Bundle Audit Committee (Open) 1 March 2024

Agenda attachments

ITEM 0 Agenda Audit Committee Open 01 March 2024

0 09:30 - OPENING ITEMS

1 Chair's welcome; apologies and confirmation of quorum

2 Declarations of Interest
Declarations of Interest

3 Minutes of last meeting: - 30 November 2023
3.1 30 November 2023

ITEM 3.1 Audit Committee OPEN Minutes 30 November 2023

4 Action Log and Matters Arising
4.1 Action Log

ITEM 4.1 Action Log

4.1 ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION

5 09:40 - 2023/24 Accounts Planning and any Emerging Issues

ITEM 5 SBAR AC - 2023-24 Accounts Planning and Emerging Issues
ITEM 5.1 NHS letter - final 23-24

6 09:50 - 2023-24 Annual Filings Schedule

ITEM 6 23-24 Paper - SBAR to AC March 2024 - Annual Filings Timetable

7 09:55 - Internal Audit Items
7.1 Internal Audit Progress Report
7.2 Audit Plan 2024/25
IA reports:
7.3 Decarbonisation
7.4 Serious Adverse Incidents Joint Investigation Framework
7.5 Strategy Development
7.6 Retention of Staff
7.7 111 Service Commissioning Arrangements (Advisory)
7.8 Capital Assurance: Vehicle Replacement Programme
7.9 ePCR Clinical Compliance

ITEM 7.1 WAST_2324_Internal Audit Progress Report_March 24_Final
ITEM 7.2 WAST_2024-25_Draft Internal Audit Plan_for ELT & AC approval
ITEM 7.3 WAST_2324-002_Decarbonisation_Final Internal Audit Report
ITEM 7.3a WAST_2324_002_Decarbonisation_PAQ
ITEM 7.4 WAST_2324-007_Serious Adverse Incidents Joint Investigation Framework_Final Internal Audit Report
ITEM 7.5 WAST_2324-006_Strategy Development_Final Internal Audit Report
ITEM 7.6 WAST_2324-016_Retention of Staff_Final Internal Audit Report
ITEM 7.7 WAST_2324-004_111 Commissioning_Final Advisory Report_for issue
ITEM 7.8 WAST-SSU-2324-01 Vehicle Replacement Programme Final Audit Report
ITEM 7.9 WAST_2324-008_ePCR Clinical Compliance_Final Internal Audit Report

8 10:35 - Audit Wales Reports
8.1 Audit Wales Update Report
8.2 Structured Assessment 2023

ITEM 8.1 WAST Audit Committee update 160224
ITEM 8.2 WAST Structured Assessment 2023 Report FINAL

8.1 10:55 - COMFORT BREAK

9 11:10 - Risk Management and Board Assurance Framework
9 Risk Management and Board Assurance Framework
9.1 Risk Management Policy

ITEM 9 Executive Summary Risk Management Report AC 010324
ITEM 9.1 Risk Management Policy v0.12 210224

10 11:25 - Audit Tracker 2.0 - December 2023

ITEM 10 SBAR Audit Tracker to Audit Committee Q3 Reporting - March 2024
ITEM 10.1 Audit Tracker 2.0 October-December 2023
ITEM 10.2 Audit Tracker 2.0 October-December 2023
ITEM 10.2a Audit Wales and HIW Audit Tracker 2.0 Q3 October-December 2023

11 11:35 - QuEST Committee Report - Clinical Audit Plan 2024/25 Approval
ITEM 11 Quest Committee Highlight Report to Audit Committee

12 11:40 - Losses and Special Payments - Payments for the Period from 1 April 2023 to 31 January 2024
ITEM 12 Executive Summary SBAR Losses and Special Payments M10 2023-24
ITEM 12.1 Annex 1 - Losses Special and Payments 2023-24 M10 Workings BD

13 11:50 - Policy Report
13.1 Policy Report
13.2 Counter Fraud, Bribery and Corruption Policy
ITEM 13.1 Executive Summary Policy Report AC 010324
ITEM 13.2 Executive Summary Counter Fraud Bribery and Corruption Policy 2024 Audit ctte March 2024
ITEM 13.2a Counter Fraud Policy 150124

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

14 Committee Priorities and Cycle of Business Monitoring Report
ITEM 14 Audit Committee Priorities and Cycle Monitoring Report
ITEM 14.1 Audit Committee Cycle of Business 2023-24 - Monitoring Report

15 Audit Committee Highlight Report - 30 November 2023
ITEM 15 Audit Committee Highlight Report November 2023
ITEM 15.1 WAST Workforce Report final

16 All Wales Audit Committee Chairs Report (November 2023)
ITEM 16 2023-11-20 AWACC AAA Report

16.1 CLOSING ITEMS

17 12:00 - Reflections & Summary of Decisions and Actions

18 Key Messages for Board

19 Any Other Business

20 Date and time of next meeting: 30 April 2024 - 09:30

AGENDA

MEETING OF THE OPEN AUDIT COMMITTEE

Held in public on **1 March 2024 from 09:30 to 12:05**

Lunch Break 30 Minutes

Closed meeting to commence at 12:35

Meeting held virtually via Microsoft Teams and in person in Cardiff

No.	Agenda Item	Purpose	Lead	Format	Time
OPENING ITEMS					
1.	Chair's welcome; apologies and confirmation of quorum	Information	Peter Curran	Verbal	10 Mins
2.	Board Member Register of Interests	To State Conflicts	Peter Curran	Verbal	
3.	Minutes of last meeting: – 3.1 30 November 2023	Approval	Peter Curran	Paper	
4.	Action Log and Matters Arising 4.1 Open Actions	Discussion	Peter Curran	Paper	
ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION					
5.	2023/24 Accounts Planning and any Emerging Issues	Assurance	Chris Turley	Paper	10 Mins
6.	2023-24 Annual Filings Schedule	Assurance	Trish Mills	Paper	5 Mins
7.	Internal Audit Items 7.1 Internal Audit Progress Report 7.2 Audit Plan 2024/25 IA reports: 7.3 Decarbonisation 7.4 Serious Adverse Incidents Joint Investigation Framework 7.5 Strategy Development 7.6 Retention of Staff 7.7 111 Service Commissioning Arrangements (Advisory) 7.8 Capital Assurance: Vehicle Replacement Programme 7.9 ePCR Clinical Compliance	Assurance	 Osian Lloyd Osian Lloyd Chris Turley Liam Williams Rachel Marsh Angela Lewis Rachel Marsh Chris Turley Andy Swinburn	Paper	40 Mins
8.	8.1 Audit Wales Update Report 8.2 Structured Assessment 2023	Assurance	Fflur Jones	Paper	20 Mins

No.	Agenda Item	Purpose	Lead	Format	Time
COMFORT BREAK [15 Mins]					
9.	9 Risk Management and Board Assurance Framework 9.1 Risk Management Policy	Assurance Endorsement	Julie Boalch	Paper	15 Mins
10.	Audit Tracker 2.0 - December 2023	Assurance	Trish Mills	Paper	10 Mins
11.	QuEST Committee Highlight Report dated 8 February 2024 - Clinical Audit Plan 2024/25 Approval at QuEST Committee.	Assurance	Trish Mills	Paper	5 Mins
12.	Losses and Special Payments – Payments for the Period from 1 April 2023 to 31 January 2024	Assurance	Chris Turley	Paper	10 Mins
13.	13.1 Policy Report 13.2 Counter Fraud, Bribery and Corruption Policy	Assurance Approval	Julie Boalch Chris Turley	Paper	10 Mins
CONSENT ITEMS **The items that follow are for information only. Should a member wish to discuss any of these items they are requested to notify the Chair so that time may be allocated to do so.**					
14.	Committee Priorities and Cycle of Business Monitoring Report	Information	Trish Mills	Paper	-
15.	Audit Committee Highlight Report – 30 November 2023	Information	Trish Mills	Paper	
16.	All Wales Audit Committee Chairs Report (November 2023)	Information	Trish Mills	Paper	
CLOSING ITEMS					
17.	Reflections & Summary of Decisions and Actions	Information	Peter Curran	Verbal	5 Mins
18.	Key Messages for Board	Information	Peter Curran	Verbal	
19.	Any Other Business	Discussion	Peter Curran	Verbal	
20.	Date and time of next meeting: 30 April 2024 – 09:30	Information	Peter Curran	Verbal	

Lead Presenters

Name of Lead	Position of Lead
Peter Curran	Non-Executive Director and Committee Chair
Julie Boalch	Head of Risk/Deputy Board Secretary
Fflur Jones	Audit Wales
Angela Lewis	Director of People and Culture
Osian Lloyd	Head of Internal Audit
Rachel Marsh	Executive Director of Strategy, Planning and Performance
Trish Mills	Board Secretary
Andy Swinburn	Executive Director of Paramedicine
Chris Turley	Executive Director of Finance and Corporate Resources
Liam Williams	Executive Director of Quality and Nursing

WELSH AMBULANCE SERVICES NHS TRUST

UNCONFIRMED MINUTES OF THE OPEN MEETING OF THE AUDIT COMMITTEE OF THE WELSH AMBULANCE SERVICES NHS TRUST HELD ON THURSDAY 30 NOVEMBER 2023 VIA TEAMS

Meeting Commenced at 09:30

PRESENT:

Martin Turner	Non-Executive Director and Committee Chair
Paul Hollard	Non-Executive Director
Ceri Jackson	Non-Executive Director

IN ATTENDANCE:

Julie Boalch	Head of Risk/Deputy Board Secretary
Lee Brooks	Executive Director of Operations
Judith Bryce	Assistant Director of Operations
David Butler	Internal Audit, NWSSP (left after Item 55/23)
Colin Dennis	Chair of the Trust Board
Eifion Jones	Internal Audit, NWSSP (left after Item 55/23)
Fflur Jones	Audit Wales
Navin Kalia	Deputy Director of Finance and Corporate Resources
Olaide Kazeem	Project Accountant Financial Services
Angela Lewis	Director of People and Culture
Martyn Lewis	Internal Audit, NWSSP
Greg Lloyd	Assistant Director of Clinical Delivery Operations (Item 55/23only)
Osian Lloyd	Head of Internal Audit, NWSSP
Rachel Marsh	Executive Director of Strategy, Planning and Performance (Item 53/23 only)
Trish Mills	Board Secretary
Steve Owen	Corporate Governance Officer
Alex Payne	Corporate Governance Manager
Felicity Quance	Deputy Head of Internal Audit, NWSSP
Duncan Robertson	Assistant Director for Clinical Development
Jonny Sammut	Director of Digital Services

Paul Seppman	Trade Union Partner
Chris Turley	Executive Director of Finance and Corporate Resources
Damon Turner	Trade Union Partner
Carl Window	Counter Fraud Manager

APOLOGIES:

Joga Singh	Non-Executive Director
Liam Williams	Executive Director of Quality and Nursing

52/23 PROCEDURAL MATTERS

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

Members noted that any declarations of interest were contained within the Trust's Register of Interests.

Minutes:

The Minutes of the Audit Committee meeting held on 14 September 2023 were approved.

Action Log

Action Number 48/23: Board/Committee Induction programme. To liaise with Paul Seppman to consider retrospective induction particularly for TU partners who are members of the Board and its sub-Committees. Trish Mills proposed this action was extended to the 1 March 2024 meeting for update. Agreed.

Action Number 50/23: Policy report. Policy review extension criteria. Was there any other risk that could be captured within the 6 criteria points, i.e., whether a policy review should be delayed. Action complete and details have been included in the criteria list. Action Closed.

Audit Committee AAA report dated 14 September 2023

The Committee AAA report dated 14 September was presented for information noting the two alerts: Amendments to the Trust's Standing Orders and a change of prescribed Committee attendees.

RESOLVED: The Committee;

(1) Noted the apologies from Joga Singh and Liam Williams;

(2) Approved the Minutes of 14 September 2023;

(3) Considered the action log noting that reference number 50/23 was closed. The other action, number 48/23 was agreed to be deferred to the March meeting; and

(4) Received the AAA report.

53/23 QUALITY ANDPERFORMANCE MANAGEMENT FRAMEWORK UPDATE

A verbal update was provided by Rachel Marsh in which the Committee were reminded that the framework consisted of five building blocks which set out the requirements to deliver quality and performance improvements. The building blocks contained aspirational and ambitious objectives for the Trust.

A steering group to oversee implementation of the framework has been established, which, particularly in relation to the Health and Social Care Act, has reviewed and amended the framework slightly. Further work to clarify how this Act aligns with the framework was underway, part of which was to revise and update the terms of reference for the steering group. A self-assessment has been completed at an organisational level against the requirements with a work plan going forward agreed.

The Committee recognised there was still further work to be carried out and it was anticipated with some additional capacity that the framework would be progressed with alacrity.

Comments:

Members acknowledged the substantial progress in refining the terms of reference and the work plan. The close monitoring of the implementation was crucial to ensuring a smooth flow with the organisation; recognising the framework will be reviewed at other Board Committees going forward as part of its implementation and development. Paul Hollard emphasised the importance of other Board Committees receiving assurance about the oversight of the Duty of Quality.

RESOLVED: The update was noted.

54/23 POLICY REPORT

Julie Boalch explained that the purpose of the report was to provide the Committee with an update on the status of the Trust's Policies as outlined on the work plan for the next two years. A priority programme of work was being established to bring the organisation's key policies up to date during 2023/24 with a further work plan agreed for 2024/25.

The work plan for 2023/24 which identified those policies for review was on schedule, with policies being reviewed at monthly policy group meetings. The Committee should note the

proactive approach being taken to consider any potential challenges such as winter pressures which may impede on the plan.
The Trust is in the process of undertaking a light touch review of the 'Policy on Policies'. Early next year this process will be strengthened further. Members also noted that the Trust was considering an electronic solution to support improvements going forward.

Comments:

Clarity was sought on some of the review dates in the workplan for 2024/2025, for example occupational health showed a review date of 2014. Julie Boalch explained this was a not an error but that the Occupational Health Policy had been issued in 2013 and had been due for review since January 2014.

It was noted that 14 policies had been identified as Standard Operating Procedures (SOP). An explanation on the rationale of when a policy becomes an SOP was sought. Julie Boalch explained there was a set of criteria that differentiated between SOPs and policies. Each document was assessed individually to consider whether it aligned with the criteria after which an approach was agreed.

Following discussion it was agreed that - given policies were reviewed regularly by the Policy Group and the Executive Leadership Team (ELT) - it was agreed that a concise report focussing on policy status without the need for detailed information could be prepared for future Committee meetings.

Paul Seppman commented that from a Trade Union perspective he was assured that the Policy Group had effectively streamlined the process, eliminating unnecessary high-level discussions. The current approach ensure that policies undergo the correct and efficient channels for approval.

RESOLVED: The Committee:

(1) Noted the updates to the policy work plans established to mitigate risk and review policies in line with appropriate review dates.

(2) Received assurance on the prioritisation and progress being made to review Policies; and

(3) Noted the next steps as outlined in the update and that future reports contain less detailed information.

55/23 INTERNAL AUDIT ITEMS

The Head of Internal Audit (HoIA), Osian Lloyd presented the reports which consisted of his update and three Internal Audit (IA) Reports.

Good progress was being made against the 2023/24 Internal Audit Plan; of the 20 reviews, four had been finalised, two were in draft, seven were in progress and seven had not been started. The Committee noted there were no changes being proposed to the plan, and the most recent submission of the KPIs were noted.

The following Internal Audit reports were received:

Senior Paramedic Role – The Internal Audit (IA) opinion was reasonable.

Felicity Quance explained that the purpose of the report was to assess the extent that Senior Paramedics (SP) were achieving their key role objectives.

The review found that while roles and responsibilities were generally clear, there were inconsistencies in how shifts were being tracked. There were also some challenges impacting on the SP's ability to provide sufficient supervision to Paramedics and Emergency Medical Technicians within their teams. It was noted that whilst the contribution to patient care was thorough, there was a need for consistent observation during ride-outs.

