2023. While there remain some operational issues, Trust management have confirmed to Welsh Government that core elements were delivered by the target date of 31st March 2022 (the date the solution for the Emergency Medical Service was required to replace the contractual expiry of the prior Digital Pen). The Programme Manager has also confirmed that operational issues currently reported do not relate to core elements.

2.5 Remaining elements include tailoring of the application for Community First Responders use, and interface with the Welsh GP Records System (an interface to bring in summary information from the Welsh GP Records system).

2.6 The most recent contractor plan now shows full delivery by 22nd February 2023 (over a month ahead of the agreed delivery date specified at the Welsh Government funding approval), with remaining contingency for unplanned over-run to the end of the funding approval period (end of March 2023).

Cost

2.7 It was confirmed that overall funding has been reduced from the original £2.541m to £2.445m (as above). This was badged by Welsh Government as a reduction driven by assessment of all-Wales funding priorities (of the Digital Priorities Investment Fund - DPIF). However, no reduction in scope or quality is envisaged, with this sum being accommodated within remaining contingency allowance.

2.8 Cost reporting confirmed that final expenditure was anticipated to be within the revised allocation of £2.445m.

Quality

2.9 Delivery of the core elements by the required date has been confirmed to Welsh Government. However, some workforce familiarisation remains ongoing.

2.10 The full range of remaining elements within the FBC remained on target for delivery prior to 31st March 2023.

2.11 Some post-implementation issues were experienced in "core" delivery, largely relating to Health Board user familiarity with the system operation and capabilities. However, the Programme Manager confirmed that all such issues relating to core delivery have now been resolved.

Governance arrangements: assurance that appropriate programme governance arrangements and resource are maintained for the current programme stage.

2.12 The programme governance was defined via a Programme Definition Document which included the programme objectives, structures, roles and responsibilities, supported by terms of reference of associated programme groups.

2.13 The Programme Board was chaired by the Executive Medical Director (the Senior Responsible Officer), and addressed wider issues impacting the programme e.g. clinical, workforce, and stakeholder issues. This was also attended by the Project Executive officer (the single point of project accountability – product delivery), and the Programme Manager. It was supported by a Project Board (chaired by the Project Executive Officer), to oversee technical implementation with the supply contractors and Digital Health and Care Wales (DHCW).

2.14 These members of the senior management team provided strong corporate linkage to the Executive and enabled effective decision making.

2.15 A programme team (established to implement the programme) was specified and funded via the Full Business Case (FBC). Following approval, it was initially supported to April 2021 by Medical Directorate staff within their current roles. Recruitment difficulties during the Covid period, and subsequent lead times substantially impacted the establishment of the full team. This meant that the key roles of Project Team Manager, and Project Support Officer were not engaged until August 2021. Associated risks and issues were appropriately reported and escalated.

2.16 Both the Programme Board and Project Board meetings were held regularly and were well attended.

2.17 Key issues were escalated to the Clinical Transformation Programme Board. However, noting the commencement of this group subsequent to the Programme Definition Document, it has been recommended that the defined governance arrangements should be updated to reflect current arrangements (**MA 1**), including escalation arrangements with key parties (**MA 2**).

2.18 While recognising these matters, **reasonable** assurance has been determined in relation to the governance arrangements applied at the programme to date.

Monitoring and reporting: an assessment of appropriate monitoring and reporting arrangements.

2.19 A range of reporting was provided with coverage including elements such as risks, finance, and issues arising.

2.20 These contained some best practice examples of monitoring and reporting e.g. time-phased dashboard of tasks – visually combining a traffic light rating of issues with delivery deadlines.

2.21 Many of these were included within a comprehensive report to Welsh Government (the Digital Priorities Investment Fund).

2.22 Regular updates of the overall cost position were reported to the Programme Board, and progress summaries were provided for the CEO Trust Board report and relevant committees.

2.23 At the time of audit, while general benefits had been specified, many still lacked quantification (advised by management to have been impacted by resource issues). However, in recognition of this outstanding task, management have

convened a review of Programme benefits with Welsh Government in August 2022 (**MA 3**).

2.24 Accordingly, while recognising the need to more fully address benefit targets, additionally noting some exemplar reporting, and comprehensive reporting to both Welsh Government and the Trust Executive, a **reasonable** assurance has been determined in relation to monitoring and reporting.

Contractual arrangements: assurance that processes to appoint the developer and any advisers provide value for money in accordance with local and national requirements.

2.25 The procurement strategy was informed prior to the agreement of the Full Business Case (FBC) by a consultancy review commissioned by WAST, as requested by Welsh Government (to examine the in-house potential of DHCW to deliver a bespoke system). This advised that an in-house option was not feasible. Accordingly, an NHS ePCR framework was utilised to progress a mini-competitive exercise to identify a preferred provider. Full details of the procurement were provided within the approved FBC.

2.26 Subsequent to the FBC approval, a contract was signed by the supplier on 1st February 2021, and the Trust on 4th February 2021 i.e. prior to contract commencement (of 8th February 2021).

2.27 Contracts were also placed for two agency staff engaged to assist in year 2 delivery (i.e. an external Project Manager, and Implementation Manager).

2.28 Noting timely and authorised contractual arrangements, a **substantial** assurance has been determined.

Approvals: evidence that appropriate approvals have been obtained at key junctures, including stakeholder agreement, and design sign-off and that the programme progresses within these approvals.

2.29 Funding was approved by Welsh Government on 15th December 2020 in the sum of £2.541m (incl. VAT).

2.30 As previously noted, this was reduced to £2.445m in July 2022. However, there have been no other changes to the agreed time / cost position with Welsh Government. The programme remains forecast to deliver within the revised funding envelope, with no reduction in delivered outcome (reduced funding being accommodated within programme contingency).

2.31 As previously noted, there was a need to engage two external agency staff to assist with the second year of the implementation programme (selected from a staffing supply framework to assure best value). It was confirmed that these were authorised in accordance with Standing Financial Instructions.

2.32 Additional revenue costs of £0.501m over the first three years of operation were identified at the FBC, to be financed via the IMTP process. These include additional post-implementation staffing.

2.33 To facilitate implementation, numerous presentations and notifications were made to health bodies and leads, preceding the implementation phase. A number of post implementation issues have shown that there may be benefit in particularly reviewing any lessons around engagement (**MA 2**)(It is recognised that engagement and Health Board priorities were complicated by the pandemic response to Covid-19 and significant pressures within Emergency departments).

2.34 Similarly, there was a need for early engagement with DHCW to ensure effective and timely delivery (**MA 4**). While recognising the above issues, no changes have been required to the approved Welsh Government funding, and the programme remains within approved time and cost parameters. A **reasonable** assurance has therefore been determined in relation to approvals.

Programme management: to determine application of an appropriate range of programme and project controls including performance management, risk management and change control.

Time and Cost management

2.35 A target deadline of 31st March 2022 was agreed with Welsh Government to coincide with the end of contractual support for the prior Digital Pen system.

2.36 The programme suffered a significant lag in recruiting resource, in part due to the impact of Covid. However, the core elements of the programme were delivered by their target date of 31st March 2022. The efforts of a significantly smaller team to deliver the programme in this context have therefore been significant.

Risk management

2.37 Risks and issues were assessed at both a programme and project level (as applicable). These registers were found to be regularly updated and reported. However, they could usefully be supplemented by reporting of total time and cost implications as compared to remaining contingency (**MA 5**).

Performance management

2.38 Regular meetings with the contractor and DHCW were utilised to manage progress against milestones, which has facilitated delivery to Welsh Government targets.

2.39 However, it is recognised that several complex and some bespoke interfaces remain.

Change management

2.40 Change registers were found to be regularly updated and supported by appropriately completed change authorisation forms. These were reported to both Programme and Project Board.

2.41 While individual roles in scrutinising and approving changes were defined, neither the Programme Board nor the Project Board (as the responsible bodies) had defined responsibilities for approving programme changes (**MA 6**).

2.42 Increases in the supply contractor costs have been minimal to date (£38,793, of which £19,535 was due to the extension of the contractor programme due to

additional time required by Health Board partners to prepare for "Go live"). These have been accommodated within the approved budget. However, the time implications of contract changes were not included within either the change schedule or change authorisation forms. This should also identify responsible parties for delay, to inform any contractual liabilities or claims (**MA 7**).

2.43 While noting the above matters, noting delivery performance to time and cost, together with controls operated, a **reasonable** assurance is determined in relation to project management.

Appendix A: Management Action Plan

Matter Arising 1: Governance arrangements (Design)		**Impact**
Welsh Health Circular 2018 (043) - NHS Wales Infrastructure Investment Guidance requires specification of the programme delivery and governance arrangements within the Business Case. These were variously defined in both the Full Business Case (FBC) and Programme Definition Document, showing escalation arrangements to the Quality, Patient Experience & Safety Committee, as well as interface between the Programme Board, the Executive Management Team, and the Strategic Transformation Board. The Clinical Transformation Board was attended by both the Executive Medical Director, and the Project Executive officer. However, this Board was newly introduced subsequent to compilation of the Programme Definition Document. The defined structures therefore required update to reflect those operating.		Potential risk that: • The programme is not effectively governed.
Recommendations		**Priority**
1.1 Management should update governance arrangements to reflect current operational arrangements.		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
1.1 Agreed. Update Programme Definition Document to include reference Clinical Transformation Programme Board – to come to ePCR Programme Board for approval and sign-off.	End of December 2022	ICT Project Manager

Matter Arising 2: Stakeholder agreements / engagement (Design)	**Impact**
Noting the wide range of stakeholders identified at the Programme Definition Document, best practice would require the development and implementation of a stakeholder engagement plan and associated stakeholder forums through the development and implementation of the programme. This would typically be provided in the first instance by formal letters of support for the Business Case by Chief Executive Officers (containing the proposed programme). Additionally, it is normally evident that users / stakeholders finalise and sign off their requirements in order to reduce the potential for programme changes (DHCW engagement is considered further at **MA 4**). Letters of support from third parties form part of the Welsh Government inclusion checklist for business cases submissions. However, in this case the Trust advised that they were not applicable for inclusion (being an electronic replacement of a paper information to third parties). In the case of ePCR, the key requirements were for user sign off of the agreed implementation time-tables and training. External stakeholders were informed by letter that ePCR forms part of a "Welsh Government sponsored" implementation. As such, management advised that this was the reason that formal stakeholder agreements were not obtained. A programme stakeholder and communication approach document was maintained, detailing engagement with all parties at each programme stage – the majority of which confirmed "significant" involvement. However, involvement of Emergency Departments was stated to be "minimal" at both the business case, and early development stages. While there were a range of communications, and presentations to relevant Health Board leads and key staff, it was evident that some issues were resolved at live implementation as recorded in issue logs. Such issues have therefore included workforce implications, and post-implementation training. However, these have not delayed implementation or resulted in additional programme costs. For context, some key dates were:	Potential risk that: • Lessons are not learnt

FBC Endorsement by Welsh Government	15th December 2020
Supplier contract commencement	8th February 2021
Welsh Government required core deployment (in September 2021 at SRO appointment)	30th November 2021
Go Live deadline (core elements) & Digipen withdrawal	31st March 2022

Management have commented that there was a "*lack of responses to formal letters to the Health Boards from the Trust.*" Via escalation and provision of a dedicated Implementation Manager supplied by WAST, "Go live" for the final Health Board area was achieved on 29th March 2022.

However, issues such as those noted above, show that there may be benefit in particularly reviewing any lessons around engagement.

While Health Board leads were informally nominated as programme links, it would be beneficial for such a collaborative programme if governance arrangements also specified third party leads, to facilitate jointly planning and programme management. This should include agreed monitoring and escalation arrangements for any issues arising.

Recommendations	Priority
Future assurance 2.1 Management should consider the timing and method of engagement of health bodies within lessons learnt e.g. formal letters of support for Full Business Case plans from CEO's.	**Medium**
Future assurance 2.2 Terms of reference, roles and responsibilities should be agreed with third parties to facilitate effective planning, management, and escalation arrangements.	**Medium**

Agreed Management Action	Target Date	Responsible Officer
2.1 Agreed. WAST to run an ePCR lessons learned workshop in Q4 2022/23	By end of Q4 2022/23	Interim Assistant Director for Research, Audit and Service Improvement & Assistant Director of Planning & Transformation
2.2 Agreed. WAST to run an ePCR lessons learned workshop in Q4 2022/23	By end of Q4 2022/23	Interim Assistant Director for Research, Audit and Service Improvement & Assistant Director of Planning & Transformation

Matter Arising 3: Benefits realisation (Operation)		**Impact**
NHS Wales Infrastructure Investment Guidance WHC 2018 (043) outlines the "*requirement*" for the service delivery model to be supported. The funding approval letter from Welsh Government (of 15th December 2020), additionally stated the need to specify agreed benefits. While a benefits register has been produced, quantified targets for all benefits have yet to be specified e.g. the ability to divert from A&E to clinic referral.		Potential risk that: • Service efficiencies are not optimised.
Recommendations		**Priority**
3.1 Management should ensure that quantified, measurable and achievable targets are set for benefits realisation.		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
3.1 Agreed. Benefits realisation to be completed by the end of the funded programme. IMTP has the benefits realisation to be completed by the end of Q4 2022/23 ongoing piece of work that has been delayed, but will be completed by end of Q4.	End of Q4 2022/23	Assistant Director of Planning & Transformation

Matter Arising 4: Lessons learnt (Operation)	**Impact**
Welsh Health Circular (WHC) 043 (2018) – NHS Wales Infrastructure Investment Guidance, requires Health Boards to undertake a post programme evaluation delivered schemes. While the core elements of the programme have been reported as successfully delivered to date, there have been pressures and issues along the way. These have included the need to engage agency staff and priced extensions to the supply contract. Potential issues (as noted in this audit) have included effective engagement with DCHW. The Stakeholder & Communication Approach detailed "significant" involvement of DHCW at project phase 1 (Feb – Nov 2021). There was engagement with DHCW both at the business case stage, and during the tender in June 2020. The Trust confirmed that the full technical specification was subsequently agreed with the supplier and DHCW during the 4 month period post signing of the contract. The Trust also engaged with DHCW prior to procurement, regarding interfacing into NHS Wales Systems. However, some issues relating to effectiveness of engagement with DCHW were evident. The audit also found escalation of issues relating to Digital Health and Care Wales engagement during 2021 and into 2022, during a time frame in which contractual delivery had commenced. The supply contract agreed a contract commencement of 8th February 2021, and delivery date for all elements by 18th November 2021. This date was based on their tender response (in July 2020) - supplying an existing system already operational elsewhere. However, required interfaces were only specified and agreed subsequent to contract commencement. Accordingly, contractual plans were initially extended from 18th November 2021 to 31st March 2022, at no additional charge from the supplier (to co-ordinate with both health bodies and DHCW). They were subsequently extended to 24th August at a charge of £19,535, and at the time of audit a revised plan had been agreed for 24th February 2023 (for which associated charges by the contractor await confirmation). These dates remain within the agreed Welsh Government targets of delivery by 31st March 2023. Management have confirmed that these latter extensions to the supply contract were planned in as contingency, as the details of functional design were not available until after the design stage.	Potential risk that: • Lessons are not applied to future projects or programme stages.

It would therefore be useful to consider the extent to which broad DHCW resource and time could be reserved at an earlier stage, or perhaps a time window built into the contract to permit better co-ordination with both DHCW, the contractor, and engagement of a programme team. Recruitment of the programme team also presented a timing issue. This could not commence until post FBC funding approval. Following a 3 – 4 month job evaluation of the new roles, initial advert during the Covid period met with no qualified applicants. Following further lead times for advert, and notice periods, this meant that the key roles of Project Team Manager, and Project Support Officer were not engaged until August 2021. In the interim, to April 2021, key programme and project lead roles were fulfilled by the Business Manager within the Medical Directorate (appointed in April 2021 as the Programme Manager). The most recent Project Manager was the third in post, with interim infill by the Programme Manager. This meant that the programme / project support officers averaged 2.5 staff over the first year compared to a target team of 8. This also impacted upon the early establishment of project structures. While a Project Board was created in 2018 an executive Programme Board was not created until May 2021 (in the period of contract performance).	

Recommendations	Priority
4.1 Management should undertake a lessons learnt review, with particular focus on enhancing DHCW and contractor co-ordination, and sufficient lead time for DCHW and mobilisation of a programme team.	**Medium**

Agreed Management Action	Target Date	le Officer
4.1 Agreed. WAST will undertake an ePCR lessons learned workshop in Q4 2022/23 This will additionally need to recognise the context of Covid-19.	End of Q4 2022/23	Interim Assistant Director for Research, Audit and Service Improvement & Assistant Director of Planning & Transformation

In 2020 during the height of the pandemic, the Trust were not allowed to send programme delivery staff into Emergency Departments to scope business change to the risks that contracting COVID posed. From March 2020 the programme team were not allowed to enter WAST offices and were provided with equipment to work from home. When lock down was lifted there was still a reluctance from Health Boards to allow any programme staff onto their sites for fear of carrying or contracting COVID on sites. Microsoft Teams was not fully rolled out in the Welsh NHS until after COVID 19 lockdown so was not established as a form of communication early in the programme. No access to offices prevented face to face meeting and any access to Video Conferencing facilities was blocked as these were predominantly available in NHS buildings. <u>Recruitment</u> Covid-19 also formed a significant part of the context here. It also took 9 months from having a job description to the start date for the candidate. This was a major problem in recruitment to all the posts. We did not anticipate having to job match posts, having recruited such positions previously, and this interaction will also be something to consider at future projects (which included time involvement by the Programme Manager for the job match panel). Additionally, by that point the UK Government has introduced the national Furlough Scheme which had a direct impact on recruitment.		

There were also potential issues as the ePCR Team roles that would involve being on site in high risk health care facilities at a time when fatalities were high prior to the UK vaccination programme. Evidence of the Trust and hospital rules are documented in the COVID enquiry report.		

Matter Arising 5: Risk register (Design)		**Impact**
The NHS Wales Infrastructure Investment Guidance states: *"Risk registers for each individual project/programme must be completed, shared and monitored, with reference not only to time, cost and quality but also operational/service impacts, functionality and benefits realisation"* As the programme progresses, and requirements become firmer, so the risks in future works and commitments are reduced. The estimated contingency requirement should be periodically updated to reflect this. While top risks were profiled at reporting, associated time and cost implications were not included. Noting the above, the risk register could usefully sum an assessment of mitigated time and cost risks for comparison to remaining contingency. Noting the absence of individual time and cost quantification at the risk register, recognising the maturity of the project (and associated risks), there would remain benefit in confirming an appropriate methodology for assessing the aggregate time and cost implications of remaining risk for comparison to remaining contingency. Note – specific recommendation is not being made here as to the system or mechanism by which the above is achieved.		Potential risks that: • Risks are not appropriately managed • Contingency is not appropriately managed
Recommendations		**Priority**
5.1 Management should confirm an appropriate methodology for assessing the aggregate time and cost implications of remaining risk for comparison to remaining contingency		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**

5.1 – Agreed – we will review the mechanisms utilised for risk management for appropriate functionality as part of a broader lessons learned exercise.	n/a	Not applicable

Matter Arising 6: Change control responsibilities (Design)	**Impact**
Best practice would assign the Programme / Project Board as the accountable body for programme delivery. The Business Case includes a section for change control which refers to the Clinical Reference Group as having responsibility for authorising changes. Responsibilities of key programme / project managers were also defined for scrutinising and managing change. A range of bodies were also involved in approving changes (as applicable), notably: • the ICT Change Advisory Board – providing permission to proceed with new releases; • the Health Informatics Change Advisory Board – providing permission to proceed with database changes; and • the ePCR Clinical Reference Group – providing permission to proceed with new developments to the application. However, terms of reference of the Project Board did not include change control, and those of the Programme Board included only understanding and managing the impacts of change. The change control log listed the authorising "change forums" to have included the ICT Clinical Advisory Forum, and individual officers. While supporting groups may apply expert scrutiny and advice, the Programme and Project Boards approval roles should be clarified.	Potential risk that: • The accountable parties are not appropriately involved in programme authorisations of time and cost changes.
Recommendations	**Priority**
6.1 The approval roles of the Programme and Project Boards should be specified.	**Medium**

Agreed Management Action	Target Date	Responsible Officer
6.1 Update Programme Definition Document to reflect approval roles and bring to ePCR Programme Board for approval.	End of December 2022	ICT Programme Manager

Matter Arising 7: Time - Change control (Design)	**Impact**
The change control register acts as the prime control document summing total programme cost changes. It was supported by change control authorisations. The contract details (at clause 19.3.4) that where delays occur due to the contractor, that they may be liable for "*the extra costs of management time*". A paper submitted to the Programme Board on 11th April 2022 details that the contractor has not been responsible for any such delay. The contract was initially extended free of charge from 18/11/21 to 31/3/22, but the contractor has levied an additional charge of £19,535 due to further client delay to 24th August 2022 (due to additional time required by Health Board partners to prepare for "Go live"). While the additional costs were approved as part of the change control process, there was therefore a need to identify time implications of any changes (and any additional resultant costs), assigning responsibility to the client or the contractor. While both the change control register and authorisation forms included costs, they did not separately identify time implications.	Potential risk that: • Management are not appropriately informed

Recommendations	**Priority**
7.1 Time implications of change control, designating client or contractor liability should be included at both change authorisations and the change control register.	**Medium**

Agreed Management Action	**Target Date**	**Responsible Officer**
7.1 Agreed – we will review the mechanisms utilised for risk management for appropriate functionality as part of a broader lessons learned exercise.	End of Q4 2022/3	Interim Assistant Director for Research, Audit and Service Improvement & The Assistant

		Director of Planning & Transformation

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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Archwilio Cymru
Audit Wales

Audit Committee Update – Welsh Ambulance Service NHS Trust

Date issued: November 2022

Document reference: 3257A2022

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

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

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Contents

Audit Committee update:

Audit Committee Update

About this document

1 This document provides the Audit Committee with an update on current and planned Audit Wales work.

2 Accounts and performance audit work are set out in this update, and information is also provided on the Auditor General's wider programme of national value for money examinations and the work of our Good Practice Exchange (GPX).

Accounts audit update

Exhibit 1 summarises the status of our key accounts audit work.

Exhibit 1 – Accounts audit work

Area of work	Current status
Audit of 2021-22 Financial Statements	Complete The Auditor General certified the Performance Report, Accountability Report and Financial Statements on 15 June. They were laid by the Senedd on 17 June, with a published statement by the Welsh Government.
Audit of the 2021-22 Charitable Funds' Financial Statements	In progress Draft audit plan has been shared with officers for review and fieldwork is due to commence early December 2022.

Performance audit update

3 The following tables set out the performance audit work included in our current and previous Audit Plans, summarising:

- work that is currently underway or completed (**Exhibit 2**); and
- planned work not yet started or revised (**Exhibit 3**).

Exhibit 2 – Work currently underway

Topic	Focus of the work	Current status and Audit Committee consideration
Quality Governance	As an extension to structured assessment, this work considered the structures, information and assurance flows that support quality governance.	Completed Presented to Audit Committee in September 2022
NHS Structured Assessment 2022	A review of the corporate arrangements in place at the Trust in relation to: • Governance and leadership. • Financial management. • Strategic planning • Use of resources (such as digital resources, estates, and other physical assets).	Clearance – Reporting to Board in January 2022 and Audit Committee in March 2022
Review of Unscheduled Care	This work will examine different aspects of the unscheduled care system and will include analysis of national data sets to present a high-level picture of how the unscheduled care system is currently working. Once completed, we will use this data	Blog and data tool published in April 2022 Part 1: Fieldwork underway Anticipated to report to Audit Committee in Spring 2023

Topic	Focus of the work	Current status and Audit Committee consideration
	analysis to determine which aspects of the unscheduled care system to review in more detail.	

Exhibit 3 – Planned work not yet started or revised

Topic	Focus of the work	Current status
Workforce planning	An assessment of workforce risks that NHS bodies are experiencing currently and are likely to experience in the future. The review will examine how local and national workforce planning activities are being taken forward to manage those risks and address short-, medium- and longer-term workforce needs	Fieldwork due to begin early 2023.

Good Practice events and products

4 In addition to the audit work set out above, we continue to seek opportunities for finding and sharing good practice from all-Wales audit work through our forward planning, programme design and good practice research.

5 There have been a number of Good Practice Exchange (GPX) events since we last reported to the Committee. Details of previous sessions can be found here. The next event is on the 7th of December Making Equality Impact Assessments more than a tick box exercise | Audit Wales. Details of future events are available on the GPX website.

NHS-related national studies and related products

6 The Audit Committee may also be interested in the Auditor General's wider programme of national value for money studies, some of which focus on the NHS and pan-public-sector topics. These studies are typically funded through the Welsh Consolidated Fund and are presented to the Public Accounts Committee to support its scrutiny of public expenditure.

7 The Audit Committee might also wish to be sighted of the recently published Audit Wales strategy, **Assure, Explain, Inspire: Our Strategy 2022-27**. This strategy sets out our 5-year vision to drive improvement and support Welsh public Services as they adapt to the challenges and opportunities of a changing world.

8 **Exhibit 4** provides information on the NHS-related or relevant national studies published during the past six months. It also includes all-Wales summaries of work undertaken locally in the NHS.

Exhibit 4 – NHS-related or relevant studies and all-Wales summary reports

Title	Publication date
Poverty in Wales data tool	November 2022
Time for Change – Poverty in Wales	November 2022
National Fraud Initiative 2020-21	October 2022
Equality Impact Assessments: More than a Tick Box Exercise?	September 2022
NHS Wales Finances Data Tool - up to March 2022	August 2022
Public Sector Readiness for Net Zero Carbon by 2030	July 2022
The Welsh Community Care Information System update	July 2022
Assure, Explain, Inspire: Audit Wales Strategy 2022-27	June 2022

9 **Exhibit 5** provides information on NHS-related or relevant national studies work in progress with indicative publication dates.

Exhibit 5 – NHS-related or relevant studies and all-Wales summary work currently in progress

Title	Indicative publication date
Orthopaedic services	2022
Unscheduled care – a whole system view	2022-23

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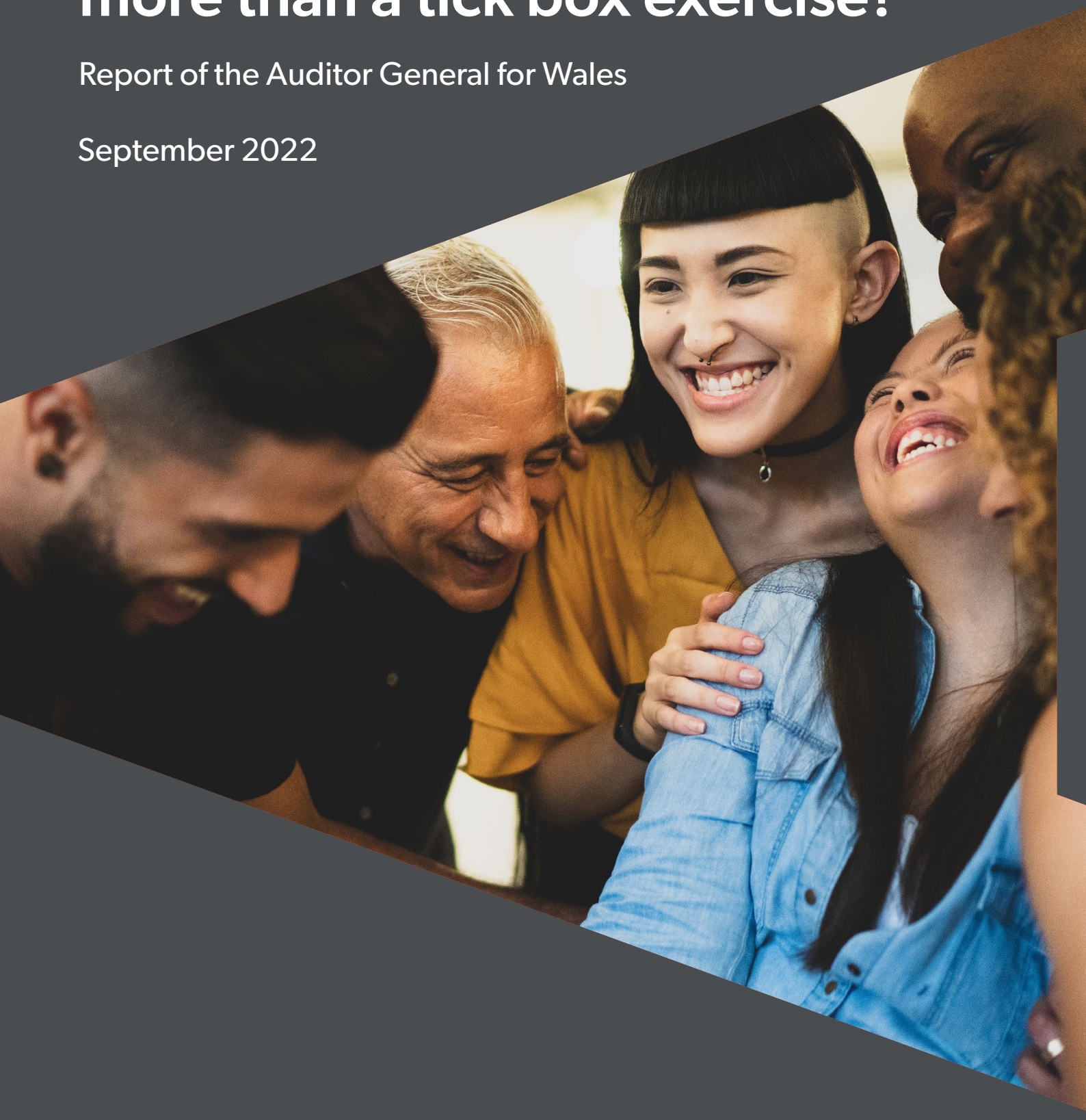
We welcome correspondence and telephone calls in Welsh and English. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Archwilio Cymru
Audit Wales

Equality Impact Assessments: more than a tick box exercise?

Report of the Auditor General for Wales

September 2022



This report has been prepared for presentation to the Senedd under section 145A of the Government of Wales Act 1998.

The Auditor General is independent of the Senedd and government. He examines and certifies the accounts of the Welsh Government and its sponsored and related public bodies, including NHS bodies. He also has the power to report to the Senedd on the economy, efficiency and effectiveness with which those organisations have used, and may improve the use of, their resources in discharging their functions.

The Auditor General also audits local government bodies in Wales, conducts local government value for money studies and inspects for compliance with the requirements of the Local Government (Wales) Measure 2009.

The Auditor General undertakes his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.

For further information, or if you require any of our publications in an alternative format and/or language, please contact us by telephone on 029 2032 0500, or email info@audit.wales. We welcome telephone calls in Welsh and English. You can also write to us in either Welsh or English and we will respond in the language you have used. Corresponding in Welsh will not lead to a delay.

Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

Contents

Auditor General's foreword

Discrimination and inequality continue to impact on the quality of life and life chances of people in Wales. My Picture of Public Services 2021 report highlighted that the COVID-19 pandemic had amplified some of the entrenched inequalities in our communities. Black Lives Matter, MeToo and other social movements have brought issues of discrimination and inequality to the forefront of public policy and debate.

Equality Impact Assessment (EIA) is an important part of the approach to tackling inequality in Wales. EIAs help public services meet their legal duties to avoid discrimination in the decisions they make and to promote equality of opportunity and cohesion.

Done well, EIAs are more than a means to show compliance. They support the growth of a mind-set and culture that put issues of equality at the heart of decision-making and policy development.

Our work shows that within individual public bodies there are good examples of aspects of the process of conducting an EIA. Through this report, I want to help all public bodies learn from those that are doing well and trying new approaches.

However, what we have seen and heard tells us that public bodies in Wales tend to use their EIAs defensively. Too often, they seem like a tick box exercise to show that the body has thought about equality issues in case of challenge. While legal challenge is of course an important risk to manage, this approach means public bodies are not using EIAs to their full potential, especially in terms of promoting equality and cohesion.

I hope this report will be of interest to anybody involved in public services and with an interest in tackling inequality and promoting equality. However, I want this work to be more than interesting. It needs to have an impact. Specifically, I expect:

- the Welsh Government to respond to the recommendations to work with partners to improve and update the overall approach to EIAs;
- all public bodies to respond to the recommendation that they review their own approaches to EIAs, including mindset and culture, drawing on the findings of this report; and
- those involved in scrutiny to use this report to challenge their organisation's overall approach to EIAs and the quality of individual EIAs used to inform their decisions.

I am pleased to say that this work has already had positive impacts. Our fieldwork questions have prompted some public bodies to check aspects of their own arrangements. And we have shared emerging findings with some public bodies that were updating their approach to EIAs. Closer to home, at Audit Wales, we are looking closely at our own processes and procedures to reflect the lessons identified in this work.

Adrian Crompton
Auditor General for Wales

Key facts

We set out below some key facts about the population in Wales in the context of the nine protected characteristics under the Equality Act 2010.

26,754 pregnancies during 2021[8]

16.5% aged under 15[1]

3.9% people who identify as gay, lesbian, bisexual or other[6]

7.8% people from a Black, Asian or minority ethnic community[5]

50.1% people with religious belief[4]

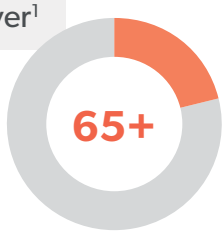
22.1% 16 to 64 year-olds identifying as disabled[2]

51.1% women[1]

48.1% people aged 16 and over who are married or in a civil partnership[3]

59% of transgender women and **56%** of transgender men said they avoided expressing their gender identity for fear of a negative reaction from others (UK)[7]

21.3% aged 65 and over[1]



3,107,500 population of Wales[1]

Sources:

1 Office of National Statistics (ONS), Population and household estimates, Census 2021, June 2022

2 StatsWales, Disability by age and sex (Equality Act definition) (2018-2020)

3 StatsWales, Marital status by age and sex (2018-2020)

4 StatsWales, Religion status by age (2018-2020)

5 ONS, Population estimates by ethnic group, England and Wales December 2021 (data for 2019)

6 StatsWales, Sexual identity by year, 2019

7 Government Equalities Office, National LGBT Survey, July 2018 (survey ran for 12 weeks from July 2017)

8 StatsWales, Initial assessment indicators for Wales, by mother's age, 2021

Key messages

Context

1 Tackling inequality is a long-standing goal of the Welsh Government. It features prominently in the 2021-2026 Programme for Government which includes the objective to 'celebrate diversity and move to eliminate inequality in all of its forms'[1]. The Well-being of Future Generations (Wales) Act 2015 makes 'A more equal Wales' a national goal. It defines this as 'a society that enables people to fulfil their potential no matter what their background or circumstances (including their socio-economic background and circumstances)'.

2 Equality Impact Assessment (EIA) is an important part of the approach to tackling discrimination and promoting equality in Wales. The Equality Act 2010 introduced the Public Sector Equality Duty (PSED) across Great Britain (**Exhibit 1**). The Welsh Government has made its own regulations[2] setting out some Wales specific duties that bodies listed in the Act need to follow to meet the PSED. Public bodies subject to the Act must assess the likely impacts of proposed policies or practices or proposed changes to existing policies or practices on their ability to meet the PSED. In doing so, they must comply with specific requirements to engage with groups likely to be impacted and monitor actual impacts.

1 Welsh Government, Programme for Government: update, December 2021
2 The Equality Act 2010 (Statutory Duties) (Wales) Regulations 2011

Exhibit 1: the Public Sector Equality Duty and protected characteristics

The PSED requires public bodies, in exercising their functions, to have due regard to the need to:

- eliminate unlawful discrimination, harassment, victimisation, and any other conduct prohibited by the Act;
- advance equality of opportunity between people who share a protected characteristic and people who do not share it; and
- foster good relations between people who share a protected characteristic and people who do not share it.

The protected characteristics are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation.

The Act and the Wales specific duties apply to public bodies including councils, NHS bodies, fire and rescue services, national parks, education bodies (further and higher education bodies and maintained schools), and the Welsh Government and some of its sponsored bodies.

3 An EIA can provide evidence that the body has met the PSED. There have been legal challenges to decisions based on the lack or adequacy of an EIA. Moreover, EIAs support good policy and decision-making more generally by:

- **ensuring decisions impact protected groups in a fair way** – EIAs can demonstrate what, if any, action could be taken to mitigate the impact on one or more protected groups negatively affected by a decision and to promote equality and cohesion;
- **support evidence-based policy or decision-making** – EIA is a clear and structured way to collect, assess and present relevant evidence to support decisions; and
- **making decision-making more transparent** – EIAs must be published where they show there is or is likely to be a substantial impact.

4 As well as the PSED, the Equality Act 2010 included provision for a new socio-economic duty for public bodies[3]. The socio-economic duty came into force in Wales on 31 March 2021. It requires that public bodies, 'when making decisions of a strategic nature about how to exercise its functions, have due regard to the desirability of exercising them in a way that is designed to reduce the inequalities of outcome which result from socio-economic disadvantage'. The Welsh Government advises public bodies to consider the socio-economic duty as part of existing processes, including impact assessments. We are currently reviewing local government's work to tackle poverty, including aspects of the socio-economic duty and the lived experience of people experiencing poverty.

About this report

5 We looked at the overall approach to undertaking EIAs in public bodies in Wales. To focus our work, we concentrated on the 44 public bodies originally subject to the Well-being of Future Generations (Wales) Act 2015. The main groups covered by the PSED that we did not include were the education bodies – further and higher education institutions and maintained schools – and Corporate Joint Committees.