Further work was required to ensure that the feedback received from SPs was reviewed and reported accordingly. Appropriate training was available to SPs to enable them to undertake their role and appropriate support and supervision was being provided to them by management. Additional work was required to ensure that the required skill enhancements were provided in order for their expectations to be met. Furthermore, management has accepted the recommendations, and the Audit Team thanked all those involved with producing this report.

The Committee noted there was an inconsistency between the limited assurance on governance arrangements and the management recommendations and sought clarification on that point. Felicity Quance explained it was limited due to the limited reporting being undertaken on the effectiveness and efficiency of the SP role. Overall, due to the many positive aspects in the broader areas of the report and the good elements being undertaken within the wider localities, it was not considered appropriate to downgrade the report from a reasonable opinion. Greg Lloyd added that the Trust was committed to evaluating the evolution of the role and learning lessons from the audit process. From a governance perspective, the Committee recognised that the audit recommendations would be monitored through the People and Culture Committee (PCC) via the Audit Tracker.

Records Management – The IA opinion was reasonable.

Martyn Lewis advised the Committee that the Trust can take reasonable assurance with its records management. The aim of the audit was to evaluate the arrangements and processes in place for records management within the Trust.

The key objectives with the review were to review the guidance in place, review the capacity of the records management team, and to look at processes to ensure the availability of records. The review also considered the storage of records and ensuring an appropriate disposal of archiving records along with the transition to enabling a digital service. Records were currently being held in a storage facility leased from Denbighshire County Council.

However, there were some challenges to overcome which included outdated policies, a small and compliance focused team which lacked resilience, and there was no comprehensive improvement plan. There were legal implications in that the NHS records being stored did not have a structured digital record deletion process which could pose a GDPR breach risk. The management were conscious that addressing these issues was crucial for future effectiveness.

Jonny Sammut, Director of Digital Services, explained that some of the resourcing issues had been historic as it was an exceedingly small team that looked after the records. Part of the management action plan was to bolster that with temporary resources form January 2024, to review the storage of records.

The Committee were surprised to see the report was given a reasonable assurance opinion when the review had assessed three limited objectives, and there were also some legal issues relating to records management. Martyn Lewis explained that the audit team were confident, following discussions with staff responsible for holding the records, that they were following the correct procedures and guidance. The current storage facility although lacking a formal legal basis, was deemed secure and that the NHS records were kept separate form Council records. The assurance lay within the balance of these factors tipping the scale towards a reasonable assurance opinion. Another important factor to understand was the significant move with digitisation of records.

Osian Lloyd added that another important factor considered was the significant move with digitisation of records. The majority of records in use at the Trust, particularly patient records, are in digital form, and most issues raised within the report related to the physical records.

Estates Condition – The Internal Audit opinion was Limited Assurance.

Eifion Jones explained that a review on the estate of all Health Boards and Trusts had been conducted across Wales. The aim was to assess the specific challenges faced by NHS Wales in relation to the estates. The review found there were several themes including risk

management, data quality, accuracy of survey information and the challenges with funding for any work required. The goal of the review was to raise the profile of estates issues. Recent discussions with Welsh Government have indicated there should be a common approach in resolving the estates issues. Currently, all the reports across the Health Boards and Trusts were of a limited assurance. Going forward, an All-Wales summary report will be produced and shared with UHBs/Trusts, WG and NWSSP:SES on common themes, best practice and future actions. We understand that NWSSP:SES have already started looking at one common theme i.e. how the data collected could be more accurate and consistent.

David Butler emphasised that the key driver within the report was the scale of the backlog across Wales. It was estimated this was in the order of three times the amount of capital funding and this had clearly posed significant risks to addressing the estates condition. The Trust had aimed to eliminate the backlog over a 10-year period. While the backlog has reduced in recent years, the Trust faced challenges disposing of sites due to stalled capital programs and a lack of recent investment. As a result, higher risk backlog was increasing, and the outlook was for further increase as the estate aged. The review highlighted there were also data quality issues and inconsistent assessments. While many areas were positively assessed, the absence of a funded strategy has led to an overall limited assurance in addressing the estate's condition. Particularly recognising that the associated risk does ultimately rest with the Trust.

Chris Turley assured the Committee that a number of discussions had been held with IA over the report and the resulting overall assurance rating when compared with much of the rest of the NHS in Wales. In this he had questioned the consistency of the rating and the methodology of the audit and suggested that the report was more of an all-Wales report rather than a Trust specific one; expressing disappointment it had been identified as a limited assurance for the Trust. There were several factors beyond the Trust's control, which included funding and the consistency of reporting. He added that the backlog maintenance has significantly reduced over the last few years compared to the rest of Wales. In terms of the management recommendations contained within the report he underlined that the Trust could only action those which were within its control. He added that traditionally, a limited assurance would need to be followed up quickly, and this would need consideration going forward.

Eifion Jones explained the rationale for the rating and the shared challenges faced by all Health Boards and Trusts in Wales and acknowledged the positive aspects of the Trust's management approach and governance arrangements. He advised that in conducting the review, organisations were benchmarked when determining the overall opinion for each audit. Whilst some other organisations across Wales were much further limited, it was felt limited was a fair assessment of the Trust. It was acknowledged that some of the recommendations were jointly owned with for example Welsh Government (WG) and Specialist Estates Services (SES), but the review has tailored those recommendations to make them implementable.

David Butler stated that across Wales there was a lack of funded strategy to eliminate the backlog adding there was a huge disparity between Health Boards in terms of what funds they had available and their backlog figures. Furthermore, whilst the Trust does have a backlog the historical context and positive aspects were acknowledged within the report.

The Committee expressed their concern that this audit had resulted in being limited, especially considering the constraints upon the Trust. It was felt that the report should have been identified as reasonable, as the review illustrated several positive aspects and recognising that a lot of the constraints were at WG and SES level.

RESOLVED: The Committee received the following reports: IA Reports: Senior Paramedic role, Records Management and Estates condition; and the IA progress report.

56/23 AUDIT WALES REPORTS

The Committee received an update report from Fflur Jones who advised that Audit Wales was actively engaged in various initiatives, including the independent examination of the Charity annual report and accounts for 2022-23, and the ongoing work on unscheduled care audit and the annual Structured Assessment. A follow up review will also be undertaken on the quality governance work that was conducted in 2022.

The Good Practice Exchange Team's recent activities were highlighted in the report, which included the NHS Wales workforce data briefing and a report on approaches to achieving net zero carbon.

The Committee queried whether, in relation to the workforce planning report, that mental health and well-being were considered when conducting the audit, especially in relation to strategic planning and workforce management. Fflur Jones commented that this topic was not extensively explored and recognising the importance, agreed to provide further information on the extent to which this was considered.

National Workforce Report and Workforce Data Briefing

Fflur Jones gave an overview on the key points from the National Workforce Report on NHS Wales. The report has identified that NHS Wales was facing significant challenges regarding vacant positions.

Despite an increase in the workforce of 27% since 2012 and with some areas increasing more than in others, this has led to vacancies with a reliance on agency staff being required to fill these gaps. There has also been an increase in NHS Wales workforce costs of 66% since 2017. Although the increase in staff generally aligns with the national referral demand with certain specialities, as an example, issues with Ophthalmology has increased by 56% since 2012, with the medical workforce in that area having decreased by 2%.

Moreover, staff turnover at a national level has increased in recent years, especially with certain staff groups such as nursing and midwifery. According to data, there were 6,800 vacant positions in NHS Wales as of March 2022. Other factors affecting the workforce include absenteeism due to sickness, with records indicating that for the year 2022/23, 1.4 million working days were lost.

Review of Workforce Planning Arrangements - WAST

Fflur Jones explained that the fieldwork for this report was undertaken between June and August 2023. It comprised of data analysis, interview and observations of meetings including this Committee.

It was concluded that the Trust has taken effective steps to mitigate the current workforce challenges and clarify its long-term strategic vision. Generally, the Trust, for those issues within its control, had plans to address the issues particularly in relation to the more immediate operational challenges. The strengths in staff engagement, robust oversight arrangements at Committee and Board level, and innovative solutions like homeworking for nurses were particularly noteworthy. There were six recommendations within the report for which there are management responses.

Angela Lewis welcomed the report and found it very useful that it was in the context of the wider NHS challenges. She gained reassurance from it that the Trust was on the right trajectory and acknowledged there were still areas that required addressing.

The Committee noted that the report had been discussed at the last People and Culture Committee (PCC) meeting and that it had received positive feedback. The main concern highlighted at the PCC meeting was the issue around clarification of agency spend, which had now been addressed and the report updated accordingly with a footnote to give context to the spend.

RESOLVED: The Committee received the Audit Wales update report, the workforce report and the workforce data briefing.

57/23 RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK

Julie Boalch explained that the purpose of the report was to provide the Committee with updates and details of the activity in relation to the Trust's principal risks. The principal risks were updated as of 15 November 2023 and each of the risks have been reviewed during this reporting period in line with the agreed schedule. Focus has been given to the risk ratings, controls, assurances, gaps and the mitigating actions identified and taken to ensure

risks achieve their target score.

There had been one material change made during this period, and this was in relation to the risk rating of Risk 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) which has achieved its target risk score of 10 (2x5). This was due to the demonstrable work that has been undertaken across the Trust in relation to the Working Safely Programme and Health & Safety. This risk will be de-escalated to the Directorate Register and monitored by the Executive Director and Directorate on a quarterly basis.

Future reviews anticipate a reduction in score of risk 139 (Failure to Deliver our Statutory Financial Duties in accordance with legislation) but an increase in risk 594 (The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death).

The Committee noted that the Risk Management Policy was currently undergoing a governance review and was due to be presented to the Committee in March 2024.

Trish Mills reminded the Committee that all the risks have been reviewed by their respective Committees with the more top-rated ones, by the Board along with the avoidable harm report. A focus going forward was the development of the Board assurance Framework and aligning the risks to the strategic objectives. Further, the Trust will continue to progress and develop the risk improvement programme.

RESOLVED: The Committee:

(1) Noted the review of each principal risk including ratings and mitigating actions;

(2) Noted the de-escalation of Risk 199 from the Corporate Risk Register to the Directorate Risk Register as this has reached its target score of 10 (2x5);

(3) Noted the update on the Risk Management Policy; and

(4) Noted the update on the Risk Management Transformation Programme.

58/23 QUARTER 2 TRACKER UPDATE

Trish Mills advised that the update provided the Committee with the current position with respect to management actions for overall and within the purview of the Committee. Since the last meeting, significant progress had been made in managing the Tracker. Discussions with Internal Audit colleagues have led to the closure of around 30% of all audit recommendations in Quarter two.

Discussions have also taken place with Internal Audit and audit owners on historical actions, and those where management actions may need to be amended in view of the current

operating context. There has been some traction with these, and discussions will continue into Quarter three with a view to closing or revising as many as possible.

The current version of the Tracker was now open for Directorate review for actions due in October, November, and December, and will be reported in the January and February Committee cycles. Members also noted that plans were underway for a richer reporting system using a new digital software system.

In September 2023 the Audit Committee approved the Audit Process and Reporting Handbook ('Handbook'). The Handbook has been further revised to include Audit Wales content and version 2.0 was included in the update for approval by the Committee. To support agility as the revised audit process embeds, the Committee was asked to confirm it was comfortable for non-material changes to be approved by the Executive Leadership Team (ELT).

RESOLVED: The Committee:

(1) Approved the changes to the Audit Process and Reporting Handbook v2.0 (at Annex 1) and agreed that non-material changes will be approved by the Executive Leadership Team; and

(2) Received assurance that the management actions for the audits within the purview of this Committee (at Annex 2), and overall (at Annex 3), were being effectively and appropriately managed and closed off in quarter; and

(3) Noted the proposal for closer scrutiny of the impact of actions in response to audit recommendations.

59/23 LOSSES AND SPECIAL PAYMENTS

Chris Turley presented the report to the Committee which received no additional commentary.

RESOLVED: The Losses and Special Payments Report for the period 1 April 2023 to 31 October 2023 were received and noted.

60/23 SPEAKING UP SAFELY UPDATE (WHISTLEBLOWERS)

Paul Hollard, Chair of the People and Culture Committee (PCC), updated Members of discussions held at the last PCC meeting concerning the Speaking Up Safely programme. The All-Wales Speaking Up Safely Framework was adopted by PCC and ratified by the Trust Board at its meeting last week. A self-assessment as requested by Welsh Government has been completed. The Committee also noted that several guardians have been appointed for confidential reporting.

Angela Lewis emphasised the importance of encouraging colleagues to use formal channels, adding that the collaboration in this area with TU colleagues has proved invaluable. The appointment of Paul Hollard as the NED champion for Speaking Up Safely has added significant support to this initiative.

RESOLVED: The Committee noted the update.

61/23 COMMITTEE CYCLE OF BUSINESS MONITORING REPORT AND PRIORITIES REPORT

The report was presented for information.

RESOLVED: The Committee Cycle of Business Monitoring Report and Priorities Report was noted.

62/23 REFLECTIONS & SUMMARY OF DECISIONS AND ACTIONS

Key messages for the Board would be captured in the AAA report.

RESOLVED: The above was noted.

63/23 AOB

Acknowledging this was Martin Turner's last meeting as the Chair of the Audit Committee, Chris Turley expressed his gratitude over the years and the significant contribution he has made to the Trust and the NHS. He will leave a lasting impact on the organisation and colleagues alike and was thanked for his valuable support and leadership. These sentiments were echoed by Paul Hollard, who expressed his thanks on behalf of all the Non-Executive Directors and wished him well for any future endeavours.

Meeting concluded at: 11:00

Date of Next Meeting: 5 March 2024

ACTION LOG

WELSH AMBULANCE SERVICES NHS TRUST - AUDIT COMMITTEE - December 2021

Ref	Date	Agenda Item	Action Note	Responsible	Due Date	Progress/Comment	Status
48/23	14 September 2023	Board/Committee Induction Programme	To liaise with Paul Seppman to consider retrospective induction particularly for TU partners who are members of the Board and its sub Committees.	Trish Mills	1 March 2024	Update for 30 November 2023 TM wrote to Paul Seppman 210923 Scope for joint chairs and TU member session being developed for Q4. Propose this is extended to March meeting for closure. Agreed, action completion date extended to March meeting. Update for 1 March 2024 Trish has developed the scope for a session with Chairs and TU members on their role and mutual expectations and will be delivered in Q4 or Q1 (2024/25) subject to stakeholder availability. PROPOSE FOR CLOSURE subject to Committee agreement	Complete
56/23	30 November 2023	Audit Wales Reports	Workforce Planning Report. Ceri Jackson, a Non-Executive Director, asked Fflur about the audit approach in relation to mental health and wellbeing, and Fflur explained that they did not look in depth at that aspect because of a previous review on taking care of the carers, but said that they were scoping work on mental health. It was requested that the work around mental health be provided in a future update report.	Fflur Jones	1 March 2024	Update for 1 March 2024 The Forward Work Programme includes a review of adult mental health and is due to be scoped shortly. Updates on that work will be brought via the audit committee update in due course. Propose for closure subject to Committee agreement	Complete

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

2023/24 Accounts Planning and any Emerging Issues

MEETING	**AUDIT COMMITTEE**
DATE	**1st March 2024**
EXECUTIVE	**Executive Director of Finance and Corporate Resources**
AUTHOR	**Olaide Kazeem – Financial Services Project Accountant**
CONTACT	**Chris Turley, 01633 626201, Chris.Turley2@wales.nhs.uk**

EXECUTIVE SUMMARY

This report provides to the Committee an update on planning undertaken, progress made and any issues arising with both the upcoming preparation and external audit of the 2023/24 Annual Accounts.

KEY ISSUES/IMPLICATIONS

Key highlights from the attached documents for the Committee to note are as follows:-

- An update has been provided on the proposed audit timetable for the 2023/24 year end audit by Audit Wales. The proposed audit certification deadline is 15 July 2024 which is 16 days shorter compared to 31 July last year. A tighter audit certification deadline of 15 June 2025 is also currently suggested for 2024/25 year end audit. The Welsh Government is yet to fully confirm this proposed timetable through the final Manual for Accounts.

- Audit Wales (AW) have signified their intention to increase the audit fee by an average of 6.4% for the audit of 2023/24 accounts. The proposed increase in audit fees is driven mainly by regulatory pressures from new auditing standard (including ISA 315) and the attendant increasing quality, recruitment challenges and rising costs of audit staff required to continue to carry out the audit work in line with the new regulatory standards. This uplift will be applied to all NHS Wales organisations.

- Areas of potential focus in the 2023/24 audit identified by AW include that driven by the NHS Wales (HBs) control total position of £123m; accruals and expenditure around year end, standards of governance and financial management, remuneration report & payment of executive salary over and above defined salary point determined by the WG.

REPORT APPROVAL ROUTE
• Audit Committee – 1st March 2023

REPORT APPENDICIES
Audit Wales Letter received 5th February 2024 - NHS – Audit of Accounts 2023-24

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)	YES
Health Improvement	NA	Socio Economic Duty	NA
Health and Safety	NA	TU Partner Consultation	NA

WELSH AMBULANCE SERVICES NHS TRUST
AUDIT COMMITTEE
2023/24 Annual Accounts Planning Update

SITUATION

1. The purpose of this brief paper is to make Audit Committee aware of the current position in relation to the planning for the upcoming preparation and audit of the 2023/24 accounts.

2. In preparation for year-end and as part Audit Wales's intention to reduce the audit period from that experienced in 2023, it has been suggested that they will reintroduce an interim audit in 2024. This is expected to take pressures off Finance and audit teams during the final audit during May and June 2024.

BACKGROUND/ASSESSMENT

Audit Fee

3. AW propose an average fee increase of 6.4% for the audit of 2023/24 accounts, in comparison with the 15% increase for the 2021/22 accounts.

Year End Timetable & Audit

4. At the time of writing, WG are yet to provide final confirmation of the final year-end submission dates via the final Manual for Accounts, however AW have proposed a revised date of 15 July 2024 for the audit certification.

5. AW have advised the interim audit will be brought back this year with continuing focus on the implementation of the new auditing standard (ISA 315) in which AW will continue to undertake a more robust risk assessment. This will entail conversations with Finance team and assessments of the systems and procedures in place to identify the level of risk of material misstatement to areas of the accounts. No date has been communicated for the interim audit as yet.

6. The attached letter provided by AW on 5th February 2024 identified much of the above along with further reflections on the audit of the 2022/23 accounts across the NHS in Wales and some areas of focus expected for the upcoming audit. Whilst not all of the these may directly impact on the Trust; discussions will continue with AWs colleagues to ensure that the Trust is in the best position possible going into this accounts and audit round.

7. At this stage, there are no further issued to raise with AC members in relation to this.

RECOMMENDED: The Committee notes the contents of this report.

Archwilio Cymru
Audit Wales

1 Capital Quarter
Tyndall Street
Cardiff / Caerdydd
CF10 4BZ
Tel / Ffôn: 029 2032 0500
Fax / Ffacs: 029 2032 0600
Textphone / Ffôn testun: 029 2032 0660
info@audit.wales / post@archwilio.cymru

[by-email]

Reference: 4037A2024

Date issued: 5 February 2024

To: NHS Directors of Finance
NHS Audit Committee Chairs
NHS Board Secretaries
Members of the NHS Technical Accounting Group
Hywel Jones – NHS Director of Finance Welsh Government
John Evans – Welsh Government
Jacqui Salmon – Welsh Government

Dear colleague

NHS – Audit of Accounts 2023-24

1 We will shortly commence our accounts audit work for all NHS bodies. We are therefore taking the opportunity to write to you with some important information on how we will undertake your 2023-24 audit.

2 Within this letter, we consider the following:

- the proposed audit timetable for 2023-24;
- a review of the 22-23 audit of accounts;
- an update on audit fees; and
- a look forward to key issues impacting on the 2023-24 accounts and other developments.

The proposed audit timetable for 2023-24

3 We wrote to you in March 2023 setting out our proposed timetable for 2022-23 coupled with our rationale. We set out a proposed timetable which reflected:

- the additional resource required to implement our new audit approach driven by ISA 315 (UK) Identifying and Assessing the Risks of Material Misstatement (Revised July 2020);

- the delays we had experienced in completing the 2021-22 Local Government accounts which in some cases ran well beyond 31 March 2023; and

- the global shortage of audit and finance professionals, which impacted on our ability to recruit and retain qualified staff.

4 Taking the above into account, we proposed the following audit certification deadlines:

- Audit of Accounts 2022-23 – certification by 31 July 2023;

- Audit of Accounts 2023-24 – certification by 30 June 2024; and

- Audit of Accounts 2024-25 – certification by 15 June 2025.

5 We are grateful for the support of colleagues in all NHS bodies, which enabled all 2022-23 audits except for one Local Health Board (LHB) to be certified by the proposed target date of 31 July 2023.

6 We have now reassessed the position for the 2023-24 audit of accounts. Our position has improved on last year. We have made progress embedding the new audit methodology and are further ahead with our audit of Local Government this year than last. However, we are still contending with recruitment and retention challenges which mean we do not envisage quite being able to meet our original planned audit certification deadline for the 2023-24 audit of accounts of 30 June 2024 (as per above).

7 We are therefore proposing the following revised audit certification deadlines:

- Audit of Accounts 2023-24 – certification by 15 July 2024; and

- Audit of Accounts 2024-25 – certification by 15 June 2025.

8 As you can see from the above, our intention is to still try and work to our original timetable for the audit of accounts 2024-25. We believe this is achievable when we take into account it will be our third year delivering audits under our new approach which should generate efficiencies. That said, the achievement of the timetable for 2024-25 is not without its challenges, particularly if market conditions persist in respect of the recruitment and retention of qualified auditors.

9 We recognise that for the forthcoming audit of accounts 2023-24, our deadline is slightly later than many bodies would like but we believe it is important to set realistic timescales given our current position and alert the Service to our proposals as soon as practically possible.

10 We will be working closely with the Welsh Government and NHS finance teams over the next few months to agree the precise timings for submission of draft accounts. There will inevitably be logistical matters to take into account at each body, and we are conscious of the need to factor in Audit Committee, Board and Annual General Meeting (AGM) dates, particularly as Health Boards and Trusts must hold an AGM no later than 31 July each year as per Standing Orders.

11 In respect of the Charitable Funds audit or the independent examination, we intend to complete these by the deadline set by the Charities Commission.

Review of the 2022-23 audit of accounts

12 Our audits of NHS accounts for the year ended 31 March 2023 were carried out under revised Auditing Standard, ISA 315. In planning our audit at individual Health Bodies, we were required to undertake more detailed and extensive risk assessment procedures to identify the risks of material misstatement and to develop an audit approach designed to address those risks.

13 This revised standard had a significant and far-reaching impact on our audit methodology, and we are grateful to Finance Teams for their engagement and the support they provided to our audit teams.

14 All audits except for one Local Health Board (LHB) were certified by the agreed administrative certification date - 31 July 2023. The delay for the final LHB was as a result of issues arising during the audit. All NHS bodies were certified before the NHS statutory deadline which is four months after submission of the draft accounts (early September 2023).

15 With regards to our audit opinions and reports, none of the NHS Trusts or Strategic Health Authorities received any qualifications. All except one of the LHBs had regularity qualifications for breach of break-even duty. In addition, a number of the LHBs had a substantive report for a failure to meet the second financial duty (lack of an approved financial plan). A summary of our NHS opinions and reports can be seen in **Appendix 1**.

16 2022-23 was a technically challenging year due to the quinquennial valuation of the NHS estate and implementation of the new leasing standard - International Financial Reporting Standard (IFRS) 16. As a result, we identified more

adjusted and unadjusted audit adjustments than in previous years. We also continued to see audit adjustments being required to remuneration report disclosures, along with issues relating to the approval of senior officer remuneration. In many cases, we also identified issues with year-end payables balances which increased audit testing. We will continue to work with individual bodies and make recommendations for improvement.

17 We held a number of meetings with key NHS finance groups during the year and we intend to continue with these meetings going forward. In particular, we welcomed our invitation to meet with the Audit and Risk Committee Chairs as a group and would be keen to do so again this year.

Update on audit fees

18 As a result of ISA 315, the revised audit approach applied in 2022-23 required us to employ more experienced, professionally qualified, staff on the audits, resulting in the larger than usual increase in your audit fee last year. We estimated that fee increase required to support the implementation of this new approach would be around 10.2%. In addition, we also applied a 4.8% fee increase last year in respect of inflation resulting in a combined average fee increase of 15%.

19 On the completion of our 2022-23 audits, we initiated a fee review as part of our post-project learning process. In summary, we concluded that the specific uplift of 10.2% to support the implementation of the revised auditing standard was not quite sufficient across all NHS audits. The total amount of further audit cost overrun incurred on NHS audits amounted to 10.1% which is equivalent to £234,000.

20 Recognising the cost pressures prevalent across NHS Wales, we have decided not to invoice for these overruns where there were no significant issues arising during the audit process. This means that we will be absorbing overspends of over £100,000. Our ability to absorb these overruns has been made possible this year by identifying additional 'one-off' efficiencies internally and should not be seen as creating a precedent for future years.

21 In terms of this year, our Fee Scheme for 2024-25 is now available Fee Scheme 2024-25 | Audit Wales. Our fee rates are increasing on average by 6.4% next year. Some further context is provided in the consultation foreword, but we have incorporated the key message into this letter.

22 Like the rest of the public sector, we are facing significant staff cost pressures. As stated above, those are exacerbated by a global shortage of audit and

finance professionals, which we are seeing reflected in our ability to recruit and retain qualified staff.

23 It is important that we do all that we can to address the recruitment and retention challenges if we are to continue to bring audit deadlines forward in accordance with the revised timetable set out above. To help offset increasing staff costs, we are taking difficult decisions to reduce our non-staff expenditure. We have moved to smaller, cheaper offices in both South and North Wales, have significantly reduced our travel and associated costs, and removed financial allowances previously paid to staff.

24 It is worth pointing out that audit fees have increased significantly across the whole audit profession in response to regulatory pressures, new auditing standards (including, but not limited to, ISA 315) and rising staff costs. The table in **Appendix 2** summarises current Public Sector Audit Appointment (PSAA) rates and then compares them to current Audit Wales fee rates. The table illustrates the very substantial change in PSAA rates over the past four years (following the Redmond Review) and highlights the very marked difference between current local government rates in England and those of Audit Wales. Whilst we are focusing on fee rates within the local government arena, this is indicative of the rising audit costs across the border.

25 Legislation requires that the fees we charge may not exceed the full cost of exercising the function to which the fee relates. We set our audit fees based on our estimated cost base, the estimated skills mix for audit work and the estimated number of days required to complete the work. We do not, and cannot, make a profit from our work. Our fees are set at a level to recover the estimated full cost but no more.

26 We are also mindful of us moving into the second year of our new audit approach and methodology. On the basis that we are more familiar with the new approach, we are expecting to see some level of efficiency. As stated above, as our fees are set at a level to only recover the full cost, where the full cost is less than the estimated fee, we will issue a refund to individual bodies. In this context, we remain determined to minimise audit fees whilst ensuring that our audit quality continues to meet rigorous standards.

27 Your Engagement Director will discuss the proposed fee for your audit once the audit commences and the risk assessment for your organisation has been completed.

A look forward to key issues impacting on the 2023-24 accounts audit and other developments

28 As well as reflecting on last year, it is important to have a look at some of the issues that could impact on the 2023-24 accounts.

29 **Projected year-end deficits** – we are mindful of the control total deficit of £123 million set by Welsh Government across the whole of the NHS and how challenging this will be for NHS bodies to meet. Given these expectations, we will focus on certain areas, particularly accruals and expenditure around year-end.

30 In terms of our wider audit responsibilities, the situation has prompted us to remain focused on themes such as financial sustainability, the realism of savings plans and the continued need for NHS to deliver value for money. Alongside these themes, the Auditor General for Wales places significant importance to seeing high standards of governance and financial management and will continue to shine a light and report on weaknesses in these areas.

31 **Executive salary pay points** – this has been a recurring theme for audit over the past few years where executive salaries have been paid over and above the defined salary point determined by the Welsh Government and where Government approval to do so has not been sought or provided. This again will be an area of focus as part of our audit work on the remuneration report. In addition, a disproportionate amount of time is spent seeking to reconcile payments to contracts of employment for senior staff. This is generally an area where health bodies could seek to improve audit evidence.

32 **Other technical changes** – at this point in time, we are not anticipating any new significant issues, but we will continue to liaise with Health and Social Services Group (HSSG) and the NHS Technical Accounting Group (TAG).

33 **Reintroduction of an interim audit** – for 2022-23, we applied little or no interim audit. This was a deliberate decision due to us commencing NHS audits much later than our normal timings. As we aim to recover and potentially bring the timetable back, we are envisaging moving back to an interim audit this year. This will hopefully take pressure off both Finance and audit teams, particularly during the final audit period scheduled for May and June 2024.

34 **Data quality / Analytics Assisted Audit (AAA)** – since the 2020-21 audit cycle, we have been using general ledger data obtained from the NHS Wales Shared Service Partnership (NWSSP) in our Analytics Assisted Audit application to support our audit work. This has realised several benefits with auditors having more accessible and timely access to the data, enhanced risk

assessments and automation of some audit tests. However, we have identified several inefficient processes and barriers to our vision of a more data driven audit, including:

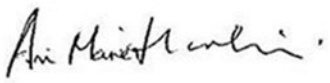
- adjustments cited on working papers not posted through the financial system;
- multiple mapping documents and inconsistent approaches for preparing the individual notes to the accounts; and
- multiple working papers to support individual notes to the accounts.

35 We are initially working with some pilot NHS bodies to try and eradicate these issues with the expectation that it will generate considerable benefits to improving data quality and time saving efficiencies for both audited bodies and auditors. We will engage with the sector on these developments during the early part of 2024.

36 We remain committed to working collaboratively with you to successfully navigate the challenges set out in this letter, building on our shared experiences. We will ensure we attend all the relevant NHS fora to discuss the content of this letter with you and will be arranging meetings with all NHS Directors of Finance and Audit Committee Chairs to provide you with an opportunity to meet with us all.

37 Thank you to you and your teams for working so well with us.

Yours sincerely



Ann-Marie Harkin
Executive Director Audit Services

Appendix 1 – A summary of NHS audit opinions and reports for 2022-23

Health Board	Qualification/Subs Report
Aneurin Bevan	Qualified Regularity – breach of first financial duty (break-even)
Swansea Bay	Qualified Regularity – breach of first financial duty (break-even)
Powys	Qualified Regularity – breach of first financial duty (break-even)
Cardiff & Vale	Qualified Regularity – breach of first financial duty (break-even) Substantive Report – failure to agree an approved financial plan (second financial duty)
Cwm Taf	Qualified Regularity – breach of first financial duty (break-even) Substantive Report – failure to agree an approved financial plan (second financial duty)
Hywel Dda	Qualified Regularity – breach of first financial duty (break-even) Substantive Report – failure to agree an approved financial plan (second financial duty)
Betsi Cadwaladr	Qualified True and Fair opinion – impact of uncertainty coming forward from 21-22 (expenditure and payables) Qualified Regularity – payment to interim executive director above WG approved pay scale not properly approved. Substantive Report – failure to agree an approved financial plan (second financial duty) Note – first financial duty (break-even) **unqualified**
Velindre	No qualifications
Public Health Wales	No qualifications

Health Board	Qualification/Subs Report
Welsh Ambulance Services NHS Trust	No qualifications
Digital Health and Care Wales	No qualifications
Health Education and Improvement Wales	No qualifications

Appendix 2 – A comparison of current Public Sector Audit Appointment (PSAA) fee rates with Audit Wales

Grade	Audit Wales Fee Rates	Public Sector Audit Appointments (PSAA) Rate Cards	
	2023-24 £	2023-24 £	2018-20 £
Partner / Director	168	414	132
Senior Manager / Manager	129	228	73
Audit Lead	106	148	47
Other	40 - 85	113	36

AGENDA ITEM No	**6**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**0**

2023-24 ANNUAL FILINGS SCHEDULE

MEETING	Audit Committee
DATE	01 March 2024
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Alex Payne, Corporate Governance Manager Julie Boalch, Head of Risk/Deputy Board Secretary
CONTACT	Email: Trish.Mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. The Annual Filings Task and Finish Group (the "Group") was re-established in November 2023 to ensure that the Trust meets the Annual Report and Accounts 2023-24 disclosure and reporting requirements as set out in the Manual for Accounts (MfA) published by Welsh Government (WG).