6 We focused primarily on understanding public bodies' approaches with a view to finding good or interesting practice and identifying any common areas for improvement. We did not evaluate individual public bodies' approaches in detail. **Appendix 1** has more detail on our audit approach and methods. Where we identify individual bodies' practices, this is not to say that they are necessarily alone in having good or interesting practices in that area.

7 Parts one to three of this report set out the findings from our consideration of the EIA process at the 44 public bodies. Below, we set out the main areas for improvement we identified. These include issues that go beyond how public bodies are conducting specific parts of the processes and offer insight about the overall approach to assessing the impacts of policies and practices and the underpinning mindset and culture.

8 The Welsh Government is currently reviewing the PSED Wales specific regulations. We have framed our key improvement areas and recommendations in the context of the opportunity the review offers to clarify aspects of the overall approach to EIAs in Wales.

3 The duty lay dormant on the statute book as the UK Government did not commence it. The Wales Act 2017 gave new powers to the Welsh Ministers and allowed them to commence the duty in Wales. It covers most types of public bodies subject to the PSED.

Key improvement areas

9 Positively, there are examples of good practice in aspects of the EIA process across the public bodies we looked at. There is also non-statutory guidance from the Equality and Human Rights Commission (EHRC)[4] and on the Equality Impact Assessment In Wales Practice Hub (the Practice Hub) about the detailed processes for conducting an EIA. Many public bodies use this guidance to shape their approaches. However, there are areas for improvement (**Exhibit 2**).

Exhibit 2: key improvement areas for EIA

	Greater clarity over which type of policies and practices must be impact assessed
	Greater clarity about the arrangements for assessing the impact of collaborative policies and practices
	Greater clarity about expectations to consider the PSED as part of an integrated impact assessment
	Better and more timely identification of the practical impacts of decisions on people and how different protected characteristics intersect
	More engagement and involvement of people with protected characteristics
	Better monitoring of the actual impacts of policies and practices on people
	A shift in the mindsets and cultures to move EIA away from being seen as an add-on ‘tick box’ exercise

4 Equality and Human Rights Commission, Assessing Impact and the Equality Duty: A Guide for Listed Public Authorities in Wales, October 2014; and Equality and Human Rights Commission, Technical Guidance on the Public Sector Equality Duty: Wales, August 2014.

Greater clarity over which type of policies and practices must be impact assessed

10 There is scope for the Welsh Government, working with partners, to clarify its expectations around which type of policies and practices must be impact assessed. As drafted, the Welsh specific duties require public bodies to assess all new policies or practices, or those under review. However, the EHRC's non-statutory guidance recognises that 'policies and practices' is a broad category and says public bodies may need to prioritise. It introduces the concepts of 'proportionality' and 'relevance', which it says public bodies can apply through a process known as 'screening'.

11 We think the current position is open to interpretation in terms of whether proportionality and relevance mean public bodies should: (a) prioritise big decisions, like budget decisions or major service change; or (b) prioritise decisions that are likely to have a big impact on certain groups, for example, small scale decisions could have a large impact on one section of the population. Further, many bodies have interpreted proportionality as determining the amount of work needing to be done to assess impacts, rather than whether a policy or practice needs an EIA.

12 The EIAs or screening decisions that public bodies publish are usually those that go to their boards or cabinets. They therefore tend to be at the more strategic or impactful end of the scale. While we did not examine in detail practices at individual bodies, we think there is a risk that public bodies may be informally filtering out smaller scale policies and practices that do not require decisions from boards or cabinet, even though they may impact on people with protected characteristics.

Greater clarity about the arrangements for assessing the impact of collaborative policies and practices

13 There is scope to clarify how public bodies should do EIAs in an environment of increasing collaboration. The law places duties on individual public bodies. Since the legislation came into force, public bodies are increasingly developing plans and delivering services through collaborative arrangements. The Welsh Government updated the legislation to extend the PSED and Wales specific duties to Corporate Joint Committees in local government, but there are other collaborative arrangements not covered. These include Public Services Boards and Regional Partnership Boards as well as multiple service specific collaborations.

14 The Welsh Government has not produced stand-alone guidance on the use of EIAs by collaborative arrangements, although guidance for Public Services Boards highlights EIA requirements for individual public bodies[5]. The EHRC's 2014 guidance predates the creation of many of these arrangements and offers high level advice that there should be a shared approach but does not say how this should work in practice.

Greater clarity about expectations to consider the PSED as part of an integrated impact assessment

15 Increasingly, public bodies are integrating their EIAs with other impact assessments. While there is no legal requirement to integrate assessments, the Welsh Government's guidance on the Well-being of Future Generations (Wales) Act[6] emphasises the opportunities for bodies to integrate their approach to different duties, including those under the Equality Act 2010. Many of the equality officers[7] we spoke to said that integrating impact assessments led to a streamlined process and a more rounded approach to thinking about impacts. The key downside can be that the assessment is longer and can appear daunting. Our review of EIAs also identified a risk that integrated impact assessments dilute the focus on the impacts of policies and practices on people with protected characteristics.

16 Public bodies are inconsistent in what they include in an integrated impact assessment. Mostly, they collate separate assessments in one document, rather than produce a truly integrated analysis of impacts. There is no specific guidance to support public bodies in conducting integrated impact assessments. Many equality officers would welcome clearer guidance from the Welsh Government about its expectations.

Better and more timely identification of the practical impacts of decisions on people and how different protected characteristics intersect

17 There are examples of EIAs that clearly identify likely impacts on groups of people. However, many EIAs we reviewed were descriptive. They identified that a policy or practice might impact on a group of people. But they did not show how it would impact people's lives in practice. This makes it more difficult for decision-makers to assess how important the likely impacts are and if any mitigating measures proposed would be sufficient.

5 Welsh Government, Shared Purpose: Shared Future Statutory Guidance on the Well-being of Future Generations (Wales) Act 2015 (SFSP 3: Collective Role (public service boards)), February 2016.

6 Welsh Government, Shared Purpose: Shared Future Statutory Guidance on the Well-being of Future Generations (Wales) Act 2015 (SFSP 2: Individual Role (public bodies)), February 2016.

7 We have used the term 'equality officer' throughout this report to refer to staff in public bodies with specific lead specialist roles for equality, whether that be their full-time job or part of their role. The way these roles are structured, and their seniority, varies.

18 In general, public bodies tend to identify negative impacts that they need to mitigate where possible. They are less likely to identify potential ways that the policy or practice could positively promote equality of opportunity and cohesion, even though this is a requirement of the PSED.Few public bodies have fully grasped the complexity of identifying likely impacts of policies and practices. None of the EIAs we looked at considered what is known as 'intersectionality'; the way that different protected characteristics combine. For example, while an EIA may identify impacts for Muslim people, it may not recognise that impacts could be very different for a Muslim woman compared to a Muslim man.

19 Many public bodies are thinking about how to identify the cumulative impacts of multiple decisions but few are doing so. Most do not have supporting systems that would enable those conducting EIAs to access the information needed about other decisions.

20 Most public bodies' formal processes and guidance say they will start thinking about impacts very early in the policy development process. However, many of the equality officers recognised that in practice EIAs often start late in the process, sometimes very shortly before a decision is due to be taken. This reduces the scope to shape the policy or practice and to mitigate impacts.

More engagement and involvement of people with protected characteristics

21 There are examples of public bodies seeking views from people with protected characteristics and drawing on their lived experience as part of the EIA. However, some third sector bodies are concerned that this does not happen nearly enough. We found that where public bodies seek views these often form part of a broader open consultation rather than focussing on specific groups with protected characteristics.

22 Some third sector organisations said that listening to people with protected characteristics was the action that would most improve EIAs. National representative public bodies could not always respond to the number of requests to take part in EIAs they receive and did not always have knowledge or information to respond to local issues.

Better monitoring of the actual impacts of policies and practices on people

23 Public bodies need to do more to monitor the impact of policies or decisions on protected groups. Equality officers at individual public bodies identified very few examples of public bodies monitoring the actual impacts of a policy or decision once implemented. Those examples put forward generally reflected broader monitoring of a policy's objectives rather than whether the impacts identified in the EIA materialised or whether there were other unanticipated impacts.

A shift in the mindsets and cultures that moves EIA away from being seen as an add-on 'tick box' exercise

24 From what we have seen there has not been a sufficient change in the mindset and culture in public services to put issues of equality at the heart of policy making. The mindset revealed by the EIA is often defensive: using EIAs to prove the body has paid due regard to equality in case of political or legal challenge. Often, the EIA seems like an additional 'tick box' exercise to be complied with rather than a tool to promote equality.

4 Recommendations

Recommendations

Clarifying the scope of the duty to impact assess policies and practices

R1 There is scope for confusion about which type of policies and practices must be subject to an assessment for their impact on the public sector equality duty. **The Welsh Government should clarify its interpretation of the duty, including whether and how it expects public bodies to apply any test of proportionality and relevance.**

Building a picture of what good integrated impact assessment looks like

R2 Many public bodies carry out integrated impact assessments that include consideration of the PSED alongside other duties. But practice is inconsistent and often involved collating multiple assessments in one place, rather than being truly integrated, **to help maximise the intended benefits of integrated impact assessments, the Welsh Government should work with key stakeholders with an interest in the areas commonly covered by integrated impact assessments and those with lived experiences, to share learning and work towards a shared understanding of what good looks like for an integrated impact assessment.**

Recommendations

Applying the equality duties to collaborative public bodies and partnerships

R3 The public sector landscape has changed since the introduction of the PSED and the Welsh specific duties, with an increasing focus on collaborative planning and delivery. **The Welsh Government should review whether it needs to update the Wales specific regulations to cover a wider range of collaborative and partnership arrangements. These include public services boards, regional partnership boards and other service specific partnerships.**

Reviewing public bodies' current approach for conducting EIAs

R4 While there are examples of good practice related to distinct stages of the EIA process, all public bodies have lessons to learn about their overall approach. **Public bodies should review their overall approach to EIAs considering the findings of this report and the detailed guidance available from the EHRC and the Practice Hub. We recognise that developments in response to our other recommendations and the Welsh Government's review of the PSED Wales specific regulations may have implications for current guidance in due course.**

Supporting arrangements for conducting EIAs

01

1.1 Conducting an EIA can be complicated. Good support can help make the process of conducting EIAs easier and more effective by having a clearly spelled-out approach and process, underpinned by clear guidance and training. And public bodies can have expert advice to hand to support those involved in assessing the impacts of decisions.

Setting out the organisation's approach to EIA

What we looked for

A clearly spelled-out approach to EIA for the organisation, including whether the EIA should form part of a wider integrated impact assessment.

What we found

Almost all public bodies had a set process for conducting an EIA, although these vary from a stand-alone EIA to producing integrated impact assessments covering a wide and varying range of other legal duties and policy priorities.

Strategic equality plans

1.2 All 44 public bodies met the requirement to produce a Strategic Equality Plan (SEP). The SEP must include an organisation's equality objectives, how they will measure progress on meeting objectives, and how they will promote knowledge and understanding of the general and specific duty. The SEP must also set out the public bodies' arrangements for assessing the likely impact of policies and practices on their ability to meet the PSED. However, in our review of SEPs we found that only 17 of the 44 bodies did so and to varying degrees of detail.

1.3 A few public bodies have gone further than simply describing arrangements. For example, Conwy County Borough Council's SEP describes in detail its process for EIA, how its Cabinet uses EIAs to support decision-making, and scrutiny committees' role in ensuring the quality of EIAs. The Council's SEP also explains how it has used EIAs to inform its equality objectives.

Organisational approach – integrated and stand-alone assessments

1.4 Nearly all public bodies (42 of 44) have a set process for undertaking EIAs. Most said that they put information on intranet sites, alongside supporting documents, contacts and most often a Word template for completion. Our review of EIAs found no standard format across public bodies, although most closely followed the approach set out in the Practice Hub. Members of the North Wales Public Sector Equality Network[8] have worked together to develop a standard template which most members of the network have adopted at least in part.

1.5 In around two-thirds (30 of 44) of public bodies we spoke to, the EIA forms part of a wider integrated impact assessment. There is no common approach to integrated impact assessments and no national guidance on what should be covered. There are some assessments that public bodies commonly include alongside the PSED (**Exhibit 3**). Some include other legal duties as well as policy priorities and practical considerations, such as finance. For example, the Welsh Government's integrated impact assessments sometimes cover climate change impacts, health impacts and economic impacts as well as a wide range of other legal duties, depending on the nature of the policy or practice.

8 The North Wales Public Sector Equality Network is an informal network of public bodies working together to advance equality. Representation includes North Wales local authorities, Betsi Cadwaladr University Health Board, North Wales Police and Police Authority, North Wales Fire and Rescue Service, Welsh Ambulance Services NHS Trust, and Snowdonia National Park Authority.

Exhibit 3: assessments commonly included in an integrated impact assessment alongside the EIA

Well-being of Future Generations	The Well-being of Future Generations (Wales) Act 2015 introduced seven well-being goals for Wales. It also established the sustainable development principle and five ways of working – long-term, integration, involvement, collaboration, and prevention – to demonstrate application of the principle. An integrated impact assessment may also include an assessment of the policy or practice against the seven goals, public bodies' individual well-being objectives and/or the five ways of working specified in the Act.
Welsh Language	The Welsh Language (Wales) Measure 2011 declares that the Welsh language has official status in Wales. It makes provision to promote and facilitate the use of the Welsh language and to treat Welsh no less favourably than English through the Welsh language standards. Part of applying the standards means that public bodies must consider the effects their policy decisions on the Welsh language.
Environmental impacts	There are various duties to carry out environmental impact assessments depending on the nature of the proposed policy or practice. These range from strategic assessments of plans and programmes to assessments of projects that potentially impact on habitats and biodiversity.
UN Convention on the Rights of the Child	The Rights of Children and Young Persons (Wales) Measure 2011 embeds consideration of the United Nations Convention on the Rights of the Child and the optional protocols into Welsh law. The UN Convention consists of 41 articles, which set out a wide range of types of rights including rights to life and basic survival needs, rights to development including education and play, rights to protection, including safeguarding from abuse and exploitation, and rights to participation and express opinions.

Socio-economic	The Socio-economic duty came into force on 31 March 2021. When making strategic decisions, such as deciding priorities and setting objectives, public bodies must consider how they can reduce inequalities associated with socio-economic disadvantage.

1.6 Most integrated impact assessments involve collating separate impact assessments into a document template. Few seem to be a truly integrated impact assessment. Some public bodies are trying to make the connections between assessments and reduce duplication. For example, Carmarthenshire County Council, Powys County Council, Gwynedd Council, Denbighshire County Council and Wrexham County Borough Council have each developed, or are developing, an IT solution to bring together the relevant information needed to inform an integrated impact assessment.

1.7 Very few public bodies solely assess the impact on the PSED even when they do not consider their assessments to be integrated. In those public bodies that report having a standalone EIA process, the EIA often also includes Welsh-language and socio-economic impacts.

1.8 Previous research has found length is a barrier to the use of impact assessments in decision-making[9]. It was hard for us to judge any EIA or integrated impact assessment as too long as many factors affect the length including the nature of the policy or decision and the number of assessments undertaken. We reviewed some documents that were very long; for example, the integrated impact assessment of the Welsh Government's remote working policy was 45,000 words (average reading time 2.5 hours). The majority for which a word count was easily identifiable ranged between 2,500 and 7,500 words (average reading time 8 to 25 minutes).

1.9 Most public bodies that have chosen not to integrate their assessments had considered the option. Reasons for not integrating assessments included a concern that there would be insufficient regard to the PSED. This may be a valid concern. Our review suggests that, in some cases, the PSED is covered in limited detail and appeared secondary to other considerations even though all the public bodies we spoke to who conduct integrated impact assessments felt they sufficiently covered the equality element.

9 Grace, C., Reducing Complexity and Adding Value: A Strategic Approach to Impact Assessment in the Welsh Government, Public Policy Institute for Wales, February 2016.

Specialist support and expertise

What we looked for

That there is specialist support and expertise available in the organisation to those conducting EIAs.

What we found

In most cases, policy leads are responsible for conducting EIAs and can access support from colleagues with knowledge in equality related issues and an in-depth understanding of the organisation's process for conducting an EIA.

1.10 In almost all public bodies, responsibility to undertake an EIA lies with the lead officer developing or reviewing a policy or practice. This is partly pragmatic, due to the number of EIAs public bodies conduct. Equality officers told us this approach meant that EIAs benefitted from policy leads' expertise on the topic area. However, they identified drawbacks, including the difficulty of ensuring consistency, getting EIAs started at the right time and ensuring quality.

1.11 All public bodies have equality officers (or equivalent) with knowledge in general equality issues and a detailed understanding of the organisation's EIA process. In all public bodies, staff conducting EIAs can ask equality officers for guidance when required. EIAs are mostly conducted without the input of an equality officer. The process at Aneurin Bevan University Health Board is one exception to this, where the first step for anyone who thinks they need to undertake an EIA is to contact the Equality Diversity and Inclusion specialist to discuss the proposed policy or practice and agree what actions they need to take, with ongoing support also provided. In smaller public bodies, where an EIA is more likely to relate to staff policies and decisions, the lead for conducting the EIA is frequently an HR officer who is also the equality officer.

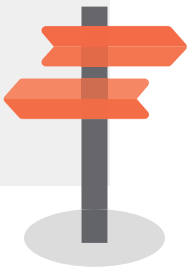
Guidance to support those conducting an EIA

What we looked for

That there is guidance to support those conducting an EIA, setting out what they need to do and when, in line with the duties and their organisation's chosen approach.

What we found

There is non-statutory national guidance and support available setting out some good practice in the stages of an EIA, although there are gaps, notably in terms of integrated impact assessments. Most public bodies have also produced their own guidance to support their EIA process.



External guidance

1.12 The Welsh Government has not published statutory guidance on the application of the PSED in Wales or the Welsh specific duties. The EHRC published non-statutory guidance on the Welsh specific duties in 2014. Welsh Government guidance encourages public bodies to integrate different duties. But there is no specific national guidance on how to conduct integrated impact assessments and what should be included.

1.13 The Welsh Government, Welsh Local Government Association, and NHS Centre for Equality and Human Rights jointly developed the Practice Hub in 2015-16. This online resource provides information and support to public bodies in Wales to undertake EIAs. It provides a detailed eight step guide to good practice in undertaking EIA and gives information on the Welsh specific duties.

Internal guidance

1.14 Internally, most public bodies have produced guidance to support their EIA process. The format and detail of the guidance and quality vary across public bodies. Some provide step-by-step guidance which outlines the process and steps for completing an EIA. Some embed practical information and links within templates.

1.15 A few public bodies do not provide guidance on their individual processes. Some of these provide direct one-to-one support from an equality officer (or equivalent) to the individual completing the assessment. Others signpost staff to the external guidance on the Practice Hub.

Training

What we looked for

That training on conducting an EIA is available for staff involved in developing EIAs and those that use them for decision-making.

What we found

Most public bodies offer training to those involved with EIAs through a variety of media.

1.16 Around two-thirds (31 of 44) public bodies we spoke to provide formal training to officers who are likely to complete or have an interest in EIA. This training frequently extends to elected members, board members and decision-makers.

1.17 Methods of training vary. Some offer face-to-face delivery of training, with much of this via video calls since the start of the COVID-19 pandemic. Many public bodies include online modules and e-learning tools on equality, and EIAs as part of their general staff training. Those public bodies that do not offer formal training nevertheless provide one-to-one support to individuals conducting EIAs and upskill them through the process.

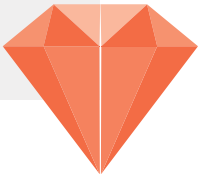
Quality assurance

What we looked for

An approach to ensuring the quality of the EIA process.

What we found

Half of public bodies had an approach to quality assurance, which varied from a simple sign-off on individual EIAs to more comprehensive peer learning to support improvement of the whole EIA process.



1.18 Half (22) of the public bodies have a quality assurance process in place for their EIA. The approach varies greatly. For some, quality assurance is about the quality of individual EIAs. Some require an EIA to be signed off by a senior officer. In Cardiff and Vale University Health Board, the lead officer conducting the EIA will work with an equality officer and a representative from Public Health Wales to review and interrogate the content of the EIA during its development. Other public bodies have begun to take a 'peer review' approach to developing EIA with input from experts from across the organisation.

1.19 A small number of public bodies use quality assurance to test the quality of their overall approach. For example, the Arts Council of Wales conducts an annual sample review of EIAs and uses the findings to improve the process.

Assessing impacts

02

2.1 The Wales specific duties require listed public bodies to assess the likely impact of proposed policies and practices, or those under review, on their ability to comply with the PSED. In doing so, they must have regard to certain types of information that they hold and meet specific requirements to engage with people or organisations that represent people with one or more protected characteristics. EHRC guidance and the Practice Hub set out in detail the steps public bodies can take to fulfil these requirements.

Screening

What we looked for

A clear approach to determining if an equality impact assessment is required.

What we found

Just over half of public bodies have a process for screening although many have stopped using screening, some due to risk of confusion or 'gaming' by staff.

2.2 There are no statutory exemptions setting out policies and practices that do not need to be assessed. However, the EHRC guidance and the practice hub include a 'screening' process to determine which policies or practices should have a full EIA.

2.3 Just over half (24 of 44) of public bodies we spoke to said that they have a screening process. Screening is most often a document template which an officer developing or reviewing a process or policy uses to determine whether they anticipate any impact on protected groups. The approach ranges in practice from a separate short impact assessment to a set of screening questions at the beginning of the full assessment template which determine whether to proceed with the full EIA.

2.4 Where a body decides it does not need a full EIA, they will usually retain a copy of the screening tool as evidence that it has considered the PSED. Most public bodies with a screening process will document the decision not to go ahead with a full EIA in the supporting papers that go to the cabinet or board.

2.5 Most often, the policy lead keeps the detailed record of screening. However, a few public bodies are trying to strengthen practice and ensure central records are maintained. For example, Cardiff Council has developed an online assessment tool to support policy leads through the process and encourage consideration of impact at the earliest stages of policy development. As well as sending advice and guidance to the officer completing the online assessment, the tool also sends a copy of the screening information to the equality officers.

2.6 The 20 public bodies who do not have a screening process had often consciously removed the screening step. Many said screening was an unnecessary step, as there are very few of their decisions that will not have potential to impact on the PSED. Some public bodies said that there was also scope for confusion, with lead officers completing a screening form, thinking it was an EIA. Others were concerned that some officers may 'game' the process: tailoring their responses to screening in a way designed to result in a decision that no further assessment was required.

2.7 Those public bodies that do not have a screening process usually provide additional guidance or a process chart, clarifying when to conduct a full EIA. All public bodies also offer the lead officer an opportunity to consult with an equality officer.

Timing

What we looked for

EIAs being started at an early stage to inform the development of a policy or decision.

What we found

All public bodies intend to carry out an EIA as early as possible, but many recognise this is often not the case in practice, and in some cases EIAs are very late in the policy development or decision-making process.

2.8 All 44 public bodies intend that EIAs should be started as early in the development or review of a policy as possible. But many public bodies acknowledged that this often does not happen in practice.

2.9 The timing of EIAs is affected by whether policy leads know that they are required to do an EIA and if resources – staff and time – are available at the appropriate point. Sometimes, if public bodies must make decisions very quickly, they either do not do an EIA or do them late in the decision-making process. This can be too late to consider changing a policy to lessen any possible negative impact or to build on positive impacts.

2.10 Decisions at the start of the COVID-19 pandemic were often made without an EIA. This reflected the urgency of decisions but meant that the impact on vulnerable people was not formally assessed. In August 2020, the Senedd's Equality, Local Government and Communities Committee[10] recommended that the Welsh Government should ensure that each major policy or legislative decision is accompanied by an effective equality impact assessment, and an analysis of the impact on human rights. The Welsh Government accepted the recommendation, and since August 2020 has published dozens of impact assessments related to the COVID-19 pandemic on its website.

10 Senedd Equality, Local Government and Communities Committee, Into sharp relief: inequality and the pandemic, August 2020.

2.11 In most public bodies, papers accompanying decisions that go to cabinets or boards contain a box or section that refers to consideration of the equality duties. This serves as a backstop to prevent public bodies from making decisions without any regard to the duties, even though this generally would be very late in the process.

Use of evidence

What we looked for

Use of a range of evidence to support the assessment, including the views of those likely to be impacted and data on lived experience.

What we found

Public bodies use a mix of evidence, although there are gaps in available data on some protected characteristics and the inclusion of the views and lived experiences of people with protected characteristics is patchy.

Quantitative data

2.12 EIAs need a sound evidence base to inform their conclusions. The depth and detail of the information base vary across organisations and by assessment The depth of information and analysis often depends on the scale of the decision and the availability of relevant and specific evidence.

2.13 All public bodies expect to include some quantitative data, such as demographic information or service level data. Around two-thirds (29 out of 44) of public bodies include at least some examples of internal information sources and point to publicly available data in their guidance and templates. Some go further. For example, Merthyr Tydfil County Borough Council includes in its guidance a detailed list of sources where policy leads can find relevant evidence, with embedded links to external data sources.

2.14 There are some significant data gaps in the data that is available to public bodies. Generally, there is little information available about some protected characteristics, particularly sexual orientation, gender reassignment, and pregnancy and maternity. Data that is available at a national level is sometimes not available at a health board, council, or ward level, which makes it difficult for public bodies to understand their local populations with protected characteristics.

Qualitative information

2.15 The inclusion of qualitative information based on the views and experiences of people with protected characteristics is also patchy. When introducing new policies or changing services public bodies often undertake a consultation exercise. In the examples we saw, these were often targeted to the public in general, and it was difficult to see if the public body had sought to engage specifically with people from protected groups.

2.16 Nonetheless, we did see examples of EIAs where evidence from engagement with groups was covered. For example, when Snowdonia National Park Authority undertook an EIA on its communication and engagement strategy, the assessment considered how the strategy could engage with people who speak languages other than English or Welsh. It also considered impacts on those who were digitally excluded, a group that is more likely to include older people and more women than men.

2.17 Some respondents to our general call for evidence said that drawing more on the views and experience of people with protected characteristics would improve the quality of EIAs. This includes engaging with individuals and grassroots organisations as well as national organisations representing protected groups. Some respondents said that public bodies should do more to publicise consultations by a range of means, including but not restricted to social media.

2.18 Some all-Wales third sector bodies responding to our call for evidence said that they were often asked to provide views for EIA and that some cannot respond to all the requests they receive. Sometimes they do not have information on local services and impacts.

2.19 A few public bodies are trying to draw on the lived experience of people with protected characteristics through different forms of consultation. Some use existing networks for staff with protected characteristics to understand different perspectives. Others, draw on existing relationships with third sector groups to understand the lived experience.

Identifying and mitigating likely impacts

What we looked for

Clear identification of likely impacts, including positive impacts in promoting equality, as well as negative ones.

Some consideration of cumulative impacts arising from other decisions that impact the same group or groups and how different protected characteristics combine (intersectionality).

Clear recommendations for mitigating negative impacts that have been acted on before the decision is made.

What we found

While there are examples of public bodies identifying specific impacts, often EIAs describe impacts in very broad terms. Very few identify the cumulative impacts of multiple decisions on groups or consider how different protected characteristics intersect. Very few can show how recommendations for mitigating impacts are followed through.

Specific impacts

2.20 Positively, our review of EIAs found examples of public bodies clearly identifying specific likely impact of policies or practices on protected groups. However, many EIAs included statistics to describe the population of people with protected characteristics without being clear how the policy or practice would likely impact on them. We also observed a tendency for EIAs to focus on negative impacts, thereby missing positive impacts and opportunities to improve cohesion and reduce inequalities.

2.21 We found that most EIAs reviewed provided data and information on each protected group separately. For example, the EIA on Conwy County Borough Council's Older Peoples' Domiciliary Care Finance and Commissioning Project set out the likely impact on people with each protected characteristic.

2.22 Most public bodies' approaches to EIA involve making recommendations to overcome negative impacts. Public bodies should incorporate mitigating actions into the policy development process, recognising it is not always possible to mitigate all negative impacts, such as with reductions in service. Very few public bodies have a process in place to track whether they have implemented the mitigating actions, after a decision is taken. In Hywel Dda University Health Board, the EIA has an associated action plan with a review date. In Aneurin Bevan University Health Board the Equality, Diversity, and Inclusion specialist keeps a database of actions arising from EIAs for monitoring purposes.

Intersectionality

2.23 Increasingly, it is understood that inequality is intersectional. People's characteristics interact in a complex way to give a unique experience of inequality. For example, the experience of a Muslim woman cannot separate 'female' and her experience as a Muslim. It will differ from that of a Muslim man and of a non-Muslim woman. However, we did not see examples of such nuanced understandings of inequality in the examples we reviewed.

Cumulative impacts

2.24 Public bodies in Wales make many decisions each year that, taken together, can be very detrimental to people from protected groups. For example, one respondent to our call for evidence gave the example of how individual decisions to reduce or close facilities and services such as public toilets, library services, day centres, and bus services had a cumulative impact on many older people who use the services. They said that, while each individual decision might not be significant, together they meant that some older people were becoming isolated.

2.25 The few instances we found where public bodies have begun to give thought to cumulative impacts tend to be when public bodies are making several decisions at the same time. For example, councils usually undertake a cumulative approach to assessing the impacts of their proposed budget each year. Individual service changes being proposed because of budget changes are assessed simultaneously allowing a better overview of potential impacts for the budget.

2.26 Typically, however, public bodies make decisions separately. One of the respondents to our call for evidence to decision-makers highlighted that it is difficult in principle to predict the likely impacts of multiple decisions in a complex landscape. Practically, the ability to take account of impacts from other decisions relies on the policy lead knowing about other decisions within an organisation and having access to the EIAs. A small number of public bodies are trying to address this information gap by using an IT solution to undertake the EIA (**paragraph 1.6**). This way, the assessment of impact for each policy change and decision is held centrally, making it easier for policy leads to bring together the information.

Decision-making

What we looked for

That the EIA and likely impacts it identifies are considered at the point of decision-making.

What we found

Equality officers' views varied around the extent to which their organisations prioritised the EIA in decision-making. Most respondents to our general call for evidence said public bodies did not pay sufficient regard to protected characteristics. The small number ofresponses from decision-makers suggest a view that the EIA is seen as a 'tick box exercise'.

2.27 The consideration given to EIAs in decision-making varies across public bodies in Wales. In general, equality officers felt that decision-makers take assurance in knowing that the policy lead has completed an EIA. Decision-makers will have access to a summary or the complete EIA accompanying each decision in their cabinet or board papers.

2.28 The equality officers we spoke to had mixed views over the extent to which their organisations placed sufficient weight on the EIA in decision-making. Over three-quarters of respondents to our general call for evidence who answered the question (29 of 37) disagreed that public bodies in Wales give appropriate due regard to people with protected characteristics when developing policies or making changes to services.

2.29 Generally, equality officers were not aware of instances where decision-makers challenged the content or recommendations of an EIA at the point of decision. Most felt that the accompanying EIA should have considered and shaped the policy sufficiently that there would be no need for such challenge at that late stage.

2.30 We only received ten responses to our call for evidence from decision-makers. While it is hard to draw conclusions from such a limited evidence base, it is notable that three of the ten referred to EIAs being used like a ‘tick box’.

Reporting and monitoring impacts

03

3.1 Public bodies must publish reports of the assessments where they show a substantial impact (or likely impact) on their ability to meet the PSED. They must also monitor the actual impact of the policies and practices subject to an equality impact assessment.

Reporting

What we looked for

Public information about decisions and a clear description of how the EIA has influenced the decision-making.

What we found

Most public bodies publish some of their EIAs as part of a wider set of papers and they are often not easy to find.

3.2 Almost all public bodies in Wales publish their EIAs, at least in part. Typically, they publish EIAs with decision-related papers, such as cabinet or board papers. There is usually a section on the body's website which holds all the papers for each meeting and is accessible to the public[11]. There are a few exceptions in some of the smaller public bodies, who do not routinely publish their EIAs.

3.3 It can often be difficult to find EIAs which relate to a specific decision on public bodies' websites. The EIAs which feature more prominently and are easier to locate often relate to strategic decisions such as budgets or key corporate strategies. Newport City Council have tried to bring EIAs into a central location on their website to make them more easily accessible, while recognising that this approach relies on the individuals completing EIAs sharing them for publication, which sometimes does not happen.

11 In some instances, bodies do not publish EIAs if they form part of a paper that is held back from publication due to its confidential or sensitive nature. However, these EIAs can sometimes be obtained via a Freedom of Information request if someone has a particular interest in seeing them.

Monitoring impacts

What we looked for

A clear approach to monitoring the impacts of the decision after it is implemented, including those identified as part of EIA as well as any unexpected impacts.

What we found

Very few public bodies monitor the impact of the decisions in the context of the PSED.

3.4 Some public bodies require those completing EIAs to identify a review date when monitoring is supposed to occur. We saw examples where EIAs set out plans for monitoring. For example, a Powys Teaching Health Board EIA included plans for monitoring service use after a change in surgery opening hours and for and independent evaluation of the service change. Also, Conwy County Borough Council's EIA for its review of domiciliary care included detailed arrangements for monitoring the impact using data and information that are routinely reported, including individual feedback from people receiving care.

3.5 However, equality officers had seen little evidence of the impact of policies and practices being monitored in light of the EIA. Those public bodies that outlined a monitoring process were often referring to the monitoring of an implementation of a policy or practice against its objectives or targets, not the impact that the decision had on people with protected characteristics.

3.6 In general, public bodies do not consider the impacts of policies and practices in terms of the PSED until there is another decision due on the same policy or practice. At that point, the body conducts a new EIA. Many of the equality officers we spoke to seemed unsure about how, in practice, they would monitor the impact of a decision on protected groups and would welcome more guidance.

Challenging EIAs

What we looked for

That the organisation identifies and applies lessons from any challenge to decisions on the basis of equality or the quality of the EIA.

What we found

Many equality officers did not think there had been any challenges to EIAs conducted by their organisation, but where there has been challenge some public bodies are using it as a learning opportunity.

3.7 Decisions made by public bodies can be challenged based on the EIA. Public bodies that do not have a clear record showing that they have considered the likely impacts of their decisions for people with protected characteristics leave themselves open to challenge. This could potentially include a judicial review. Some equality officers did not know what process someone would use to challenge an EIA. The majority said that any challenges would go through their general complaints process, with the involvement of the relevant service, equality officers and legal team.

3.8 Many equality officers thought there had not been any challenge to an EIA conducted by their organisation. Those that were aware of challenge taking place said that it was something that happens infrequently. Almost half of respondents to our general call for evidence who answered the question (17 of 35) said they had challenged some aspect of an EIA. We do not know if this was a formal or informal challenge.

3.9 Equality officers who had experienced challenge to an EIA said their organisation can resolve the issues either by making changes to a policy or practice, or by providing evidence that they had considered the impacts. Respondents to our general call for evidence gave examples of issues they raised being resolved. For example, one had objected to the EIA conducted on a new bus interchange because the council had not sought the views of people with protected characteristics on the proposals. Following their intervention, people with low vision visited the site and suggested changes to make the interchange more accessible.

3.10 While there are positive examples of public bodies responding to challenge, several respondents to our general call for evidence who had challenged aspects of an EIA reported not receiving any response to their challenge. A few equality officers told us that their organisation had learnt from the experience of having an EIA challenged. One had used examples of challenge from other public bodies to inform its EIA training as a particularly useful way of making impacts more easily understood to lead officers conducting EIAs.

Appendices

1 Audit approach and methods

1 Audit approach and methods

Audit approach

Our main aim was to provide insight about the approach to EIAs undertaken across the public sector in Wales. We wanted to highlight good practice and identify opportunities to improve. To help shape our thinking about what good practice to look for, we drew heavily on existing guidance materials, in particular that produced by the Equality and Human Rights Commission (EHRC) and the Equality Impact Assessment in Wales Practice Hub hosted by Public Health Wales NHS Trust.

We set out to explore to what extent public bodies have integrated their approach to undertaking EIAs, including the new socio-economic duty and the cumulative impact of decisions. We also explored what difficulties public bodies experience that affect the quality and timeliness of EIAs. We looked at how public bodies monitor the impact of decisions on their population. Each of the sub-sections in the main body of this report describes what we were looking for through our work.

In looking across the public bodies, we focused on the 44 public bodies originally subject to the Well-being of Future Generations (Wales) Act 2015. The Auditor General for Wales is the external auditor of each of these bodies, which include local authorities, health boards and some NHS trusts, national parks, and fire and rescue services. They also include the Welsh Government and some of its sponsored bodies. Our audit coverage did not include education bodies – further education, higher education or maintained schools – that are subject to the PSED. It also did not include the four Corporate Joint Committees (CJCs) established by the Local Government and Elections (Wales) Act 2021 and which are subject to the PSED.

Audit methods

Document review: We reviewed documents from each of the 44 public bodies, including those relating to the equality plans and details of the organisation's EIA process. We also reviewed details of their process for integrated impact assessments. We reviewed a sample of 29 EIAs provided by public bodies: 11 by local authorities, eight by health bodies, two fire and rescue, two national parks and six by the Welsh Government or its sponsored bodies.

Interviews: We interviewed the equality officers or their equivalent in each of the 44 bodies. We have used the term 'equality officer' throughout this report to refer to staff in public bodies with specific lead specialist roles for equality, whether that be their full-time job or part of their role. The way these roles are structured, and their seniority, varies.