2. The Annual Report includes the Performance Report and the Accountability Report. The MfA indicates that the overarching structure of the Annual Report for 2023-24 has not changed; however, the Trust will be required to prepare and publish a Duty of Quality and a Duty of Candour report for 2023-24.

3. A timetable for the Annual Filings has been developed and is set out in Annex 1. A supplementary (fuller) schedule is in place for contributions to the various sections of the Annual Report which will be managed by the Group. The Finance Team will maintain a timetable and work programme for the production of the accounts.

4. The timetable has been drafted based on the draft MfA, and the schedule is subject to change as confirmation from WG is yet to be received. The Committee is asked to note that Audit Wales have issued correspondence dated 05 February 2024 indicating that they are proposing a certification deadline of the 15 July 2024. This will affect the second half of the filing schedule (post submission of the draft Annual Report to WG). In light of this, the Corporate Governance Team have proposed dates for extraordinary Audit Committee and Trust Board meetings in early July 2024. The date of the Trust's Annual General Meeting is not yet clear.

RECOMMENDATION

5. The Audit Committee is requested to approve:

5.1 The Annual Filings 2023-24 schedule;
5.2 The circulation of the draft reports for review and comment by email as set out at paragraph 8.3.

KEY ISSUES/IMPLICATIONS
Given the tight timeframes within which the annual report must be prepared, and the contributions from multiple sources, a structured approach will be adopted to allow for oversight and escalation.

REPORT APPROVAL ROUTE
19 February 2024: ADLT – Review of Annual Filings Timetable

REPORT APPENDICES
n/a

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

SITUATION

1. The Annual Filings Task and Finish Group ("Group") was re-established in November 2023 to take a structured approach to the 2023-24 Annual Filings requirements as set out in the Manual for Accounts (MfA) published by Welsh Government.

BACKGROUND

2. The Welsh Government Manual for Accounts 2023-24 requires the Trust to submit as a single PDF document, a three-part Annual Report and Accounts. The Annual Report includes the Performance Report and Accountability Report.

ASSESSMENT

3. The Annual Report requires contributions from a number of individuals including performance and planning, partnerships and engagement, corporate governance, finance, people and culture, and others. The MfA indicates that the overarching structure of the Annual Report for 2023-24 has not changed; however, the Trust will be required to prepare and publish a Duty of Quality and a Duty of Candour report for 2023-24.

4. Whilst the Performance Report is drafted by the Performance Team there is close coordination with those drafting the Accountability Report. Where governance information that would otherwise appear in the Accountability Report would flow better by appearing in the Performance Report, close cross-referencing is required to ensure duplication is reduced, messaging is consistent, and the data set is the same.

5. The development of the Financial Accounts will have an established timetable, and whilst it is not intended that the Group will manage this work, finance colleagues are part of the Group to ensure a coordinated approach, synchronicity of dates, management of contributions to the Accountability Report, and the publishing of the final single PDF Annual Report and Accounts.

6. The below timetable has been developed to include key submission dates to Welsh Government, Audit Wales, Trust Board, and the Audit Committee – based on the draft Manual for Accounts and communications from Audit Wales: -

2023/24 DRAFT ANNUAL FILINGS TIMETABLE

HIGH LEVEL DEADLINES	ACTION	DETAIL	EXECUTIVE LEAD
03/05/2024	Submission Deadline	Draft 23/24 Unaudited Accounts	Chris Turley
10/05/2024	Submission Deadline	Draft Annual Report	Trish Mills
15/07/2024	Submission Deadline	Final Annual Report & Accounts to Audit Wales	Chris/Trish
DEADLINE	**ACTION**	**DETAIL**	**EXECUTIVE LEAD**
07/02/2024	DL for ADLT Paper	DL for submission of paper for ADLT	
19/02/2024	ADLT Meeting Date	Paper received with filings schedule	Trish Mills
21/02/2024	DL for AC Paper	DL for submission of paper for AC	Trish Mills
01/03/2024	**Audit Committee Meeting**	Receipt of paper at AC setting out the annual filings timetable for approval	Trish Mills
16/02/2024-23/02/2024	Commissioning of AR/PR	Review of narrative ownership and commissioning	Trish Mills
26/02/2024-28/03/2024	**DRAFTING**	Drafting by stakeholders	Trish Mills
02/04/2024	Submission to CGT	Submission of draft narrative of the AR/PR	Trish Mills
08/04/2024	Submission to Board Secretary for Review	Annual Report - for review by Board Secretary no later than the 08 April	Trish Mills
17/04/2024	DL for ELT paper - Draft AR	Draft AR to ELT for receipt / comment	Trish Mills
17/04/2024	Email Circulation	Circulate to ADLT for their awareness	Trish Mills
24/04/2024	**ELT Meeting**	Receipt of draft AR	Trish Mills
24/04-26/04	Review of AR/PR	Review of AR/PR by RM/TM/HB/AP & Final Edits	Trish Mills
26/04/2024	**Email Circulation**	Draft RemReport to RemCom	Trish Mills
26/04/2024	**Email Circulation**	Draft AR to AC for awareness and comment	Trish Mills
26/04/2024	**Email Circulation**	Draft ARA to Board - for awareness	Trish Mills
03/05/2024	**Submission Deadline**	Draft Unaudited Accounts to WG/Audit Wales	Chris Turley
03/05/2024	DL for comments by Audit Com.	DL for responses by Audit Committee	Trish Mills
06/05-09/05	Final Review / Updates of Draft ARA	Final draft/review, ahead of submission on the 12th May	Trish Mills
10/05/2024 (12:00)	**Submission Deadline**	Draft Annual Report to WG/Audit Wales	Trish Mills
STC 19/06/2024	DL for papers for ELT	DL for papers for ELT	Trish Mills
26/06/2024	Submission of final AR to ELT	Final 23/24 ARA submitted to ELT	Chris/Trish
w/c 01 July 2024	Submission DL	Final 23/24 ARA submitted for Audit Committee	Chris/Trish
08/07/2024	**Meeting of Audit Committee - DATE TBC**	Audit Committee to scrutinise/endorse final 22/23 ARA [1 hour]	Chris/Trish
w/c 01 July 2024	Submission DL	Final ARA Submitted for Trust Board	Chris/Trish
09/07/2024	**Meeting of Trust Board - DATE TBC**	Trust Board - Approval/sign-off of audited ARA [30 mins]	Chris/Trish
15/07/2024	**Submission DL**	AUDIT WALES TO SUBMIT FINAL AUDITED ARA	Chris/Trish
01/08/2024 - TBC	Submission DL	Issue ARA to Melfyn/Kate for Translation	Trish Mills
01/08/2024 - 31/08/2024	Ongoing	Translation	Trish Mills
TBC	Submission DL	Submission of papers for AGM	Trish Mills
July - September 2024 - TBC	**Annual General Meeting**	Presentation of the 23/24 ARA	Trish Mills / Estelle Hitchon

7. The Committee is asked to note that Audit Wales have issued correspondence dated 05 February 2024 indicating a proposed certification deadline of the 15 July 2024. This could affect the second half of the filing schedule (post submission of the draft Annual Report to WG). Given the certification schedule proposed by Audit Wales is the 15 July 2024, the Corporate Governance Team is proposing that additional extraordinary meetings of Audit Committee and Trust Board are held week commencing 08 July ahead of the proposed certification deadline. These meetings are in addition to those substantive meetings already scheduled and approved for 2024/25.

8. The Audit Committee is asked to note the following: -

   8.1 A supplementary timetable will be developed by the Group to manage contributions from colleagues towards the various sections of the Annual Report, its layout and Welsh translation (which will be completed in-house by the Welsh Language Translator).

   8.2 The draft Annual Report, signed off in accordance with the above timetable, will not include a finalised public facing document. This will not delay any review of the draft by Welsh Government or Audit Wales as it is not a statutory requirement.

   8.3 Due to the scheduling of Trust Board and Committee meetings, it is proposed that some draft documents will be provided to members by email circulation towards the end of April 2024 for review and comment.

8.4 The timetable has been drafted based on the draft MfA, and the schedule is subject to change based on the final dates confirmed by the WG. If changes are made it is anticipated they will affect the final filing deadlines, as opposed to the earlier draft submission deadlines. Any significant changes will be brought to the attention of the Committee.

8.5 The placement of the Annual General Meeting (AGM) for 2024 is unclear because the final schedule is yet to be confirmed. It is possible that it will take place later than the 31 July (as required by Standing Orders) and in line with the 2023 AGM. The Committee will be updated in due course once guidance is received from Welsh Government.

RECOMMENDATION

9. **The Audit Committee is requested to approve:**

9.1 The Annual Filings 2023-24 schedule;
9.2 The circulation of the draft reports for review and comment by email as set out at paragraph 8.3.

Internal Audit Progress Report

Audit Committee

March 2024

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

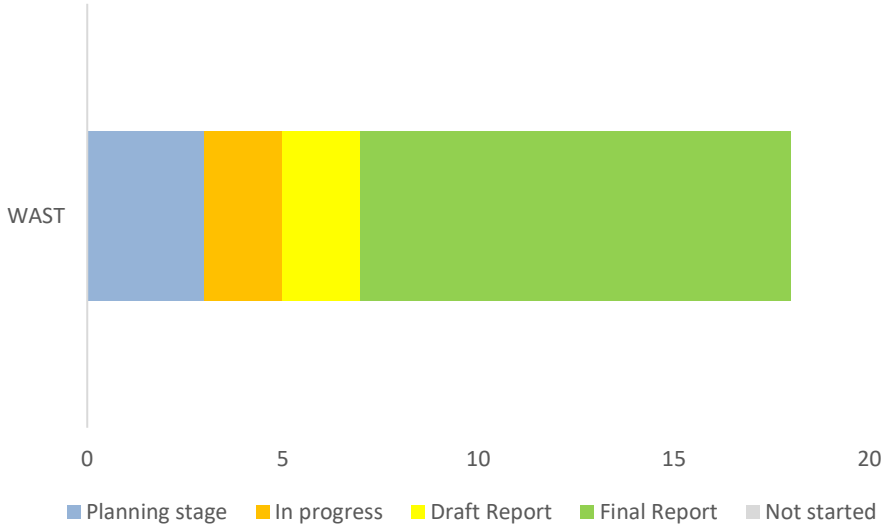
1. Introduction

The purpose of this report is to:

- highlight progress of the 2023/24 Internal Audit Plan to the Audit Committee; and
- provide an overview of other activity undertaken since the previous meeting.

2. Progress against the 2023/24 Internal Audit Plan

There are 18 reviews in the 2023/24 Internal Audit Plan, and overall progress is shown below.



Detailed progress in respect of each of the reviews in the 2023/24 Internal Audit Plan is summarised in Appendix A.

3. Proposed changes to approved plan

- Delivery of Major Change Programmes – this audit is deferred following completion of the project and consideration by the Trust to deescalate the related principal risk from the Corporate Risk Register. Our 2020/21 review of Transformation Programmes: Change Management was awarded reasonable assurance.

- Integrated Quality and Performance Management Framework - At the request of management, we are proposing to defer this review to the 2024/25 Internal Audit Plan to allow time for processes to embed.

4. Planning 2024/25

The draft plan has been discussed by the Executive Team and issued to Non-Executive Directors for comment. The final version is included in papers for the Committee to consider for approval.

The plan will remain flexible throughout 2024/25 in response to new and emerging risks. We will re-visit the approved plan on a regular basis to allow discussion of priorities.

5. Engagement

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

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

6. Key Performance Indicators

Correct on 31 January 2024

Indicator	Status	Actual	Target
Operational Audit Plan agreed for 2023/24		March	By 30 June
Audits reported over planned		12	13
Work in progress		3	
Report turnaround: time from fieldwork completion to draft reporting [10 days]		10 out of 12	80%
Report turnaround: time taken for management response to draft report [15 days]		3 out of 7	80%
Report turnaround: time from management response to issue of final report [10 days]		5 out of 6	80%

Key:

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

7. Recommendation

The Audit Committee is invited to:

- note the above; and
- Approve the proposed changes at section 3.

Appendix A: Progress against 2023/24 Internal Audit Plan

Review	Status	Rating	Key matters arising	Anticipated Audit Committee[1]
Risk management and assurance	Planning			June 2024
Decarbonisation	Final report	Limited	We recognise the significant work the Trust has been undertaking to address the requirements of the Decarbonisation Strategic Delivery Plan. However, the overall rating is in line with that determined across NHS Wales and reflects the complexity and range of risks associated with this area which, along with the financial shortfalls, impacts on the Trust's ability to deliver on the wider decarbonisation agenda. Other matters include completion of the risk register, at both Programme and Corporate level, and ongoing regular review; and review of the membership and attendance at the Decarbonisation Programme Board.	March 2024
Delivery of Major Change Programmes			Deferred	
111 Service Commissioning Arrangements (Advisory)	Final report	N/A	Clarity over roles and responsibilities within the National Collaboration Agreement; Develop a mechanism to enable post-implementation learning of benefits and impact to service delivery; Enhancements to governance arrangements to strengthen oversight; Opportunities to strengthen reporting of the commissioning arrangements; and Review of risk registers.	March 2024
Integrated Quality and Performance Management Framework			Deferred	

[1] May be subject to change

Review	Status	Rating	Key matters arising	Anticipated Audit Committee[1]
Strategy Development	Final report	Reasonable	Delays to the Engagement Framework Delivery Plan; and opportunities to improve how the Trust measures and reports progress.	March 2024
Serious Adverse Incidents Joint Investigation Framework	Final report	Reasonable	Areas of non-compliance with Section 4 (Joint Investigation Process) of the NHS Wales National Policy, noting which a review of the internal policy should be undertaken.	March 2024
Electronic Patient Clinical Record: Clinical compliance	Final report	Reasonable	Oversight of training completion and limitations and accuracy of reporting.	March 2024
Senior Paramedic Role	Final report	Reasonable	Ensuring Senior Paramedics are appropriately discharging areas of responsibility; The need to address the disparity in the allocation of Paramedics and Technicians, to ensure appropriate level of supervision and support; Monitoring of training compliance and ensuring that the required clinical skill enhancements are provided; Limited reporting evaluating the impact and effectiveness of the role.	November 2023
Clinical Audit	Planning			June 2024
Volunteers Governance	In progress			June 2024
Seatbelt Action Plan	Draft report			April / June 2024
Records Management	Final report	Reasonable	Reviewing the resource available to the Records Management Team; Defining an improvement plan for the organisation; Ensuring records held with third parties are subject to formal agreement; Identification and assessment of storage sites; Ensuring all records are disposed of according to schedules.	November 2023
Technical Resilience	Final report	Reasonable	Fully recording the contents of the VPH datacentre; Finalising a service catalogue and recording the	November 2023

Review	Status	Rating	Key matters arising	Anticipated Audit Committee[1]
			resilience position; Testing resilience for non-critical services; and fully defining recovery plans for all systems and ensuring resilience position is reflected in these.	
ICT Contract Management	Draft report	Reasonable		April / June 2024
Retention of Staff	Final report	Reasonable	Finalisation and ratification of the 'Moving on Interview' process, with a clear timetable for its roll out; and evaluation of the effectiveness of the initiatives that have recently been introduced to improve staff retention.	March 2024
Disciplinary Case Management – Compassionate Leadership	In progress			June 2024
Recommendations tracker	Planning			June 2024
Capital & Estates				
Estates Assurance: Estate Condition	Final report	Limited	We recognise the significant work the Trust has been undertaking to manage the current estate condition against other competing priorities. However, the overall rating is in line with that determined across NHS Wales, given the common challenges faced by each organisation, and reflects that identified estate risks cannot be managed within existing funding. Other matters include current / forward investment approvals do not presently match the approved plans to eliminate "high" and "significant" risk backlog; the need to confirm appropriate levels of investment and an appropriately resourced maintenance team, to assess and address backlog maintenance; the need to ensure effective monitoring and reporting against targets; an appropriate methodology for the annual update; and accurate performance indicators.	November 2023

Review	Status	Rating	Key matters arising	Anticipated Audit Committee[1]
Capital Assurance: Vehicle Replacement Programme	Final report	Reasonable	Ensure compliance with Standing Orders for Trust Board approval of contracts; Enhance reporting and review of the procurement strategy to ensure best value; Ensure procurement and contractual arrangements obtain best value from strategic partnering; Detail variances to programme at business cases; Demonstrate optimal vehicle procurement numbers; and to better align the project management and business case processes with best practice.	March 2024

[1] May be subject to change

Annual Internal Audit Plan: Draft Internal Audit Charter

February 2024

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

1. Introduction

This document sets out the Internal Audit Plan for 2024/25 (the Plan) detailing the audits to be undertaken and an analysis of the corresponding resources. It also contains the Internal Audit Charter which defines the over-arching purpose, authority and responsibility of Internal Audit and the Key Performance Indicators for the service.

The Accountable Officer (the Trust Chief Executive) is required to certify, in the Annual Governance Statement, that they have reviewed the effectiveness of the organisation's governance arrangements, including the internal control systems, and provide confirmation that these arrangements have been effective, with any qualifications as necessary including required developments and improvement to address any issues identified.

The purpose of Internal Audit is to provide the Accountable Officer and the Board, through the Audit Committee, with an independent and objective annual opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control. The opinion should be used to inform the Annual Governance Statement.

Additionally, the findings and recommendations from internal audit reviews may be used by Trust management to improve governance, risk management, and control within their operational areas.

The Public Sector Internal Audit Standards (the Standards) require that 'The risk-based plan must take into account the requirement to produce an annual internal audit opinion and the assurance framework. It must incorporate or be linked to a strategic or high-level statement of how the internal audit service will be delivered in accordance with the internal audit charter and how it links to the organisational objectives and priorities.'

Accordingly, this document sets out the risk-based approach and the Plan for 2024/25. The Plan will be delivered in accordance with the Internal Audit Charter and the agreed KPIs which are monitored and reported to you. All internal audit activity will be provided by Audit & Assurance Services, a part of NHS Wales Shared Services Partnership (NWSSP).

1.1 National Assurance Audits

The proposed Plan includes assurance audits on some services that are provided by Digital Health and Care Wales (DHCW), NWSSP and the National Commissioning Unit (NCU) (the new Joint Committee for Welsh Health Specialised Services Committee (WHSSC), Emergency Ambulance Services Committee (EASC) and the National Collaborative Commissioning Unit (NCCU)) on behalf of NHS Wales. These audits will be included in Appendix A when agreed formally. These audits are part of the risk-based programme of work for DHCW, NWSSP and Cwm Taf Morgannwg UHB (for NCU) but the results, as in previous years, are reported to the relevant organisation and are used to inform the overall annual Internal Audit opinion for those organisations.

2. Developing the Internal Audit Plan

2.1 Link to the Public Sector Internal Audit Standards

The Plan has been developed in accordance with Standard 2010 – Planning, to enable the Head of Internal Audit to meet the following key objectives:

- the need to establish risk-based plans to determine the priorities of the internal audit activity, consistent with the organisation's goals;
- provision to the Accountable Officer of an overall independent and objective annual opinion on the organisation's governance, risk management, and control, which will in turn support the preparation of the Annual Governance Statement;
- audits of the organisation's governance, risk management, and control arrangements which afford suitable priority to the organisation's objectives and risks;
- improvement of the organisation's governance, risk management, and control arrangements by providing line management with recommendations arising from audit work;
- confirmation of the audit resources required to deliver the Internal Audit Plan;
- effective co-operation with Audit Wales as external auditor and other review bodies functioning in the organisation; and
- provision of both assurance (opinion based) and consulting engagements by Internal Audit.

2.2 Risk based internal audit planning approach

Our risk-based planning approach recognises the need for the prioritisation of audit coverage to provide assurance on the management of key areas of risk, and our approach addresses this by considering:

- the organisation's risk assessment and maturity;
- the organisation's response to key areas of governance, risk management and control;
- the previous years' internal audit activities; and
- the audit resources required to provide a balanced and comprehensive view.

Our planning takes into account the NHS Wales Planning Framework and other NHS Wales priorities, such as the duties of Quality and Candour, and is mindful of significant national changes that are taking place. In addition, the plan aims to reflect any significant local changes occurring as identified through the Integrated Medium-Term Plan (IMTP) and other changes within the organisation, assurance needs, identified concerns from our discussions with management, and emerging risks.

We will ensure that the plan remains fit for purpose by recommending changes where appropriate and reacting to any emerging issues throughout the year. Any necessary updates will be reported to the Audit Committee in line with the Internal Audit Charter.

While some areas of governance, risk management and control will require annual consideration, our risk-based planning approach recognises that it is not possible to audit every area of an organisation's activities every year. Therefore, our approach identifies auditable areas (the audit universe). The risk associated with each auditable area is assessed and this determines the appropriate frequency for review.

In addition, we will, if requested, also agree a programme of work through both the Directors of Corporate Governance and Directors of Finance networks. These audits and reviews may be undertaken across all NHS bodies or a particular sub-set, for example at Health Boards only.

Therefore, our audit plan is made up of a number of key components:

1) Consideration of key governance and risk areas: We have identified a number of areas where an annual consideration supports the most efficient and effective delivery of an annual opinion. These cover Governance, Board Assurance Framework, Risk Management, Clinical Governance and Quality, Financial Sustainability, Performance Monitoring & Management and an overall IM&T assessment. In each case we anticipate a short overview to establish the arrangements in place including any changes from the previous year with detailed testing or further work where required.

2) Organisation based audit work – this covers key risks and priorities from the Board Assurance Framework and the Corporate Risk Register together with other auditable areas identified and prioritised through our planning approach. This work combines elements of governance and risk management with the controls and processes put in place by management to effectively manage the areas under review.

3) Follow up: this is follow-up work on previous limited and unsatisfactory assurance reports as well as other high priority recommendations. Our work here also links to the organisation's recommendation tracker and considers the impact of their implementation on the systems of governance and control.

4) Work agreed with the Directors of Corporate Governance, Directors of Finance, other executive peer groups, or Audit Committee Chairs in response to common risks faced by a number of organisations. This may be advisory work in order to identify areas of best practice or shared learning.

5) The impact of audits undertaken at other NHS Wales bodies that impacts on the Trust, namely NWSSP, DHCW and NCU.

6) Where appropriate, Integrated Audit & Assurance Plans will be agreed for major capital and transformation schemes and charged for separately. Health bodies are able to add a provision for audit and assurance costs into

the Final Business Case for major capital bids.

These components are designed to ensure that our internal audit programmes comply with all of the requirements of the Standards, supports the maximisation of the benefits of being an all-NHS Wales wide internal audit service, and allows us to respond in an agile way to requests for audit input at both an all-Wales and organisational level.

2.3 Link to the Trust's systems of assurance

The risk based internal audit planning approach integrates with the Trust's systems of assurance; therefore, we have considered the following:

- a review of the Board's vision, values and forward priorities as outlined in the Annual Plan and three year Integrated Medium Term Plan (IMTP);
- an assessment of the Trust's governance and assurance arrangements and the contents of the corporate risk register;
- risks identified in papers to the Board and its Committees (in particular the Audit Committee and the Quality, Patient Experience and Safety Committee);
- key strategic risks identified within the corporate risk register and assurance processes;
- discussions with Executive Directors regarding risks and assurance needs in areas of corporate responsibility;
- cumulative internal audit knowledge of governance, risk management, and control arrangements (including a consideration of past internal audit opinions);
- new developments and service changes;
- legislative requirements to which the organisation is required to comply;
- planned audit coverage of systems and processes provided through NWSSP, DHCW and NCU;
- work undertaken by other supporting functions of the Audit Committee including Local Counter-Fraud Services (LCFS) and the Post-Payment Verification Team (PPV) where appropriate;
- work undertaken by other review bodies including Audit Wales and Healthcare Inspectorate Wales (HIW); and
- coverage necessary to provide assurance to the Accountable Officer in support of the Annual Governance Statement.

2.4 Audit planning meetings

In developing the Plan, in addition to consideration of the above, the Head of Internal Audit has met and spoken with a number of Trust Executive and Non-Executive Directors to discuss current areas of risk and related assurance needs.

The draft Plan has been provided to the Trust's Executive Management Team and the Non-Executive Directors to ensure that Internal Audit's focus is best targeted to areas of risk.

3. Audit risk assessment

The prioritisation of audit coverage across the audit universe is based on both our and the organisation's assessment of risk and assurance requirements as defined in the Board Assurance Framework and Corporate Risk Register.

The maturity of these risk and assurance systems allows us to consider both inherent risk (impact and likelihood) and mitigation (adequacy and effectiveness of internal controls). Our assessment also takes into account corporate risk, materiality or significance, system complexity, previous audit findings, and potential for fraud.

4. Planned internal audit coverage

4.1 Internal Audit Plan 2024/25

The Plan is set out in Appendix A and identifies the audit assignments, lead executive officers, outline scopes, and proposed timings. It is structured under the six components referred to in section 2.2.

Where appropriate the Plan makes cross reference to key strategic risks identified within the corporate risk register and related systems of assurance together with the proposed audit response within the outline scope.

The scope, objectives and audit resource requirements and timing will be refined in each area when developing the audit scope in discussion with the responsible executive director(s) and operational management.

The scheduling takes account of the optimum timing for the performance of specific assignments in discussion with management, and Audit Wales requirements if appropriate.

The Audit Committee will be kept appraised of performance in delivery of the Plan, and any required changes, through routine progress reports to each Audit Committee meeting.

The majority of the audit work will be undertaken by our regionally based teams with support from our national Capital & Estates team, in terms of capital audit and estates assurance work, and from our Digital and IT team, in terms of Information Governance, IT security and Digital work.

4.2 Keeping the plan under review

Our risk assessment and resulting Plan is limited to matters emerging from the planning processes indicated above.

Audit & Assurance Services is committed to ensuring its service focuses on priority risk areas, business critical systems, and the provision of assurance

to management across the medium term and in the operational year ahead. As in any given year, our Plan will be kept under review and may be subject to change to ensure it remains fit for purpose.

Consistent with previous years, and in accordance with best professional practice, an unallocated contingency provision has been retained in the Plan to enable Internal Audit to respond to emerging risks and priorities identified by the Executive Management Team and endorsed by the Audit Committee. Any changes to the Plan will be based upon consideration of risk and need and will be presented to the Audit Committee for approval.

Regular liaison with Audit Wales as your External Auditor will take place to coordinate planned coverage and ensure optimum benefit is derived from the total audit resource.

5. Resource needs assessment

The plan has been put together on the basis of the planning process described in this document. The plan includes sufficient audit work to be able to give an annual Head of Internal Audit Opinion in line with the requirements of Standard 2450 – Overall Opinions.

Audit & Assurance Services confirms that it has the necessary resources to deliver the agreed plan.

Provision has also been made for other essential audit work including planning, management, reporting and follow-up.

If additional work, support or further input is necessary to deliver the plan, we will look to deliver it from within our resources. It is possible, in exceptional cases, that an additional fee may be charged. Any change to the plan will be based upon consideration of risk and need and presented to the Audit Committee for approval.

The Standards enable Internal Audit to provide consulting services to management. The commissioning of these additional services by the Trust, unless already included in the plan, is discretionary. Accordingly, a separate fee may need to be agreed for any additional work.

Under the approach we have adopted for a number of years, the top slice provided to us to undertake the internal audit programme is supplemented by an additional charge for work undertaken over and above the 'top slice' arrangements. To this end the Trust has agreed to pay an additional £44,422 to cover this additional audit work.

Also, under the approach we have adopted since the formation of NWSSP we charge for the specialist Capital and Estates work delivered as a part of the agreed plan. For 2024/25 this additional charge is £23,406, which reflects previous years requirements. The audit of major programmes/projects will be facilitated through the Integrated Assurance and Approval Plans agreed at the respective business cases approved and funded by Welsh Government. There are currently no Trust projects

proposed for review facilitated through the Integrated Assurance and Approval Plan process during 2024/25.

Therefore, the Trust will be charged an additional amount of £67,828 which is over and above the 'top slice' recharge agreed as part of NWSSP's overall funding for 2024/25.

6. Action required

The Audit Committee is invited to consider the Internal Audit Plan for 2024/25 and:

- approve the Internal Audit Plan for 2024/25;
- approve the Internal Audit Charter; and
- note the associated Internal Audit resource requirements and Key Performance Indicators.

Osian Lloyd

Head of Internal Audit (Welsh Ambulance Services NHS Trust)
Audit and Assurance Services
NHS Wales Shared Services Partnership

Appendix A: Internal Audit Plan 2024/2025

Planned output	Audit Ref	Corporate Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
Annual Governance Statement	N/A	N/A	To provide commentary on key aspects of Board Governance to underpin the completion of the statement.	Chief Executive / Board Secretary	Q4
Risk Management & Assurance	1		To review the robustness of the Board Assurance Framework (BAF) process, as one of the key mechanisms that the Trust has in place to monitor its strategic risks.	Board Secretary	Q4
Follow Up	2		To review the systems in place to monitor progress with the implementation of actions in response to internal audit reports.	Board Secretary / Executive Team	Q4
Procurement and Contract Management (All Wales Review)	3	139	To provide assurance that the Trust has appropriate procurement and contract management arrangements in place.	Director of Finance and Corporate Resources	Q2/Q3
Vehicle Accident Management	4	139	To assess the management of accidents relating to Trust vehicles,	Director of Finance and Corporate	Q2

Planned output	Audit Ref	Corporate Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
			and the mitigating actions being taken to reduce the rate of occurrence.	Resources / Director of People and Culture	
Integrated Quality Performance and Management Framework	5	224	To review the deployment of the framework and assess the extent it is being embedded across the Trust.	Director of Planning and Performance / Director of Quality & Nursing	Q1/Q2
Seasonal Forecasting and Modelling	6	424	To assess the Trust's approach to forecasting and modelling, to include focus on winter resilience planning.	Director of Strategy, Planning and Performance	Q4
Exposure to Fumes	7	160, 199	To evaluate the actions being taken by the Trust to ensure the health and wellbeing of staff exposed to fumes as a result of delays in handovers of care at hospital.	Director of Quality and Nursing / Director of Operations	Q1/Q2
Public Engagement & Community Involvement	8		A review of compliance with the Health and Social Care Quality Engagement Act and alignment with the Trust's IMTP.	Director of Quality and Nursing / Director of Partnerships	Q2/Q3

Planned output	Audit Ref	Corporate Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
				and Engagement	
Rollout of Penthrox	9		To assess the impact of the roll out of Penthrox on patients and staff, following the recent announcement that it can be administered by ambulance crews and Community First Responders.	Director of Paramedicine	Q2/Q3
Overtime Controls	10	139	To provide assurance on the adequacy of the processes in place to control and monitor the level of overtime allocation, in line with the Trust's Financial Savings Plan.	Director of Operations / Director of Finance and Corporate Resources	Q1
Start of Shift Procedure	11		To assess compliance with the start of shift procedure, including the preparation of vehicles and to ensure that key equipment and medicines are available.	Director of Operations	Q4
Emergency Nurse Communications System Implementation	12	223	To provide assurance that benefits realised reflect those identified at the outset of system implementation.	Director of Operations	Q4

Planned output	Audit Ref	Corporate Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
111 Wales Website	13	458	To assess whether the 111 Wales website enables secure and effective provision of patient services.	Director of Digital	Q3/4
111 Digital Operations	14	260, 458	To assess whether the digital operation of 111 is safe and effective, with mitigations plans in place for any weaknesses identified and tracked to resolution.	Director of Digital	Q2/3
Data Quality	15		Review of the structures and processes for ensuring data quality and accurate reporting within the Trust.	Director of Digital	Q1/2
Rostering Policy	16	223, 160, 100, 283	To assess adherence to the Trust's Resource Policy to ensure the effective deployment of the workforce.	Director of Operations / Director of People and Culture	Q2
Occupational Health and Wellbeing Support	17	160, 558	To evaluate the programmes in place to improve the occupational health service and promote staff wellbeing, and the arrangements in place to monitor effectiveness.	Director of People and Culture	Q2/3
Speaking up safely	18	160, 558	To review the implementation of the framework and assess its impact in	Director of People and	Q4

Planned output	Audit Ref	Corporate Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
			promoting a culture that enables staff to raise concerns.	Culture / Board Secretary	
Capital Systems	19	139	Having been omitted from internal audit plans in recent years, it is proposed to reintroduce periodic capital systems audits. These audits review the control framework, systems and processes in place to manage discretionary, EFAB or other capital / estates funded schemes (not progressed through integrated audit plans (IAP) – ensuring compliance with minimum requirements. The focus of the audit for 2024/25 may include: initial governance arrangements; tendering and/or selection; and approval to award and contract completion.	Director of Finance and Corporate Services	Q4
Estates Assurance: Energy Management	20		Recognising the increase in utility costs and the associated financial risks, the audit will examine the arrangements in place to manage energy consumption, optimisation, conservation and efficiency. The audit	Director of Finance and Corporate Services	Q3

Planned output	Audit Ref	Corporate Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
			will look to gain assurance the appropriate arrangements are in place to gather data, ensuring that the data is of suitable quality/ reliability. The audit will also look at resulting strategies and/ or plans to address key risks.		
NHS Wales national audit work	N/A	N/A	To collate the assurances derived from the review of NHS Wales bodies that provide services to this organisation and contribute to its overall system of control. This will cover some of our work at Health Education & Improvement Wales, Public Health Wales, NHS Wales Shared Services Partnership, Digital Health and Care Wales and Emergency Ambulance Services Committee.	Board Secretary	Q4

Please note: The national audits undertaken at DHCW, NWSSP and NCU will be added later.