Call for evidence: We sought wider views about people's experience of EIAs through a call for evidence between October 2021 and June 2022. We publicised this generally and in particular to third sector organisations. We received 40 responses, 23 from individuals and 15 responding on behalf of an organisation (two did not say).

We also sought the views of decision-makers through a separate call for evidence open between February and June 2022. We received ten responses (eight from individuals working in local authorities, one health and one fire and rescue).

While the responses we received to the calls for evidence are not necessarily representative of individuals, the third sector or decision-makers, they have provided useful detail which we have included through the report and which informed our overall analysis.

Stakeholder engagement: The EHRC is responsible for promoting and enforcing equality and non-discrimination laws. We met with officials in the EHRC Wales Team regularly throughout our work, discussing our scope and emerging findings. We also met with the Welsh Local Government Association's equality network and the Chair of the All-Wales NHS Equality Leadership Group. We interviewed officials from the Welsh Government with responsibility for equality policy.

Wider audit intelligence: We drew on existing intelligence from our local financial and performance audit work, where that was relevant to equality impact assessments.

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The National Fraud Initiative in Wales 2020-21

Report of the Auditor General for Wales

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Since we last reported on the National Fraud Initiative (NFI) in Wales in October 2020, outcomes valued at £6.5 million have been recorded. The cumulative total of outcomes from the NFI in Wales since NFI started in 1996 are now £49.4 million. Across the UK, the cumulative total of NFI outcomes is now £2.37 billion.

NFI outcomes in Wales decreased by £1.5 million to £6.5 million in the 2020-21 exercise. This was primarily because fewer ineligible claims for Council Tax Single Persons Discount and Housing Benefit claims were detected, reflecting the fact that some local authorities started review of NFI matches later than normal due to Covid-19 pressures.

Data sharing enables matches to be made between bodies and across national borders. Data submitted by Welsh bodies for the 2020-21 NFI exercise helped organisations in other parts of the UK to identify 153 cases of fraud and error with outcomes of £183,045.

While the majority of Welsh NFI participants display a strong commitment to counter fraud, 13 of the 22 Welsh local authorities identified 95% of the fraud and error outcomes achieved by the sector. This suggests that some local authorities have either failed to recognise the importance of the exercise or are unwilling to allocate adequate, skilled counter-fraud resources to investigate the NFI matches.

One Welsh local authority, Cardiff Council, agreed to participate in an exercise designed to identify fraud and error in applications for COVID-19 business support grants by verifying applicant bank details and trading status. These checks helped to identify outcomes of just under £0.6 million relating to 41 fraudulent or erroneous applications.

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Recommendations

- All participants in the NFI exercise should ensure that they maximise the benefits of their participation. They should consider whether it is possible to work more efficiently on the NFI matches by reviewing the guidance section within the NFI secure web application.
- Where local auditors recommend improving the timeliness and rigour with which NFI matches are reviewed, NFI participants should take appropriate action.
- Audit committees, or equivalent, and officers leading the NFI should review the NFI self-appraisal checklist. This will ensure they are fully informed of their organisation's planning and progress in the 2022-23 NFI exercise.

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NFI outcomes

NFI is a counter-fraud exercise across the UK public sector which aims to prevent and detect fraud. NFI uses data sharing and matching to help confirm that services are provided to the correct people.

An NFI outcome describes the overall amounts for fraud, overpayments and error that are detected by the NFI exercise and an estimate of future losses that it prevents.

The NFI recorded outcomes of £6.5 million in 2020-21.

NFI outcomes cumulatively in the UK since 1996-97

£2.37 billion

NFI outcomes cumulatively in Wales since 1996-97

£49.4 million

NFI outcomes across the UK from the 2020-21 exercise

£443 million

NFI outcomes in Wales from the 2020-21 exercise

£6.5 million

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Trends in outcomes

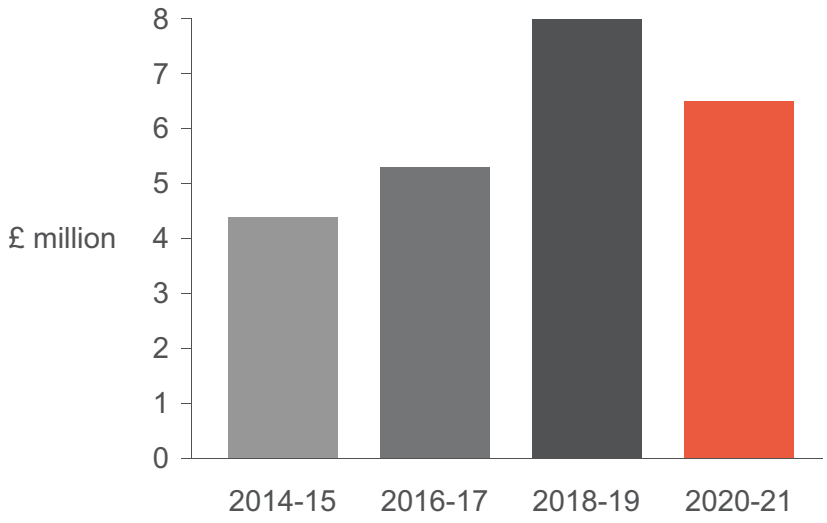
Outcomes in Wales have decreased by £1.5 million to £6.5 million in the 2020-21 exercise. Reasons for the decrease in outcomes include:

- the number of fraudulent or erroneous claims for Council Tax Single Persons Discount detected fell from 3,939 in the 2018-19 exercise to 1,987 in the 2020-21 exercise, resulting in outcomes in this area reducing by £2 million; and
- the number of fraudulent or erroneous claims for Housing Benefit detected fell from 179 in the 2018-19 exercise to 82 cases in the 2020-21 exercise, resulting in outcomes in this area reducing by £0.6 million.

The above fall in outcomes was offset in part by:

- an increase in the number of fraudulent or erroneous applications for social housing detected from 74 in the 2018-19 exercise to 237 in the 2020-21 exercise, resulting in increased outcomes of £0.6 million; and
- the detection of 43 fraudulent or erroneous claims for COVID-19 business support grants resulting in cumulative outcomes of £0.6 million.

Outcomes of £6.5 million were identified in the 2020-21 exercise



While overall outcomes have fallen, this is in part because many NFI participants started review of NFI matches later than normal due to work pressures arising from the COVID-19 pandemic.

The only UK nation which saw an increase in 2020-21 NFI outcomes was England. This increase was due to a significant increase in pension outcomes from matching UK-wide pension scheme data.

Late savings arising from NFI 2020-21 will be reported as part of the NFI 2022-23 exercise.

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How the latest outcomes compare to the last exercise

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Seven areas generated almost 98% of outcomes

The areas which generated the most outcomes from the current exercise are as follows:

Category	£	Cases
Council tax discounts	£2.6m	1,987
Blue badges	£1.4m	2,717
Housing waiting lists	£0.8m	237
Housing benefit	£0.6m	84
COVID-19 business support grants	£0.6m	43
Council tax reduction scheme	£0.2m	214
Creditor payments	£0.1m	9

Once overpayments have been identified, public bodies can take appropriate action to recover the money. As at 31 March 2022, 81% of overpayments had been recovered or were in the process of being recovered.

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Council tax discounts

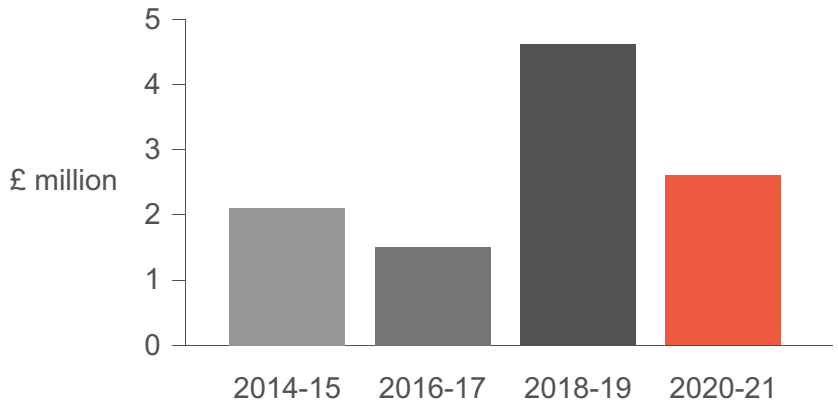
People living on their own, or with no countable adults in the same household, are eligible for a 25% single person discount (SPD) on their annual council tax bill.

Council tax SPD data is matched to electoral register data to help find where people are receiving the discount, but are not the only countable adult at their residence.

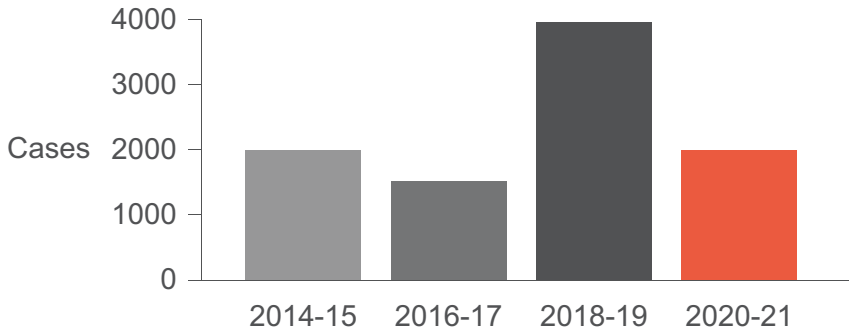
The 2020-21 NFI exercise found that the total council tax discount incorrectly awarded across Welsh local authorities totalled £2.6 million. This is an average outcome of £1,305 for each case (£1,003 per case in the 2018-19 NFI). Review of the NFI matches led to the cancellation of 1,987 SPD claims.

While the number of fraudulent or erroneous SPD claims detected fell from 3,939 to 1,987 in the current exercise, this is partly due to investigation of the matches being delayed due to the COVID-19 pandemic. Many claims have been cancelled since the cut-off date for reporting the NFI 2020-21 exercise and these 'late results' will be reported within NFI 2022-23.

Outcomes of **£2.6 million** in 2020-21



1,987 cases in 2020-21



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Pensions

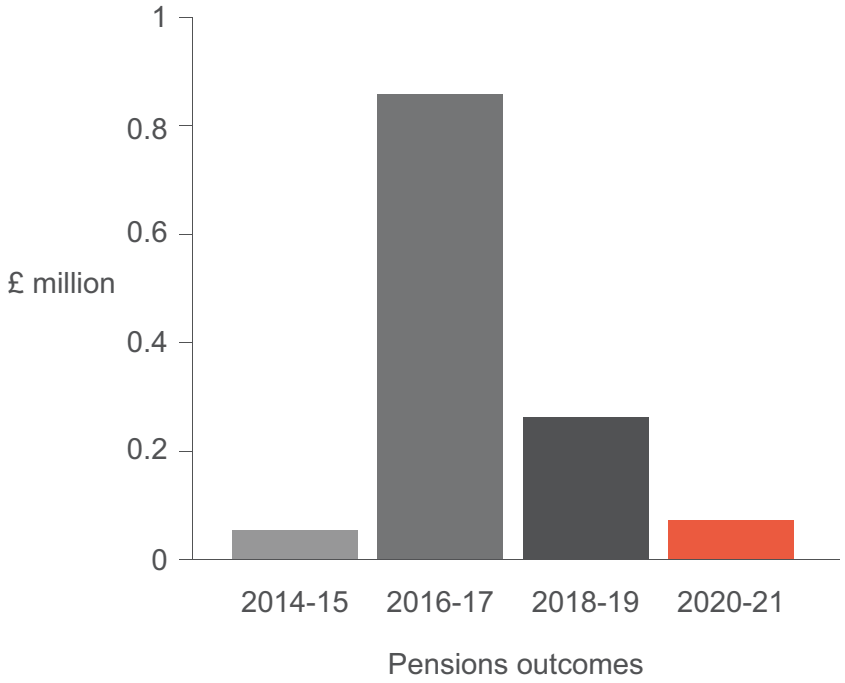
The NFI provides local authorities that administer pensions with an efficient and effective way of checking that they are only paying people who are alive.

The exercise found nine instances where pensions had remained in payment after pensioners had died compared to ten cases in NFI 2018-19.

In total, pensions outcomes for the 2020-21 NFI exercise are £0.073 million.

This is a reduction of £0.26 million from the 2018-19 NFI exercise, and reflects the continuing impact of the 'tell us once' reporting process which is ensuring that local authorities become aware of the decease of pensioners earlier. While the number of cases detected by NFI has remained almost unchanged from NFI 2018-19, the average value of each case has fallen from £26,396 to £8,160, because the period of time pensions remained in payment after pensioners' death was shorter.

Outcomes of **£0.073 million** in 2020-21



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Housing benefit

The NFI provides local authorities and the Department for Work and Pensions (DWP) with the opportunity to identify a wide range of benefit frauds and errors.

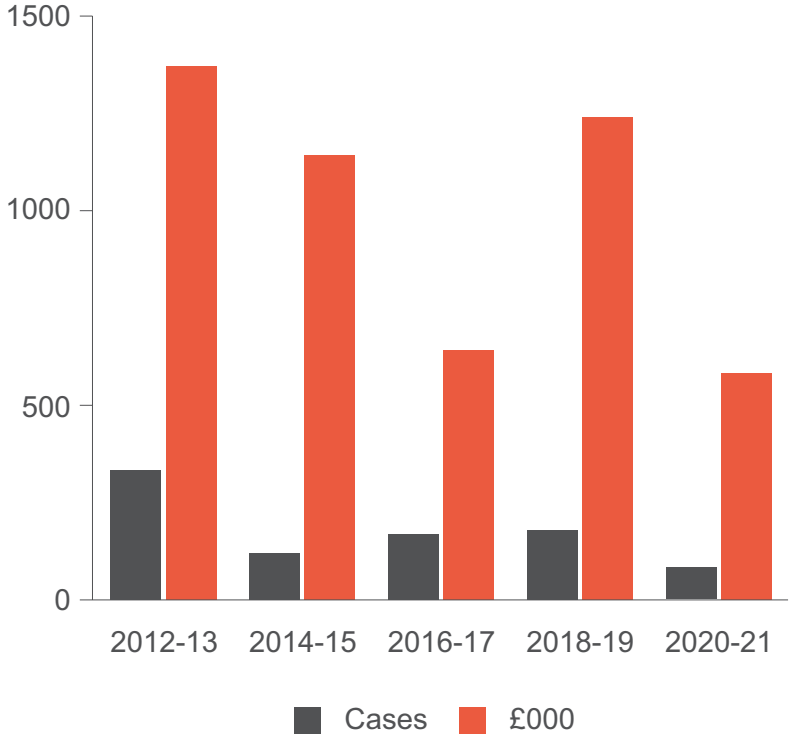
Housing benefit data is matched to student loans, payroll, pensions, housing benefit, housing tenants, licences, deceased person and Amberhill* data to help identify ineligible claims.

The value and number of housing benefit cases recorded with overpayments has reduced from £1.2 million (179 cases) in the 2018-19 exercise to £0.6 million (82 cases) in the 2020-21 exercise.

The fall in housing benefit cases outcomes is mainly due to matches between housing benefit and payroll and pension payments not being included in the 2020-21 exercise. These matches historically identified significant outcomes. These matches were not included as similar data matching is undertaking by the DWP's Verify Earnings and Pensions (VEP) Alerts service which identifies discrepancies between payroll and pension details held by HM Revenue & Customs and council benefits services. Alerts from VEP are sent to local authorities to investigate discrepancies.

*Amberhill is a system used by the Metropolitan Police to authenticate documents presented for identity.

Outcomes of **£0.6 million** in 2020-21



The majority of fraudulent and erroneous claims for housing benefit detected by local authorities in the 2020-21 exercise related to students who were in receipt of housing benefit when not entitled.

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Case Study: Housing benefit

Carmarthenshire County Council

The Council continues to recognise the value of NFI in protecting the public purse against the threat of fraud risks and considers NFI as being invaluable in the detection and prevention of fraud. The NFI 2020-21 exercise identified 33 housing benefit to student loan matches and of these 13 were high risk matches. Historically the Council has achieved significant results from this specific report and, as in previous exercises, extended the checking process to all matches. Review of the report identified fraud in 30% of the matches, where it was established that benefit customers had failed to declare they were in receipt of student finance/loans. These ten investigations identified overpayments of benefits in excess of £33,000. The Council has recovered the overpayments or remains in the process of full recovery.

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Blue badges

The blue badge parking scheme allows people with mobility problems to park for free at on-street parking meters, in pay and display bays, in designated blue badge spaces, and on single or double yellow lines in certain circumstances.

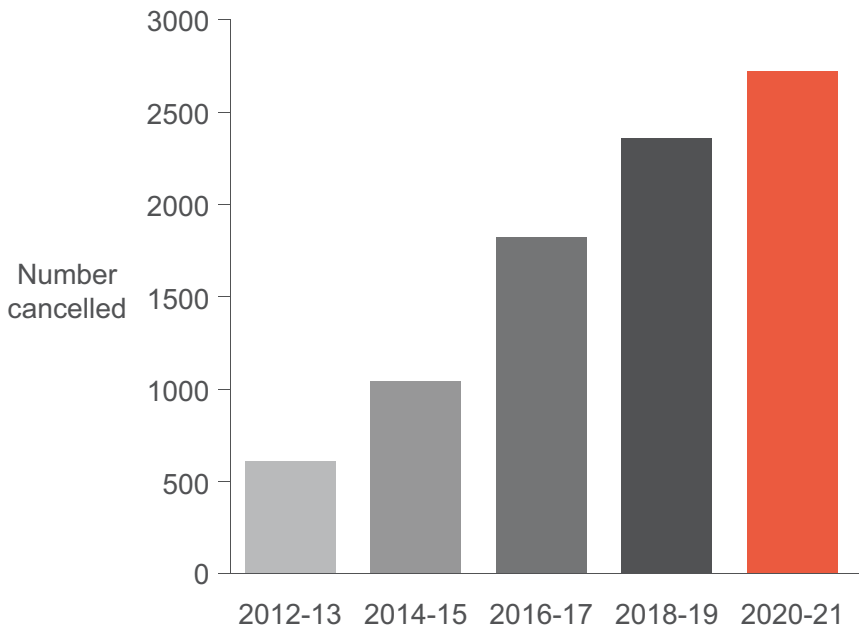
Blue badge data is matched to deceased persons and Amberhill data.

Badges are sometimes used or renewed improperly by people after the badge holder has died. It is an offence for an unauthorised person to use a blue badge.

NFI 2020-21 resulted in the cancellation of 2,717 blue badges in Wales. The number of badges cancelled has increased in each NFI exercise since NFI 2012-13. The estimated value of these cases is £1.4 million based on a calculation of the annual estimated cost of lost parking revenue and the likelihood of these blue badges being misused.

The increase in outcomes is due to a growing recognition of the need to prevent misuse of blue badges. Not only does such misuse reduce parking revenues, it also limits the parking facilities available to genuine blue badge holders.

2,717 outcomes in NFI 2020-21



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Housing waiting lists

NFI uses housing waiting list data to identify possible cases of waiting list fraud. This happens when an individual has registered on the waiting list but there are possible undisclosed changes in circumstances or false information has been provided. This was a new data set for the 2016-17 NFI exercise.

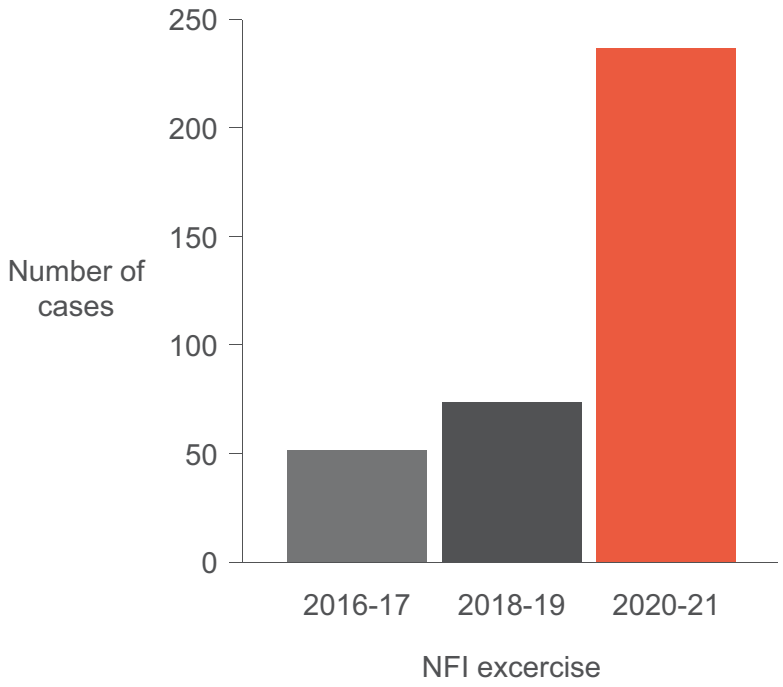
Housing waiting list data is matched to waiting list, housing benefit, housing tenants, deceased persons and Amberhill data.

Local authorities identified 237 cases where applicants were removed from waiting lists compared to 74 cases in 2018-19.

The estimated value of these cases is just under £0.8 million based on a calculation of the annual estimated cost of housing a family in temporary accommodation and the likelihood a waiting list applicant would be provided with a property.

The increase in the number of applications cancelled is due to increased efforts by local authorities to review the NFI matches thereby helping ensure that social housing is only provided to eligible persons.

Number of applicants removed from housing waiting lists



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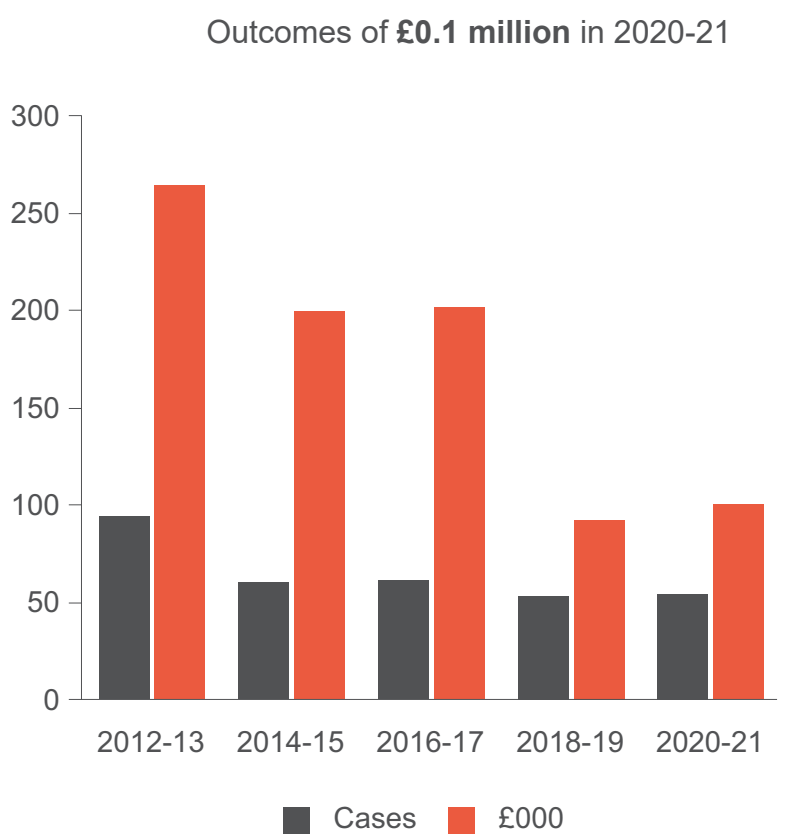
Creditor payments

The NFI provides an efficient way to check for duplicate payments and that payments are only made to appropriate creditors.

Creditor payment data is also matched to payroll and Companies House data to help identify undisclosed staff interests in suppliers.

NFI 2020-21 resulted in 54 creditor payment outcomes totalling just over £0.1 million compared to 53 outcomes totalling just under £0.1 million in NFI 2018-19. Recovery action has already taken place or is in process for all of these overpayments.

Creditor payment outcomes have reduced over NFI exercises as participating bodies have improved their internal control systems.



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Council tax reduction

Council tax reduction helps those on low incomes to pay their council tax bills.

The NFI provides local authorities with the opportunity to identify a range of council tax reduction frauds and errors.

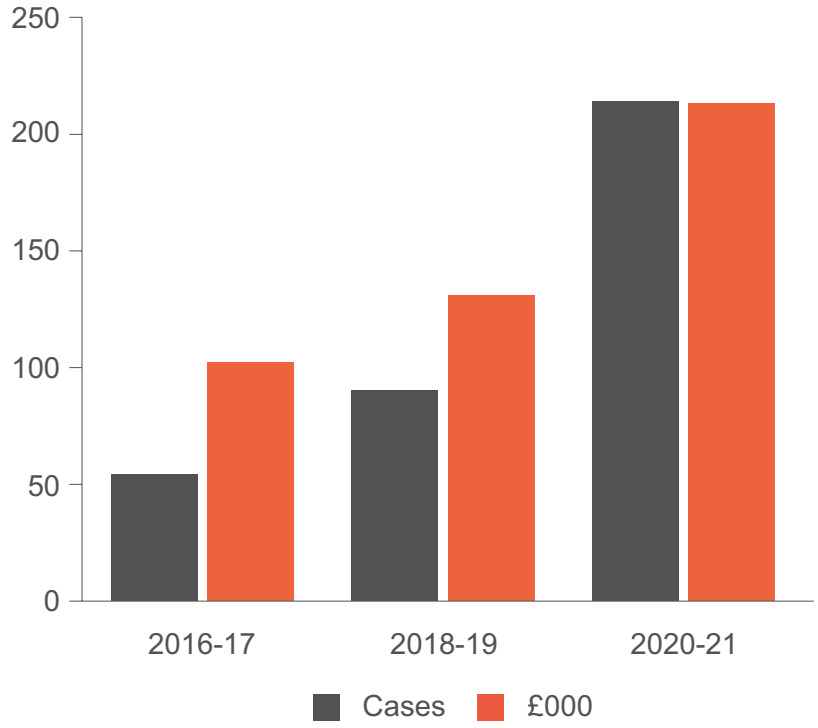
Council tax reduction data is matched to council tax reduction, payroll, pensions payroll, housing benefits, housing tenants, licences, deceased persons and Amberhill data.

The 2016-17 NFI was the first time council tax reduction data sets were included within the NFI.

Outcomes of £0.21 million were identified in the 2020-21 NFI and claims for council tax reduction were amended or cancelled in 214 cases.

The average value of each case was £1,015 compared to £1,457 in NFI 2018-19 suggesting that fraud and error is being identified earlier.

Outcomes of **£0.21 million** in 2020-21



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Case study: Vale of Glamorgan Council

The Council has a proactive and comprehensive approach to reviewing all NFI matches. All council tax reduction matches are reviewed by the Investigation Officer against the Council's internal systems to try and establish the current household status of claimants. One such match appeared to show the claimant had not declared an occupational pension that had been in payment since 2018. The Investigation Officer advised the Benefits Team that further investigation was required. The Benefits Team liaised with the Revenues Team and found there was another person residing at the address who was also in receipt of an undeclared occupational pension and who had received a substantial lump sum pension payment in 2018. Despite numerous attempts to verify the current situation with the claimant, the claimant failed to respond. The Council has cancelled the claim and the claimant has agreed to repay an overclaim of £4,775 in monthly instalments.

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Use of HMRC Data in NFI

In NFI 2020-21, for the first time, Welsh NFI matches were enriched by HMRC data provided under the provisions of the Digital Economy Act 2017. The HMRC data is proving highly effective in helping to identify applicants who have claimed means-tested benefits and discounts but have not declared income that should have been declared on their applications.

Case Study: Denbighshire County Council

The Council proactively reviewed matches between Council Tax Reduction Scheme (CTRS) and HMRC's household composition. One match suggested there was an undeclared non-dependant in the household from 2017, so benefit payments were suspended. The Benefits Team had previously been notified that the person had left the household in March 2017. On investigation, the customer confirmed the failure to declare the non-dependant since May 2017. The NFI match showed the earnings of the non-dependant to be around the threshold at which the highest deduction to the claimant's benefits would apply, so in the absence of further evidence of the non-dependent's income, the is highest deduction was applied. This resulted in an overclaim totalling £20,782. The Council is in the process of recovering the overclaim.

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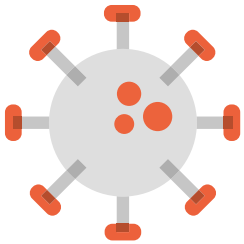
COVID-19 business support grants



In response to the COVID-19 pandemic, the Welsh Government put in place a package of measures to support businesses through the crisis. One of these measures included providing grant funding through Welsh local authorities to some retail, hospitality and leisure businesses and to businesses classified as small businesses for business rate purposes. NFI matched these grants to ensure that businesses were not inappropriately claiming multiple grants and that grants were not being awarded to known fraudsters. These checks only identified two cases of fraud and error amounting to £20,000, providing assurance that these practices were not common.

NFI also made optional tools available to local authorities to confirm that grant applicants were actively trading before the COVID-19 pandemic, and that bank account details provided by applicants related to legitimate business accounts. One Welsh local authority, Cardiff Council, used these tools in conjunction with other internal controls to identify 41 cases of fraud and error with a value of £575,000.

Case Study: Cardiff Council

Following the use of various upfront application and payment controls, the Council used a multi-layered approach to post payment verification and assurance processes for COVID-19 business support grants. NFI provided a useful source of intelligence as part of these post payment checks. The Corporate Fraud Investigation Team and colleagues in Business Rates used a range of investigative techniques and identified £575,000 of payments for recovery. For example, one NFI match indicated that a company had ceased trading, online enquiries suggested the business had closed and a Companies House check showed the company had dissolved prior to the grant eligibility date. The company had not notified the Council that they had ceased trading and were not eligible for the grant. The Council has recovered, or is is seeking to recover the overclaims wherever there is a realistic chance of doing so.

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Payments to residential care homes

In previous NFI exercises, NFI has matched residential care home data to deceased persons to identify cases where a care home resident has died, but the local authority has not been notified and so has continued to make payments to the care home.

In NFI 2018-19, 11 cases of overpayments were identified where Welsh local authorities were continuing to pay care homes for residents who had died. The average value of these cases was £14,545.

Due to the unintended consequence of a change to legislation affecting Wales, Scotland and England, it was not possible to undertake matching in this area as part of NFI 2020-21. The Auditor General is working with the Cabinet Office and Audit Scotland to find a legislative solution that will allow this matching to be undertaken in future NFI exercises.

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Matches benefiting other public bodies

One key benefit of a UK-wide data matching exercise is that it enables matches to be made between bodies and across national borders. Data provided by Welsh participants for the 2020-21 NFI exercise helped other public bodies outside Wales identify outcomes worth just over £183,000.

Sector of source data	£	Number of outcomes
Local authorities	162,776	135
NHS	15,811	17
Fire	4,458	1
Total	**183,045**	**153**

Most of these outcomes relate to housing benefits, housing waiting lists, and council tax reductions. For example, payroll data from a health board may allow a local authority to identify a housing benefit overpayment.

For those public bodies taking part in the NFI which may not always identify significant outcomes from their own matches, it is important to appreciate that providing their data can help other bodies and sectors identify frauds and overpayments.

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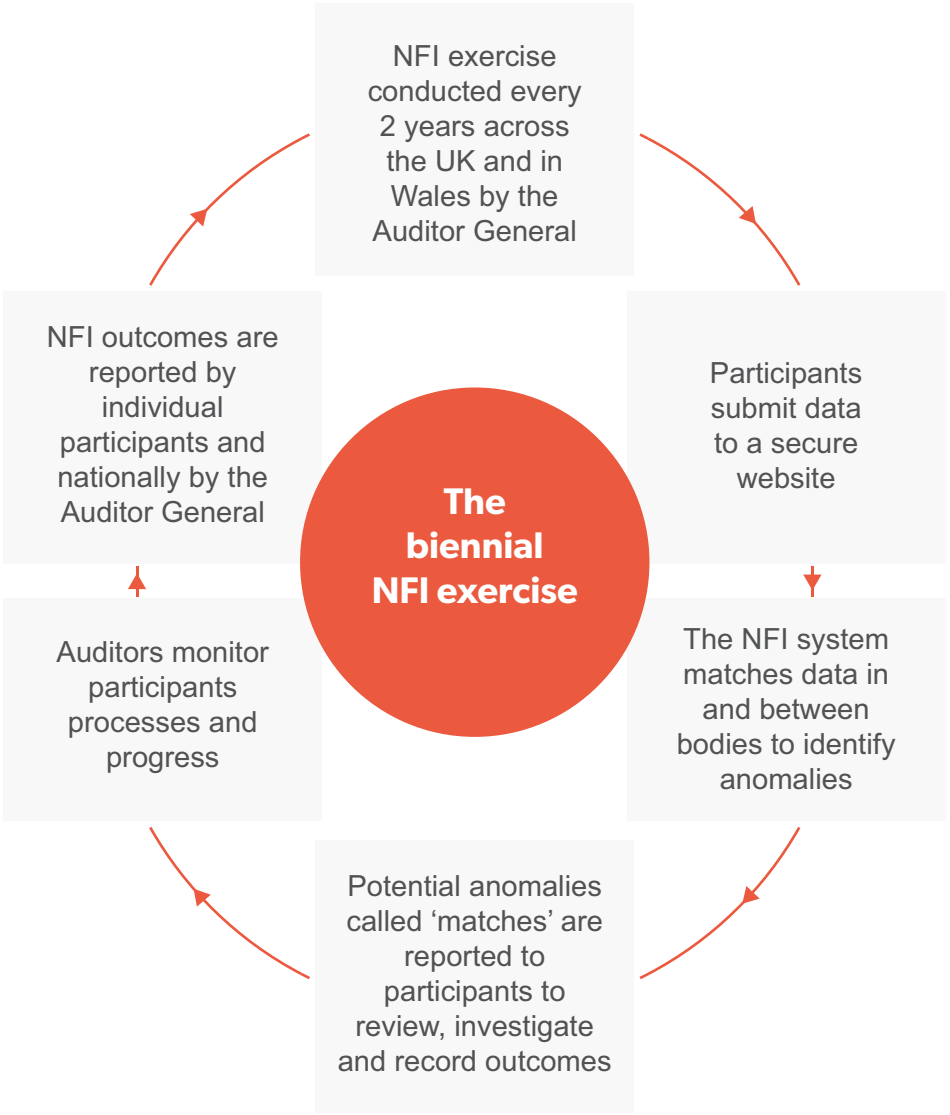
The NFI is a counter-fraud exercise across the UK public sector which aims to prevent and detect fraud. The Auditor General, Cabinet Office, Audit Scotland, and the Northern Ireland Audit Office lead the exercise in Wales, England, Scotland, and Northern Ireland, respectively. The NFI takes place biennially and enables public bodies to use computer data matching techniques to detect fraud and error.

The main purpose of the NFI is to ensure funds and services are provided to the correct people, but the NFI can also identify individuals entitled to additional services or payments eg housing benefit matches may identify customers entitled to council tax discount or reduction.

We carry out the NFI process under powers in the Public Audit (Wales) Act 2004. It is important for all parties involved that this exercise is properly controlled and data handled in accordance with the law. The Auditor General's Code of Data Matching Practice summarises the key legislation, and controls governing the NFI data matching exercise.

In Wales, the Auditor General has mandated unitary local authorities and NHS bodies to participate in the NFI. The Welsh Government, some Welsh Government Sponsored Bodies, and Audit Wales participate on a voluntary basis.



Key messages

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How bodies work with the NFI

The success of the NFI is dependent on the proactivity and effectiveness of participant bodies in investigating the data matches.

Most participating Welsh public bodies managed their roles in the 2020-21 NFI exercise well.

However, some bodies could be far more pro-active in their approach to the NFI. In particular, some local authorities reviewed very few of the matches they received, and as a consequence did not do sufficient work to address potential frauds. This was due to some participants failing to recognise the importance of the exercise and/or an unwillingness to allocate adequate, skilled counter-fraud resources to investigate the NFI matches.

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Future developments

- The Auditor General is considering how to further develop the scope of NFI in Wales and areas of potential data-matching currently being explored include, housing tenancies, GP patient registration, business rates.
- The 2022-23 NFI is now underway. Data sets have been reviewed following a period of consultation and NFI participants are starting to submit data for matching.
- The Auditor General continues to work with the Welsh Government to promote and enhance participation in the NFI across Wales.

The Auditor General is independent of the Senedd and government. He examines and certifies the accounts of the Welsh Government and its sponsored and related public bodies, including NHS bodies. He also has the power to report to the Senedd on the economy, efficiency and effectiveness with which those organisations have used, and may improve the use of, their resources in discharging their functions.

The Auditor General also audits local government bodies in Wales, conducts local government value for money studies and inspects for compliance with the requirements of the Local Government (Wales) Measure 2009.

The Auditor General undertakes the National Fraud Initiative in Wales under Part 3A of the Public Audit (Wales) Act 2004 which empowers him to conduct data matching exercises for the purpose of assisting in the prevention and detection of fraud in or with respect to Wales and to publish the results of any such exercise.

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.