Appendix B: Key performance indicators (KPI)

KPI	SLA required	Target 2024/25
Audit plan 2024/25 agreed/in draft by 30 April	✓	To deliver plan
Audit opinion 2024/25 delivered by 31 May	✓	To deliver opinion
Audits reported versus total planned audits, and in line with Audit Committee expectations	✓	varies
% of audit outputs in progress	No	varies
Report turnaround fieldwork to draft reporting [10 working days]	✓	95%
Report turnaround management response to draft report [15 working days maximum]	✓	80%
Report turnaround draft response to final reporting [10 working days]	✓	95%

Appendix C: Internal Audit Charter

1 Introduction

1.1 This Charter is produced and updated annually to comply with the Public Sector Internal Audit Standards. The Charter is complementary to the relevant provisions included in the organisation's own Standing Orders and Standing Financial Instructions.

1.2 The terms 'board' and 'senior management' are required to be defined under the Standards and therefore have the following meaning in this Charter:

- Board means the Board of Welsh Ambulance Services NHS Trust with responsibility to direct and oversee the activities and management of the organisation. The Board has delegated authority to the Audit Committee in terms of providing a reporting interface with internal audit activity; and
- Senior Management means the Chief Executive as being the designated Accountable Officer for Welsh Ambulance Services NHS Trust. The Chief Executive has made arrangements within this Charter for an operational interface with internal audit activity through the Board Secretary.

1.3 Internal Audit seeks to comply with all the appropriate requirements of the Welsh Language (Wales) Measure 2011. We are happy to correspond in both Welsh and English.

2 Purpose and responsibility

2.1 Internal audit is an independent, objective assurance and advisory function designed to add value and improve the operations of Welsh Ambulance Services NHS Trust. Internal audit helps the organisation accomplish its objectives by bringing a systematic and disciplined approach to evaluate and improve the effectiveness of governance, risk management and control processes. Its mission is to enhance and protect organisational value by providing risk-based and objective assurance, advice and insight.

2.2 Internal Audit is responsible for providing an independent and objective assurance opinion to the Accountable Officer, the Board and the Audit Committee on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. In addition, internal audit's findings and recommendations are beneficial to management in securing improvement in the audited areas.

2.3 The organisation's risk management, internal control and governance arrangements comprise:

- the policies, procedures and operations established by the organisation to ensure the achievement of objectives;
- the appropriate assessment and management of risk, and the related system of assurance;
- the arrangements to monitor performance and secure value for money in the use of resources;
- the reliability of internal and external reporting and accountability processes and the safeguarding of assets;
- compliance with applicable laws and regulations; and
- compliance with the behavioural and ethical standards set out for the organisation.

2.4 Internal audit also provides an independent and objective consulting service specifically to help management improve the organisations risk management, control and governance arrangements. The service applies the professional skills of internal audit through a systematic and disciplined evaluation of the policies, procedures and operations that management have put in place to ensure the achievement of the organisations objectives, and through recommendations for improvement. Such consulting work contributes to the opinion which internal audit provides on risk management control and governance.

3 Independence and Objectivity

3.1 Independence as described in the Public Sector Internal Audit Standards as the freedom from conditions that threaten the ability of the internal audit activity to carry out internal audit responsibilities in an unbiased manner. To achieve the degree of independence necessary to effectively carry out the responsibilities of the internal audit activity, the Head of Internal Audit will have direct and unrestricted access to the Board and Senior Management, in particular the Chair of the Audit Committee and Accountable Officer.

3.2 Organisational independence is effectively achieved when the auditor reports functionally to the Audit Committee on behalf of the Board. Such functional reporting includes the Audit Committee:

- approving the internal audit charter;
- approving the risk based internal audit plan;
- approving the internal audit resource plan;
- receiving outcomes of all internal audit work together with the assurance rating; and
- reporting on internal audit activity’s performance relative to its plan.

3.3 While maintaining effective liaison and communication with the organisation, as provided in this Charter, all internal audit activities shall remain free of untoward influence by any element in the organisation, including matters of audit selection, scope, procedures, frequency, timing, or report content to permit maintenance of an independent and objective attitude necessary in rendering reports.

3.4 Internal Auditors shall have no executive or direct operational responsibility or authority over any of the activities they review. Accordingly, they shall not develop nor install systems or procedures, prepare records, or engage in any other activity which would normally be audited.

3.5 This Charter makes appropriate arrangements to secure the objectivity and independence of internal audit as required under the standards. In addition, the shared service model of provision in NHS Wales through NWSSP provides further organisational independence.

3.6 In terms of avoiding conflicts of interest in relation to non-audit activities, Audit & Assurance has produced a Consulting Protocol that includes all of the steps to be undertaken to ensure compliance with the relevant Standards that apply to non-audit activities.

4 Authority and Accountability

4.1 Internal Audit derives its authority from the Board, the Accountable Officer and Audit Committee. These authorities are established in Standing Orders and Standing Financial Instructions adopted by the Board.

4.2 The Minister for Health and Social Services has determined that internal audit will be provided to all health organisations by the NHS Wales Shared Services Partnership (NWSSP). The service provision will be in accordance with the Service Level Agreement agreed by the Shared Services Partnership Committee and in which the organisation has permanent membership.

4.3 The Director of Audit & Assurance leads the NWSSP Audit and Assurance Services and after due consultation will assign a named Head of Internal Audit to the organisation. For line management (e.g. individual performance) and professional quality purposes (e.g. compliance with the Public Sector Internal Audit Standards), the Head of Internal Audit reports to the Director of Audit & Assurance.

4.4 The Head of Internal Audit reports on a functional basis to the Accountable Officer and to the Audit Committee on behalf of the Board. Accordingly, the Head of Internal Audit has a direct right of access to the Accountable Officer, the Chair of the Audit Committee and the Chair of the organisation if deemed necessary.

4.5 The Audit Committee approves all Internal Audit plans and may review any aspect of its work. The Audit Committee also has regular

private meetings with the Head of Internal Audit.

4.6 In order to facilitate its assessment of governance within the organisation, Internal Audit is granted access to attend any committee or sub-committee of the Board charged with aspects of governance.

5 Relationships

5.1 In terms of normal business the Accountable Officer has determined that the Board Secretary will be the nominated executive lead for internal audit. Accordingly, the Head of Internal Audit will maintain functional liaison with this officer.

5.2 In order to maximise its contribution to the Board's overall system of assurance, Internal Audit will work closely with the organisation's Board Secretary in planning its work programme.

5.3 Co-operative relationships with management enhance the ability of internal audit to achieve its objectives effectively. Audit work will be planned in conjunction with management, particularly in respect of the timing of audit work.

5.4 Internal Audit will meet regularly with the external auditor, Audit Wales, to consult on audit plans, discuss matters of mutual interest, discuss common understanding of audit techniques, method and terminology, and to seek opportunities for co-operation in the conduct of audit work. In particular, Internal Audit will make available their working files to the external auditor for them to place reliance upon the work of Internal Audit where appropriate.

5.5 The Head of Internal Audit will establish a means to gain an overview of other assurance providers' approaches and output as part of the establishment of an integrated assurance framework.

5.6 The Head of Internal Audit will take account of key systems being operated by organisation's outside of the remit of the Accountable Officer, or through a shared or joint arrangement, such as the Digital Health and Care Wales, NHS Wales Shared Services Partnership and the National Commissioning Unit.

5.7 Internal Audit strives to add value to the organisation's processes and help improve its systems and services. To support this Internal Audit will obtain an understanding of the organisation and its activities, encourage two-way communications between internal audit and operational staff, discuss the audit approach and seek feedback on work undertaken.

5.8 The Audit Committee may determine that another Committee of the organisation is a more appropriate forum to receive and action individual audit reports. However, the Audit Committee will remain the final reporting line for all our audit and consulting reports.

6 Standards, Ethics, and Performance

6.1 Internal Audit must comply with the Definition of Internal Auditing, the Core Principles, Public Sector Internal Audit Standards and the professional Code of Ethics, as published on the NHS Wales e-governance website.

6.2 Internal Audit will operate in accordance with the Service Level Agreement and associated performance standards agreed with the Audit Committee and the Shared Services Partnership Committee. The Service Level Agreement includes a number of Key Performance Indicators, and we will agree with each Audit Committee which of these they want reported to them and how often.

7 Scope

7.1 The scope of Internal Audit encompasses the examination and evaluation of the adequacy and effectiveness of the organisation's governance, risk management arrangements, system of internal control, and the quality of performance in carrying out assigned responsibilities to achieve the organisation's stated goals and objectives. It includes but is not limited to:

- reviewing the reliability and integrity of financial and operating information and the means used to identify measure, classify, and report such information;
- reviewing the systems established to ensure compliance with those policies, plans, procedures, laws, and regulations which could have a significant impact on operations, and reports on whether the organisation is in compliance;
- reviewing the means of safeguarding assets and, as appropriate, verifying the existence of such assets;
- reviewing and appraising the economy and efficiency with which resources are employed, this may include benchmarking and sharing of best practice;
- reviewing operations or programmes to ascertain whether results are consistent with the organisation’s objectives and goals and whether the operations or programmes are being carried out as planned;
- reviewing specific operations at the request of the Audit Committee or management, this may include areas of concern identified in the corporate risk register;
- monitoring and evaluating the effectiveness of the organisation's risk management arrangements and the overall system of assurance;
- ensuring effective co-ordination, as appropriate, with external

auditors; and

- reviewing the Annual Governance Statement prepared by senior management.

7.2 Internal Audit will devote particular attention to any aspects of the risk management, internal control and governance arrangements affected by material changes to the organisation's risk environment.

7.3 If the Head of Internal Audit or the Audit Committee consider that the level of audit resources or the Charter in any way limit the scope of internal audit or prejudice the ability of internal audit to deliver a service consistent with the definition of internal auditing, they will advise the Accountable Officer and Board accordingly.

8 Approach

8.1 To ensure delivery of its scope and objectives in accordance with the Charter and Standards, Internal Audit has produced an Audit Manual (called the Quality Manual). The Quality Manual includes arrangements for planning the audit work. These audit planning arrangements are organised into a hierarchy as illustrated in Figure 1.

Figure 1: Audit planning hierarchy

NHS Wales Level	NWSSP overall audit strategy	Arrangements for provision of internal audit services across NHS Wales
Organisation Level	Entity strategic 3-year audit plan	Entity level medium term audit plan linked to organisational objectives priorities and risk assessment
	Entity annual internal audit plan	Annual internal audit plan detailing audit engagements to be completed in year ahead leading to the overall HIA opinion
Business Unit Level	Assignment plans	Assignment plans detail the scope and objectives for each audit engagement within the annual operational plan

8.2 NWSSP Audit & Assurance Services has developed an overall audit strategy which sets out the strategic approach to the delivery of audit services to all health organisations in NHS Wales. The strategy also includes arrangements for securing assurance on the national transaction processing systems including those operated by DHCW and NWSSP on behalf of NHS Wales.

8.3 The main purpose of the Strategic 3-year Audit Plan is to enable the Head of Internal Audit to plan over the medium term on how the

assurance needs of the organisation will be met as required by the Standards and facilitate:

- the provision to the Accountable Officer and the Audit Committee of an overall opinion each year on the organisation's risk management, control and governance, to support the preparation of the Annual Governance Statement;
- audit of the organisation's risk management, control and governance through periodic audit plans in a way that affords suitable priority to the organisation's objectives and risks;
- improvement of the organisation's risk management, control and governance by providing management with constructive recommendations arising from audit work;
- an assessment of audit needs in terms of those audit resources which 'are appropriate, sufficient and effectively deployed to achieve the approved plan';
- effective co-operation with external auditors and other review bodies functioning in the organisation; and
- the allocation of resources between assurance and consulting work.

8.4 The Strategic 3-year Audit Plan will be largely based on the Board Assurance Framework where it is sufficiently mature, together with the organisation-wide risk assessment.

8.5 An Annual Internal Audit Plan will be prepared each year drawn from the Strategic 3-year Audit Plan and other information and outlining the scope and timing of audit assignments to be completed during the year ahead.

8.6 The strategic 3-year and annual internal audit plans shall be prepared to support the audit opinion to the Accountable Officer on the risk management, internal control and governance arrangements within the organisation.

8.7 The annual internal audit plan will be developed in discussion with executive management and approved by the Audit Committee on behalf of the Board.

8.8 The NWSSP Audit Strategy is expanded in the form of a Quality Manual and a Consulting Protocol which together define the audit approach applied to the provision of internal audit and consulting services.

8.9 During the planning of audit assignments, an assignment brief will be prepared for discussion with the nominated operational manager. The brief will contain the proposed scope of the review along with the relevant objectives and risks to be covered. In order to ensure the scope of the review is appropriate it will require agreement by the

relevant Executive Director or their nominated lead and will also be copied to the Board Secretary.

9 Reporting

9.1 Internal Audit will report formally to the Audit Committee through the following:

- An annual report will be presented to confirm completion of the audit plan and will include the Head of Internal Audit opinion provided for the Accountable Officer that will support the Annual Governance Statement.
- The Head of Internal Audit opinion will:
  a) State the overall adequacy and effectiveness of the organisation's risk management, control and governance processes;
  b) Disclose any qualification to that opinion, together with the reasons for the qualification;
  c) Present a summary of the audit work undertaken to formulate the opinion, including reliance placed on work by other assurance bodies;
  d) Draw attention to any issues Internal Audit judge as being particularly relevant to the preparation of the Annual Governance Statement;
  e) Compare work actually undertaken with the work which was planned and summarise performance of the internal audit function against its performance measurement criteria; and
  f) Provide a statement of conformity in terms of compliance with the Public Sector Internal Audit Standards and associated internal quality assurance arrangements.
- For each Audit Committee meeting a progress report will be presented to summarise progress against the plan. The progress report will highlight any slippage and changes in the programme. The findings arising from individual audit reviews will be reported in accordance with Audit Committee requirements; and
- The Audit Committee will be provided with copies of individual audit reports for each assignment undertaken unless the Head of Internal Audit is advised otherwise. The reports will include an action plan on any recommendations for improvement agreed with management including target dates for completion.

9.2 The process for audit reporting is summarised below:

- Following the closure of fieldwork and the resolution of any queries, Internal Audit will discuss findings with operational

managers to confirm understanding and shape the reporting stage;

- Operational management will receive discussion draft reports which will include any proposed recommendations for improvement within 10 working days following the discussion of findings. A copy of the draft report will also be provided to the relevant Executive Director;
- The draft report will give an assurance opinion on the area reviewed in line with the criteria at Appendix B (unless it is a consulting review). The draft report will also indicate priority ratings for individual report findings and recommendations;
- Operational management will be required to respond to the draft report in consultation with the relevant Executive Director within 15 working days of issue, identifying actions, identifying staff with responsibility for implementation and the dates by which action will be taken;
- The Head of Internal Audit will seek to resolve any disagreement with management in the clearance of the draft report. However, where the management response is deemed inadequate or disagreement remains then the matter will be escalated to the Board Secretary. The Head of Internal Audit may present the draft report to the Audit Committee where the management response is inadequate or where disagreement remains unresolved. The Head of Internal Audit may also escalate this directly to the Audit Committee Chair to ensure that the issues raised in the report are addressed appropriately;
- Reminder correspondence will be issued after the set response date where no management response has been received. Where no reply is received within 5 working days of the reminder, the matter will be escalated to the Board Secretary. The Head of Internal Audit may present the draft report to the Audit Committee where no management response is forthcoming;
- Internal Audit issues a Final report to Executive Director within 10 working days of receipt of complete management response. Within this timescale Internal Audit will quality assess the responses, and if necessary return the responses, requiring them to be strengthened.
- Responses to audit recommendations need to be SMART:
  - Specific
  - Measurable
  - Achievable
  - Relevant / Realistic

- Timely.

- The relevant Executive Director, Board Secretary and the Chair of the Audit Committee will be copied into any correspondence.
- The final report will be copied to the Accountable Officer and Board Secretary and placed on the agenda for the next available Audit Committee.

9.3 Internal Audit will make provision to review the implementation of agreed action within the agreed timescales. However, where there are issues of particular concern provision may be made for a follow-up review within the same financial year. Issue and clearance of follow up reports shall be as for other assignments referred to above.

9.4 Timescales are to be included in all initial scopes sent prior to commencing an audit.

10 Access and Confidentiality

10.1 Internal Audit shall have the authority to access all the organisation's information, documents, records, assets, personnel and premises that it considers necessary to fulfil its role. This shall extend to the resources of the third parties that provide services on behalf of the organisation.

10.2 All information obtained during the course of a review will be regarded as strictly confidential to the organisation and shall not be divulged to any third party without the prior permission of the Accountable Officer. However, open access shall be granted to the organisation's external auditors.

10.3 Where there is a request to share information amongst the NHS bodies in Wales, for example to promote good practice and learning, then permission will be sought from the Accountable Officer before any information is shared.

11 Irregularities, Fraud & Corruption

11.1 It is the responsibility of management to maintain systems that ensure the organisation's resources are utilised in the manner and on activities intended. This includes the responsibility for the prevention and detection of fraud and other illegal acts.

11.2 Internal Audit shall not be relied upon to detect fraud or other irregularities. However, Internal Audit will give due regard to the possibility of fraud and other irregularities in work undertaken. Additionally, Internal Audit shall seek to identify weaknesses in control that could permit fraud or irregularity.

11.3 If Internal Audit discovers suspicion or evidence of fraud or irregularity, this will immediately be reported to the organisation's Local Counter Fraud Service (LCFS) in accordance with the

organisation's Counter Fraud Policy & Fraud Response Plan and the agreed Internal Audit and Counter Fraud Protocol.

12 Quality Assurance

12.1 The work of internal audit is controlled at each level of operation to ensure that a continuously effective level of performance, compliant with the Public Sector Internal Audit Standards, is being achieved.

12.2 The Director of Audit & Assurance will establish a quality assurance and improvement programme designed to give assurance through internal and external review that the work of Internal Audit is compliant with the Public Sector Internal Audit Standards and to achieve its objectives. A commentary on compliance against the Standards will be provided in the Annual Audit Report to the Audit Committee.

12.3 The Director of Audit & Assurance will monitor the performance of the internal audit provision in terms of meeting the service performance standards set out in the NWSSP Service Level Agreement. The Head of Internal Audit will periodically report service performance to the Audit Committee through the reporting mechanisms outlined in Section 9.

13 Resolving Concerns

13.1 NWSSP Audit & Assurance was established for the collective benefit of NHS Wales and as such needs to meet the expectations of client partners. Any questions or concerns about the audit service should be raised initially with the Head of Internal Audit assigned to the organisation. In addition, any matter may be escalated to the Director of Audit & Assurance. NWSSP Audit & Assurance will seek to resolve any issues and find a way forward.

13.2 Any formal complaints will be handled in accordance with the NWSSP complaint handling procedure. Where any concerns relate to the conduct of the Director of Audit & Assurance, the NHS organisation will have access to the Managing Director of Shared Services.

14 Review of the Internal Audit Charter

14.1 This Internal Audit Charter shall be reviewed annually and approved by the Board, taking account of advice from the Audit Committee.

Simon Cookson
Director of Audit & Assurance
NHS Wales Shared Services Partnership
February 2024

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ
Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Decarbonisation

Final Internal Audit Report

February 2024

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-2324-002
Report status:	Final
Fieldwork commencement:	9 July 2023
Fieldwork completion:	28 September 2023
Draft report issued:	8 November 2023 & 26 January 2024 (updated)
Draft report meeting:	29 November 2023
Management response received:	9 February 2024 & 15 February 2024
Final report issued:	15 February 2024
Auditors:	Osian Lloyd, Head of Internal Audit; Felicity Quance, Deputy Head of Internal Audit; Donna Morgan, Audit Manager
Executive sign-off:	Chris Turley, Executive Director of Finance & Corporate Services
Distribution:	Richard Davies, Assistant Director of Capital & Estates; Joanne Williams, Head of Capital Estates; David Holmes Fleet Manager; Nicci Stephens, Environment & Sustainability Manager; Lucinda Wassall, Project Manager.
Committee:	Audit Committee

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

Acknowledgement:

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

Executive Summary

Report Opinion

	Trend
Limited  More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.	N/A

Assurance summary[1]

Objectives		Assurance
1	Governance	Reasonable
2	Localised Strategies	Limited
3	Funding Strategy	Limited
4	Monitoring and Reporting	Reasonable
5	Project Delivery	Reasonable

Purpose

The NHS in Wales faces unprecedented challenges balancing the management of the delivery of the decarbonisation agenda and associated risks, against other competing priorities and within existing funding constraints.

The primary source of funding being Estates Funding Advisory Board (EFAB) and the requirement for the Trust to contribute 30% from their discretionary funding.

The audit sought to consider progress against the NHS Wales Decarbonisation Strategic Delivery Plan and the Trust's Decarbonisation Action Plan - demonstrating how the Trust will implement the NHS Wales Decarbonisation Strategic Delivery Plan initiatives.

It is recognised that prior to the development of the Strategic Delivery Plan, NWSSP commissioned a Carbon Footprint assessment for the whole of NHS Wales (2018/19). This assessment influenced the approach set out in the Strategic Delivery Plan and provides the initial baseline emissions data for target setting.

Overview

We recognise the significant work the Trust has been undertaking across all directorates to address the requirements of the Decarbonisation Strategic Delivery Plan., However, given the complexity and range of risks associated with this area, and noting that these cannot be managed by the Trust within the existing funding, to meet the targets set by the Welsh Government, an overall **limited** assurance has been determined. Further, recognising the financial shortfalls and being cognisant of the wider financial pressures across NHS Wales, the risks associated with the achievement of the Decarbonisation Action Plan and the ability to deliver on the wider decarbonisation agenda will be a challenge going forward and tough choices will need to be made by the Trust.

This assurance opinion is in line with that determined across NHS Wales, given the common challenges faced by each organisation.

Further matters arising (see **Appendix A**) concerning the areas for refinement and further development have also been noted including:

- Completion of the risk register, at both Programme and Corporate level, and ongoing regular review of the risk register; and
- Review of the membership at Decarbonisation Programme Board noting the number of apologies / non-attendance recorded.

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Attendance at Decarbonisation Programme Board	1	Operation	Medium
2	Delivery of the DAP	1, 2, 3	Operation	High
3	Risk Management	2, 3	Operation	Medium
4	Funding Strategy	3	Design	High

1. Introduction

1.1 The Welsh Government is party to international agreements to reduce carbon emissions and control climate change, most notably as arising from the 2016 Paris Accord. Accordingly, they have sought to create a framework of controls, guidance and support to achieve these aims.

1.2 The Welsh Government declared a climate emergency in 2019 and committed to achieving a Net Zero public sector by 2030.

1.3 The *NHS Wales Decarbonisation Strategic Delivery Plan* was published in March 2021 and responds to the climate emergency declaration and recognises that the NHS has a critical role to play in contributing towards this target as the largest public sector organisation in Wales.

1.4 The plan sets interim targets for the whole of the NHS (from a 2018/19 base) of carbon budget reduction of 16% by 2025 and 34% by 2030.

1.5 Category targets were also set for:

- Buildings;
- Procurement;
- Fleet and business travel; and
- Staff, patient, and visitor travel.

1.6 All Wales activity support streams have been created, including Estates planning, and approaches to healthcare.

1.7 The Welsh Government has made funding available NHS-wide of circa £8.1m (which includes each organisation matching 30% of the WG contribution from their own discretionary programme) for decarbonisation initiatives via the Estates Funding Advisory Board in both 2023/24 and 2024/25

1.8 This audit seeks to build upon our advisory review undertaken in 2022/23, which identified that the implementation plans had not been sufficiently developed to allow meaningful testing and to provide an assurance rating to respective Audit Committees. Accordingly, the decision was taken to provide an overview of the overarching position across NHS Wales and provide an action plan of common themes which were considered by the Trust. Noting the advisory nature of the report, the recommendations were not included formally on the Trust's Internal Audit recommendation tracker; however, we have included updates on some of the recommendations (where relevant) within the body of this report which demonstrates that they are being taken forward by the Trust.

1.9 The risks considered during the review were:

- Regulatory/legislative risk through not achieving mandated reductions in carbon emissions;
- Reputational risk by failing to meet emission targets; and

- Failing key stakeholders by not reducing carbon emissions which have a detrimental effect on health and, not meeting the requirements of the Wellbeing of Future Generations Act (2016).

1.10 The wider role of NWSSP Procurement, in the decarbonisation agenda, has not been audited as part of this review.

2. Detailed Audit Findings

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

	Recommendation Priority			
	High	Medium	Low	Total
Control Design	1	-	-	1
Operating Effectiveness	1	4	-	5
Total	2	4	-	6

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

Objective 1: Appropriate governance arrangements have been established in relation to decarbonisation that integrate with existing organisational accountability and reporting structures.

2.3 Our national report for 2022/23 highlighted that internal reporting had been limited, and that there was therefore a need to fully roll-out the structures to support appropriate monitoring and reporting within NHS Wales organisations. It is evident that progress to establish sound governance arrangements in respect of decarbonisation has been made at the Trust in recent months.

2.4 The governance framework includes:

- A Decarbonisation Programme Board (see para 2.6);
- Operational Groups within the existing structure (see paras 2.7 & 2.43);
- Representation at Committee level (see para 2.8); and
- Representation at Board level.

2.5 Applying project management principles, an approved Project Initiation Document (PID), outlining the scope of the Decarbonisation Programme and the relationship between the Programme Management Team and Corporate Management at the Trust is in place; and has been updated regularly to reflect the dynamic nature of the decarbonisation agenda at the Trust.

2.6 The Decarbonisation Programme Board was established in January 2023 and acts as a central forum for senior management across the Trust to oversee the Decarbonisation agenda. The Programme Board is chaired by the Director of

Partnerships and Engagement, with the Director of Finance and Corporate Resources also named as the Senior Responsible Officer. The terms of reference have recently been agreed (August 2023) by Programme Board members and state that meetings will be held quarterly. Four meetings have been held to date and an action log is in operation to monitor and manage the agreed actions from each meeting; however, from review of the minutes, attendance appears to be a challenge noting the number of apologies and non-attendance recorded. **See MA1**. Management recognise this issue but also note it is one of their better attended meetings.

2.7 Fleet, Estates and other operational groups (where relevant) feed into the Decarbonisation Programme Board (also see para 2.43).

2.8 The Decarbonisation Programme Board reports to the Capital Management Board, with the Finance and Performance Committee having a further oversight role. Decarbonisation initiatives, alongside the Trust's IMTP, are also considered at the Strategic Transformation Board, which meets on a quarterly basis.

2.9 The Programme Board is responsible for recommending and monitoring the developments and delivery of the Trust's Decarbonisation Action Plan (DAP). It represents, at managerial level, the business user and supplier interests of the programme and is the decision maker responsible for the commitment of resources (staff, money, equipment etc.). It is also responsible for the management and review of the decarbonisation risk register. For further details in relation to risk management, refer to ***audit objective 2***.

2.10 Our prior year report raised that recruiting to additional operational posts has proven difficult across Wales, with the limited appointments to date coming from the existing public sector staff pool. Noting that these appointments are key to being able to implement the agreed strategies, it is positive to note that the Trust has not experienced these issues. An internal team structure for meeting the decarbonisation initiatives has been established. Executive leadership is provided by the Director of Finance and Corporate Resources, who is supported by the Fleet Manager and Assistant Director of Capital and Estates. The latter is further supported by the Head of Capital Development (with Project and Programme Managers) and Head of Estates and Facilities (with an Environmental & Sustainability Manager and Officer). There were no vacancies in the internal structure at the time of audit, however we acknowledge that three of the nine members of the team had been in post for a relatively short period of time (at the date of fieldwork, less than a year).

2.11 Roles and responsibilities in respect of decarbonisation obligations were not explicitly stated in individuals' job descriptions; but are referenced in the DAP for ownership of actions. The efficacy of monitoring arrangements occurs when the DAP is reviewed at Decarbonisation Programme Board. The DAP, at the date of fieldwork (V6, October 2023) has assigned owners for all bar one actions. The exception is linked to the NHS expenses system which is outside of the control of the Trust and has been raised at the National Programme Board.

2.12 Regular reporting and liaison with Welsh Government and NWSSP was evident. For further details in relation to the reporting arrangements in place, refer to ***audit objective 4***.

2.13 In respect of training, there is an All Wales 'Environmental, Waste & Energy' e-learning module on ESR that staff can complete. This isn't a mandatory training module therefore compliance isn't monitored. The Environment & Sustainability Manager advised that they had attended the carbon literacy training by 'Ystadau Cymru'. Our prior year report noted that in accordance with the NHS Wales Decarbonisation Strategic Delivery Plan, HEIW/collaborative training should be commissioned on an All-Wales basis to provide both common and tailored decarbonisation training. We understand that HEIW is currently developing a suite of training to address this requirement, therefore no recommendation has been raised at this report.

Conclusion:

2.14 Appropriate governance arrangements have been put in place to enable the Trust to progress towards the achievement of its decarbonisation targets. Owners are assigned to each of the actions included within the DAP and we note that guidance is being sought at a national level for the one action that is outside of the control of the Trust; and this will continue to be monitored by the Decarbonisation Programme Board. Noting that the challenges of attendance at this Board need to be addressed, we have assigned **reasonable** assurance to this objective.

Objective 2: A tailored decarbonisation strategy and action plan has been developed in accordance with available legislation and guidance; documents have been appropriately scrutinised and approved prior to submission to Welsh Government; and the strategy and plan are adequately reflected within wider organisational documentation such as the IMTP.