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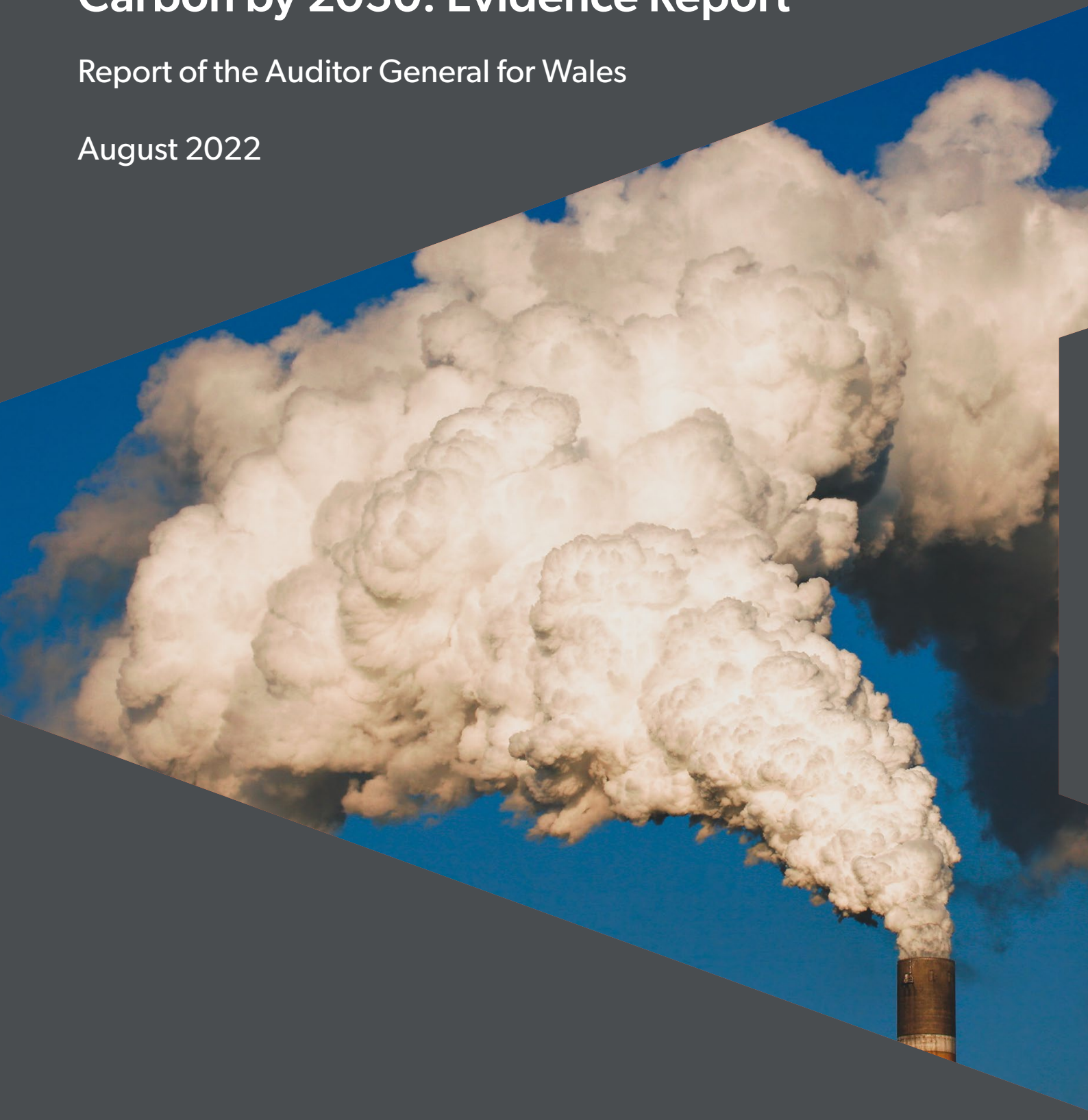
Public Sector Readiness for Net Zero Carbon by 2030: Evidence Report

Report of the Auditor General for Wales

August 2022



This report has been prepared for presentation to the Senedd under the Government of Wales Act 2006, the Public Audit (Wales) Act 2004 and the Well-being of Future Generations (Wales) Act 2015.

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

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Detailed report

Background

1 Climate change is one of the world's defining challenges and it requires immediate action from everyone. A landmark report by the United Nations in August 2021 said that human activity is changing our climate in unprecedented ways and that drastic reductions in carbon emissions are necessary.

2 The latest climate projections for Wales show an increased chance of milder, wetter winters and hotter, drier summers, rising sea levels and an increase in the frequency and intensity of extreme weather events. The implications are clearly stark.

3 A crucial way to mitigate the further impacts of climate change is to reduce carbon emissions. In March 2021, following advice from the Climate Change Committee[1] in December 2020, the Welsh Government set targets for a 63% carbon reduction by 2030, an 89% reduction by 2040, and a 100% reduction by 2050[2]. In addition, the Welsh Government set out a more challenging collective ambition for the Welsh public sector[3] to be net zero carbon by 2030 (the 2030 collective ambition).

4 In June 2021, the Welsh Government published its Programme for Government 2021-2026 which puts tackling the climate and nature emergencies at the heart of the new government. The Programme for Government also makes a series of commitments to embed a response to climate change in everything the Welsh Government does.

1 The Climate Change Committee (CCC) is an independent, statutory body established under the Climate Change Act 2008. Its role is to advise the UK governments on emissions targets and to report on progress made in reducing greenhouse gas emissions and preparing for and adapting to the impacts of climate change.

2 Net zero does not mean eliminating greenhouse gas emissions but balancing the greenhouse gas emissions with the amount of gas being removed from the atmosphere.

3 The Welsh Government's definition of the 'public sector' in this case covers 65 bodies as set out in Appendix 2 of the Welsh Government, Public sector net zero data: baseline and recommendations, June 2022.

5 The Welsh Government has also published Net zero carbon status by 2030: A route map for decarbonisation across the Welsh public sector (the public sector route map) to support the Welsh public sector in achieving the collective ambition. Alongside the public sector route map the Welsh Government has published the net zero reporting guide and associated spreadsheet to allow the public sector to capture and report emissions on a consistent basis. Our separate key findings report provides further detail on the national strategic direction for decarbonisation and its underpinning policy and legislative framework.

6 The Auditor General has committed to carrying out a long-term programme of work on climate change. Our first piece of work is a baseline review that asks: '**How is the public sector preparing to achieve the Welsh Government's collective ambition for a net zero public sector by 2030?**'. To inform the baseline review, 48 public bodies, including the Welsh Government, completed a call for evidence. **Appendix 1** explains our audit approach and methods.

7 We have published two reports to share our findings:

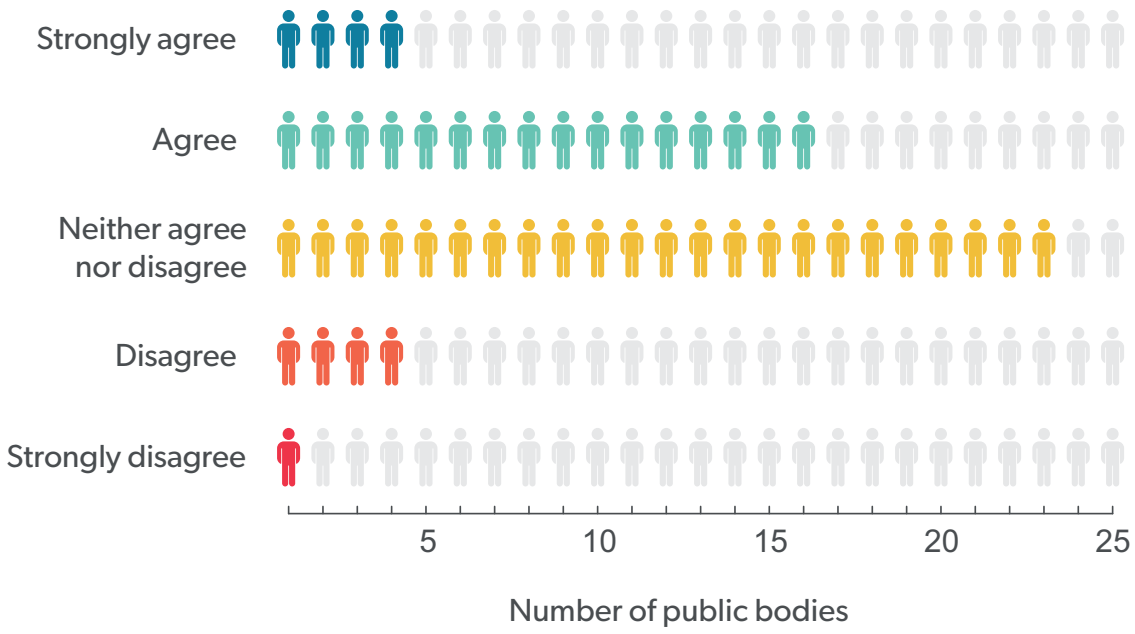
a **key findings report**: a summary report, published in July 2022, that targets senior leaders and those with scrutiny roles in public bodies, with the aim of inspiring them to increase the pace of their work on achieving the 2030 collective ambition. In that report, we set out the overall conclusion from our work and five calls for action for organisations to tackle the common barriers to decarbonisation in the public sector. The key findings report also notes that application of the sustainable development principle and the frameworks provided by the Well-being of Future Generations (Wales) Act 2015 can be used to help organisations to decarbonise.

b **this evidence report**: supplementing the key findings report by providing more detailed findings and data from the call for evidence and our wider work.

Confidence in meeting the 2030 collective ambition

8 We found considerable uncertainty (and clear doubt from some) about whether the collective ambition for a net zero public sector will be achieved by 2030. **Exhibit 1** shows that in our call for evidence, 20 out of 48 bodies agreed or strongly agreed they were confident that their organisation would meet the 2030 collective ambition, whereas 23 said they neither agreed nor disagreed and five disagreed or strongly disagreed.

Exhibit 1: public bodies' responses to the statement, 'Our organisation is confident that it will meet the 2030 target to have net zero carbon emissions'



Source: Audit Wales call for evidence

9 For NHS bodies, the NHS Wales Decarbonisation Strategic Delivery Plan (the NHS plan) includes a target to deliver a 34% reduction in carbon emissions by 2030. This target is based on a calculation about the reduction in emissions that can be realistically expected from the 46 initiatives set out in the plan. Our evidence from NHS bodies indicates considerable uncertainty about meeting this target (as well as the more challenging net zero ambition). **Paragraph 50** provides further consideration of the barriers to achieving the 2030 collective ambition.

10 The evidence suggests there is a need for greater clarity on how the 34% target fits within the wider context of the 2030 collective ambition. The Welsh Government has deliberately set a stretching collective ambition to stimulate action, although it is not a statutory target. At the same time, the NHS has set itself a less stretching target of a 34% reduction by 2030, while other parts of the public sector do not have separate targets. The health sector accounts for around a third of the public sector carbon emissions in Wales[4]. If the NHS was to achieve only a 34% reduction in emissions, it would make it significantly more difficult to achieve an overall net zero position across the public sector.

11 **Exhibit 2** provides examples of what public bodies told us in relation to the 2030 collective ambition and the likelihood of it being achieved.

4 As set out in Public Sector Net Zero: data and recommendations, health boards and trusts produced 1,134,000 tonnes of CO2 against a total of 3,279,000 tonnes produced by the public sector as a whole in 2020-21.

Exhibit 2: some comments from public bodies about the 2030 collective ambition

- ‘We recognise the enormity of the challenge we face.’
- ‘We are committed to contributing to the Welsh Government’s ambition for the public sector to be net zero by 2030 and will endeavour to deliver on or exceed the targets it sets.’
- ‘Not yet sufficiently clear what it will mean in practice.’
- ‘We do not have complete confidence that we will be able to measure the results of our actions.’
- ‘It will involve decarbonisation action in areas that we have yet to develop decarbonisation expertise, for example, in procurement and local area energy planning.’
- ‘If our entire supply chains are not zero carbon, then we cannot be either.’
- ‘The council is committed to achieving its net zero ambitions, notwithstanding the challenges.’
- ‘The level of financial investment will be a driver in whether or not we achieve our ambition and how quickly we’re able to act.’

Source: Audit Wales call for evidence

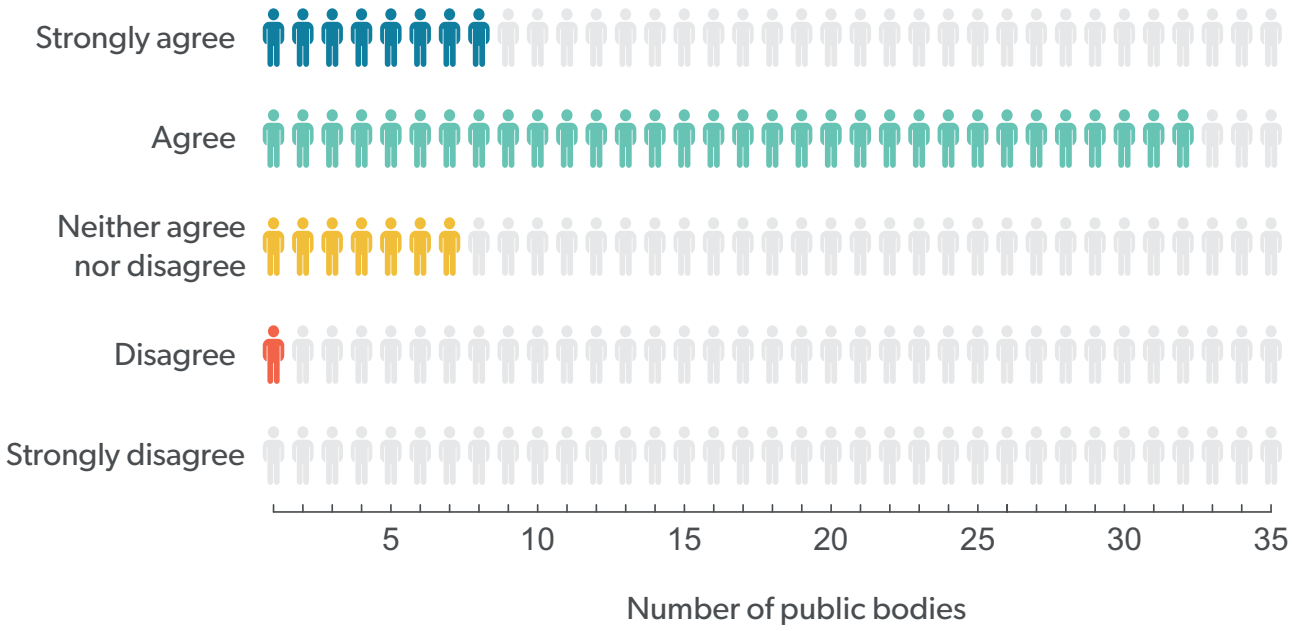
“We recognise the enormity of the challenge we face”

Strategic direction and action planning for decarbonisation

National strategic direction

12 **Exhibit 3** shows that public bodies were generally positive about the Welsh Government's strategic direction on decarbonisation. Public bodies were also largely positive about the way in which the Welsh Government had engaged with them through various channels over the approach to achieving net zero.

Exhibit 3: public bodies' responses to the statement, 'The Welsh Government has set a clear strategic direction for public bodies in Wales to support the achievement of their 2030 carbon reduction targets'



Source: Audit Wales call for evidence

13 **Exhibit 4** provides examples of what public bodies told us in relation to the national strategic direction.

Exhibit 4: some comments from public bodies about the national strategic direction

- 'Welsh Government have set a clear strategic direction in terms of ambition and there is a clear and consistent message in terms of where we need to get to.'
- 'We have used the strategic direction and guidance as a framework to develop an organisational climate change plan.'
- 'The strategic direction has been set out clearly by Welsh Government but how we get there as local authorities, and the support we receive is not clear.'
- 'I believe that the government could be offering more support ensuring that the guidance provided is consistent for everyone.'
- 'Further work is required by (Welsh Government) to publicise the wider strategic narrative and tools available.'
- 'The National (NHS Wales) Strategic Decarbonisation Plan provides a clear direction of travel for Wales and robust evidence base for the priorities within (our area).
- 'The NHS Wales Decarbonisation Strategic Delivery Plan sets out a number of actions with clear timelines.'

Source: Audit Wales call for evidence

"The strategic direction has been set out clearly by Welsh Government but how we get there as local authorities…is not clear"

14 The public sector route map is a key part of the national strategic direction. Some public bodies told us they view the public sector route map as a high-level thematic and strategic framework. They told us it sets the overall direction, and is an accessible, well-presented and user-friendly document. Several bodies made comments about the usefulness of the route map as a tool for explaining, identifying, developing and delivering actions. Some also told us that the route map was a valuable aid for explaining responsibilities and requirements to senior management, members and board members.

15 Nevertheless, several non-NHS bodies said they wanted more help to translate the strategy into local, day-to-day operations, through their action plans. These organisations told us that while the public sector route map provides a high-level template, they need more clarity, support and guidance on how to decarbonise. The Welsh Government told us that it deliberately designed the route map to be a high-level framework to assist public bodies in developing local solutions based on individual circumstances, rather than a one-size-fits-all approach. In addition, the Welsh Government does provide other sources of support to public bodies through the Welsh Government Energy Service and through the Wales Funding Programme, as set out in **paragraph 22**.

16 **Exhibit 5** provides a summary of some concerns public bodies expressed about the public sector route map. **Exhibit 18** expands on some of these concerns as part of a discussion about wider barriers to decarbonisation.

Exhibit 5: summary of concerns from public bodies about the public sector route map

- **Timeliness**: Overall, public bodies felt there was consistency between the direction set by the Welsh Government and their individual approaches. However, due to the timing of the route map's publication[5], some bodies had already started developing their own strategies and action plans so there is not always complete read across to the route map. There is an opportunity to fully align when strategies and action plans are refreshed.
- **Detail**: the public sector route map needs additional clarity, support and guidance on how to decarbonise.
- **Targets**: some of the targets and the timeframes to achieve them are very challenging.
- **Funding**: there is a lack of planned, long-term, external investment from the Welsh Government to support delivery.
- **Inconsistency**: potential for inconsistent interpretation of the guidance and the reporting requirements.
- **Calculations**: further detail and clarity are needed in the carbon calculator, specifically in relation to the procurement and land use themes.

Source: Audit Wales call for evidence

5 The Welsh Government chose to delay publication of the route map during the COVID-19 pandemic because it did not want to overburden public bodies at such a difficult time.

Sector-specific strategies and support for decarbonisation

17 In the health and care sector, the Welsh Government has convened the Climate Change and Decarbonisation Programme Board for Health and Social Care, to help lead, support and give strategic oversight to decarbonisation work. Guidance on decarbonisation is available to NHS bodies through the NHS plan which was published alongside the public sector route map in May 2021. The Carbon Trust and the NHS Wales Shared Services Partnership developed the NHS plan, which sets out 46 initiatives for decarbonisation that will be assessed and reviewed in 2025 and 2030.

18 The NHS plan aligns with the public sector route map, provides more detail and allocates responsibility for initiatives and actions to different parts of NHS Wales. The NHS plan focuses on traditional areas of decarbonisation, such as buildings and transport. While these remain important areas of focus, the Welsh Government has acknowledged that the section on decarbonising healthcare[6] is less detailed, reflecting the developing practice in this area.

19 Our call for evidence responses from NHS bodies demonstrated a focus on and commitment to delivering the actions set out in the NHS plan. And while there appears to be support in the health sector for the NHS plan, the Welsh Government recognises there is scope to strengthen its co-ordination and leadership.

20 In local government, the Welsh Local Government Association is developing tailored support and guidance for councils on decarbonisation. The Welsh Government funds the Welsh Local Government Association transition and recovery support programme. Focussing on the key themes of the public sector route map, the programme provides a range of support including toolkits, commissioned research on interventions to achieve net zero, training to build knowledge and expertise, and events to facilitate sharing of best practice. The Welsh Government is also part of the Local Government Climate Strategy Panel which supports and gives strategic overview to decarbonisation work in local government.

21 The Welsh Government does not currently plan to produce specific decarbonisation plans for other sectors covered by the public sector route map. However, it acknowledges that more support and guidance may be needed for bodies outside of the NHS and local government.

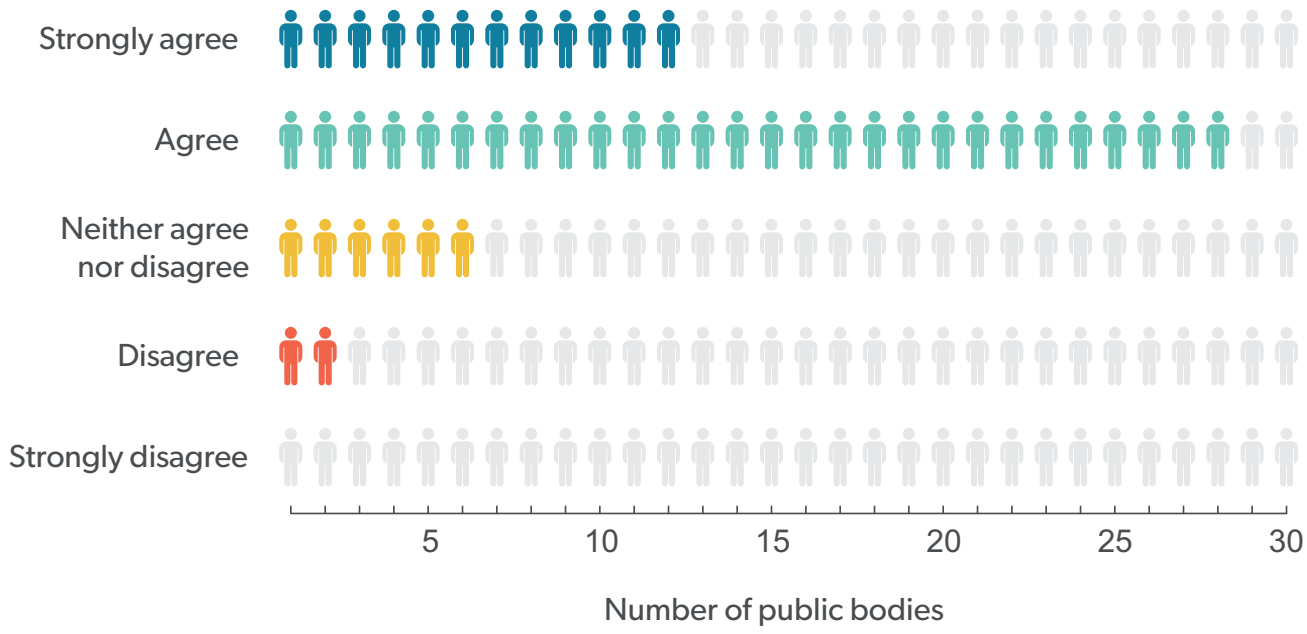
6 Decarbonising healthcare refers to reducing carbon emissions in health services rather than decarbonising the physical infrastructure surrounding healthcare. Examples include the use of medical gases and inhalers that involve greenhouse gases.

22 The Welsh Government is providing other central assistance on decarbonisation, including support through the Welsh Government Energy Service (WGES) and grant funding for various programmes. The WGES provides technical advice and other support to public sector bodies and community enterprises on energy efficiency, renewable energy projects and fleet improvements. The WGES annual report provides further information about the support it provides. The Welsh Government has made funding available for public sector decarbonisation projects through the Wales Funding Programme, which aims to make buildings and assets more energy efficient.

Local strategic direction

23 **Exhibit 6** shows that most public bodies were confident their organisation had set a clear, local strategic direction to deliver the 2030 collective ambition.

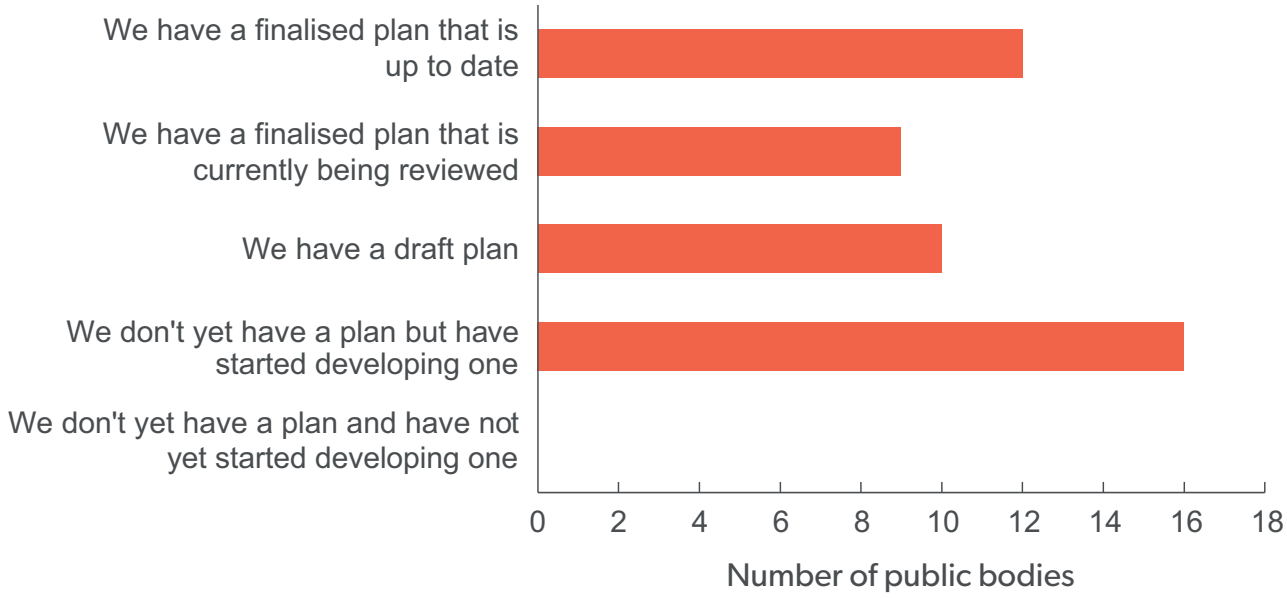
Exhibit 6: public bodies' responses to the statement, 'Our organisation has set a clear strategic direction to support the achievement of the 2030 carbon reduction targets'



Source: Audit Wales call for evidence

24 However, **Exhibit 7** shows that public bodies are at very different stages in setting out their action plans for decarbonisation. Within these responses, NHS bodies appeared to be a bit further behind local government.

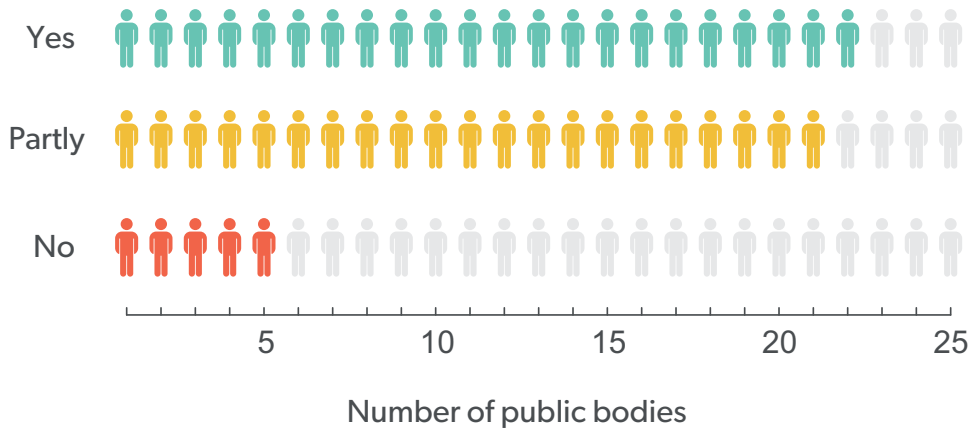
Exhibit 7: status of public bodies' action plans



Note: One public body did not respond to this question.
Source: Audit Wales call for evidence

25 **Exhibit 8** shows variation in the extent to which public bodies are using the public sector route map to guide their own strategic approach, with five responding to say that they are not using it at all.

Exhibit 8: public bodies' responses to the question, 'Is your organisation using the Welsh Government's public sector route map to guide its approach to reducing carbon emissions?'



Source: Audit Wales call for evidence

Governance and leadership arrangements for decarbonisation

26 It is important that public bodies have effective internal governance and leadership arrangements to drive decarbonisation. Public bodies described various existing and new structures, including boards and dedicated senior staff groups. For example, all NHS bodies have an identified director or executive director to oversee decarbonisation. Responses to the call for evidence also acknowledged that clear structures are essential and need to be regularly reviewed to ensure they remain fit for purpose.

27 Public bodies recognised the importance of engaging all staff in the critical issue of decarbonisation, but they acknowledged that more needs to be done. Upskilling of staff through training was identified as key to supporting the delivery of the 2030 collective ambition. However, more needs to be done to ensure upskilling covers the whole staff base and not just senior leaders or those charged with governance.

28 **Exhibit 9** provides examples of what public bodies told us in relation to their governance and leadership arrangements for decarbonisation.

Exhibit 9: some comments from public bodies about their governance and leadership arrangements for decarbonisation

- ‘A climate and nature emergency officer group has been established to lead, facilitate and support the delivery of the action plan.’
- ‘The health board has established a sustainability and decarbonisation programme board led by the Executive Director Finance.’
- ‘The council has just appointed … a Climate Change Manager.’
- ‘We are building decarbonisation into the clinical model which will be operating in new hospital infrastructure going through business case stages.’
- ‘Some early adopter clinical departments are creating their own sustainability action plans.’
- ‘[We] will appoint a board director as decarbonisation lead (and senior responsible officer) and establish a steering group to oversee our decarbonisation programme.’
- ‘The Sustainable Group is chaired by the Executive Director of Strategy and attended by staff from across the health board, including clinicians and those networked into a wide range of partner forums.’
- ‘The council established its cross-party Climate Change and Ecological Emergency Working Group after declaring the climate and ecological emergency. The Working Group was supported by a team of officers.’

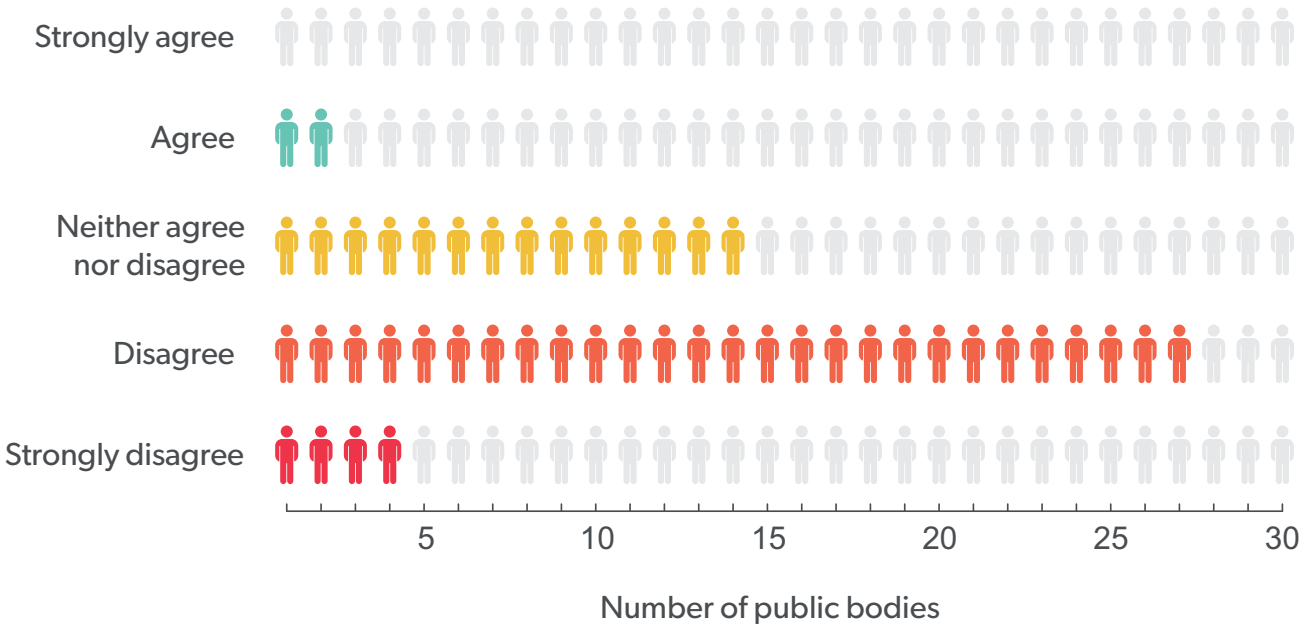
Source: Audit Wales call for evidence

“We are building decarbonisation into the clinical model”

Financial implications of decarbonisation

29 **Exhibit 10** shows that most public bodies have not fully assessed the financial implications of meeting the 2030 collective ambition. A few responses to the call for evidence included costings of specific recent or imminent projects but we did not see evidence of fully costed, long-term decarbonisation programmes. We are aware that some public bodies have since developed more detailed estimates for short to medium-term expenditure.

Exhibit 10: public bodies' responses to the statement, 'Our organisation has fully assessed the financial implications of meeting the 2030 carbon reduction targets'



Note: One public body did not respond to this question.
Source: Audit Wales call for evidence

30 In some cases, public bodies told us that they have not assessed the financial implications because they have not yet set out a clear set of actions and activities to achieve net zero. However, they were aware of the urgency and the need to increase the pace of implementing actions. Public bodies were very clear that decarbonisation at scale will require significant additional financial resources and that the absence of these funds will be a significant barrier to progress.

31 Public bodies need to plan their finances in such a way that they can deliver their decarbonisation strategies and action plans. This will require long-term planning because decarbonisation will need investment for many years. It will also require immediate expenditure because if the 2030 collective ambition is to be met, urgent action is essential. Public bodies told us significant long-term investment will be needed, particularly in relation to making their infrastructure fit for purpose to enable the decarbonisation of operations. However, public bodies expressed uncertainty over what additional funding would be available from the Welsh Government. They also pointed to the short-term nature of public sector funding and budget cycles making their longer-term financial planning more difficult.

32 The Welsh Government told us they are providing targeted funding for public bodies in certain areas but they also said they are unable to fund all activity required. The Welsh Government acknowledges that there will be additional costs in some areas and that funding will be provided to bridge some of those gaps, when moving to low carbon alternatives, for example, the increased cost of purchasing electric fleet rather than those powered by traditional fossil fuels. However, the Welsh Government said that as decarbonisation becomes increasingly mainstreamed into routine thinking, public bodies should not be focussed on additional funding, and they should move to a position where decarbonisation is funded through their existing budgets as a result of a strong business case.

33 **Exhibit 11** provides further examples of what public bodies told us in relation to the financial implications of decarbonisation.

Exhibit 11: some comments from public bodies about the financial implications of decarbonisation

- ‘The financial implications of decarbonisation have not been fully considered.’
- ‘We recognise that we have further work to do on this front.’
- ‘The council recognises that achieving its net zero ambition will have implications for its budget in the short and long term.’
- ‘Until the council formulates a detailed fully costed 2030 net zero delivery plan the council is unable to accurately assess the financial implications.’
- ‘It should be acknowledged that funding will be required to deliver the aim of net zero by 2030.’
- ‘There are no cost estimates for medium-term levels of expenditure.’
- ‘The cost of decarbonising our clinical operations has not been estimated.’

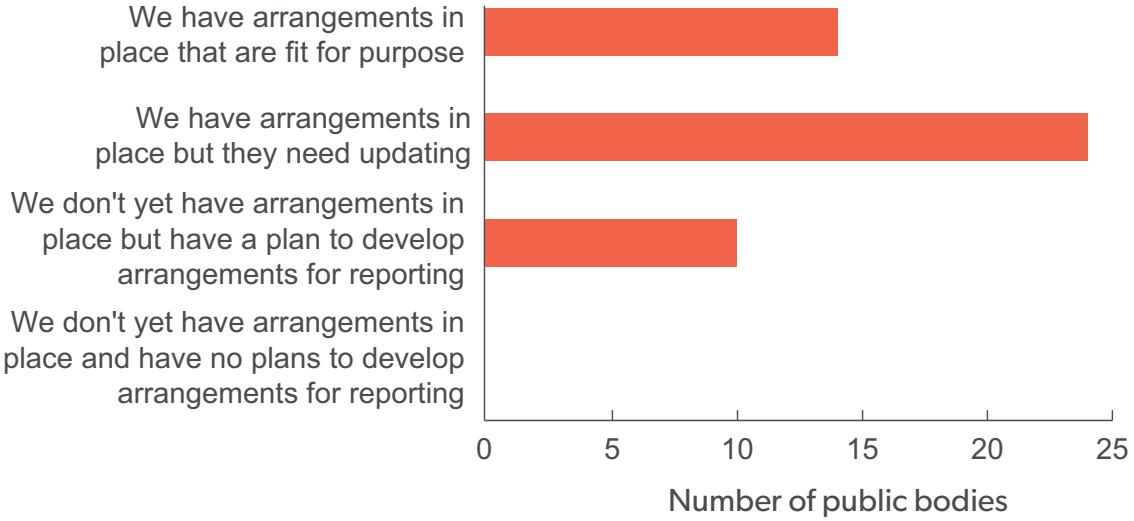
Source: Audit Wales call for evidence

“The council recognises that achieving its net zero ambition will have implications for its budget in the short and long term”

Reporting progress on decarbonisation

34 Public bodies need to understand where their emissions are coming from so they can check if they are making progress and prioritise their actions. We found that data issues are a major barrier to having a shared understanding of the problem and to taking strategic decisions about the solutions. **Exhibit 12** shows that 14 bodies indicated they had reporting arrangements that they felt were fit for purpose, 10 did not have arrangements in place, and 24 had arrangements that needed updating.

Exhibit 12: public bodies' responses to the question, 'Which of the following options best describes your organisation's arrangements for reporting on progress towards net zero carbon emissions?'



Source: Audit Wales call for evidence

35 Current monitoring and reporting tend to be done through reports or dashboards to cabinet, council, board, scrutiny committee or other groups. Some bodies report on decarbonisation as part of reporting progress on their corporate plans or wellbeing objectives. Some responses pointed to dedicated climate groups and other arrangements that have been set up specifically to monitor and report on decarbonisation activity.

36 Overall, the evidence suggests there is scope for improved reporting on decarbonisation. This finding aligns with a blog we published in February 2022 that called for clearer information on climate change actions to be included in public bodies' financial statements, to ensure greater transparency and accountability.

37 The Welsh Government has published a common reporting methodology (see **paragraph 5**) for public bodies to report their emissions through the Welsh Public Sector Net Zero Reporting Guide and net zero reporting spreadsheet. The Welsh Government asked public bodies to submit the first data by October 2021 for the 2020-21 financial year.

38 In responses to our call for evidence, public bodies generally recognised the usefulness of having a common reporting methodology but found aspects of the submission challenging and highlighted problems with the data collection in October 2021. Some responses pointed to concerns over calculation methods, particularly regarding supply chain. In relation to supply chain emissions, public bodies pointed to the fact that the calculation is based on the cost of the contract rather than the actual emissions generated by the product or service procured. Public bodies also called for further clarity of definitions to ensure consistent interpretation and reporting. Some responses also noted that existing systems were not able to capture the required data, and had to be updated, or new systems had to be put into place. This was often time consuming and resource intensive.

39 Public bodies pointed to some other concerns about the common reporting methodology. Some respondents said the way in which emissions from land use is reported is too simplistic.

40 NHS bodies also raised concerns about duplication with already established reporting on carbon emissions such those required by the Estates and Facilities Performance Management System[7]. This created confusion in the first reporting year. NHS bodies wanted further clarity to avoid duplication between these reporting requirements.

7 The Estates and Facilities Performance Management System is a comprehensive set of estates and facilities data. The Welsh Government set up the system in 2002 to improve the management of the NHS estate. It allows NHS bodies to compare performance against other NHS bodies in Wales and England.

41 The Welsh Government recognises improvements are required in the existing reporting approach and has committed to learning from feedback and improving methods and systems where required. The Welsh Government commissioned consultants, to review the first submission of data from public bodies and, in June 2022, the Welsh Government published the consultancy report, Welsh Public Sector Net Zero: Baseline and recommendations in full. The report states that the figures include significant uncertainty, particularly in relation to supply chain emissions, which it said represented 87% of public sector emissions. Plus, the data has not been thoroughly audited. The figures also suggest emissions across Wales for the public sector reduced by 5% between 2019-20 and 2020-21.

42 As this is the first year of the reporting guide, it is a period of learning, and the calculation for reporting emissions will be further developed where required. Following feedback from public bodies, and the review of the data submissions from an external consultant, the Welsh Government published a revised reporting guide and tool in July 2022.

43 **Exhibit 13** provides examples of what public bodies told us in relation to the monitoring and reporting on decarbonisation.

Exhibit 13: some comments from public bodies about monitoring and reporting on decarbonisation

- ‘We followed the emissions reporting guidance as closely as possible.’
- ‘Two distinct areas need to be strengthened/clarified which are waste and supply chain.’
- ‘We appreciate the advantages of having a consistent format to aid our own and Welsh Government monitoring of progress.’
- ‘The supply chain emissions reporting method needs significant refinement in order to be considered accurate.’
- ‘Current data gathering and reporting functions require updating.’
- ‘We are developing the necessary reporting tools to meet the requirements of the Net Zero Carbon Reporting Guidance.’

Source: Audit Wales call for evidence

“We appreciate the advantages of having a consistent format to aid our own and Welsh Government monitoring of progress”

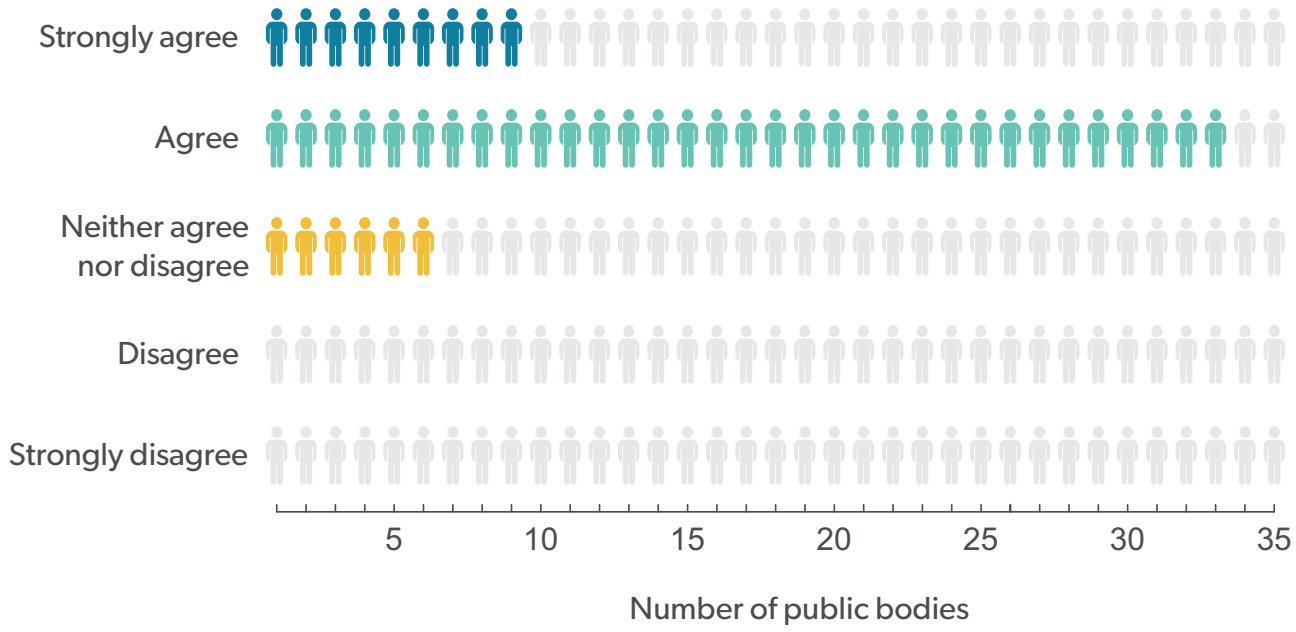
Collaboration and engagement with other bodies, staff, and citizens

44 To support collaboration and engagement at a national level, the Welsh Government published Climate Change: Welsh Government Engagement Approach 2022-26 in June 2021. The document refers to a Team Wales approach, where everyone in Wales plays a role in collective action on climate change. The engagement approach has two key objectives:

- to generate timely and effective engagement of stakeholders on matters of climate change; and
- to strengthen and grow the coalition of Team Wales to tackle the climate emergency.

45 **Exhibit 14** shows that public bodies feel they are working well with other organisations on decarbonisation. And **Exhibit 15** sets out comments made by public bodies about their collaborative efforts to date and aspirations for the future.

Exhibit 14: public bodies' responses to the statement, 'Our organisation is effectively collaborating with other bodies to achieve the 2030 carbon reduction targets'



Source: Audit Wales call for evidence

Exhibit 15: some comments from public bodies about collaboration

- ‘Through the public services board (PSB) we have established a Climate Emergency Board which comprises existing PSB members, but also additional organisations including utility providers and our local university.’
- ‘As part of our Well-being Plan work, we are currently working collaboratively with our partners and are in the early stages of developing a Climate Strategy for the city.’
- ‘We are working closely with public sector partners through the North Wales Regional Leadership Board. We participate in the North Wales Decarbonisation Advisory Group.’
- ‘We have completed an informal analysis of who we need to work with, but we have not yet completed a formal analysis of partners.’
- ‘Collaboration between NHS organisations has been low, though is changing through Welsh Government setting up a Climate Change Programme Board.’
- ‘We have multiple representatives on the Decarbonisation Action Plan: Community of Experts. This will share learning and good practice across the health boards in Wales.’
- ‘We feel that a formal Welsh public sector decarbonisation working group would address some of the challenges faced by serving communities covered by multiple local authority agencies.’

Source: Audit Wales call for evidence

“We feel that a formal Welsh public sector decarbonisation working group would address some of the challenges”

46 Some bodies have set up their own local collaborative arrangements for decarbonisation, whereas other bodies are collaborating through Welsh Government or Welsh Local Government Association convened arrangements or through statutory fora such as public services boards. A significant proportion of bodies had also involved external experts in their decarbonisation efforts, such as the Carbon Trust.

47 Smaller bodies, such as the national parks and Welsh Government sponsored bodies, told us they have been collaborating well with each other. They said that due to their size, they are somewhat reliant on external expertise and advice in relation to decarbonisation.

48 Some public bodies acknowledged that their focus to date had been on establishing internal structures, rather than on external collaboration. And notwithstanding the responses shown in **Exhibit 14**, many public bodies agreed that collaboration and engagement needed to be strengthened.

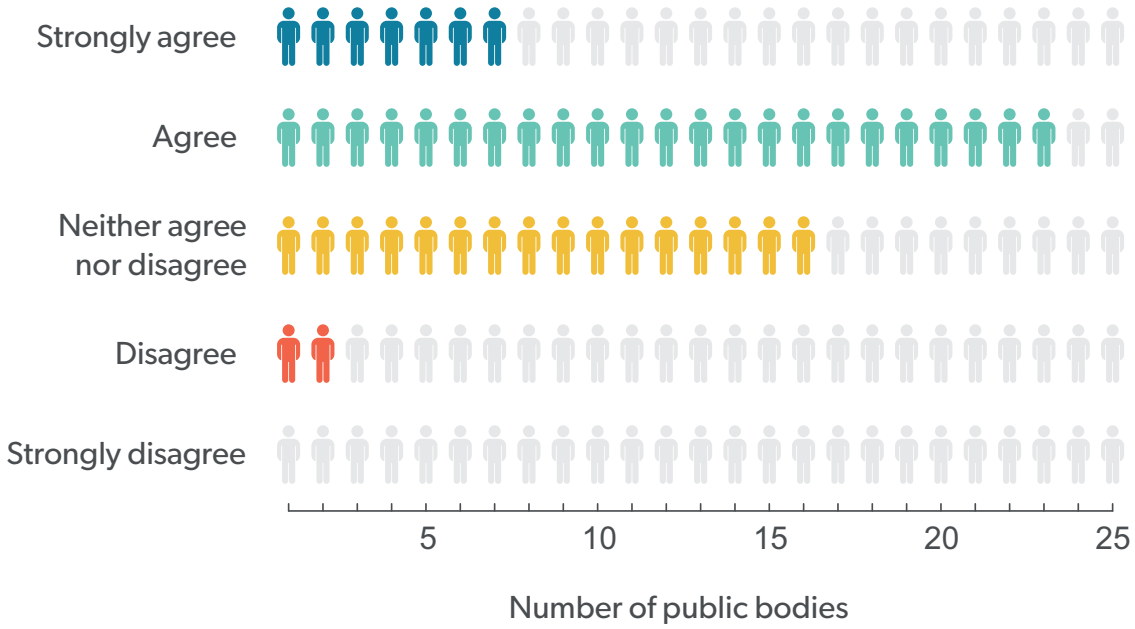
49 There is scope for stronger engagement and involvement with staff and the public. **Exhibit 16** shows mixed views from public bodies about the extent to which they are engaging and involving their staff. And **Exhibit 17** shows that only 15 of the 48 public bodies we contacted were confident that they were effectively engaging with the full diversity of the population. Some public bodies told us about engagement with the public through mechanisms such as online surveys, social media channels and community groups but they generally acknowledged that this engagement needs to improve. This is significant as both our 2019 report on fuel poverty[8] and the Decarbonisation of Homes in Wales Advisory Group[9] found there are some difficult trade-offs between social justice and carbon reduction goals. Engagement with the full diversity of the population should help public bodies in their efforts to make a just transition[10] towards net zero carbon emissions.

8 Auditor General for Wales, Fuel Poverty, October 2019

9 Decarbonising Homes in Wales Advisory Group, Better Homes, Better Wales, Better World: Decarbonising existing homes in Wales, July 2019

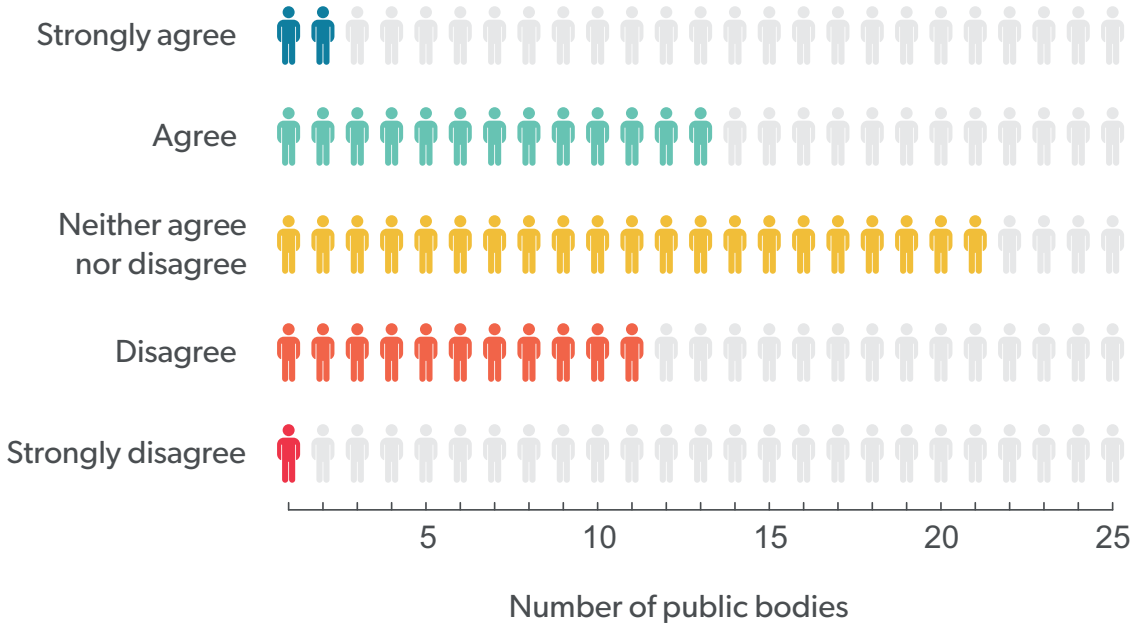
10 A 'just transition' means taking action on climate change and greening the economy in a way that is as fair and inclusive as possible to everyone concerned. Policy 1 in Net Zero Wales Carbon Budget 2 (2021-2025) sets out the Welsh Government's views on a just transition.

Exhibit 16: public bodies' responses to the statement, 'Our organisation is effectively engaging with and involving staff to achieve the 2030 carbon reduction targets'



Source: Audit Wales call for evidence

Exhibit 17: public bodies' responses to the statement, 'Our organisation is effectively engaging with the full diversity of our population to achieve the 2030 carbon reduction targets'

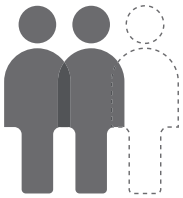


Source: Audit Wales call for evidence

Barriers, opportunities and interesting practices on decarbonisation

50 We asked public bodies about the barriers to achieving the 2030 collective ambition. **Exhibit 18** summarises the barriers they told us about that were largely common across the public sector, many of which are explored earlier in the report. One common theme was that decarbonisation is complex, requiring significant investment and that many of the easy wins had been achieved. However, public bodies were aware that the pace of activity needs to increase and there are reputational risks of not doing so.

Exhibit 18: summary of public bodies' views about barriers to meeting the 2030 collective ambition

Barriers	
Finance 	This was the most commonly mentioned barrier. Bodies pointed to the need for significant and sustained revenue and capital investment in the short and long term. They said there was a particular need for investment in improving infrastructure, estates, appliances and equipment that are not fit for carbon reduction. These matters are discussed further in **paragraphs 29 to 33**.
Staff capacity and skills gaps 	Public bodies told us existing staff capacity is stretched delivering public services. Decarbonisation is a complex area and public bodies feel they do not have the skills and expertise in this area. There is considerable competition for people with specialist expertise and knowledge. Financial constraints make it difficult for some bodies to bring in additional staff. In addition, as the private sector can offer higher salaries, public bodies are at a disadvantage in attracting staff.

Understanding the activities required

Public bodies are still building an understanding of the specific activities that are needed to decarbonise and how these should be prioritised. Public bodies feel that they need additional support and guidance on how to translate the strategic approach into action.

Culture, education and training

Embedding decarbonisation in day-to-day activities can represent a significant cultural shift. Some public bodies told us that decarbonising is complex and it may be difficult to change longstanding approaches to delivery.

Some bodies said there is the potential for staff apathy to having to undertake additional decarbonisation activities on top of the day job. Significant communication with staff will be required to obtain buy in and extensive training will also be needed to upskill staff to deliver.

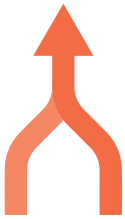
Technology and infrastructure

Many new technologies are expensive and public bodies are cautious about investing due the risks of the technology not being effective or becoming obsolete.

In other areas, such as the development of electric-powered ambulances and fire appliances, public bodies told us the technologies were not developing quickly enough and in some cases were prohibitively expensive.

There were also concerns about a lack of electric charging points and insufficient grid capacity to cope with the growing reliance on electricity.

Supply and demand issues are also a problem in relation to some new technologies, where technologies are sought-after but are limited in supply.

Data 	Public bodies recognised the usefulness of having a common methodology for reporting carbon emissions. However, some responses pointed to concerns over calculation methods, particularly regarding supply chain and land use, and called for further clarity of definitions to ensure consistency. Some responses noted that existing systems were not able to capture the required data, and had to be updated, or new systems had to be put into place. This was often time consuming and resource intensive. NHS bodies raised concerns about duplication with existing reporting arrangements on emissions.
Joined-up approach 	Some respondents told us that a wholesale change of thinking is required, with a more co-ordinated and joined-up approach across the public sector, driven by the Welsh Government. One example given related to the assessment of new and emerging technologies. Public bodies were concerned about investing in technologies that were quickly superseded or were not best practice, so a single public sector-wide decision over what is best would help mitigate this risk.
Third parties 	Third parties have a role to play in helping public bodies move towards the 2030 collective ambition. For example, emissions from partners in the procurement chain, and the high demand for limited specialist resources and newer technologies such as electric vehicles meaning they are often not available. The Office of the Future Generations Commissioner for Wales has recommended previously that public bodies should set out clearly how they have considered the carbon impact of their procurement decisions[11].

Source: Audit Wales call for evidence

11 Office of the Future Generations Commissioner, Procuring well-being in Wales, February 2021.

51 While public bodies identified a range of barriers to achieving the 2030 collective ambition, they also see some opportunities associated with decarbonisation (**Exhibit 19**) and shared with us some examples of interesting practices that they felt other bodies could potentially learn from (**Exhibit 20**).

Exhibit 19: some opportunities that public bodies told us about in relation to decarbonisation

Public bodies highlighted opportunities to:

- build on the profile of climate change from COP26 to take advantage of the raised public awareness and build relationships with local communities and other stakeholders;
- increase collaboration with other organisations, to share best practice in working towards decarbonisation and to develop local procurement approaches;
- increase the use of new and developing technologies, realise cost savings from renewable energies and consider the economic and job creation possibilities arising from new green industries;
- increase awareness of the urgency of decarbonisation with staff, executives, boards and members, and to revise governance and leadership arrangements to ensure decarbonisation is incorporated into everyday business and decision making; and
- build on flexible working practices that arose during the COVID-19 pandemic to further exploit digital technologies in service delivery and everyday working.

Source: Audit Wales call for evidence

Exhibit 20: some examples of interesting practices that other bodies could learn from

Cardiff and Vale University Health Board

The health board is involved in an initiative called Green Health Wales to build a community of healthcare professionals who can share experience with their colleagues across the country. Green Health Wales aims to empower the health and social care sector with the tools and knowledge to address the climate crisis.

The health board has not estimated the cost of net zero building infrastructure on the current estate configuration, however, specialists in 2021 estimated that in a new-build scenario of the University Hospital of Wales and the University Hospital Llandough, the cost of net zero building infrastructure could be between £89 million and £266 million.

Denbighshire County Council

The council established its cross-party Climate Change and Ecological Emergency Working Group after declaring the climate and ecological emergency. A key recommendation from the working group was to amend the council's constitution to include the need to have 'regard to tackle climate and ecological change' in the principles of decision making. The council has now formally committed to consider climate and ecological change when making all council decisions.

Swansea Bay University Health Board

The health board is developing a trajectory tool to measure the impact of different scenarios of financial input into decarbonisation measures. It will use the tool to monitor the efficacy of its decarbonisation measures.

A solar farm is directly connected to Morriston Hospital which supplies 30% of its electricity.

Blaenau Gwent County Borough Council

The council has been involved in establishing a mitigation steering group through the Blaenau Gwent Local Well-being Partnership, and residents' priorities have informed the group's work through the recommendations of the Blaenau Gwent Climate Assembly. The council, in its decarbonisation plan, has identified a number of transition pathways to follow in order to achieve net zero. Each transition pathway represents a coherent area of action with distinct, low carbon technologies, business models and infrastructure. These pathways have been developed to allow each to proceed at their own appropriate pace. Achievement of the pathways is supported by best practice readiness assessments adapted from tools developed by Place-Based Climate Action Network for Leeds Climate Commission.

Rhondda Cynon Taf County Borough Council

The council has established a 'Let's Talk' engagement website where members of the public can leave comments and ideas about a range of climate change matters.

Natural Resources Wales (NRW)

NRW's Carbon Positive Project, part funded by the Welsh Government to show leadership in how the public sector can measure and reduce its carbon impact, has informed the development of both the public sector route map and the net zero reporting guide. As part of the project, NRW is taking steps to not just reduce carbon emissions but enhance and protect carbon stored on the land it manages and share its experiences to encourage further decarbonisation in Wales.

Neath Port Talbot Council

The council is collaborating with a private company that specialises in the re-use of waste gases from industrial processes to enable conversion into biofuels. The plan is to deliver a pilot project within Neath Port Talbot which will utilise waste gases from the steel industry. It is anticipated that once fully operational, the plant will generate 30 million gallons of biofuels for use in the aviation industry each year.

The council's Lost Peatlands Project seeks to restore more than 540 hectares of historic landscape and habitat, including peat bogs and pools, heathland, grassland and native woodland.

Numerous public bodies

Several organisations gave us examples of:

- using the new construction or redevelopment of facilities to significantly improve their carbon footprint;
- procurement of low emission vehicles;
- installation of electric vehicle charging points;
- renewable energy generation on site;
- development of operational staff networks; and
- installation of energy efficient heating and lighting systems.

Source: Audit Wales call for evidence

Appendices

1 Audit approach and methods

1 Audit approach and methods

In November 2021, we issued a call for evidence to 48 public bodies, asking questions about their baseline position in achieving the 2030 collective ambition. Most public bodies responded in the period December 2021 to January 2022. We sent the call for evidence to the bodies covered by the Well-being of Future Generations (Wales) Act 2015 at the time. This included all principal councils, fire and rescue authorities, national park authorities, health boards and NHS trusts, and the larger Welsh Government sponsored bodies.

We also sent the call for evidence to the Welsh Ambulance Services NHS Trust, Digital Health and Care Wales, and Health Education and Improvement Wales to ensure we had a more complete picture across the NHS. We also sent the call for evidence to NHS Wales Shared Services Partnership (NWSSP), which is an independent mutual organisation, owned and directed by NHS Wales, that delivers a range of services for and on behalf of NHS Wales. NWSSP is hosted by and operates under the legal framework of Velindre University NHS Trust, which is itself covered by the Well-being of Future Generations (Wales) Act 2015.

We received responses from all bodies that were sent the call for evidence although in a small number of instances not all questions were answered. Where questions were not answered by all public bodies, this is set out in a note to each relevant graph.

To inform our work we held discussions with relevant stakeholders including the Welsh Government, the Office of the Future Generations Commissioner for Wales, representatives of NHS Wales and the Welsh Local Government Association. We also reviewed key documents, including policies and guidance, and other relevant information provided to us by the Welsh Government and other stakeholders.

We did not undertake a detailed review at each of the public bodies. While we have largely relied on what they reported through their call for evidence responses and any supporting documentation, we have also sought to triangulate our findings through discussions with stakeholders and evidence from our wider document and data review. We also shared and discussed our emerging findings at a public webinar held in May 2022. 109 people from outside Audit Wales attended the webinar, representing a range of public, private and third sector organisations.

As stated earlier in this report, the Auditor General has committed to a long-term programme of work on climate change. We have already reported on the decarbonisation efforts of fire and rescue authorities, we have begun to review council decarbonisation action plans and we are preparing a report on flood risk management. Following a recent consultation on our future work programme, we are considering our next steps in relation to auditing actions to decarbonise and to adapt to the changes already happening to our climate.

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AGENDA ITEM No	**6**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**2**

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

MEETING	Audit Committee
DATE	1st December 2022
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Julie Boalch, Head of Risk, Deputy Board Secretary
CONTACT	Julie.Boalch@wales.nhs.uk

EXECUTIVE SUMMARY

1. The purpose of the report is to provide assurance in respect of the management of the Trust's 18 principal risks.

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

3. The BAF, in Annex 2, provides the Committee with an opportunity to review the controls in place against each principal risk and the assurance provided against those control where applicable. This will assist Members in evaluating current risk ratings.

4. The gaps in controls and assurance are set out on the BAF, as are the actions planned to address any gaps. This detail provides Members with an insight into the planned activity, as much as can be anticipated from time to time, to reduce the risk to a level of tolerance set by the target score. This format will continue to evolve as part of the risk transformation programme.

5. Risks are allocated to appropriate Directors to drive the reviews and actions to mitigate the risks. In addition to directorate reviews there are formal risk review discussions with the Assistant Directors Leadership Team (ADLT) and the Executive Management Team (EMT) in relation to risk escalation, changes in ratings, and any new risks for inclusion on the Corporate Risk Register.

6. In addition, this paper provides a progress update in respect of the Risk Transformation Programme as detailed in the Integrated Medium Term Plan (IMTP) (2022/25).

RECOMMENDATION:

7. **Members are asked to consider and discuss the contents of the report and:**
   a) **Note the closure of Risk 311 from the Corporate Risk Register.**
   b) **Note the inclusion of the new Risk 557 on the Corporate Risk Register at a score of 16.**
   c) **Review the Board Assurance Framework.**
   d) **Note the update on the Risk Management Transformation Programme.**

KEY ISSUES/IMPLICATIONS
The key issues and implications are set out in the Executive Summary above.

REPORT APPROVAL ROUTE
The report has been considered by: • ADLT – 17th October 2022 • ADLT – 31st October 2022 • EMT – 9th November 2022 • Trust Board – 24th November 2022 Each of the Corporate Risks were considered by the following Committees, as relevant to their remit, during the reporting period: a) **People & Culture Committee** (5th September 2022) b) **Quality, Safety & Patient Experience** (10th November 2022) c) **Finance & Performance Committee** (14th November 2022)

REPORT ANNEXES
• SBAR report. • Annex 1 - Summary table describing the Trust's Corporate Risks. • Annex 2 - Board Assurance Framework

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

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

SITUATION

1. The purpose of this report is to provide an activity update in relation to the Trust's 18 Corporate Risks.

2. A summary report describing each of the Corporate Risks as of 31st October 2022 is detailed in Annex 1.

3. The risk owners have updated progress against these risks in accordance with the review schedule in place across the Trust, with the highest scoring risks reviewed monthly.

4. The Board Assurance Framework (BAF) report is included in the paper in Annex 2.

BACKGROUND

5. The Board Assurance Framework provides Members with an opportunity to review the controls in place against each principal risk and the assurance provided against those control where applicable. This will assist Members in evaluating current risk ratings.

6. Risks are allocated to appropriate Directors to drive the reviews and actions to mitigate the risks. In addition to directorate reviews there are formal risk review discussions with the Assistant Directors Leadership Team (ADLT) and the Executive Management Team (EMT) in relation to risk escalation, changes in ratings, and any new risks for inclusion on the Corporate Risk Register.

ASSESSMENT

7. There are currently 18 Corporate Risks on the register which are described in the summary table in Annex 1. The table sets out the articulation of each of the Corporate Risks including new titles and summary descriptions, utilising an '*if, then, resulting in*' approach, the Executive Owner of the Risk and the Risk score with any changes that have occurred during the period.

8. The EMT has approved the Corporate Risk activity described in this paper.

Corporate Risks

9. The full detail of each Corporate Risk, including controls, assurances, gaps and mitigating actions form part of the improved Board Assurance Framework (BAF) detailed in Annex 2.

10. In addition, Members are asked to note that the actions, which were contained in the July 2022 Board paper on avoidable harm and outlined at the last meeting, are included in the action section of the BAF for the Trust's highest scoring risks 223 and 224 which are both rated 25. These actions seek to mitigate in real time,

avoidable harm in the context of extreme and sustained pressure across the urgent and emergency care service.

Closure and De-Escalation of Risks

11. As foreshadowed at the September 2022 Board meeting, the Executive Risk Owner and ADLT recommended that Risk 311 be closed from the Corporate Risk Register which was approved by the EMT.

12. **Risk 311** - Inability of the Estate to cope with the increase in FTEs

IF *the cumulative impact on the estate of the EMS Demand & Capacity Review and the NEPTS Review is not adequately managed*

THEN *there is a risk that the Estate will not be able to cope with the increase in FTEs*

RESULTING IN *potential failure to achieve the benefits/outcomes of the programme and reputational damage to the Trust*

13. This risk was created to provide an organisational focus that ensured the Trust had sufficient estate to cope with increases in staff associated with the EMS Demand & Capacity Review and the NEPTS Demand & Capacity Review, in particular, closing the relief gap in EMS Response. Managing this risk has largely been discharged through the estate interim plan within the EMS Operations Transformation Programme; therefore the risk can be closed.

14. There is however, a generic and ongoing risk that the Trust's technical planning is not sufficiently integrated to appropriately manage changes to the workforce and the associated knock on impact on the estate. A new risk will be developed during the next reporting cycle to articulate this as a risk.

New Corporate Risks

15. One new risk has been assessed and approved for inclusion on the CRR as follows:

16. **Risk 557** - *Potential impact on services as a result of Industrial Action*

IF *trade unions take industrial action in response to the national pay award*

THEN *this is likely to disrupt our ability to provide a safe, efficient and good quality service in the 6 core areas the business.*

RESULTING IN *potential harm to patients, adverse effect to patient outcomes, increase in SAIs/concerns/coroners cases, negative media reports, and impact on the Trust's corporate reputation.*

17. The Executive Risk Owner and ADLT recommended the inclusion of the risk on the CRR at a score of 16 (4x4) which was approved by the EMT.

Transfer of Risks

18. No risks have transferred between Directorates or Committees during this reporting period.

Changes to Risk Scores

19. There have been no changes to risk scores since the last meeting in September 2022.

Development of New Risks

20. **Risk 538** - A risk has been developed to reflect the possible consequence of a further delay to the implementation of the new Integrated Information System (Salus); however, due to ongoing commercial discussions and a delay to some delivery milestones, the detail of this risk will need to be reviewed and finalised to capture the emerging position and differentiate it from any realised issues. An update is expected from the Programme team and the supplier that will shape the final risk assessment ahead of presentation to Trust Board in January 2023.

21. **Risk 542** - *Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Plan*

    This risk has been fully articulated and is navigating Trust risk governance processes. It is expected that this will be included on the CRR during the next reporting cycle.

Further Review of Risks

22. Work continues to consider and develop potential new Risks for inclusion on the CRR in the following areas:

    - *Patient Safety/Putting Things Right Team*
    - *Supply Chain Issues – Digital Equipment*
    - *Business Continuity Risks*
    - *Securing Stakeholder Support to Deliver the Strategy and IMTP*
    - *Capacity to deliver change (IMTP)*
    - *Ongoing Impact of CoVID and Increasing Demand for Services (IMTP)*

Board Assurance Framework

23. The BAF is included at annex 2 which focusses the Board on the key risks that are mapped to the IMTP deliverables and that might compromise the achievement of the Trust's strategic objectives. Until such time as the more mature and strategic BAF is developed during 2023/24 as part of the risk transformational programme, these key risks are the corporate risks due to their relationship to the IMTP delivery and their risk ratings.

Risk Management Transformation Programme

24. The Risk Management Transformation Programme was included in the IMTP (2022/2). The immediate priority of the programme was to undertake a detailed

review of each of the Trust's Corporate Risks which has been completed. This work strengthened the articulation of these risks and any new risks including title, summary descriptions, controls, assurances and any gaps or additional actions required.

25. The programme reports to the Strategic Transformation Programme Board and all elements are currently on target; however, Committee are asked to note that the Risk Management Policy and associated procedures will be presented at the meeting in March 2023 rather than December 2022 for approval.

RECOMMENDED

26. **Members are asked to consider and discuss the contents of the report and:**
    a. **Note the closure of Risk 311 from the Corporate Risk Register.**
    b. **Note the inclusion of the new Risk 557 on the Corporate Risk Register at a score of 16.**
    c. **Review the Board Assurance Framework.**
    d. **Note the update on the Risk Management Transformation Programme.**

Annex 1 – Corporate Risk Register Summary

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
223 QuEST	The Trust's inability to reach patients in the community causing patient harm and death	**IF** significant internal and external system pressures continue **THEN** there is a risk of an inability and/or a delay in ambulances reaching patients in the community **RESULTING IN** patient harm and death	Director of Operations	**25 (5x5)** →
224 QuEST	Significant handover delays outside A&E departments impacts on access to definitive care being delayed and affects the trust's ability to provide a safe and effective service	**IF** patients are significantly delayed in ambulances outside A&E departments **THEN** there is a risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised **RESULTING IN** patients potentially coming to harm and a poor patient experience	Director of Quality & Nursing	**25 (5x5)** →
160 PCC	High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service	**IF** there are high levels of absence **THEN** there is a risk that there is a reduced resource capacity **RESULTING IN** an inability to deliver services which adversely impacts on quality, safety and patient/staff experience	Director of Workforce & Organisational Development	**20 (5x4)** →
201 PCC	Damage to Trust reputation following a loss of stakeholder confidence	**IF** the stability of the Trust deteriorates to a level where service delivery fails to meet patient safety, national standards and contractual obligations **THEN** there is a risk of a loss of stakeholder confidence in the Trust **RESULTING IN** damage to reputation and increased external scrutiny	Director of Partnerships & Engagement	**20 (4x5)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
139 FPC	Failure to Deliver our Statutory Financial Duties in accordance with legislation	**IF** the Trust does: • not achieve financial breakeven and/or • does not meet the planning framework requirements and/or • does not work within the EFL and/or • fails to meet the 95% PSPP target and/or • does not receive an agreement with commissioners on funding (linked to 458) **THEN** there is a risk that the Trust will fail to achieve all its statutory financial obligations and the requirements as set out within the Standing Financial Instructions (SFIs) **RESULTING IN** potential interventions by the regulators, qualified accounts and impact on delivery of services and reputational damage	Director of Finance & Corporate Resources	**16 (4x4)** →
244 FPC	Estates accommodation capacity limitations impacting on EMS Clinical Contact Centre's (CCC) ability to provide a safe and effective service	**IF** the Trust is unable to increase accommodation capacity **THEN** there is a risk that EMS CCC will not be able to accommodate all roles during periods of escalation and surge management or expand operations to support new initiatives **RESULTING IN** EMS CCC being unable to deliver services effectively which adversely impacts on quality, safety and patient/staff experience	Director of Operations	**16 (4x4)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
245 FPC	Failure to have sufficient capacity at an alternative site for EMS Clinical Contact Centres (CCCs) which could cause a breach of Statutory Business Continuity regulations	**IF** CCCs are unable to accommodate additional core functions and do not have alternative site arrangements in place in the event of a business continuity incident **THEN** there is a risk that EMS CCCs cannot utilise other CCC's space, accommodation and facilities **RESULTING IN** potential patient harm and a breach of the requirements of the Civil Contingencies Act (2004) and Contingency Planning Regulations (2005)	Director of Operations	**16 (4x4)** →
458 FPC	A confirmed commitment from EASC and/or Welsh Government is required in relation to funding for recurrent costs of commissioning	**IF** sufficient recurrent funding is not forthcoming there is a risk that the Trust will be committed to additional expenditure through delivery of the IMTP and in year developments which are only recognised by commissioners on a cost recovery basis **THEN** there is a risk that the Trust may not be able to deliver services and there will be a lack of funding certainty when making recurrent cost commitments. Any potential 'exit strategies' from developed services could be challenging and harmful to patients. **RESULTING IN** patients not receiving services, the Trust not achieving financial balance and a potential failure to meet statutory obligations causing reputational damage	Director of Finance & Corporate Resources	**16 (4x4)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
NEW 557 **PCC**	Potential impact on services as a result of Industrial Action	**IF** trade unions take industrial action in response to the national pay award **THEN** this is likely to disrupt our ability to provide a safe, efficient and good quality service in the 6 core areas the business **RESULTING IN** potential harm to patients, adverse effect to patient outcomes, increase in SAIs/concerns/coroners cases, negative media reports, and impact on the Trust's corporate reputation	Director of Workforce & Organisational Development	**16 (4x4)**
199 PCC	Failure to embed an interdependent and mature health and safety culture which could cause harm and a breach in compliance with Health & Safety statutory legislation	**IF** there is a failure to embed an interdependent and mature health and safety culture, effective arrangements and associated governance **THEN** there is a risk of a potential breach in compliance with the requirements of the Health & Safety at Work etc. Act 1974 and associated regulations and other statutory instruments **RESULTING IN** death or serious injury, and punitive actions from multiple enforcement agencies including penalties and adverse publicity leading to damage to reputation	Director of Quality & Nursing	**15 (3x5)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
260 FPC	A significant and sustained cyber-attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems	**IF** there is a large-scale cyber-attack on WAST, NHS Wales and interdependent networks which shuts down the IT network and there are insufficient information security arrangements in place **THEN** there is a risk of a significant information security incident **RESULTING IN** a partial or total interruption in WAST's ability to deliver essential services, loss or theft of personal/patient data and patient harm or loss of life	Director of Digital Services	**15 (3x5)** →
543 FPC	Major disruptive incident resulting in a loss of critical IT systems	**IF** there is an unexpected or uncontrolled event e.g. flood, fire, security incident, power failure, network failure in WAST, NHS Wales or interdependent systems **THEN** there is a risk of a loss of critical IT systems **RESULTING IN** a partial or total interruption in WAST's effective ability to deliver essential services	Director of Digital Services	**15 (3x5)** →
558 PCC	Deterioration of staff health and wellbeing in as a consequence of both internal and external system pressures	**IF** significant internal and external system pressures continue **THEN** there is a risk of a significant deterioration in staff health and wellbeing within WAST **RESULTING IN** increased sickness levels, staff burnout, poor staff and patient experience and patient harm	Director of Workforce & Organisational Development	**15 (3x5)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
100 FPC	Failure to persuade EASC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience	**IF** WAST fails to persuade EASC/Health Boards about WAST ambitions **THEN** there is a risk of a delay or failure to receive funding and support **RESULTING IN** a catastrophic impact on services to patients and staff and key outcomes within the IMTP not being delivered	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 Workforce & Organisational Development	**12 (3x4)** →
283 FPC	Failure to implement the EMS Operational Transformation Programme	**IF** there are issues and delays in the planning and organisation of the EMS Demand & Capacity Review Implementation Programme **THEN** there is a risk that WAST will fail to implement the EMS Operational Transformation Programme to the agreed performance parameters **RESULTING IN** potential patient harm, deterioration in staff wellbeing and reputational damage	Director of Strategy Planning & Performance	**12 (3x4)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
311 FPC **CLOSED**	Inability of the Estate to accommodate the increase in FTEs	**IF** the cumulative impact on the estate of the EMS Demand & Capacity Review and the NEPTS Review is not adequately managed **THEN** there is a risk that the Estate will not be able to cope with the increase in FTEs **RESULTING IN** potential failure to achieve the benefits/outcomes of the programme and reputational damage to the Trust	Director of Finance & Corporate Resources	**12 (3x4)** →
424 FPC	Prioritisation or Availability of Resources to Deliver the Trust's IMTP	**IF** resources are not forthcoming within the funding envelope available to WAST (link to risk 139) **THEN** there is a risk that there is insufficient capacity to deliver the IMTP **RESULTING IN** delay or non-delivery of IMTP deliverables which will adversely impact on the Trust's ability to deliver its strategic objectives and improvement in patient safety and staff wellbeing	Director of Strategy Planning and Performance	**12 (3x4)** →

Annex 2 – Board Assurance Framework

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	18/10/2022	TREND	25 (5x5)
		Date of Next Review:	18/11/2022		

IF	THEN	RESULTING IN		Likelihood	Consequence	Score
significant internal and external system pressures continue	there is a risk of an inability and/or a delay in ambulances reaching patients in the community	patient harm and death	Inherent	4	5	20
			Current	5	5	25
			Target	2	5	10

IMTP Deliverable Numbers: 3, 7,9,11, 12, 14,16, 18, 21, 22, 26

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

CONTROLS	ASSURANCES
1. Patient Flow Co-Ordination based in the Grange University Hospital	**Internal** **Management (1st Line of Assurance)** 1. Patient Flow Coordinators (PFCs) are a commissioned service by the Health Board (x2 in ABUHB specifically for GUH) with a bespoke job description, these link directly with the National Delivery Managers in ODU
2. Regional Escalation Protocol	2. Daily conference calls to agree RE levels in conjunction with Health Boards
3. Immediate release protocol	3. 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)
4. Resource Escalation Action Plan (REAP)	4. 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.
5. 24/7 Operational Delivery Unit (ODU)	5. Shift reports from ODU & ODU Dashboard received by Exec, SOT and On-Call Team at start/end. Provides operational oversight with dynamic CSP review and system escalation as required.
6. Gold/Strategic, Silver/Tactical and Bronze/Operational 24 hour/ 7 day per week system to manage escalation plans	6. Same as 5 - Shift reports from ODU & ODU Dashboard received by Exec, SOT and On-Call Team at start/end. Provides operational oversight with dynamic CSP review and system escalation as required.
7. Limited Alternative Care Pathways in place	7. 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.
8. Consult and Close (previously Hear and Treat)	8. Monitoring CSD rates through AQIs. Consult and Close volumes form part of EMS CCC weekly reports to SLT. Regular reporting of incident volumes to Operational Review Groups. Summary level information about Consult and Close volumes, targets, trends and recontact rates reported to TB and sub-committees. Metrics relating to Ambulance Quality Indicators (AQI) published on a quarterly basis by EASC. Bi-monthly EASC Provider reports. Consult and Close performance reported in Joint Executive Team meeting every 6 months with Welsh Government. NWSSP Information Management Internal Audit report February 2022 (External Assurance)
9. Advanced Paramedic Practitioner (APP) deployment model	9. Qlik sense APP dashboard monitors performance and provides assurance that APPs are flowing patients into alternatives to emergency department. Qlik sense is a national report and can drill down into regional, local and individual performance as required
10. Clinical Safety Plan	10. Clinical agreement – agreeing escalation to higher levels, ODU dashboard, AACE paper through National Director of Operations group
11. Recruitment and deployment of CFRs	11. Volunteers are another resource for response, Volunteer
12. ETA scripting	12. The ETA Dashboard is a tactic that was signed off by EMT – there is a dashboard that supports scripting analysed by comparing with real time data
13. Clinical Contact Centre (CCC) emergency rule	13. CCC Emergency Rule is policy that has been signed off by Execs.
14. National Risk Huddle	14. 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.
15. Handover Improvement Plans agreed between Health Boards and WAST	15. Improvement plans are reviewed by EAST
16. Summer/Winter initiatives	16. Monitoring through SLT and STB
17. CHARU implementation	17. Monitored via the EMS project Board
18. National Transfer & Discharge Model	18. Task and Finish Group established

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	18/10/2022	TREND	25 (5x5)
		Date of Next Review:	18/11/2022		

IF significant internal and external system pressures continue	THEN there is a risk of an inability and/or a delay in ambulances reaching patients in the community	RESULTING IN patient harm and death		Likelihood	Consequence	Score
			Inherent	4	5	20
			Current	5	5	25
			Target	2	5	10

19. Conveyance Reduction	19. This is part of the weekly performance review and aligned to Care Closer to Home Programme
20. Access to Same Day Emergency Care (SDEC) for paramedic referrals	20. This forms part of the handover improvement plans in place with Health Boards
21. Mental Health Practitioners in cars	21. Part of the Care Closer to Home workstream
22. Roll out of ECNS	22. Reported through QuEST
23. Clinical Model and clinical review of code sets	23. Reported through QuEST
24. Remote Clinical Support Strategy	24. Strategic Transformation Board – IMTP deliverable
25. 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)	25. Formally documented action plan – actions captured are contained within and monitored via the Performance Improvement Plan (PIP)
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Acknowledgement and acceptance of risk by Health Boards and balancing the risks across the whole system	None immediately identified but subject to continual review
2. Blockages in system e.g. internal capacity within Health Boards which affect patient flow	
3. Covid capacity streaming	
4. Transition Plan/Inverted Triangle – bid for transition plan has been put in and is now subject to funding	
5. Local delivery units mirroring WAST ODU	
6. Handover delays link to risk 224	
7. Tolerance in Health Boards has become the norm. As delays have increased, there appears to be no visible appetite to address these issues	
8. There is an ambition that no handover should exceed 4 hours and for lost hours to handover to be reduced by 25% but given the track record over last 6 months there is a low confidence in attaining this.	
9. Outputs from the NHS System Reset – it is a closer collaboration to address some of the system blockages and reduce system pressures. This is the aspiration	
Please note that the gaps listed are not WAST's and are therefore outside of the control of WAST	

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	31.12.22	Rural model options are being explored. Discussions have been opened up with one workshop held another scheduled for 28th October 2022 with the aim of producing a set of recommendations for consideration by SLT and EMT.
2. Leading Change Together (forum to progress workforce related work streams jointly with TUPs)	ADLT Sub-Group	30.09.22 - Paused	
3. EMS Demand & Capacity i.e. review and implementation of new EMS rosters	Assistant Director of Operations EMS	Extended from 30.09.22 to 31.12.22	On schedule to implement all EA and UCS rosters by the end of November 2022. CHARU rosters may drift into December 2022 due to recruitment and training.
4. Transition arrangements post pandemic	Executive Pandemic Team / Assistant Director of Strategic Planning (BCRT Chair)	Complete 30/08/22	Transition complete
5. Recruit and train more Advanced Paramedic Practitioners – Value Based Healthcare Fund bid for up to 50 WTE (I) [Source: Action Plan presented to Trust Board 28/07/22]	TBA	TBA	

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	18/10/2022	TREND	25 (5x5)
		Date of Next Review:	18/11/2022		

IF significant internal and external system pressures continue	THEN there is a risk of an inability and/or a delay in ambulances reaching patients in the community	RESULTING IN patient harm and death		Likelihood	Consequence	Score
			Inherent	4	5	20
			Current	5	5	25
			Target	2	5	10

6. Maximise the opportunity from Consult and Close – stretch to 15% and beyond (I) [Source: Action Plan presented to Trust Board 28/07/22]	Assistant Director of Operations, Integrated Care	31.12.22	Work undertaken to map influences and progress towards each. Trajectory cast until December 2022 - 15% to be achieved through efficiencies.
7. 24/7 operational oversight by ODU with dynamic CSP review and system escalation as required (I) [Source: Action Plan presented to Trust Board 28/07/22]	Assistant Director of Operations, National Operations & Support	Complete	System in place and ongoing.
8. Weekly REAP review by senior Operations Directorate team with assessment of action compliance (I) Source: Action Plan presented to Trust Board 28/07/22]	Director of Operations / Operations Senior Leadership Team	Complete	In place and ongoing - Weekly Performance Meetings occur every Tuesday lunchtime to review performance, etc and determine REAP level.
9. Recruitment and deployment of new CFRs (I) [Source: Action Plan presented to Trust Board 28/07/22]	Assistant Director of Operations, National Operations & Support / National Volunteer Manager	Ongoing	Additional CFR Trainers and Operations Assistants appointed to support recruitment and training of new CFRs. Volunteer Management Team, supported by the Volunteer Steering Group, now embarking on volunteer recruitment programme and increasing public engagement to raise awareness about volunteering opportunities available within WAST.
10. Transition Plan (I) [Source: Action Plan presented to Trust Board 28/07/22]			
11. Overnight Falls Service extension (I) [Source: Action Plan presented to Trust Board 28/07/22]	Assistant Director of Quality & Governance / Head of Quality Improvement	TBA	Level 2 Falls Service implemented as a pilot. Awaiting evaluation of the pilot and assessment of outcomes and potential longevity of this initiative.
12. External Controls detailed within the Action Plan presented to Trust Board on 28/07/22: a. Audit Wales's investigation of Urgent and Emergency Care System. Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time? (E) b. Consideration of additional WAST schemes to support risk mitigation through winter (I) c. NHS Wales educes emergency department handover lost hours by 25% (E) d. NHS Wales eradicates all emergency department handover delays in excess of 4 hours (E) e. Alterative capacity equivalent to 1000 beds (E) f. Implement nationwide approach to emergency department 'Fit 2 Sit' (E) g. Implementation of Same Day Emergency Care services in each Health Board (E) h. National Six Goals programme for Urgent and Emergency Car (E)			

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:	31/10/2022	TREND	25 (5x5)
		Date of Next Review:	30/11/2022	→	

IF patients continue to be significantly delayed in ambulances outside Accident and Emergency Departments	**THEN** there is a continued risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised	**RESULTING IN** patients coming to significant harm and a poor patient experience		Likelihood	Consequence	Score
			Inherent	5	5	25
			Current	5	5	25
			Target	3	2	6

IMTP Deliverable Numbers: 7,9, 10, 11, 12, 13, 14, 15, 16, 23, 24, 25, 26, 33, 35

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

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 Delivery Unit under the *Framework for the Investigation of Patient Safety Serious Incidents (SIs)* V2.2, dated July 2019.	1. Patient safety reporting and escalation through the Serious Clinical Incident Panel (SCIF), Patient Safety Highlight Reports, Health Board specific reports in place with escalation through WAST governance framework.
2. WAST membership of the working group 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 commended in August 2022.	2. Workshop with system partners in place with executive directors of nursing attendance – next meeting 08.09.2002 – plan to finalise revised approach to Appendix B process by November 2022.
3. WAST and system compliance with National Standards - 15-minute handover (NHS Wales Hospital Handover Guidance v2 (May 2016)	3. Monthly Integrated Quality and Performance Report, Health Informatics reports, APP dashboard monitors, reports on app use by Consultant Connect and shared at local and corporate meetings regarding patient safety and handover of care position across NHS Wales and NHS England.
4. WAST Clinical Notice in place - Escalating a clinical concern with a deteriorating patient outside the Emergency Department (11.02.2021). National Early Warning Score (NEWS) trigger of 5 or above for escalation to hospital clinicians. NEWS data available via EPCR (electronic patient care record).	4. NEWS data now available via ePCR and escalation system in place. Learning from incident reporting processes.
5. Workstreams put in place to meet requirements of *Right care, right place, first time Six Goals for Urgent and Emergency Care A policy handbook 2021–2026.* Goal 4 incorporates the reduction of handover of care delays through collective system partnership. WAST membership at system workshops supported by Commissioners looking at handover of care delays which includes the implementation of the Fit2Sit programme and handover of care checklist pan NHS Wales. Learning from NWAS shared that indicates up to 20% of ambulance arrivals may be suitable for Fit 2 Sit Additionally, the Emergency Ambulance Services Committee (EASC) have stated that no delay should exceed 4 hours.	5. Monthly Integrated Quality and Performance Report
6. Hospital Ambulance Liaison Officer (HALO) (Some health Boards).	6. Patient Flow Coordinators (PFCs) are a commissioned service by the Health Board (x2 in ABUHB specifically for GUH) with a bespoke job description, these link directly with the National Delivery Managers in ODU.
7. Regional Escalation Protocol and Resource Escalation Action Plan (REAP).	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 via Strategic Command structure.
8. Staff from WAST, Health Boards and third sector organisations assisting to meet patient's Fundamentals of Care as best they can in the circumstances.	8. Confirmed through Healthcare Inspectorate Wales (HIW) workshops and Health & Care Standards self-assessment process
9. 24/7 Operational Delivery Unit (ODU) escalating handover delays / patient condition to Health Board colleagues.	9. Shift reports from ODU & ODU Dashboard received by Exec, SOT and On-Call Team at start/end. Realtime management and escalation of risks and harm with system partners. Triggering and escalation levels within CSP to best manage patient safety in the context of prevailing demand and available response capacity. Monitoring, escalation and reporting of extreme response or handover delays
10. Gold/Strategic, Silver/Tactical and Bronze/Operational 24 hour/ 7 day per week system to manage escalation plans.	10. Shift reports from ODU & ODU Dashboard received by Exec, SOT and On-Call Team at start/end.
11. Escalation forums to discuss reducing and mitigating system pressures.	11. Daily risk huddles are recorded, and documented actions are shared with stakeholders and progress monitored via the ODU.
12. WAST Education and training programmes include deteriorating patient (NEWs), tissue viability, dementia awareness, mental health.	12. Integrated Quality and Performance Report (June 85% target met)
13. Clinical audit programme	13. Clinical audit programme with oversight from the Clinical Quality Governance Group.

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:	31/10/2022	TREND	25 (5x5)
		Date of Next Review:	30/11/2022	→	

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

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

14. Workshop set up by the Deputy Chief Ambulance Commissioner to respond to the findings in the Health Care Inspectorate Wales (HIW) Report *Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover* (undertaken 2021). WAST has senior representation at this meeting. – assurance is that HIW approve and sign off WAST elements and Health Board elements of recommendations.	14. Workshop set up by the Deputy Chief Ambulance Commissioner to respond to the findings in the Health Care Inspectorate Wales (HIW) Report Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover (undertaken 2021). WAST has senior representation at this meeting.
15. Escalation of patient safety concerns by Trust Board: featured in provider reports to the Emergency Ambulance Committee (EASC); been the subject of Accountable Officer correspondence to the NHS Wales Chief Executive; numerous escalations to professional peer groups initiated by WAST Directors; and coverage at Joint Executive Meetings with Welsh Government. Evidence submission to Senedd Health and Social Care Committee. Written evidence submitted during Q4 21/22 to the committee to assist their inquiry into Hospital Discharge and its impact on patient flow through hospitals Report published in June 2022 containing 25 recommendations with recommendation six specifically WAST related stating "The Welsh Government should explain how the targets outlined in the Minister for Health and Social Service's statement of 19 May 2022 on urgent and emergency care and the Six Goals Programme to eradicate ambulance patient handover delays of more than four hours and reduce the average ambulance time lost per arrival by 25 per cent (from the October 2021 level) have been set. It should also confirm the target dates for the achievement of these targets."	15. Monthly Integrated Quality and Performance Report, CEO Reports to Trust Board and Board sub-committee oversight and escalation.
	External Sources of Assurance **Management (1st Line of Assurance)**
	1. Monitoring and oversight of the Ambulance Quality Indicators (AQIs) including handover of care timeliness and Commissioning Framework by the Chief Ambulance Services Commissioner (CASC) and Joint Executive Team meeting Welsh Government (I&E).
	2. Healthcare Inspectorate Wales (HIW) 'Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover' Report and system wide improvement plan with working group in place with WAST senior representation. Oversight by HIW and CASC
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
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.	1. Strengthen and triangulate patient safety metrics and look back data at ED, service and corporate level for baseline data for improvement projects and WAST reports.
2. Inconsistent review of potentially serious / catastrophic patient safety incidents in line with the Framework for the Investigation of Patient Safety Serious Incidents (SIs) V2.2, dated July 2019 (frequently referenced as 'Appendix B' Reports) by Health Boards pan NHS Wales and lack of ownership of system risks. Lack of whole system approach to handling patient safety incidents resulting from system pressures*.	2. Implementation of revised process, engagement and outcome and improvement measures at system level – to be confirmed.
3. Lack of implementation and holding to account regarding the NHS Wales of the Handover Guidance v2 and recognition of the patient safety risks pan NHS Wales*.	3. 15-minute handover target is not being achieved pan-Wales consistently and has led to a substantial growth in emergency ambulance handover lost hours from c6000 hours per month at the end of 2018 to in excess of 22000 hours per month during Q4 21/22 and Q1 22/23. This scale of lost emergency ambulance capacity has peaked at 30% per month of the entire emergency ambulance fleet..
4. Variation in responsiveness at Emergency Departments to the escalating concerns regarding patients' NEWS*.	4. Strengthen patient safety reports and audit processes as system embeds.
5. (a) Variation in appetite across the Health Boards to implement Fit2Sit, citing overcrowded emergency department waiting rooms as the reason. Limited confidence in system engagement to address Goal 4 and achieve reduction in handover delays*. 5. (b) Protracted timescales in the Right care, right place, first time Six Goals for Urgent and Emergency Care - A policy handbook 2021–2026. Goal 4 'Improving ambulance patient handover, ensuring no one arriving by ambulance at an Emergency Department waits more than 60 minutes from arrival to handover to a clinician – by the end of April 2025. The number of people waiting over this period for ambulance patient handover will reduce on an annual basis until that point'. No detail on incremental improvements required at emergency department level or oversight mechanisms. EASC have stated that no delay should exceed 4 hours although WAST is yet to see any demonstrable plans to support this*.	5. 15-minute handover target is not being achieved pan-Wales consistently.

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:	31/10/2022	TREND	25 (5x5)
		Date of Next Review:	30/11/2022	➡	

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

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

6. Variation pan Wales / England as position not implemented across all emergency departments*.	6.
7.	7.
8. Variation pan Wales / England as position not implemented across all emergency departments*.	8. Health & Care Standards self – assessment in progress.
9. Variable response pan Wales / England. WAST have minimal control on this at patient level*.	9.
10.	10.
11. Variable response pan Wales / England. WAST have minimal control on this at patient level*.	11.
12.	12.
13. Transition to ePCR impacting on data temporarily	13.
14. National steer required to confirm the accountability arrangements regarding patients in ambulances outside of the emergency departments. The seven Local Health Boards (LHBs) in Wales are responsible for planning and securing delivery of primary, community, secondary care services, and also the specialist services for their areas*.	14. HIW approve and sign off WAST elements of recommendations.
15.	15.
	External Gaps in Assurance 1. Lack of escalation and response to AQIs by the wider urgent care system and regulators
	2. Lack of collective system response to HIW 'Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover' Report. Meetings cancelled x 2 in May 2022. WAST has representation on the working group*

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
Right care, right place, first time Six Goals for Urgent and Emergency Care A policy handbook 2021–2026 – Goal 4: Rapid response in physical or mental health crisis.	CEO	• WAST is represented on the Clinical Reference Group by the Director of Paramedicine	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
Handover checklist implementation – Nationally WAST Quality Improvement (QI) Project	WAST QI Team (QSPE)	• Checkpoint Q4 2022/23	Timeframes awaited via Emergency Department Quality & Delivery Framework (EDQDF)
Implement nationwide approach to emergency department 'Fit 2 Sit'	CMO/CNO	• Acceptance at meeting of Chairs and CEOs led by Director General for Health and Social Services and the NHS Wales Chief Executive on 08.06.2022 that a national approach to Fit 2 Sit should be adopted. Chief Medical Officer and Chief Nursing Officer to champion development through peer groups • Checkpoint Q4 2022/23	Emergency Department Quality & Delivery Framework final version drafted for consultation / approval.
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	• Checkpoint Q4 2022/23	Incremental improvements to quality and safety data and information to enable triangulation. Access to ePCR data (NEWS) now available.
Continued Health Board interactions – my next patient, patient safety team dialogue – proactive conversations with Health Board Directors of Quality & Nursing.	Executive Director of Quality & Nursing	• Monthly	Monthly meetings continue to be held and the content of the health board reports are currently under review
HIW Improvement Plan / Workshop– WAST inputs / influencing improvements Response and improvement actions to Healthcare Inspectorate Wales Inspection report (2021) 'Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover' which links to Fundamentals of Care.	Assistant Director of Quality & Nursing	• August 2022 in progress • Checkpoint Q4 2022/23	

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:	31/10/2022	TREND	25 (5x5)
		Date of Next Review:	30/11/2022	➡	

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

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

Participation in the CASC led workshop to reform *the Framework for the Investigation of Patient Safety Serious Incidents (SIs) V2.2, dated July 2019*.	Assistant Director of Quality & Nursing	• Checkpoint post pilot Q4 2022/23	Revised joint investigation approach agreed which is to be piloted from November 2022.
Recruit additional frontline capacity – additional £3m non recurrent 22/23 allocation	Director of Workforce & Organisational Development	• Recruitment decision made at EMT on 15.06.2022 for 100 WTE with offers already made to ACA2s and EMTs on hold list • Courses to commence in Q2 2022/23 with first new deployments in Q3 2022/23 • Offers also made to all 61 NQPs from "Big Bang" event • Correspondence to CASC confirming action taken sent 21.06.2022 with request for recurrent funding source set out • End of Q3 and into Q4 2022/23	
Recruit and train more Advanced Paramedic Practitioners – Value Based Healthcare Fund bid for up to 50 WTE	Director of Paramedicine	• Bid to Value Based Healthcare Fund made for up to 50 WTE APPs to commence fulltime education for 12 months from January 2023 • Q4 2023/24	
Senior system influencing	Trust Chair Chief Executive Officer	• Ensure that system safety and avoidable harm remain a live topic of discussion in all relevant fora • Seize opportunities as they emerge that can contribute to mitigating avoidable harm • JESG forum used to raise awareness amongst Emergency Service Chief Officers who have written twice to NHS Wales Chief Executive to convey the impact of our inability to respond to incidents in the community on their core service provision	Ongoing
Emergency Department cohorting	Director of Operations	• Provide additional clinical staff and suitable space for patients arriving by ambulance to be held at the emergency department awaiting admission enabling the ambulance to be released • In place at Morriston and The Grange	Ongoing
Transition Plan	Chief Executive Officer	• Formally submitted to Commissioners in December 2021 and subsequently subject to a part year funding request of Welsh Government on 24 May 2022 this plan sought to grow our establishment to a further 294 WTE having forecast the challenges currently being seen • Around two thirds of the growth was to deploy additional response capacity (now provided in part by 4 above) whilst the system took action to reduce emergency department handover delays • Around one third of the growth was to accelerate the transition to a new model of service delivery (inverting the triangles) – also now subject to a separate bid as in 5 above	Transition now complete. **CLOSE**
Overnight falls service extension	Director of Quality & Nursing	• Review current extension to falls scheme that has temporarily been running on night duty • Benefit derived but further improvement in utilisation and overall volume of work undertake are necessary in the next 3 months • Scheme extension agreed to 31 March 2023	
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?	Chief Executive Officer	• Conducted in three phases over the next 6 to 9 months 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)	

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:	31/10/2022	TREND	25 (5x5)
		Date of Next Review:	30/11/2022		

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

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

		• WAST will proactively support this work and offer best practice examples from other jurisdictions that can support benchmarking and improvement activities • Q1 2023/2024	
Consideration of additional WAST schemes to support overall risk mitigation through winter	Director of Operations	• Summer performance forecast complete and winter underway imminently • Discussions underway during Q2 to create new/further schemes to support operational delivery through winter • Q3 2022/23	
National 111 awareness campaign	Director of Partnerships and Engagement Director of Digital	• National public awareness campaign funded by Welsh Government to promote appropriate use of services (111 as an alternative to 999/ED where appropriate) • Upgrade to 111 website and symptom checkers also underway • Q3 2022/23	

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:	18/10/2022	TREND	20 (5x4)
		Date of Next Review:	18/11/2022	➡	

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: 1,5, 9, 10, 12, 17, 18, 19, 20, 26, 34

EXECUTIVE OWNER	Director of Workforce & Organisational Development	ASSURANCE COMMITTEE	People and Culture Committee

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. Managing Attendance at Work Policy/Procedures in place	1. (a) Policy reviews to ensure policies and procedures are fit for purpose (b) Audits by People Services on sickness
2. Respect and Resolution Policy	2. Policy reviews to ensure policies and procedures are fit for purpose
3. Raising Concerns Policy	3. Policy reviews to ensure policies and procedures are fit for purpose
4. Health and Wellbeing Strategy	4.
5. Operational Workforce Recruitment Plans	5.
6. Roster Review & Implementation	6.
7. Return to Work interviews are undertaken	7.
8. Training	8.
9. Directors receives monthly email with setting out ESR sickness data	9.
10. Operational managers receive daily sickness absence data via GRS	10.
11. People Services & Occupational Health & Wellbeing support/Employee Assistance Programme	11.
12. WAST Keep Talking (mental health portal)	12.
13. Suicide first aiders	13.
14. TRiM	14.
15. Peer Support network	15.
16. Coaching and mentoring framework	16.
17. Staff surveys	17.
18. Stress risk assessments	18.
19. Sickness statistics are reported to SLT, SOT, People & Culture Committee, Trust Board and the CASC	19. Sickness forms part of Workforce Scorecard to People & Culture Committee
20. External agency support e.g. St John Ambulance, Fire and Rescue	20.
21. Strategic Equality Objectives	21. Policy reviews to ensure policies and procedures are fit for purpose
22. Volunteers	22.
23. Monthly reviews of colleagues on Alternative duties	23. Action plans arising from meetings with colleagues implemented through monthly diarised meetings
24. Manager guidance on managing Alternative duties	24.
25. Fortnightly report on absence to EMT and report to every meeting of People & Culture Committee	25. Minuted meetings and action logs for EMT & People & Culture Committee
	External Management (2nd Line of Assurance)
	1a. All Wales review of All Wales Attendance at Work Policy
	Independent Assurance (3rd Line of Assurance)
	1b. Internal Audits scheduled through Shared Services Partnership (controls 1 - 24)
	2. Audit Wales – Taking Care of the Carers report in October 2021 (controls 1 - 24)

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:	18/10/2022	TREND	20 (5x4)
		Date of Next Review:	18/11/2022	➡	

IF	THEN	RESULTING IN		Likelihood	Consequence	Score
there are high levels of absence e.g. sickness and alternative duties	there is a risk that there is reduced resource capacity	an inability to deliver services which adversely impacts on quality, safety and patient/staff experience	Inherent	4	4	16
			Current	5	4	20
			Target	3	4	12

GAPS IN CONTROLS	GAPS IN ASSURANCE
1. (a) Consistency and Application in Managing Attendance at Work Policy (b) Education and communication with managers about resources available and how to implement it e.g. stress risk assessments	1. There are other factors that impact on sickness which can't be controlled
4a. Wellbeing policy currently being produced 4b. There is no steering group for Health and Wellbeing – there are plans to restart the group	8. Reporting on training compliance
9 and 10 It is not known what is undertaken with respect to the data covered in assurances 9 and 10 once it is received	9, 10 and 19 Absence data is not updated in a timely manner into ESR by managers
1 – 22 Education and communication with managers about resources available and how to implement it e.g. stress risk assessments	
	External Gaps in Assurance None identified at the present moment

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Implementation of Improving Attendance project	Deputy Director of Workforce & OD	30.09.23	Underway and ongoing
2. Implementation of Behaviours Refresh Plan	Assistant Director – Inclusion, Culture and Wellbeing	31.10.22	Underway and ongoing
3. Long term sickness absence deep dive	Deputy Director of Workforce & OD	31.07.23	Underway and ongoing
4 . Develop guidance for line managers to support addressing challenging conversations and change	Deputy Director of Workforce & OD	31.07.22 Complete	Training written rollout underway - complete
5. Roll out platform for raising concerns (in relation to Freedom to Speak Up Arrangements)	Freedom to Speak Up Arrangements Task & Finish Group	Extended from 31.07.22 to 30.11.22	Pushed out date in terms of project plans
6. Strengthen Freedom to Speak Up Arrangements policy and advice	Deputy Director of Workforce and OD	31.05.23	
7. Create a Manager and Staff training plan for Freedom to Speak Up Arrangements	Deputy Director of Workforce and OD	31.05.23	
8. Accountability meetings with senior ops managers	Deputy Director of Workforce & OD	30.09.22	Underway and ongoing
9. Attendance Management training for managers	Deputy Director of Workforce & OD	31.12.22	Underway and ongoing – now BAU 1.11.22
10.PADR review including wellness questions	Assistant Director – Inclusion, Culture and Wellbeing	Complete	Complete. New PADR distributed October 22.
11.Restart the Health and Wellbeing Steering Group	Assistant Director – Inclusion, Culture and Wellbeing	Complete	Complete – group started 17.10.22 and will meet quarterly.
12. Roll out of meta data compliance policy solution	Senior ICT Security Specialist	31.12.22	

Risk ID 201	Damage to Trust reputation following a loss of stakeholder confidence	Date of Review:	01/11/2022	TREND	20 (4x5)
		Date of Next Review:	01/12/2022	➡	

IF the stability of the Trust deteriorates to a level where service delivery fails to meet patient safety, national standards and contractual obligations	**THEN** there is a risk of a loss of stakeholder confidence in the Trust	**RESULTING IN** damage to reputation and increased external scrutiny		Likelihood	Consequence	Score
			Inherent	4	5	20
			Current	4	5	20
			Target	3	5	15

IMTP Deliverable Numbers: 2,18, 26, 34, 38

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

CONTROLS	**ASSURANCES**
	Internal **Management (1st Line of Assurance)**
1. Regular engagement with senior stakeholders e.g. Ministers, senior Welsh Government officials, commissioners, elected politicians and NHS Wales organisational system leaders	1. Agendas, minutes and documents of engagement events
2. Challenging of media reports to ensure accuracy	2. Programme of daily media engagement
3. Media liaison to ensure relationships developed with key media stakeholders	3. Programme of daily media engagement
4. Engagement Framework approved by the Board July 2022	4. Issues of reputation monitored at EMT via weekly Forward Look item – minuted meetings and action logs.
5. Engagement Framework Delivery Plan	
6. Engagement governance and reporting structures are in place	5. Relevant information which impacts on reputation is reported and scrutinised via all internal committees e.g. EMT, FPC, PCC, QuEST & Audit Committee – minuted meetings and action logs
7. Escalation procedure for issues to the Board	6. Minuted meetings, action logs and Board papers
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Inability to control external environment	1.
2. Dependency on Commissioners' decisions	2.
3. Unpredictable external environment affecting the way the Trust operates	3.
4.	4.
5. Engagement Framework Delivery Plan in development and due to be considered by the Board in November 2022	5. Engagement Framework Delivery Plan in development and due to be considered by Board in November 2022
6. Lack of resilience in the function – team is very small so any absences would have an impact on ability to respond	6.

Actions to reduce risk score or address gaps in controls and assurances	**Action Owner**	**By When/Milestone**	**Progress Notes:**
1. Submit refreshed Board Engagement Framework to Trust Board for approval	Director of Partnerships & Engagement	26.05.22 Complete	Approved July 2022
2. Report progress on Engagement Framework Delivery Plan to the People and Culture Committee	Director of Partnerships & Engagement	30.12.22	Likely to be considered by January 2023 Trust Board
3. Monitoring internal Quality and Performance of Trust	Executive Management Team Finance and Performance Committee Quality, Safety and Patient Experience Committee People and Culture Committee Audit Committee	31.03.23 Checkpoint Date	
4. Engaging with internal and external stakeholders to develop confidence	CEO & Director of Partnerships & Engagement	31.03.23 Checkpoint Date	
5. Monitoring external factors that may affect the Trust	CEO & Director of Partnerships & Engagement	31.03.23 Checkpoint date	

Risk ID 139	Failure to deliver our Statutory Financial Duties in accordance with Legislation	Date of Review:	31/10/2022	TREND	16 (4x4)
		Date of Next Review:	30/11/2022		

IF the Trust does:	THEN there is a risk that the Trust will fail to achieve all of its statutory financial obligations and the requirements as set out within the Standing Financial Instructions (SFIs)	RESULTING IN potential interventions by the regulators, qualified accounts and impact on delivery of services and reputational damage

- not achieve financial breakeven and/or
- does not meet the planning framework requirements and/or
- does not work within the EFL and/or
- fails to meet the 95% PSPP target and/or
- does not receive an agreement with commissioners on funding (linked to 458)

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

IMTP Deliverable Numbers: 10, 18, 28, 30, 34. 35, 37,38

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

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

Risk ID 139	Failure to deliver our Statutory Financial Duties in accordance with Legislation	Date of Review:	31/10/2022	TREND	16 (4x4)
		Date of Next Review:	30/11/2022	➡	

IF the Trust does:	THEN there is a risk that the Trust will fail to achieve all of its statutory financial obligations and the requirements as set out within the Standing Financial Instructions (SFIs)	RESULTING IN potential interventions by the regulators, qualified accounts and impact on delivery of services and reputational damage

- not achieve financial breakeven and/or
- does not meet the planning framework requirements and/or
- does not work within the EFL and/or
- fails to meet the 95% PSPP target and/or
- does not receive an agreement with commissioners on funding (linked to 458)

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

	10. Monthly monitoring returns into Welsh Government
	Independent Assurances (3rd Line of Assurance)
	1-10 Internal audit reviews covering
	1-10 External audit reviews

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

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Continuing negotiations with Commissioners	Director of Finance and Corporate Resources/ Director of Strategy Planning and Performance	31/03/23 – Checkpoint Date	
2. Embed a transformative savings plan and ensure organisational buy in	ADLT and Savings subgroup	31/03/23 – Checkpoint Date	
3. Embed value-based healthcare working through the organisation	Executive Management Team and Value Based Healthcare Group	31/03/23 – Checkpoint Date	
4. WIIN support for procurement, savings and efficiencies	WAST Improvement and Innovation Network group	31/03/23 – Checkpoint Date	
5. Foundational economy, Decommissioning and procurement to mitigate social and economic wellbeing of Wales	Estates, Capital and Fleet Groups, NHS Wales Shared Services Partnership	31/03/23 – Checkpoint Date	

Risk ID 244	Estates accommodation capacity limitations impacting on EMS Clinical Contact Centre's (CCC) ability to provide a safe and effective service	Date of Review:	14/11/2022 (SLT)	TREND	16 (4x4)
		Date of Next Review:	14/12/2022	➡	

IF the Trust is unable to increase accommodation capacity	**THEN** there is a risk that EMS CCC will not be able to accommodate all roles during periods of escalation and surge management or expand operations to support new initiatives	**RESULTING IN** EMS CCC being unable to deliver services effectively which adversely impacts on quality, safety and patient/staff experience

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

IMTP Deliverable Numbers: 1,5,9, 10,18, 28, 30, 34

EXECUTIVE OWNER	Director of Operations	ASSURANCE COMMITTEE	Finance and Performance Committee

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1. Temporary call handling provision in Carmarthen	1. Monitoring of Performance standards for call handling (daily) and dispatch (weekly) to identify impacts on service with further investigation on a monthly basis
2. Maximum use of space at the Bryn Tyrion site	2. All desks have been realigned to 2m physical distancing as part of covid preparations
3. Maximum use of space at the Vantage Point House (VPH) site	3. Review of VPH undertaken – November 2021 Staffing levels are managed according to maximum desk space on each centre. In VPH, because of agile working there is capacity for non-dispatch functions.
4. Prioritisation of space utilisation for each shift by CCC management team and alignment to priorities associated with safe service delivery	4. Business continuity tracker for staffing levels updated daily
	External Not applicable
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Call handling provision is a short-term solution and not fully resilient	1. Carmarthen solution for call handling is temporary
2. Lack of resilience in temporary accommodation may trigger risk if business continuity plans are invoked	2. Reconfiguration work reviewed by architects during pandemic preparation and earlier have yet to be delivered.
3. Current social distancing plans for EMS CCC do not provide solutions for the dispatch environment in Carmarthen	*3.* Agile working solution would be compromised in an ICT outage and paper-based approach would be used
4. Current social distancing plans for EMS CCC provide limited solutions for call handling and dispatch in Bryn Tyrion	
5. Current social distancing plans for EMS CCC provide limited solutions for dispatch environment in VPH.	
6. Estates Strategy is silent on risk associated with CCC environment	

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Review current estate to identify moderate workplans to maximise available capacity within existing estate.	Assistant Director of Operations – Resourcing & EMS Coordination	30.09.22 Complete	Review took place to maximise capacity, some additional desks and roster planning supported. Site specific updates are as follows: Capacity within Central & West CCC (Carmarthen) which has been extended to provide extra accommodation for additional EMDs required to comply with Covid regulations. South East CCC (VPH) is currently undergoing renovation, but there are plans to provide additional capacity for EMS CCC when it is completed in January 2023 – this is to be achieved by the Ambulance Care Team (NEPTS CCC) moving upstairs to create some additional space. In terms of the North CCC, a plan has been submitted for consideration at the Estates SOP. In addition, the ADO Integrated Care has been part of a broader discussion as part of a T&F group. There are longer term plans to potentially move to more suitable and spacious

Risk ID 244	Estates accommodation capacity limitations impacting on EMS Clinical Contact Centre's (CCC) ability to provide a safe and effective service	Date of Review:	14/11/2022 (SLT)	TREND	16 (4x4)
		Date of Next Review:	14/12/2022		

IF the Trust is unable to increase accommodation capacity	THEN there is a risk that EMS CCC will not be able to accommodate all roles during periods of escalation and surge management or expand operations to support new initiatives	RESULTING IN EMS CCC being unable to deliver services effectively which adversely impacts on quality, safety and patient/staff experience

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

			accommodation in the North but there are technology requirements to enable the move away from the current Airwave equipment, which is projected to be affected at the end of 2023.
2. Develop digital solutions for remote supervision and clinical support to maximise virtual network of CCC reducing capacity required in existing sites.	EMS CCC Area Manager	12.07.22 Complete	Remote supervision implemented 12.07.22. Action Complete.
3. Option appraisal required to review options for increasing CCC capacity. This should be aligned to the HIW review recommendation for the North CCC estates strategy and expanding this to support the pan-Wales estates position.	Assistant Director – Capital & Estates	31.12.22 – Checkpoint Date	Task and Finish group appointed into Estates to complete this work. Checkpoint later in Q3 2022-23.
4. Based on modelling data under D&C review explore any efficiencies that can be gained in CCC estates through revised dispatch models maximising use of digital technology	CCC SE Manager	30.06.22 Checkpoint Date	Checkpoint review complete. Project change is being developed and revised action/date to be added.

Risk ID 245	Failure to have sufficient capacity at an alternative site for EMS Clinical Contact Centres (CCCs) which could cause a breach of Statutory Business Continuity regulations	Date of Review:	14/11/2022 (SLT)	TREND	16 (4x4)
		Date of Next Review:	26/05/2022	➡	

IF	THEN	RESULTING IN
CCCs are unable to accommodate additional core functions and do not have alternative site arrangements in place in the event of a business continuity incident	there is a risk that EMS CCCs cannot utilise other CCC's space, accommodation and facilities	potential patient harm and a breach of the requirements of the Civil Contingencies Act (2004) and Contingency Planning Regulations (2005)

	Likelihood	Consequence	Score
Inherent	3	5	15
Current	4	4	16
Target	2	4	8

IMTP Deliverable Numbers: 1, 5, 9

EXECUTIVE OWNER	Director of Operations	ASSURANCE COMMITTEE	Finance and Performance Committee

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1. Trust Business Continuity Procedure and Incident Response Plan	1. Debrief from significant business continuity incidents which are put into organisational learning spreadsheet. Governance with respect to this goes through SOTs. Full review of Incident Response plan every 3 years and partial review annually unless there is a major learning point. This is currently undergoing a partial review. BCPs and BIAs should be reviewed annually by their owners. Annual schedule of testing
2. National EMS CCC Business Continuity Plan (reviewed in March 2021)	2. Business Continuity Plan is up to date and has been reviewed and is currently waiting sign off. Business continuity exercise undertaken on 9.03.22.
3. Clinical remote working arrangements	3. SOP in place with respect to Clinical Remote Working – this is being reviewed at present moment
4. Single instance CAD allowing virtualisation which enables staff to work anywhere	4. CAD alerts if there are systems issues
5. ITK (Interoperability Toolkit) technology in place which provides connectivity with other UK ambulance Trusts. This is used on a daily basis	5. Monitoring undertaken locally at least weekly
	External Not applicable
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
• If CAD is not functional then any impact of current controls would be negated by need to move physical staff	• Business continuity plan requires increased duties for existing staff as a result of lack of physical accommodation (link to risk 244)

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

Risk ID 458	A confirmed commitment from EASC and/or Welsh Government is required in relation to funding of recurrent costs of commissioning services to deliver the IMTP and/or any additional services	Date of Review:	31/10/2022	TREND	16 (4x4)
		Date of Next Review:	30/11/2022	➡	

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

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

IMTP Deliverable Numbers: 2, 12, 16, 18, 23, 24, 25, 26, 28,30, 34, 37, 38

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

CONTROLS	**ASSURANCES**
	Internal **Management (1st Line of Assurance)**
1. Financial governance and reporting structures in place	1. Risk is reviewed quarterly at F&P and a report is submitted bimonthly to Trust Board
2. Financial policies and procedures in place	2.
3. Setting and agreement of recurrent resources	3.
4. Budget management meetings	4. Diarised dates for budget management meetings. If an area is in financial deficit, the meeting would be at least once a month. If the area is in balance or surplus, the meeting would be quarterly.
5. Budget holder training	5. Diarised dates for budget holder training
6. Annual Financial Plan	6. Submission to Trust Board in March annually
7. Regular financial reporting to EFG & FPC in place	7. Diarised dates for EFG and FPC with full financial reports
8. Regular engagement with commissioners of Trust's services	**External** **Management (1st Line of Assurance)** 1. Accountability Officer letter to Welsh Government e.g. November 2021 3 and 8 EASC management meetings. Monthly meetings with EASC and DAG meetings for NEPTS. Meetings are diarised 9. Monthly monitoring returns
9. Welsh Government reporting on a monthly basis	**Independent Assurance (3rd Line of Assurance)** 2. Internal Audit reviews of financial policies & procedures as part of their audit plan
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
• Lack of clarity regarding EASC/Welsh Government commitments with respect to recurrent funding	1. Dialogue with EASC and DAG does not always result in recurrent arrangements (outside of WAST control)

Actions to reduce risk score or address gaps in controls and assurances	**Action Owner**	**By When/Milestone**	**Progress Notes:**
1. A formal approach to service change to be developed providing secure recurrent funding with commissioners.	Deputy Director of Finance	31.12.22	
1. Develop a Value Based Healthcare system approach with commissioners. This would mean that funding would flow more seamlessly between organisations and would go some way to mitigating the risk of not receiving recurrent funding.	Deputy Director of Finance	31.12.22	

Risk ID 557	Potential impact on services as a result of Industrial Action	Date of Review:	09/11/2022	TREND	16 (4x4)
		Date of Next Review:	08/12/2022	NEW	

				Likelihood	Consequence	Score
IF trade unions take industrial action in response to the national pay award	**THEN** this is likely to disrupt our ability to provide a safe, efficient and good quality service in the 6 core areas the business	**RESULTING IN** potential harm to patients, adverse effect to patient outcomes, increase in SAIs/concerns/coroners cases, negative media reports, and impact on the Trust's corporate reputation	Inherent	3	4	12
			Current	4	4	16
			Target	2	4	8

IMTP Deliverable Numbers:

EXECUTIVE OWNER	Director of Workforce & Organisational Development	**ASSURANCE COMMITTEE**	People and Culture Committee

CONTROLS	**ASSURANCES**
	Internal **Management (1st Line of Assurance)**
1. Planning process in place	1. Industrial action plan agreed and published
2.	2.
	External **Independent Assurance (3rd Line of Assurance)**

GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Need to determine life and limb cover to meet our legal requirements under the Industrial Action Regulations	1. Awaiting outcome of ballot
2.	2.
3.	3.
4.	4.
5.	5.

Actions to reduce risk score or address gaps in controls and assurances	**Action Owner**	**By When/Milestone**	**Progress Notes:**
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Risk ID 199	Failure to embed an interdependent and mature health and safety culture which could cause harm and a breach in compliance with Health & Safety statutory legislation	Date of Review:	31/10/2022	TREND	15 (3x5)
		Date of Next Review:	30/11/2022	⬇	

IF	THEN	RESULTING IN
there is a failure to embed an interdependent and mature health and safety culture, effective arrangements and associated governance	there is a risk of a potential breach in compliance with the requirements of the Health & Safety at Work etc. Act 1974 and associated regulations and other statutory instruments	death or serious injury, and punitive actions from multiple enforcement agencies including penalties and adverse publicity leading to damage to reputation

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

IMTP Deliverable Numbers: 1, 7, 9, 12, 16, 17, 24, 25, 26, 33, 35, 38

EXECUTIVE OWNER	Director of Quality and Nursing	ASSURANCE COMMITTEE	People and Culture Committee

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
2. Systematic review and assessment of Health and Safety arrangements and Governance (Health & Safety Management system)	2. Assessment criteria set for management system (all Wales system)
3. Health & Safety Governance and reporting arrangements e.g. committees and sub-groups	3. Monthly H&S report to ADLT, quarterly report and annual report to ADLT, H&S committee, EMT, PCC
4. Provision of dedicated health and safety expertise and advice	4. Working Safely team ceased on 31st September 2022
5. Health & Safety Policy and procedures	5. H&S Policy approved in 2018
6. Mandatory Health and Safety training	6. Quarterly statistics available from ESR and this forms part of Head of Health and Safety's quarterly report
7. Scheduled H&S visits and inspections	7. Head of Health and Safety's monthly report to ADLT
8. Risk assessments (including local risk assessments -Covid 19, workplace risk assessments, risk assessments covering EMS and NEPTs activities, operations risk assessments)	8. Workplace risk assessments are undertaken by local management teams, reviewed by H&S team and monitored by BCRT. Other risk assessments and SOPs are held on Sharepoint and have been submitted
9. Working Safely Programme Board, Dynamic Delivery Action Group & Programme Manager to provide oversight of Working Safely Action Plan	9. Working Safely Action Plan has been agreed and this is being held to account by Strategic Transformation Board. Deliverables are being monitored fortnightly through Dynamic Delivery Group meeting. Terms of reference for Dynamic Delivery Group are approved.
10. IOSH Managing Safely for Managers training in place	10. Attendance and competency figures provided in a monthly report to ADLT and quarterly report to committees and above
11. IOSH Leading Safely for Directors and Senior Managers training in place	11. Attendance and figures provided in monthly report to ADLT. Personal safety commitments are being monitored on a quarterly basis 12. Workforce review commenced 3rd October 2022, significantly increasing capacity within the function.
12. Board development day covering Health & Safety Management and Culture training occurred in April 2022	13. Diarised meeting
13. Health and Safety Management system has been approved. This includes the recognised document approval routes for health and safety documentation.	14. Minuted at ADLT meeting in May 2022
15. IOSH Leading Safely training delivered to Board and Executive Team on 26 July 2022.	**External** **Independent Assurance (3rd Line of Assurance)** 16. Internal Audit to be undertaken in Q4 22/23 (controls 1– 10) 17.
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
6. (a) Baseline audit for (a) not to be commenced till Q1 2022 (***being addressed in Actions 1 & 7)*** (b) Lack of cultural baseline to demonstrate H&S awareness (covering control a) ***(being addressed in Action 5)***	2.
7.	3. Subgroups of H&S committee currently under review
8.	After September 2022, uncertainty over capacity to deliver to the Working Safely programme
9. The Health and Safety Policy and some procedures are due to be reviewed by the end of Q1 2022 in Q1 2022 (***being addressed in Action 1***)	4. (a) Review of H&S Policy is due at end of Q1 2022 (b) Workforce Transformational change will influence content within H&S policy

Risk ID 199	Failure to embed an interdependent and mature health and safety culture which could cause harm and a breach in compliance with Health & Safety statutory legislation	Date of Review:	31/10/2022	TREND	15 (3x5)
		Date of Next Review:	30/11/2022	⬇	

IF there is a failure to embed an interdependent and mature health and safety culture, effective arrangements and associated governance	**THEN** there is a risk of a potential breach in compliance with the requirements of the Health & Safety at Work etc. Act 1974 and associated regulations and other statutory instruments	**RESULTING IN** death or serious injury, and punitive actions from multiple enforcement agencies including penalties and adverse publicity leading to damage to reputation		Likelihood	Consequence	Score
			Inherent	4	5	20
			Current	4	5	20
			Target	2	5	10

10. Poor uptake in statutory and mandatory H&S training ***(being addressed as part of Actions 2 – 3)***	5.
11.	6. Schedule for H&S inspections and visits commenced September 2022. Metrics to be developed and presented at relevant service area meetings for monitoring and action where required.
12.	7. (a) Current copies of risk assessments and SOPs are not available at all stations (b) Do not know how many SOPs are required until baseline audit completed
13. Operational pressures on service impacting on Working Safely Programme delivery (covering control h) (being addressed in Action 1)	8.
14. Staff availability to attend training ***(being addressed in Action 4)***	9.
15. Effective learning from events to be documented ***(being addressed in Action 1)***	10. (a) H&S team in discussions with best way of monitoring Personal safety commitments (b

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
8. Delivery of the Working Safely Action Plan (WSAP) (Priority top 25)	Head of Health & Safety	31.09.22	**Pump and Prime phase commenced 01.09.21.**
9. IOSH Leading Safely training to be delivered to Exec Team and Board (forms part of WSAP)	Head of Health & Safety	31.12.22	**Training delivered to Board and Executive team on 26.07.22. Further sessions scheduled for Q3 & Q4 for new members.**
10. WAST Leading Safely Behavioural Audit training to Exec Team and Board (forms part of WSAP)	Head of Health & Safety	31.12.22	**Discussion with Board Secretary ongoing in relation to delivery.**
11. H&S team workforce review (accompanying Business Case forms part of this) (this forms part of WSAP)	Head of Health & Safety	31.03.22 Completed	Completed H&S Workforce report was presented and discussed at EMT on 6.04.22. Director of Finance and Corporate Resources would be formulating a paper for discussion at the ADLT/EMT meeting on 13.04.22 to discuss the issue of investment in Corporate Services based on the evidence provided in H&S Workforce report.
12. Culture survey to all members of staff (forms part of WSAP)	Head of Health & Safety	30.09.22	**Survey developed and to be presented at National H&S Committee on 02.11.22**
13. A compliance register that describes the requirements of the various Health & Safety legislation that the Trust needs to comply with (part of WSAP)	Deputy Head of H&S	30.06.22 Completed	**Compliance Register framework developed Q2 2022.**
14. An initial assessment will provide assurance on how we are complying with the legislation.	Deputy Head of H&S	Assurance - 30.06.22 Rolling programme of assessments – 31.12.22 (Checkpoint date)	**Some initial assessments undertaken. Further assessments to be undertaken during Q3 2022.**

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:	31/10/2022	TREND	15 (3x5)
		Date of Next Review:	30/11/2022		

IF	THEN	RESULTING IN
there is a large-scale cyber-attack on WAST, NHS Wales and interdependent networks which shuts down the IT network and there are insufficient information security arrangements in place	there is a risk of a significant information security incident	a partial or total interruption in WAST's ability to deliver essential services, loss or theft of personal/patient data and patient harm or loss of life

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

IMTP Deliverable Numbers: 7,8,9,10,12, 16,18,21,23, 24,25, 26, 38

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

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1. Appropriate policy and procedures in place for Information/Cyber Security	1. Information Security Policy reviewed every 3 years (currently due for renewal). Incident Policy and Procedure put in place in February 2022 – renewed annually.
2. Trust Business Continuity Procedure and Incident Response Plan	2. Debrief from significant business continuity incidents captured within organisational learning spreadsheet. Governance with respect to this goes through SOTs. Full review of Incident Response plan every 3 years - currently undergoing a partial review. BCPs and BIAs should be reviewed annually by their owners. Annual schedule of testing
3. IT Disaster Recovery Plan	3. Organisation-wide tabletop exercise undertaken in March 2022 with all BC leads and Digital teams.
4. Relevant expertise in Trust with respect to information security	4. Staff undertake relevant training courses e.g. CISSP to increase knowledge and expertise
5. Data Protection Officer in post	5. In job description of Head of ICT
6. Cyber and information security training and awareness	6. Training statistics are available on ESR and from Phish threat module
7. Mandatory Information Governance training which includes GDPR	7. Training statistics reported on by Information Governance department
8. ICT tests and monitoring on networks & servers	8. Any issues would be identified and flagged and actioned
9. Information Governance framework	9. WAST self-assesses its Information Governance Framework against the Welsh Information Governance toolkit.
10. Internal and NHS Wales governance reporting structures in place	10. Internal WAST Information Governance Steering Group & All Wales Information Governance Management Advisory Group (IGMAG) meets quarterly, National Ambulance Information Governance Group (NIAG) meets every 2 weeks, Operational Security and Service Management Board (OSSMB) (national) – daily/weekly meetings and minuted meetings every 2 months. Minutes and actions logs available for meetings.
11. Checks undertaken on inactive user accounts	11. Software in place to run check on inactive accounts as and when
12. Business Continuity exercises	12. Annual schedule of testing
13. Operational ICT controls e.g. penetration testing, firewalls, patching	13. Monthly scans on infrastructure. Penetration testing has occurred for different systems. 2 physical firewalls on networks to monitor traffic. Monthly patching occurs or as and when.
14. Security alerts	14. Daily alerts are received. Anti-virus alerts received as and when threat discovered
	External **Independent Assurance** NHS Wales Cyber Response Unit independent view of Network and Information Systems (NIS) Directive compliance within last 4 – 5 months (covering controls 1 -,3 – 11, 13 – 14
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Not all information security procedures are documented	1. No regular Cyber/Info Security KPIs are reported to senior management committees

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:	31/10/2022	TREND	15 (3x5)
		Date of Next Review:	30/11/2022		

IF	THEN	RESULTING IN
there is a large-scale cyber-attack on WAST, NHS Wales and interdependent networks which shuts down the IT network and there are insufficient information security arrangements in place	there is a risk of a significant information security incident	a partial or total interruption in WAST's ability to deliver essential services, loss or theft of personal/patient data and patient harm or loss of life

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

2. Lack of understanding and compliance with policy and procedures by all staff members	*2.* Cyber awareness campaigns could be undertaken more regularly e.g. bi-monthly
3. No organisational information security management system in place	
4. IT Disaster Recovery Plan does not include a cyber response	
5. Departments do not communicate in a timely manner with Digital Services around putting in new processes, new projects and procurement and this has a cyber security, information governance and resource impact	

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1.Establish Cyber and Information Security KPIs	Director of Digital Services	31.12.22	Draft KPIs have been agreed and produced for quarterly reporting. Q1 and Q2 are currently being reviewed within ICT prior to wider circulation .
2.Discuss how cyber risk is reviewed and frequency of review	Director of Digital Services	28/10/22 Close – now Business as Usual	a. The ongoing cyber threat to the organisation is continually monitored using daily comms feeds and automated alerts from various external sources. b. The corporate cyber risk assessment will be reviewed monthly at the Digital Leadership Group informed by the threat and intelligence monitoring and national strategic trends.
3.Suite of business continuity exercises that departments can undertake to test their plans to be provided.	North Resilience Manager	28/10/22 Complete	The Trust has run two exercise Joshua & Joshua 2 to test departments readiness
4.Exercise template report which shows recommendations to be created	North Resilience Manager	31.12.22 - Ongoing	Exercise reports being drafted
5.Formalise Cyber Incident Response Plan	Head of ICT	31.12.22 – Checkpoint Date	Ongoing
6.Implement Meta Compliance Policy Solution	Senior ICT Security Specialist	31.12.22 – Checkpoint Date	Ongoing

Risk ID 543	Major disruptive incident resulting in a loss of critical IT systems	Date of Review:	31/10/2022	TREND	15 (3x5)
		Date of Next Review:	30/11/2022		

IF there is an unexpected or uncontrolled event e.g. flood, fire, security incident, power failure, network failure in WAST, NHS Wales or interdependent systems	**THEN** there is a risk of a loss of critical IT systems	**RESULTING IN** a partial or total interruption in WAST's ability to deliver essential services, loss or theft of personal/patient data and patient harm or loss of life

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

IMTP Deliverable Numbers:

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

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1. Trust Incident Response Plan and Department Business Continuity Plans	1. Full review of Incident Response plan every 3 years and partial review annually unless there is a major learning point. Annual schedule of testing of BCPs.
2. IT Disaster Recovery Plan	2. Recent ICT tabletop exercise undertaken
3. Recovery/contingency plans for critical systems	3. Reports from tabletop exercises
4. Service management processes in place	4. Documented and approved service management processes in place
5. Incident Management Policy, Procedure and Process	5. Incident Policy and Procedure put in place in February 2022. This would be required annually and if there is a system change, the review would be earlier
6. Regular data back ups	6. Daily report on status of backup and fully automated process. Log kept of where restores are undertaken
7. Resilient and high availability ICT infrastructure in place	7.
8. Robust security architecture and protocols	8.
9. Diverse IT network (both data and voice) delivery at key operational sites	9.
10. Regular routine maintenance and patching	10.
11. Environmental controls	11.
12. Intelligence gathered from suppliers with respect to future tool sets and enhancements	12. Via email and webinars
	External **Independent Assurance** • 2021_16 Internal Audit review of IM&T Control Assessment – baseline exercise • 2021_19 Internal Audit review of ICT Disaster Recovery – Limited Assurance • NIS Directive internal audit report 2022 – Reasonable Assurance (covering controls 1-12)
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
Non identified	Undertaking Cyber Essentials assessment

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Suite of business continuity exercises that departments can undertake to test their plans to be provided.	North Resilience Manager	31.12.22 Checkpoint date	
2. Exercise template report which shows recommendations to be created	North Resilience Manager	31.12.22 Checkpoint date	
3. Cyber Essentials assessment to be completed	Head of ICT	31.12.22 Checkpoint date	

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:	01/11/2022	TREND	15 (3x5)
		Date of Next Review:	01/12/2022		

IF significant internal and external system pressures continue	**THEN** there is a risk of a significant deterioration in staff health and wellbeing within WAST	**RESULTING IN** increased sickness levels, staff burnout, poor staff and patient experience and patient harm

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

IMTP Deliverable Numbers:

EXECUTIVE OWNER	Director of Workforce & OD	ASSURANCE COMMITTEE	People & Culture Committee

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1. Health and wellbeing strategy in place and shared across the Trust.	1. Review undertaken of the Health and Wellbeing Strategy by Assistant Director annually.
2. People Services & Occupational Health & Wellbeing support/Employee Assistance Programme	2. Regular review meetings with all external providers to ensure they meet requirements of the SLA contracts. Regular management information received so that trends can be monitored.
3. Self-referrals or managerial referrals to Occupational Health	3. Regular reports submitted by Occupational Health team to WOD Business Meetings for monitoring.
4. Wellbeing support and training for line managers	4. Diarised meetings, webinars and workshops in place through a rolling programme.
5. Development of range of wellbeing resources for staff and line manager	5. Tools are available on WAST intranet. Occupational Health and Wellbeing teams visit stations, A&E , CCCs and other locations regularly where operational staff are based to promote the occupational health and wellbeing offer.
6. Peer support network forum	6. Agendas and minutes of meetings produced for each meeting.
7. WAST Keep Talking (mental health portal)	7. Available on intranet for staff to access easily.
8. TRiM	8. TRiM Coordinator has regular dialogue with TRiM managers and practitioners. Project plan and training schedule in place. Information in TRim Teams folder.
9. Coaching and mentoring framework	9. Information on intranet on Learning launch pad available to all staff.
10. Acting on results of staff surveys relating to staff experience	10. Each Directorate has developed their own action plan to address staff surveys.
11. HSE stress risk assessments	11. Undertaken by managers and advice is provided on how to use them by Occupational Health team.
12. KPIs are reported monthly to WOD regarding Occupational Health and Wellbeing activity	12. Received at WOD Business Meetings monthly.
13. Wellbeing drop-in sessions for CCC and 111 staff	13. Diarised sessions in place as part of the programme.
14. Fast track physiotherapy	14. Regular review meetings with physiotherapy provider and monthly monitoring information received at WOD Business meetings.
15. Specialist trauma counselling service	15. Same as 15.
16. Regular psycho-educational sessions with managers and staff	16. Diarised sessions
17. Compassionate leadership training sessions	17. Same as 17 in place as part of the programme.
18. Chaplaincy programme	18. Training plan and minutes of meetings produced quarterly for the Wellbeing Team – to be reviewed.
19. Occupational Health team inclusion in sickness and absence meetings	19. Diarised meetings in place.
	External **Independent Assurance** Audit Wales – Taking Care of the Carers report in October 2021
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
	4. Reporting on wellbeing training take up
11. Need to increase the education and communication with managers about stress risk assessments	• Lack of awareness about staff wellbeing services
	• Effects of REAP 4 affecting the ability of staff to engage with staff health and wellbeing services

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

Risk ID 558	Deterioration of staff health and wellbeing in the face of continued system pressures as a consequence of workplace experiences	Date of Review:	01/11/2022	TREND	15 (3x5)
		Date of Next Review:	01/12/2022		

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

1. Restart the Health and Wellbeing Steering Group (link to risk 160)	Assistant Director – Inclusion, Culture and Wellbeing	Completed	First meeting was on 17/10/2022. This however does not yet bring down the score of the risk as the Steering Group meeting was to re-establish a way forward. Next meeting to be scheduled within 2 months.
2. Increase the education and communication with managers about stress risk assessments	Assistant Director – Inclusion, Culture and Wellbeing	31.12.22 Checkpoint Date	OH to undertake workshops with CCC managers – dates to be confirmed this week.

Risk ID 100	Failure to persuade EASC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience	Date of Review:	09/08/2022	TREND	12 (3x4)
		Date of Next Review:	08/11/2022		

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

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

IMTP Deliverable Numbers: 2, 3, 4, 6, 11, 14, 29, 34

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

CONTROLS	ASSURANCES
	Internal & External **Management (1st Line of Assurance)**
1. EASC/WAST Forward Plan for EMS and NEPTS in place and monitored at EASC meetings	1. Minutes of meetings and a standard agenda item
2. EASC and its 2 sub-committees established as a forum to discuss WAST's strategy	2. Minutes of meetings and a standard agenda item
3. Weekly catch up between CASC/CEO	3. Meetings are diarised every week
4. Collaboration between EASC and WAST on specific projects e.g. Amber Review, EMS Operational Transformation Programme, Ambulance Care Programme	4. Representatives are co-opted onto meetings and frequency is between 3–6 weeks. Set agendas with NCCU reps co-opted.
5. Monthly CASC Quality and Delivery Meeting established	5. Formal meeting with agendas, minutes and action logs available.
6. Patient Safety information e.g. Appendix B incidents, weekly/monthly patient safety reports produced	6. These reports supplied to Director of Quality and Nursing in Health Boards and other senior stakeholders fortnightly
7. Programme structure has been established for 'inverting the triangles' including EASC	7. It exists and has had its first meeting
	External **Management (1st Line of Assurance)** 1. Plans go to every bi-monthly meeting 2. Meet bi-monthly and agendas, minutes and action logs available
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. EASC meetings focus largely on EMS and cursory note of NEPTS	1. Health Boards are not sending Patient Safety Incidents that are National Reportable Incidents to the Delivery Unit (identified within a Delivery Unit audit)
2. Governance coordination between NCCU and WAST to be improved.	2. Identified need for a governance meeting between NCCU and WAST to manage the overall commissioner/provider interface
3.	7. This is a new structure that has been established and is yet to be embedded and tested for assurance
Xx WAST's ability to influence hospital handover delays (this is outside of the Trust's control and a Health Board responsibility)	
Xx Funding does not flow in a manner to balance demand with capacity (this is outside of WAST's control)	

	Action Owner	By When/Milestone	Progress Notes:
1. Agree and influence EASC/Health Boards that sufficient funding to be provided to WAST	CEO WAST	31.12.22 – Checkpoint Date	30.09.22 Additional £3m provided for +100 FTEs into Response by 23/01/23.
2. Agree and influence EASC/Health Board of the need for significant reduction in hospital handover hours	CEO WAST	31.12.22 – Checkpoint Date	30.09.22 4 hour handover backstop agreed and -25% reduction in handover from October 2021 baseline.
3. Increased understanding of NEPTS by EASC	Director of Strategy Planning and Performance	31.12.22 – Checkpoint Date	30.09.22 "Focus on" session at May 2022 EASC and NCCU represented on Ambulance Care Programme Board.
4. Governance meeting between NCCU and WAST to manage the commissioner provider interface	Assistant Director Commissioning & Performance	31.12.22 – Checkpoint Date	30.09.22 Meeting in place and meeting regularly.
5. Utilising the engagement framework to engage with the stakeholders	Director of Partnerships & Engagement AD Planning & Transformation	31.12.22 Checkpoint date	30.09.22 Significant engagement through roster review briefings.

Risk ID 163	Maintaining Effective & Strong Trade Union Partnerships	Date of Review:	22/08/2022	TREND	12 (4x3)
		Date of Next Review:	21/11/2022	➡	

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

IMTP Deliverable Numbers: 2, 4, 6, 11, 20, 34

EXECUTIVE OWNER	Director of Workforce and Organisational Development	ASSURANCE COMMITTEE	People & Culture Committee

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1. Agreed (Refreshed) TU Facilities Agreement developed in partnership	1. Agreed document which states governance arrangements and the criteria for time off for TU activity etc.
2. Go Together Go Far (GTGF) statement and CEO/TU Partners statement	2. Both parties refer to the documents and are signed up/committed to it
3. IPA Workshops	3. Meetings completed with participation from TUs and senior managers. Attendance lists are available
4. Trade Union representation at Trust Board, Committees	4. Committee or Board ask TU representative for feedback or whether they have been consulted. Big issues items progress as planned as a result of TU partner buy in
5. Monthly Informal Lead TU representatives and Chief Executive meetings	5. Diarised meetings
6. Staff representative management in Task & Finish Groups	6. Good attendance and commitment is observed at the meetings. TU partners listed as members in terms of reference
7. Fortnightly TUP Cell meetings	7. Diarised meetings with a formal agenda. Any business needed to be discussed is included in the agenda. Good attendance and commitment observed at meetings.
8. Local Co-Op Forums, and informal monthly meetings between TUs and Senior Operations Team	8. Consistency of invitation and good attendance/commitment observed at meetings. Trade Union representations on SOT meetings
9. Quarterly Report on TU activity to People and Culture Committee	9. Report at every P& C committee meeting regarding activities TUPs involved with which is noted. Whenever Partnerships are discussed, the value of these is formally minuted in the Board and Committee minutes
	External Not applicable

GAPS IN CONTROLS	GAPS IN ASSURANCE
1. Need to move back to business-as-usual footing	None identified
2. Facility to manage situations where there is a failure to agree, to avoid grievance and disputes from occurring	

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Clarify the formal and informal consultation and engagement framework and definitions	Deputy Director of Workforce & Organisational Development	Extended from 31.05.22 to 31.12.22	Formal engagement framework is defined with the re-establishment of the WASPT model. Further work is being done on the engagement model below WASPT through SLT and SOT. TU cell will be stood down. Shadow WASPT Board scheduled for 22nd September
2. Agree the ToR for refreshed Partnership Forum meeting and move back to a business-as-usual footing	Deputy Director of Workforce & Organisational Development	31.10.22	Underway and good progress now being made
3. Proposed externally facilitated mediation session(s) building on the IPA workshops and specifically to address the thorny issue of what happens when we fail to agree	Deputy Director of Workforce & Organisational Development	31.10.22	Rearranged date 24.08.22 due to COVID in ACAS facilitators. First ACAS sessions delivered in June. Joint ACAS session with TUPs and Senior Team delivered on 24.08.22. Awaiting report from ACAS advised they are finalising by 23.09 and will forward week of 26th Sept. Draft plan in development to capture actions from the

Risk ID 163	Maintaining Effective & Strong Trade Union Partnerships		Date of Review:	22/08/2022	TREND	12 (4x3)
			Date of Next Review:	21/11/2022		

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

			meeting. Actions from the ACAS recommendations will be added on receipt.
4. Minutes of formal Partnership Forum should be reported to PCC or Board in future (return to BAU).	Deputy Director of Workforce & Organisational Development	Extended from 30.09.22 to 31.10.22	

Risk ID 283	Failure to implement the EMS Operational Transformation Programme	Date of Review:	09/08/2022	TREND	12 (3x4)
		Date of Next Review:	08/11/2022	➡	

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

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

IMTP Deliverable Numbers: 3, 7, 17, 18, 19, 20, 27

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

CONTROLS	**ASSURANCES**
	Internal **Management (1st Line of Assurance)**
1. Implementation Programme Board in place – meetings held every 3 weeks with the DASC and TU reps on the membership	1. Minutes and papers of Implementation Programme Board
2. Executive sponsor and Senior Responsible Owner (SRO) for programme in place	2. Project Initiation Document (PID) detailing structure and minutes of Implementation Programme Board
3. Programme Manager and Programme support office in place (for delivery of the programme)	3. Same as 2
4. Programme risk register	4. Highlight reports showing key risks reported to STB every 6 weeks
5. Assurance meetings held with Strategic Transformation Board (STB) every 6 weeks and with CEO every 3 weeks	5. Highlight reports presented to STB every 6 weeks
6. Programme budget in place (including additional £3m funding for 22/23)	6. Programme budget monitoring report is provided to the Implementation Programme Board – every 6 weeks and letter received from CASC on £3m funding for 22/23
7. Programme documentation and reporting is in place to Programme Board every 3 weeks and STB receives highlight report	7. PID and Programme Plan Summary kept up to date**.** PID is presented to the STB if there is a significant change in the programme deliverables. Programme Plan Summary reported to the Implementation Programme Board every 3 weeks.
8. Regular engagement with the Commissioner and Trade Unions and representation	8. Commissioner and TU participation at the Implementation Programme Board
9. Management of external stakeholder and political concerns	9. Communications and Engagement Plan sets out WAST's arrangements for engagement with stakeholders
10. Secured specialist consultancy to support decision making	10. Reports and contractual compliance
11.	**External** **Management (1st Line of Assurance)**
	a. Deputy Ambulance Services Commissioner sits on the Implementation Programme Board
	b. Emergency Ambulance Service Committee Management Group receives a highlight report every two months
	c. EASC receives an update every 2 months on the programme as part of the WAST Provider Report

GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Current controls on workforce buy in are not sufficient due to changes in working practices	1. Project Initiation Document (PID) needs to be updated to reflect 22/23 budget position
2. System pressures – patient handover delays at hospitals (link to risks 223 & 224)	2. No prompts from STB for programme PID or risk register updates

Actions to reduce risk score or address gaps in controls and assurances	**Action Owner**	**By When/Milestone**	**Progress Notes:**
1. Increase in engagement on the specifics of change through facilitation mechanisms	Assistant Director – Commissioning & Performance	31.12.22 – Checkpoint Date	30.09.22 Significant engagement through roster review project.
2. More capacity requested (transition plan)	Assistant Director of Planning & Transformation	31.12.22 – Checkpoint Date	30.09.22 Transition plan not funded, but +100 FTE agreed.
3. Engage with key stakeholders to reduce handover delays	CASC	31.12.22 – Checkpoint Date	30.09.22 Reduction commitments agreed, but trend is still upwards.

Risk ID 283	Failure to implement the EMS Operational Transformation Programme		Date of Review:	09/08/2022	TREND	12 (3x4)
			Date of Next Review:	08/11/2022		

IF there are issues and delays in the planning and organisation of the EMS Demand & Capacity Review Implementation Programme	THEN there is a risk that WAST will fail to implement the EMS Operational Transformation Programme to the agreed performance parameters	RESULTING IN potential patient harm, deterioration in staff wellbeing and reputational damage		Likelihood	Consequence	Score
			Inherent	4	4	16
			Current	3	4	12
			Target	2	4	8

4. Reduce abstractions in particular sickness absence	Deputy Director of Workforce & OD	31.12.22 – Checkpoint Date	30.09.22 Sickness absence reducing, but abstractions high linked to sickness, but also training abstraction linked to the +100.
5. Engage with Assistant Director of Planning and Transformation on process for PID updates	Assistant Director – Commissioning & Performance	31.12.22 Checkpoint Date	30.09.22 HoT recruited and now started. Initial contact made with HoT. PID is up to date.

Risk ID 311	Inability of the Estate to cope with the increase in FTES	Date of Review:	22/08/2022	TREND	12 (3x4)
		Date of Next Review:	21/11/2022	⬇	

IF the cumulative impact on the estate of the EMS Demand & Capacity Review and the NEPTS Review is not adequately managed	**THEN** there is a risk that the Estate will not be able to cope with the increase in FTEs	**RESULTING IN** potential failure to achieve the benefits/outcomes of the programme and reputational damage to the Trust

	Likelihood	Consequence	Score
Inherent	**4**	**4**	**16**
Current	**3**	**3**	**9**
Target	**2**	**3**	**6**

IMTP Deliverable Numbers: 1,3, 9, 10, 17, 18, 28, 30, 34

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

CONTROLS	**ASSURANCES**
	Internal **Management (1st Line of Assurance)**
1. Programme governance and reporting structures in place e.g. Estates SOP Delivery Group and EMS Operational Transformation Programme Board, Integrated Strategic Planning Group Technical subgroup	1. Highlight report goes to Estates SOP Delivery Group every other month, report to EMS Operational Transformation Programme Board every 6 weeks, Technical Group meet monthly and there is an agenda, minutes and an action log
2. "Mega" spreadsheet combining all information into total cumulative impact on estate (and fleet) held by Assistant Director, Commissioning and Performance	2. Information is sense checked by AD Commissioning and Performance and reviewed by Integrated Technical Planning Group
3. Programme risk register sits with EMS Programme Board.	3. On agenda of meetings of Board
4. Risk logs held with respect to delivery of aspects of the project	4. Regional meetings are held regularly, and projects are discussed
5. Project Manager in place (for delivery of the solutions identified)	5. This resource is allocated to projects
6. Interim estates solution project	6. Regional meetings are held regularly, and projects are discussed
7. Finance and Corporate Resources directorate delivery plan	7. Reports go every 6 weeks to the Strategic Transformation Board
	External Not applicable
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. NEPTS D&C Review – Ambulance Care Programme Board	**1.** Information is received in an ad hoc and fragmented manner as opposed to a regular method from Operations
2. NEPTS Covid recovery planning	
3. Finance may be a constraint to delivery of solutions when problem is identified	

Actions to reduce risk score or address gaps in controls and assurances	**Action Owner**	**By When/Milestone**	**Progress Notes:**
2. NEPTS and EMS – confirmation required from Operations functions about current and future numbers	Senior Management within Operations, Workforce & OD, Strategy Planning & Performance	31.12.22 – Checkpoint Date	
TBC			

Risk ID 424	Resource availability (capital) to deliver the organisation's Integrated Medium-Term Plan (IMTP)	Date of Review:	09/08/2022	TREND	12 (3x4)
		Date of Next Review:	08/11/2022	➡	

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

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

IMTP Deliverable Numbers: 5,9,10, 17, 28

EXECUTIVE OWNER	Director of Strategy Planning & Performance	ASSURANCE COMMITTEE	Strategic Transformation Board and Finance and Performance Committee

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. Prioritisation of IMTP deliverables	1. Prioritisation detailed in IMTP and reviewed and agreed at Strategic Transformation Board
2. Financial policy and procedures	2.
3. Governance and reporting structures e.g. Strategic Transformation Board (STB)	3. IMTP sets out delivery structures and meeting minutes are available
4. Assurance meetings with Welsh Government and Commissioners	4. Agendas, minutes and slide decks available
5. Transformation Support Office (TSO) which supports the major delivery programmes	5. Paper on TSO to Strategic Transformation Board
6. Project and programme management framework	6. PowerPoint pack detailing PPM
7. Regular engagement with key stakeholders	7. Stakeholder Engagement Framework
	Independent Assurance (3rd Line of Assurance) 2. Subject to Internal Audit

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

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Recruit a Head of Transformation	Assistant Director of Planning	30.09.22 Complete	Recruited 02.08.22 in post on 01.11.22
2. Review the PPM	Head of Transformation	31.03.23 – Checkpoint Date	
3. Develop Benefits Realisation plans in line with Quality and Performance Management framework	Assistant Director of Planning/Assistant Director, Commissioning & Performance	Extended from 30.09.22 – To 31.03.23 Checkpoint Date	Reviewed action and extended checkpoint date. Work ongoing.
4. A formal approach to service change to be developed providing secure recurrent funding with commissioners (link to risk 458)	Deputy Director of Finance	31.12.22	

IMTP Deliverable Key

No.	IMTP Deliverable
1	We will recover our systems of working and implement new ways of working developed during the pandemic as we learn to live with COVID-19
2	We will engage with a range of stakeholders, developing genuine Pan-Wales representation on partnership structures and delivering strong political and media relationships across the spectrum
3	We will develop and deliver a collaborative programme of work to design and implement new models within EMS (Inverting the Triangles)
4	We will work with partners to promote and expand use of 111 across Wales
5	We will increase the capacity and capability of the clinical teams for 111 and 999 callers, increasing clinical information available to them and we will create one integrated national team
6	We will work with partners to increase the number of seamless 24/7 pathways from the 111 clinical team to appropriate face to face consultations
7	We will take steps to continuously improve the safety and quality of the service and provide an improved patient experience
8	We will increase accessibility, content and user experience of the 111 Digital front end, which can offer increasingly personalised advice
9	We will increase and balance response capacity and capability across urban and rural area of Wales
10	We will increase skill levels and resources (information, equipment and technology) available to clinicians on scene to allow them to most effectively assess and treat patients
11	We will work with partners to increase number of seamless 24/7 referral pathways as alternatives to ED conveyance and improve hospital handover
12	We will take steps to continuously improve the safety and quality of the service and provide an improved patient experience
13	We will develop and deliver an improvement plan for NEPTS and increase capacity where required to meet demand
14	We will develop and implement with partners an-All Wales transfer and discharge service
15	We will continue to deliver against our Transport Solutions Programme to embed as a business-as-usual approach to service delivery
16	We will take steps to continuously improve the safety and quality of the service and provide an improved patient experience
17	We will improve resource availability, tackling absence and recruitment challenges to deliver improved performance
18	We will effectively manage risk, governance and compliance to promote and protect colleague and patient safety, and ensure a safe, productive and fair work environment
19	We will purposefully shape our future People and Culture Strategy to equip our people to thrive in a changing environment
20	We will foster a culture of belonging and wellbeing where our people can engage, feel supported and represented
21	We will improve access to, and availability of services via the 111 Wales website and other digital channels (NHS Wales app)
22	Improved signposting to the most appropriate service
23	Improved digital tools and services to empower our teams to do their best
24	We will use modern technology to reduce repeat tasks and improve processes
25	Standardised information architecture and common approach to data and analytics across the organisation

26	We will deliver greater insights to WAST and NHS Wales, through improved data sharing, analytics and visualisation
27	Improved resilience, flexibility and interoperability for the 999-call platform
28	We will provide an improved financial plan to support our ambitions
29	Finalise our organisational position on achieving University Trust Status (UTS) in collaboration with WG, embracing a culture of learning, research and innovation
30	We will deliver the Estates Strategic Outline Plan
31	We will implement the Environmental and Sustainability Strategy
32	Deliver the Fleet SOP
33	We will secure and implement Quality Management and control systems
No.	**IMTP Deliverable**
34	We will transform the way we work and engage with people
35	We will revisit and implement the Public Health Plan
36	We will implement the Clinical Strategy to support developments across our service ambitions
37	We will deliver a values-based approach
38	We will deliver strong risk management processes and embed a Trust-wide risk culture that embeds the principles of good governance

AGENDA ITEM No	**7**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**1**

LOSSES AND SPECIAL PAYMENTS - PAYMENTS FOR THE PERIOD FROM 1ST APRIL 2022 TO 31st OCTOBER 2022

MEETING	**Audit Committee**
DATE	**1st December 2022**
EXECUTIVE	**Chris Turley, Executive Director of Finance and Corporate Resources**
AUTHOR	**Jessica Price, Deputy Head of Financial Accounting**
CONTACT	**Chris Turley Chris.Turley2@wales.nhs.uk**

EXECUTIVE SUMMARY

In accordance with SFI's this report presents to the Committee details of Losses and Special Payments made during the seven months from 1st April 2022 to 31st October 2022 (**Annex 1**).

KEY ISSUES/IMPLICATIONS

Total net Losses and Special Payments made were as follows:-

- period 1st April 2022 to 31st October 2022 £0.103m

REPORT APPROVAL ROUTE
Audit Committee 1st December 2022 – no action required for information under SFI's only

REPORT APPENDICES
Annex 1 – Summary and details of payments made for the seven months to 31st October 2022

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

WELSH AMBULANCE SERVICES NHS TRUST
AUDIT COMMITTEE
LOSSES AND SPECIAL PAYMENTS - PAYMENTS FOR THE PERIOD FROM 1st APRIL 2022 TO 31st OCTOBER 2022

SITUATION

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

BACKGROUND

2. This report presents to the Committee details of Losses and Special Payments made during the seven months from 1st April 2022 to 31st October 2022 (**Annex 1**).

ASSESSMENT

3. Total net Losses and Special Payments made during the period 1st April 2022 to 31st October 2022 amounted to £0.103 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 seven months to 31st October 2022 payments made exceeded reimbursements received by £0.103m. All payments made during this period have been done so within the delegated limits.

5. During October you will note the Welsh Risk Pool reimbursements amounted to £0.075m. The majority of which, £0.070m, relates to the reimbursement of a finalised personal injury case against the Trust.

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

Welsh Ambulance Services NHS Trust
Losses and Special Payments

Annex 1

Summary of payments for the seven months to 31st October 2022:

	£
April 2022	£109,893.12
May 2022	£141,037.72
June 2022	-£121,785.57
July 2022	£104,081.28
August 2022	-£242,461.55
September 2022	£31,524.41
October 2022	£80,621.95
November 2022	£0.00
December 2022	£0.00
January 2023	£0.00
February 2023	£0.00
March 2023	£0.00
	£102,911.36

Losses and Special Payments Breakdown:

Payment Type	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
	£	£	£	£	£	£	£	£	£	£	£	£	
Claimants Solicitor Costs	40,455.00	40,731.00	83,866.00	23,200.00	233,182.00	5,000.00	38,656.00	0	0	0	0	0	£465,090.00
Counsel fees	10,825.00	5,339.00	2,827.50	17,195.63	9,050.00	1,150.00	6,077.08	0	0	0	0	0	£52,464.21
CRU	0	29,816.83	3,686.00	1,312.00	0	3,791.00	33,858.00	0	0	0	0	0	£72,463.83
Damages	12,875.00	23,200.00	42,374.31	21,095.87	17,600.00	0	39,000.00	0	0	0	0	0	£156,145.18
Defence Costs	4,061.02	2,318.90	2,368.87	4,012.20	221.79	4,510.46	532.10	0	0	0	0	0	£18,025.34
Expert Witness	15,024.00	10,140.75	6,587.50	7,740.00	2,400.00	2,856.25	1,350.00	0	0	0	0	0	£46,098.50
Vehicle Repairs	12,155.60	29,491.24	5,156.51	29,525.58	6,786.46	14,216.70	36,038.77	0	0	0	0	0	£133,370.86
WRP Refund	0.00	0	-268,652.26	0	-518,151.70	0	-74,890.00	0	0	0	0	0	-£861,693.96
Property Repairs	14,497.50	0	0	0	6,449.90	0	0	0	0	0	0	0	£20,947.40
Court Refund	0.00	0	0	0	0	0	0	0	0	0	0	0	£0.00
Total	**£109,893.12**	**£141,037.72**	**-£121,785.57**	**£104,081.28**	**-£242,461.55**	**£31,524.41**	**£80,621.95**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**£102,911.36**

Welsh Ambulance Services NHS Trust
Losses and Special Payments

Summary of payments for the seven months to 31st October 2022:

Key

MN Medical Negligence
PI Personal Injury
DP Damage To Property

	£	
PI cases < £1,000	1,167.22	3 Cases
DP cases < £1,000	15,434.65	33 Cases
22RT4MN0018	20.09	
23RT4MN0006	39.42	
23RT4MN0001	80.36	
23RT4MN0009	130.58	
22RT4MN0013	206.64	
23RT4MN0005	455.69	
22RT4MN0001	465.63	
21RT4MN0013	1,000.00	
21RT4PI0035	1,000.00	
22RT4MN0011	1,050.00	
22RT4PI0016	1,100.00	
20RT4PI0008	1,122.96	
22RT4EG0005	1,200.00	
22RT4DP0091	1,213.84	
19RT4PI0061	1,225.00	
23RT4MN0008	1,275.00	
18RT4MN0023	1,287.00	
23RT4DP0042	1,352.44	
23RT4PI0001	1,366.20	
22RT4DP0042	1,382.04	
23RT4DP0010	1,449.49	
23RT4GN0016	1,500.00	
22RT4DP0099	1,500.40	
22RT4DP0102	1,520.13	
21RT4GN0014	1,600.00	
23RT4DP0002	1,651.41	
23RT4DP0003	1,659.37	
23RT4DP0037	1,794.00	
23RT4DP0007	1,827.40	
22RT4DP0085	1,866.60	
23RT4DP0015	1,907.45	
23RT4DP0011	1,948.86	
22RT4PI0040	2,000.00	
22RT4GN0011	2,020.00	
22RT4DP0013	2,020.20	
23RT4DP0008	2,053.80	
23RT4DP0043	2,073.64	
23RT4DP0038	2,111.40	
23RT4DP0001	2,157.23	
23RT4DP0016	2,310.44	
23RT4DP0020	2,315.47	
22RT4DP0094	2,320.14	
23RT4DP0017	2,376.89	
22RT4DP0086	2,377.60	
23RT4PI0006	2,510.00	
23RT4DP0019	2,700.43	
19RT4MN0008	3,021.00	
22RT4DP0090	3,108.94	
18RT4MN0016	3,148.75	
23RT4DP0032	3,377.62	
22RT4GN0014	3,400.00	
23RT4DP0005	3,437.50	
22RT4DP0057	3,522.90	
22RT4PI0036	3,560.00	
22RT4GN0004	3,670.00	
23RT4DP0024	3,921.48	
22RT4DP0101	4,421.27	
23RT4DP0039	4,665.00	
22RT4MN0012	4,676.50	
23RT4DP0018	5,440.85	
16RT4MN0009	5,500.00	
20RT4PI0028	5,942.00	
18RT4MN0012	6,140.00	
22RT4PI0038	6,239.29	
20RT4PI0035	6,645.00	
23RT4DP0012	6,665.40	
21RT4GN0011	6,950.00	
21RT4MN0009	7,022.50	
23RT4DP0014	7,049.48	
22RT4PI0026	7,151.00	
22RT4PI0008	7,207.00	
22RT4MN0002	7,534.48	
19RT4DP0079	7,964.82	
23RT4DP0013	8,612.22	
21RT4PI0009	9,132.00	
21RT4DP0086	10,387.33	
20RT4MN0011	10,472.75	
19RT4PI0049	12,325.00	
23RT4DP0033	12,659.74	
21RT4PI0022	12,991.00	
19RT4PI0060	13,376.00	
20RT4PI0042	14,865.00	
20RT4PI0007	19,137.33	
22RT4DP0080	20,947.40	
18RT4MN0001	25,035.00	
21RT4PI0001	37,668.00	
20RT4MN0019	42,653.00	
20RT4PI0025	42,980.83	
20RT4MN0010	48,985.20	
17RT4MN0007	70,510.00	
21RT4PI0017	72,967.00	
19RT4PI0008	123,871.63	
18RT4MN0005	128,499.00	
22RT4GN0017	-350.00	WRP REFUND
22RT4GN0008	-500.00	WRP REFUND
21RT4GN0016	-1,250.00	WRP REFUND
22RT4GN0007	-1,750.00	WRP REFUND
18RT4MN0001	-1,830.00	WRP REFUND
21RT4GN0014	-2,560.00	WRP REFUND
21RT4GN0008	-5,000.00	WRP REFUND
20RT4MN0006	-7,682.00	WRP REFUND
19RT4PI0053	-56,834.01	WRP REFUND
18RT4MN0023	-221,366.50	WRP REFUND
18RT4PI0060	-272,886.25	WRP REFUND
20RT4MN0010	-289,685.20	WRP REFUND
Total	**102,911.36**	

Sep-22

Case Reference	Details	Amount (£)
17RT4MN0007	Defence Costs	1,560.00
17RT4MN0007	Expert witness	950.00
18RT4MN0016	Expert witness	106.25
18RT4MN0016	Expert witness	375.00
19RT4PI0008	Claimants Solicitor Costs	5,000.00
19RT4PI0008	CRU	678.00
19RT4PI0008	Defence Costs	1,871.88
19RT4PI0061	Counsel fees	412.50
20RT4MN0011	Expert witness	1,425.00
20RT4MN0011	Counsel fees	325.00
20RT4MN0011	Counsel fees	12.50
20RT4MN0019	CRU	2,388.00
20RT4PI0035	CRU	725.00
21RT4PI0001	CRU	240.80
21RT4PI0001	CRU	240.80
21RT4PI0001	CRU	-481.60
22RT4DP0013	Defence Costs	305.80
22RT4PI0048	Counsel fees	400.00
23RT4DP0016	Vehicle Repairs	5,154.99
23RT4DP0016	Vehicle Repairs	2,310.44
23RT4DP0018	Vehicle Repairs	1,542.30
23RT4DP0024	Vehicle Repairs	657.92
23RT4DP0027	Vehicle Repairs	450.00
23RT4DP0028	Vehicle Repairs	231.96
23RT4DP0029	Vehicle Repairs	4,936.17
23RT4DP0029	Vehicle Repairs	-4,936.17
23RT4DP0031	Vehicle Repairs	452.15
23RT4DP0032	Vehicle Repairs	3,377.62
23RT4DP0033	Vehicle Repairs	39.32
23RT4EG0009	Defence Costs	40.18
23RT4PI0001	Defence Costs	732.60
Totals		**31,524.41**

Oct-22

Case Reference	Details	Amount (£)
18RT4MN0001	WRP Refund	- 1,830.00
18RT4PI0060	WRP Refund	- 70,000.00
19RT4DP0079	Vehicle Repairs	7,964.82
19RT4PI0060	Claimants Solicitor Costs	7,806.00
19RT4PI0060	Damages	4,000.00
19RT4PI0060	Claimants Solicitor Costs	1,295.00
19RT4PI0061	Counsel fees	400.00
20RT4MN0011	Expert witness	1,350.00
20RT4MN0011	Counsel fees	656.25
20RT4MN0011	Defence Costs	84.00
20RT4PI0007	Counsel fees	1,458.33
20RT4PI0007	Claimants Solicitor Costs	9,904.00
20RT4PI0007	Damages	7,500.00
21RT4EG0001	CRU	891.00
21RT4GN0014	WRP Refund	- 2,560.00
21RT4MN0009	Counsel fees	937.50
21RT4PI0017	Damages	25,000.00
21RT4PI0017	CRU	32,967.00
21RT4PI0017	Claimants Solicitor Costs	15,000.00
22RT4DP0013	Defence Costs	300.30
22RT4DP0094	Vehicle Repairs	2,320.14
22RT4GN0008	WRP Refund	- 500.00
22RT4MN0012	Counsel fees	1,525.00
22RT4PI0016	Counsel fees	1,100.00
22RT4PI0026	Damages	2,500.00
22RT4PI0026	Claimants Solicitor Costs	4,651.00
23RT4DP0026	Vehicle repairs	331.25
23RT4DP0026	Vehicle Repairs	- 331.25
23RT4DP0033	Vehicle Repairs	12,620.42
23RT4DP0034	Vehicle Repairs	412.06
23RT4DP0035	Vehicle Repairs	267.00
23RT4DP0036	Vehicle Repairs	457.85
23RT4DP0037	Vehicle Repairs	1,794.00
23RT4DP0038	Vehicle Repairs	2,111.40
23RT4DP0039	Vehicle Repairs	4,665.00
23RT4DP0040	Vehicle Repairs	66.61
23RT4DP0040	Vehicle Repairs	- 66.61
23RT4DP0041	Vehicle Repairs	100.00
23RT4DP0041	Vehicle Repairs	1,840.32
23RT4DP0041	Vehicle Repairs	257.21
23RT4DP0041	Vehicle Repairs	- 2,197.53
23RT4DP0042	Vehicle Repairs	1,352.44
23RT4DP0043	Vehicle Repairs	2,073.64
23RT4DP0045	Vehicle Repairs	980.00
23RT4DP0045	Vehicle Repairs	539.50
23RT4DP0045	Vehicle Repairs	- 1,519.50
23RT4MN0009	Defence Costs	130.58
23RT4PI0012	Defence Costs	17.22
Totals		**80,621.95**

AGENDA ITEM No	**8**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	1

AUDIT REPORT

MEETING	Audit Committee
DATE	1st December 2022
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Julie Boalch, Head of Risk and Corporate Governance
CONTACT	Julie.Boalch@wales.nhs.uk

EXECUTIVE SUMMARY

1. The purpose of the report is to provide the Audit Committee with an update in respect of internal and external reviews and an update in respect of activity since the last meeting.

2. **Members are asked to receive and discuss the contents of the report and:**
   a) **Consider the audit activity since the last Audit Committee in September 2022.**
   b) **Consider the proposals to address each recommendation particularly those that have been further extended beyond agreed deadlines.**

KEY ISSUES/IMPLICATIONS

3. The report provides an update in respect of audit recommendations resulting from Internal Audit and external reviews.

4. Relevant sections of the audit tracker assigned to the following Committees were considered during this period for scrutiny and strategic oversight as follows:

   a. **People & Culture Committee** (5th September 2022)
   b. **Quality, Safety & Patient Experience Committee** (10th November 2022)
   c. **Finance & Performance Committee** (14th November 2022)

REPORT APPROVAL ROUTE

5. The details of the report have been submitted to:
   - ADLT – 16th October 2022
   - ADLT – 31st October 2022
   - EMT – 9th November 2022

REPORT APPENDICIES
6. The Audit Tracker has been circulated as a separate document – Appendix 1

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

WELSH AMBULANCE SERVICES NHS TRUST
AUDIT COMMITTEE
AUDIT REPORT

SITUATION

1. This paper provides an update in respect of audit recommendations made resulting from internal and external audit reviews.

BACKGROUND

2. The audit recommendation tracker is in place for the purpose of tracking progress across the Trust to ensure that recommendations contained in internal and external audit review reports were actioned and in a timely manner.

3. This tracker provides Senior Managers with a workable tool that allows for closer scrutiny of audit recommendations and is designed to provide a more detailed focus as to the reasons why recommendations are overdue or have not progressed within the agreed timeframes. This will highlight areas that may require additional support and ensures there are clear mechanisms in place to escalate any issues.

ASSESSMENT

Internal Audit Highlights

4. At the time of issuing the paper, there were a total of 98 current internal audit recommendations on the tracker. 33 recommendations were marked as complete at the September 2022 Audit Committee and removed from the tracker.

5. 21 recommendations were added to the tracker resulting from 2 Internal Audit Reports which were presented to the Audit Committee in September 2022. All 21 of these recommendations were assigned to the Finance & Performance Committee for oversight and were from Reasonable and rated reports as follows:

- Fleet Maintenance – Reasonable Assurance
- Major Incidents – Reasonable Assurance

6. The status of each of the current internal audit recommendations is described in the table below.

Status	Total Number of Recommendations on the tracker	High Priority	Medium Priority	Low Priority
Overdue	39	10	28	1
Not yet due*	29	5	21	3
Complete	30	4	18	8
Total	98	19	67	12

* accepting extensions have been applied in line with the agreed pandemic arrangements.

7. Of the 10 high priority recommendations showing as overdue these relate to the following reports:

- 2020/21 Clinical Contact Centres Performance Management - Reasonable Assurance review - proposed completion date extended to January 2024.
- 2021/22 Role of the Advanced Paramedic Practitioner Review – proposed for completion in November 2022.
- 2021/22 NEPTS Transfer of Operations – Limited Assurance Review – proposed completion date extended from September to December 2022.
- 2021/22 Waste Management – Limited Assurance Review - proposed completion date extended from September to December 2022.
- 2021/22 Risk Management Review – Reasonable Assurance Review – proposed completion date is June 2023.
- 2021/22 Respiratory Protective Equipment – Reasonable Assurance Review – proposed completion date has been extended to March 2023
- 2022/23 Fleet Maintenance – Reasonable Assurance Review – proposed completion date extended from September to November 2022.

8. The total number of recommendations, separated by financial year, and status this period is described below.

Financial Year	Total No. of Recommendations on the tracker	Complete	Overdue	Not Yet Due
2019/20	3	0	3	0
2020/21	14	9	5	0
2021/22	60	19	30	11
2022/23	21	2	1	18
Total	98	30	39	29

9. There are 3 recommendations showing as overdue from 19/20 reports, all of which are of medium priority. One relates to the Trust's Risk Appetite Statement from the Risk Management and Assurance review which forms part of the Risk Transformation programme currently underway. This will not be completed until approximately June 2023.

10. The remaining two recommendations outstanding from 2019/20 relate to the Information Systems Security Leavers Reasonable Assurance Follow Up Review, both of which were expected to be completed by the end of March 2022; however, is now proposed that these be extended to the end of December 2022 and March 2023 respectively.

11. The number of recommendations by assurance rating and level of priority are described below.

Assurance Ratings	Total No. of Recommendations on the tracker	High Priority	Medium Priority	Low Priority
Limited	8	5	3	0
Reasonable	88	14	63	11
Substantial	0	0	0	0
Not Rated	2	0	1	1
Total	98	19	67	12

12. Each of the 98 recommendations were subject to a monthly review by the Assistant Directors Leadership Team since the last Audit Committee in September 2022 to ensure that realistic timescales were proposed where necessary and any new completion dates assigned with a strong narrative and rationale to support this.

13. The Governance team continue to seek assurance from Executives to ensure that:

- Recommendations have been considered and completed within agreed timeframes and,
- All is being done to ensure that the follow up of recommendations will not result in further *Limited* or *No Assurance* rated reports.

External Audit Reviews

14. Section 2 on the tracker describes 12 recommendations made as a result of the Taking Care of the Carers external review.

15. These are described in the table below.

Status	Number of Recommendations
Overdue	8
Not yet due	4
Complete during this period	
Total	12

RECOMMENDED:

16. **Members are asked to receive and discuss the contents of the report and:**
    a) Note the audit activity since the last Audit Committee in September 2022.
    b) Consider the proposals to address each recommendation particularly those that have been further extended beyond agreed deadlines.

AGENDA ITEM No	**9**
OPEN or CLOSED	**Open**
No of APPENDIX ATTACHED	**0**

Committee Priorities 2022/23

MEETING	Audit Committee
DATE	1 December 2022
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Trish Mills, Board Secretary
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. This report updates the Committee on progress against the priorities it set for 2022/23.

2. Progress is steady across all priorities.

RECOMMENDATION

3. The Committee is asked to note the update.

KEY ISSUES/IMPLICATIONS

No issues to raise.

REPORT APPROVAL ROUTE

Not applicable

REPORT APPENDICES

None

REPORT CHECKLIST

Confirm that the issues below have been considered and addressed		Confirm that the issues below have been considered and addressed	
EQIA (Inc. Welsh language)	Yes	Financial Implications	N/A
Environmental/Sustainability	N/A	Legal Implications	N/A

Estate	N/A	Patient Safety/Safeguarding	N/A
Ethical Matters	N/A	Risks (Inc. Reputational)	N/A
Health Improvement	N/A	Socio Economic Duty	N/A
Health and Safety	N/A	TU Partner Consultation	N/A

COMMITTEE PRIORITIES FOR 2022/23

SITUATION

4. This report updates the Committee on progress against the priorities it set for 2022/23.

BACKGROUND

5. During the course of the 2021/22 effectiveness reviews, it was agreed that it is good practice for Committees to set priorities for the forthcoming year.

6. The Committee's priorities, which are set out below, were agreed by the Trust Board in May 2022 and will be tracked quarterly.

ASSESSMENT

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

Priority	Progress
1. Develop an induction programme for new Audit Committee Members	• The overarching new Board member induction programme is complete other than the roles and responsibilities for trade union representatives. This should be completed by mid-September. • The induction programme is in use for new Board members and includes a scrutiny toolkit, however in collaboration with Audit Wales we are looking to produce Audit Committee specific induction material and checklists. • In addition, a bespoke WAST finance induction for new members is also being developed with the Finance Team. • An addition to the induction programme is in development for Board members specifically around ESR, expenses, digital and payroll and will be complete by 31 December 2022.
2. The transformation of risk management and the Board Assurance Framework (BAF).	• The Committee received a progress report on the risk management programme in June 2022. • The programme is part of the IMTP with oversight of the IMTP in Finance and Performance Committee. • The programme includes maturity of risk management and the BAF through 2022/23 and into 2024, and improvements are noted by the Audit Committee with the regular risk management reports. • The risk management policy and procedure will come to this committee for approval as part of that programme.

RECOMMENDATION

8. The Committee is asked to note the update.

ALL WALES GROUP REPORT

ALL WALES AUDIT COMMITTEE CHAIRS (AWACC) MEETING

HIGHLIGHT REPORT

Date of Meeting	**13 October 2022, 09:30**
Chair Name ***Chair Organisation***	Martin Turner Audit Committee Chair Welsh Ambulance Services NHS Trust
Secretariat ***Secretariat Organisation***	Trish Mills, Board Secretary Alex Payne, Corporate Governance Manager Welsh Ambulance Services NHS Trust

Members Present:	
Martin Turner	Welsh Ambulance Services NHS Trust [Chair]
Dyfed Edwards	Public Health Wales
Iwan Jones	Aneurin Bevan University Health Board
Marian Jones	Digital Health and Care Wales
Gill Lewis	Health Education and Improvement Wales
Paul Newman	Hywel Dda University Health Board
Patsy Roseblade	Cwm Taf Morgannwg University Health Board
John Union	Cardiff and Vale University Health Board
Martin Veale	Velindre University NHS Trust
Nuria Zolle	Swansea Bay University Health Board
In Attendance:	
Trish Mills	Board Secretary, Welsh Ambulance Services NHS Trust
Simon Cookson	Internal Auditor, NWSSP [Item 1-2]
Richard Harris	Audit Wales [Item 3]
Dave Thomas	Audit Wales [Item 3-4]
Jonathan Morgan	Observer - Health Education and Improvement Wales
Apologies:	
Medwyn Hughes	Betsi Cadwaladr University Health Board
Alison Lewis	Health Education & Improvement Wales
Stella Parry	Powys Teaching Health Board
Mark Taylor	Powys Teaching Health Board

The following is a summary of the main issues discussed at the meeting

1. Minutes from the 19/05/22 & Outstanding Actions

1.1. The minutes from the meeting held on the 19 May 2022 were agreed as an accurate record. There were no requests for amendments or comments and accepted.

1.2. The actions were reviewed. Action ‘AWACC (22) 15’ was closed; action ‘AWACC (22) 17’ will be discussed under work programme arrangements; all other actions were complete.

The following is a summary of the main issues discussed at the meeting

2. Internal Audit Update [Business Development & Analysis Update]

2.1. Simon Cookson delivered a presentation to the group on the audit activity via the new dashboard. The number of reviews and trends across categories and financial years could be observed, in addition to comparison by organisation.

2.2. The following was noted:

- That similar individual organisational presentations will be delivered;
- That is necessary to consider how to use and share the database;
- That user access to the database must be considered;
- The intention is for this information to be used in the 'background';
- That benchmarking the data outside of Wales could be helpful;
- Internal Audit (IA) have approached other IA colleagues to seek such data;
- IA will share the database with Audit Committees, as requested;
- The primary audience is the AWACC and the Board Secretaries Network;
- That it would be helpful for the database to include emergent themes;
- That this database could potentially be subject to misuse.

2.3. IA are content to develop and share the database in whichever way is considered preferable and will take advice from the AWACC. The database is to enable learning; however, it does enable organisational comparison.

2.4. The future approach to IA planning was considered; Simon Cookson stated that this database could be used to inform the future approach in regard to identifying themes which require attention.

2.5. Simon Cookson will socialise the database with other stakeholders, after which the AWACC will decide how to take it forward. Simon will return to the AWACC at its next meeting to follow up this work **[Action].**

3. Audit Wales – External Audit Update

3.1. Dave Thomas and Richard Harris spoke to the group in regard to two matters – the Fee Scheme Consultation and the Work Programme. In regard to the *Fee Scheme Consultation* the following was noted: -

- The Consultation included info regarding the change to audit approach;
- The fee increase is not yet known;
- Plans will be issued in early 2023 which will set out the detail.

3.2. The group discussed resource / workforce challenges within Audit Wales, and the risks that this poses for service delivery. Audit Wales continue to work closely with local finance teams / organisations on this matter;

The following is a summary of the main issues discussed at the meeting

3.3. In regard to the *Work Programme* the following was noted: -

- The wider VfM work programme across all sectors has been shared;
- The structured assessments have been progressed;
- Follow-up to the planned care for orthopaedic services will soon be published;
- Summary of quality governance findings will soon be published;
- There is work on unscheduled care, including review of discharge planning;
- There will be a thematic review of workforce planning.

3.4. Audit Wales would expect to be involved in giving evidence to the Pandemic Inquiry, however they are yet to be invited to do so. There is output from the Test, Trace and Protect report which could be helpful, for example.

4. Work Programme and Operating Arrangements

4.1. The group considered its operation and the business it should receive going forward. The suggestions received for how the group should operate, and the business to receive included: -

- Focus on all-Wales audit activities that affect all bodies, e.g., decarbonisation;
- Focus on all-Wales areas of high-risk activity, e.g., cyber-security;
- Approach to counter-fraud and associated resources to support;
- The socialisation and use of the Internal Audit analysis dashboard;
- Welsh Language Standards compliance – involve the Commissioner;
- The Internal Audit approach / best practice regarding capital projects;
- Related lessons learned from capital projects/programme activity;
- The Gateway review process / compliance;
- All-Wales high-risk compliance requirements, inc. Welsh Language;
- Understanding of the macro-economic environment, in context;
- Partnership working and associated audit management.

4.2. The group agreed to focus on two or three areas at its next meeting, supported by Trish Mills. The preference for its next meeting was for the group to consider counter-fraud and de-carbonsiation;

4.3. Additionally, the group will receive business in relation to the Welsh Language Standards at its next meeting. If this is not practical it will be received at the subsequent meeting;

4.4. Dave Thomas will support the discussion regarding management of capital projects from an individual organisational point of view, as opposed to inclusion for discussion at AWACC;

4.5. Dave Thomas will consider this matter and feedback any useful questions to support Independent Board Members' in governing the management of capital projects to the Chair and Trish Mills **[Action];**

The following is a summary of the main issues discussed at the meeting

4.6. In regard to the macro-economic environment topic, it may be possible for the members to attend meetings of the respective Finance Directors – to better understand the position **[Action];**

4.7. The group agreed the importance of returning to cyber-security as an ongoing audit issue. Trish Mills will support the arrangements for the next meeting and prepare the agenda as discussed.

5. Update from All Wales Board Secretaries Network and Audit Working Group

5.1. Updates from External Audit and Internal Audit: -

- External audit: update on national reviews (climate change; wellbeing audit; unscheduled care work, national quality governance etc);
- Internal audit: Delivered a demonstration of the internal audit analysis tool (discussed by the group earlier).

5.2. Demonstration from the Finance Academy on an interactive awareness tool for the Standing Financial Instructions which has been developed. This tool is very useful for Board Member inductions.

5.3. NHS Executive Governance: -

- The Board Secretaries Network has representation on the Governance and Finance workstream for the development of the NHS Executive;
- The timescales to establish the Executive are very challenging (by the 1 January 2023);
- A PID to consider the complex issues is in development, and the Governance and Finance workstream is working through it;
- Given the interdependencies with the mandate development and functions development workstream, it's too early to provide a substantive update.

5.4. 111 Governance: -

- Received a presentation from Richard Bowan and Nicola Bowen from the 111 Programme Team in light of the proposed transition of the 111 Programme Board to Goal 2 delivery group;
- The Board Secretaries Network have raised various agreements that require updating with Richard Bowan, and in particular Rani Malleson from Aneurin Bevan as host, is leading this work.

5.5. Conflicts of Interest: -

- Cardiff and Vale are piloting to target doctors' declarations;
- Reviewing ESR functionality and ability to generate Power BI dashboards;
- Considering Civica to support managing declarations of interest.

The following is a summary of the main issues discussed at the meeting

5.6. Covid-19 Inquiry: -

- Discussions around preparedness for Module three core participant status;
- Core participant applications likely required in a three-week period;
- The Network will discuss further the principle of whether this is done individually or collaboratively;

6. Any Other Business

6.1. At Trish Mills' request, the group considered how best to record and disseminate its discussions. It was asked that Trish investigate whether production of a highlight report rather than minutes is accepted practice, but it was agreed that this would be acceptable for the record of this meeting **[Action].**

7. Next meeting:

7.1. The date for the next meeting is to be agreed; Trish to consider options **[Action].**