2.15 As noted in para 2.9, a DAP has been developed. The current version (V6, October 2023) outlines how the Trust will meet the requirements of the national NHS Wales Decarbonisation Strategic Delivery Plan; and is subject to a quarterly review at the Decarbonisation Programme Board. There are currently 144 actions detailed for the Trust to address; but we acknowledge that exemptions (61), as determined by the NWSSP Decarbonisation Co-ordination Reporting (DCR) Group, have been applied thus reducing the applicable actions to 83.

2.16 Alongside the generic objectives requiring completion by all NHS Wales organisations, the Trust was also provided with additional objectives within the national NHS Wales Decarbonisation Strategic Delivery Plan directed solely at fleet. We note that this is the biggest challenge for the Trust, accounting for circa 80% of its emissions.

2.17 Challenges to the achievement of the objectives in respect of fleet are as follows:

- Capital funding for the annual fleet replacement programme has reduced;
- The Fleet Manager has advised that 77 NEPTS vehicles are due for replacement based on age profile;

- Hybrid / electric vehicles are more expensive (recognising that the Trust needs to strike a balance between prioritising reducing its emissions but also maintaining the number of vehicles in its fleet to meet service demand);
- Lead times for ordering vehicles are unpredictable and often lengthy following the pandemic (circa 18 months);
- The technology for emergency ambulances is not available at present. Trials in London for an electric emergency ambulance have not been successful; and
- The infrastructure for electric charge points for commercial vehicles (emergency ambulances) is not in place and there are concerns that the grid may not be able to support them.

2.18 The current RAG status of the delivery against DAP is reported to be 'amber', noting that 13% of the remaining applicable actions are rated red (urgent attention required) and 43% are rated amber (some attention required). This, however, is an improvement on the 'red / amber' status which was the starting point. The Trust has highlighted that the financial shortfalls (see audit objective 4) will impact on the organisation's ability to make further progress on the DAP.

2.19 The RAG status of the Trust's overall confidence of delivering the target reduction in emissions by 2025 is currently reported to be 'amber', again, an improvement against the previous status which was 'red'. However, there remains a real risk that the Trust may not be able to contribute effectively to the NHS carbon reduction targets and the Welsh Government's ambition for public sector carbon neutrality by 2030. See **MA2**.

2.20 The NHS Wales Carbon Footprint 2018/19 influenced the approach set out in the Strategic Delivery Plan and provides the initial baseline emissions data for target setting. However, as noted in our prior year report, issues were identified with the baseline data and the disaggregation of the data for reporting purposes. We, therefore, recommended that each organisation should seek assurance on the accuracy of the baseline data.

2.21 Carbon emissions reported for 2022/23 have seen a significant increase in value, as has been faced by all NHS Wales organisations, and this has been due to a change in the data collection by Welsh Government and the inclusion of aspects of emissions data which were previously not applicable. The following table sets out the variations across key categories:

Category	2022/23 Kg CO^2e	2022/21 Kg CO^2e	Difference Kg CO^2e
Medical Gases	739,904,200	n/a	n/a
Flurocarbonated Gas	971,686	n/a	n/a
Fleet Fuel	13,039,762	13,066,596	(26,834)
Electricity	855,981	951,327	(95,346)
Water	2,654	2,604	50
Gas/LPG	605,076	732,989	(127,914)

Business Miles	543,227	503,687	39,540
Domestic Waste	39,767	48,751	(8,984)
Fleet Waste	781	639	142
Commuting & homeworking	283,737	275,193	8,544
Land sequestration	-14,535	n/a	(14,535)
Supply chain	17,146,514	16,759,929	386,585
Total	**773,378,849**	**32,341,716**	
Renewables	(27,312)	(4,117)	(23,195)

2.22 Whilst continuing to report in accordance with Welsh Government requirements, the Trust is investigating alternative methods for calculation. At the Welsh Government Estates Engagement Forum (May 2023) it was reported that '*lack of clarity relating to the 2018/19 carbon reduction benchmark has seen WAST develop its own for clarity. Using the Aether reporting schedule for 2021/22, previous years data has been used to develop an acceptable baseline for comparison'.* The Environment and Sustainability Manager confirmed that the Trust's calculations of carbon emissions using this alternative method has been reported to both Welsh Government and NWSSP DCR Group. No further feedback has been provided; and there has been no formal notification of a change to the baseline figures for the Trust. Recognising that feedback is awaited on this revised baseline calculation, and that it has been recognised as a high-rated risk which continues to be highlighted to the Decarbonisation Programme Board and the Finance & Performance Committee, no recommendation has been raised.

2.23 We recognise that in addition to challenges with its fleet (see para 2.17), there are wider challenges that the Trust faces, as it evolves in line with its long-term strategy 'Delivering Excellence', in the achievement of its DAP. These have been effectively reported in the risk register and are subject to routine scrutiny/appropriate mitigating actions including:

- lack of funding;
- increasing workforce which may result in increased carbon emissions;
- restraints with its existing estate (e.g., older buildings / stations are not sustainable buildings and therefore require further investment);
- management of shared buildings noting circa 40% of the Trust's estate is shared (e.g., with the police / fire services or with health boards); and
- changes to emissions reporting (e.g., medical gases were previously omitted). Whilst we appreciate medical gases are not part of the DAP, their inclusion in reporting will increase the Trust's reported carbon emissions and, as per para 2.19, impact the Welsh Government's ambition for carbon neutrality by 2030. We note that this latter change has not been explicitly captured on a Trust risk register. See **MA3**.

2.24 We note that decarbonisation is linked to each of the strategic ambitions in the IMTP. In terms of wider strategies and policies, we also note that an Environment

Strategy 2020-2025 has been developed alongside the Trust's DAP, which aligns to the requirements of the NHS Wales Decarbonisation Strategic Delivery Plan.

2.25 In respect of risk management, a Decarbonisation Programme Board risk register was initially developed in March 2023 and is monitored via the Trust's Decarbonisation Programme Board. It was updated in August 2023 and includes 25 open risks, eight of which have a score of 25. From review of the register we noted that the column 'Date Closed / Next Update Due' was incomplete throughout the risk register. Although we recognise that these risks are active risks, we considered that a date for 'next update due' may be recorded to facilitate effective, proactive monitoring of each risk. **See MA3.**

2.26 Recent changes to the Trust's requirement to include medical gases within its carbon emissions reporting should also be captured within a Trust risk register – see para 2.19.

2.27 As reported to the Finance and Performance Committee, given the complexity and range of risks within this work, a programme level risk management approach has been adopted. Work continues to articulate the level of corporate risk for consideration at Board level and we note that discussions have been ongoing, since July 2023, in respect of the development of Risk 542: *Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Plan.* See **MA3**

Conclusion:

2.28 A Decarbonisation Action Plan (which is also the Trust's Decarbonisation Strategy) has been developed and approved by the Trust; and reported to Welsh Government in accordance with the requirements of NHS Wales Decarbonisation Strategic Delivery Plan. The risk register is reviewed and updated at the Decarbonisation Programme Board; however, work is required to finalise the decarbonisation programme risk for inclusion in the Corporate Risk Register. We recognise that the Trust's carbon footprint had increased in value (as is the same for all NHS Wales organisations) since the initial baseline assessment, as a result of the inclusion of aspects of emissions data which were previously not applicable. As recommended in our prior year report, the Trust is investigating alternative methods for calculation of emissions but these have yet to be approved by Welsh Government. Current reporting indicates that there remains a real risk that the Trust may not be able to contribute effectively to the NHS carbon reduction targets and the Welsh Government's ambition for public sector carbon neutrality by 2030.. Accordingly, we have assigned **limited** assurance.

Objective 3: An appropriate funding strategy targeting discretionary, EFAB and All-Wales funding is in place.

2.29 As recommended in our prior year report, DAPs should be supported by funding strategies e.g., differentiating between local/national funding, revenue or capital funding. Management advised that an initial 10-year capital cost estimate had been provided to Welsh Government, along with some high-level specific estimates of costs of the delivery of the DAP itself and noted that some elements couldn't yet be accurately costed. The Trust continues to prioritise schemes and bid for

additional resources against existing funding streams; however, there remains a material risk that such is unaffordable noting the current financial climate and considering total funding requirements across NHS Wales. **See MA4**

2.30 EFAB funding of £2.1m was allocated to the Trust for fire, infrastructure and decarbonisation, for the period 1 April 2023 to 31 March 2025, of which the Trust contributes 30% (£630k). A number of EFAB funded schemes were underway at the Trust, for which business cases were submitted and approved by Welsh Government, with those specifically identified as decarbonisation totalling £568.8k for 2023/24. Welsh Government had funded 70% (£398.2k) and the Trust had funded 30% (£170.6k) from its discretionary capital. Refer to ***audit objective 5*** for further details.

2.31 For 2024/25 the Trust has been successful in obtaining £417.5k of funding under the EFAB scheme to introduce more decarbonisation workstreams totalling £596.4k (inclusive of the Trust's 30% contribution). This work will include the installation of solar PV panels, battery storage and EV charging infrastructure at seven sites; and roof replacements at three sites.

2.32 We note that for 2023/24, decarbonisation projects were not included in the discretionary capital funding allocation following a prioritisation exercise led by the Executive Director of Finance and Corporate Resources and noting the limited funds available.

2.33 The 2023/24 Fleet Business Justification Case (£18m) containing decarbonisation and electric vehicle initiatives was approved by the Trust Board and submitted to Welsh Government. All Wales Capital funding of £9m was approved for this BJC for fleet for 2023/24. This was 50% of what was requested and so a prioritisation exercise was undertaken to ensure funding will be invested where it's needed most. The outcome is that emergency ambulances will be prioritised in this financial year, as agreed by the ELT (Executive Leadership Team) and ADLT.

2.34 A separate audit of the delivery of the vehicle replacement programme is being undertaken by the NWSSP Audit & Assurance Specialist Services Unit as part of the 2023/24 internal audit plan.

2.35 Given the ongoing scarcity of funding, the Capital Management Team is currently considering options appraisals for its funding strategy for the next financial year (e.g., request the shortfall not approved for 2023/24 as well as the funding needed for 2024/25 versus requesting approval for the shortfall for 2023/24 only versus asking for the funding needed for 2024/25 alone). The Trust is also proactively considering sustainable investments for its future.

2.36 It was noted at its qualitative report that the Trust will seek to both maximise its investments and learn lessons to strengthen continued future bids for funding via any available sources. We were advised that the Trust is also looking at alternative funding options for future investments including, Asset Collaboration Funding, Invest to Save and Salix funding (the latter of which provides grants for public sector bodies to fund heat decarbonisation and energy efficiency measures).

Conclusion:

2.37 An initial 10-year capital cost estimate had been provided to Welsh Government, along with some high-level specific estimates of costs of the delivery of the DAP itself. The Trust continues to prioritise schemes and bid for additional resources against existing funding streams. However, recognising the financial shortfalls, and being cognisant of the wider financial pressures across NHS Wales, and the impact that this may have in being able to deliver on the decarbonisation agenda, we assign this objective as providing **limited** assurance.

Objective 4: Appropriate monitoring and reporting arrangements are in place to provide ongoing assurance on the implementation of the strategy and action plan.

2.38 As noted under ***audit objective 1***, our national report for 2022/23 highlighted that internal reporting had understandably been limited, with the level of reporting increasing after Welsh Government's review of the DAPs. The recent changes made to the governance arrangements within the Trust supports that the profile of decarbonisation has increased to reflect the challenge faced.

2.39 The Decarbonisation Programme Board is responsible for recommending and monitoring the developments and delivery of the DAP. The DAP provides ongoing assurance on the implementation of the strategy. Refer to para 2.8 for details of the reporting lines in place.

2.40 Decarbonisation was included within the IMTP updates at both the May and August 2023 Strategic Transformation Board meetings. Updates against IMTP delivery are undertaken on a quarterly basis in line with the terms of reference.

2.41 An 'Environment, Decarbonisation and Sustainability' update was provided at the September 2023 Finance and Performance Committee, and focus on this area going forward is included in the Committees work programme. A highlight report to Trust Board (May 2023) has also been evidenced. Reporting on carbon emissions is undertaken through the annual report to Welsh Government (see para 2.46). Management advised that to prepare emissions data, on a more frequent is currently onerous and time consuming, and not possible for all categories.

2.42 In addition, the Transport Project Board, EFAB Meeting and Environmental and Sustainability groups are also in place internally to monitor and report on the decarbonisation agenda to provide ongoing assurance.

2.43 The Trust's update to the Welsh Government Estates Engagement Forum states that '*increased levels of reporting in relation to Decarbonisation has become a resource issue'*. A significant number of reports are required which require considerable time and resource/ effort to develop. This has also been highlighted within the Trust as it places a significant pressure on the small WAST team and potentially distracts from the ability to focus on progressing actions.

2.44 We also note that the Trust attends several external groups pan Wales to liaise and share information in respect of the decarbonisation agenda. Groups including:

- Health and Social Care in Wales Climate Emergency Programme Board; supported by the following project boards:
    - the Buildings, Estates, Land Use and Planning (BELP);
    - procurement and transport;
    - social care; and
    - approach to healthcare / service design.
- Community of Experts (a monthly nationwide group hosted by WG);
- Transport Task and Finish Group (hosted by NWSSP);
- Decarbonisation Co-Ordination Reporting ((DCR), hosted by NWSSP);
- Emergency Services Environment and Sustainability Group (UK wide blue light services environment leads);
- Sustainable Development Co-Ordinator's Cymru (Public Sector Wales Environment Manager:
- North Wales Decarbonisation Officer Group (public sector energy based);
- Joint public services board environment groups (public sector biodiversity based); and
- GrEAN – Environment Managers Group (all UK ambulances services).

2.45 The Trust is required to submit annual quantitative and qualitative reports (the latter of which was formerly required every six months) to Welsh Government detailing the progress of their contribution to the Climate and Nature Emergency and associated targets as outlined in the Trust's plan. Management have advised that no feedback was provided following the September 2022 submission of the quantitative and qualitative reports. A further qualitative report was submitted in April 2023. No feedback was reported from this submission either.

2.46 The Trust is also required to present a quarterly report to NWSSP's DCR Group led by NWSSP on behalf of the Welsh Government. The DCR is responsible for collating the reporting of the delivery of the NHS Wales Decarbonisation Strategic Delivery Plan for the health boards and Trusts pan NHS Wales.

2.47 Two reports have been submitted to DCR to date:

i. The first report was a pilot focusing on Transport and Procurement only (issued June 2023)

ii. The second report addressed all workstreams for the period of quarter one (2023/24). At the date of audit fieldwork, the dashboard had yet to be finalised and issued by DCR.

2.48 The Trust's return was analysed and collated into a dashboard. The overall RAG status for transport and procurement for NHS Wales collectively was amber. The dashboard was subsequently submitted to the Health and Social Care Climate Emergency (HSCCE) Project Board, and then to the HSCCE National Programme Board for review in July 2023.

2.49 It was noted that the Trust continues to work towards achieving the DAP actions but recognises its limitations of a challenging capital programme and wider financial constraints which will limit the ability to prioritise decarbonisation specific schemes (refer to ***audit objective 3***).

Conclusion:

2.50 Appropriate internal monitoring and reporting controls are in place for providing assurance on the decarbonisation agenda at the Trust. However, it is noted that many of the governance structures in place are recent and will take time to mature. Further, from review of the external reporting streams, the number of outputs required places a significant pressure on the small WAST team and potentially distracts from the ability to focus on progressing actions Accordingly, we have provided **reasonable** assurance in this area.

Objective 5: Projects included within the 2023/24 funding commitments have been successfully delivered, and appropriate arrangements are in place to secure available funding during 2024/25.

2.51 As noted at para 2.33, capital funding of £9m was approved for the 2023/24 Fleet Business Justification Case. At the time of audit, this project is on course to be delivered on time, and within budget. The delivery of the vehicle replacement programme is subject to a separate audit by the NWSSP Audit & Assurance Specialist Services Unit as part of the 2023/24 internal audit plan.

2.52 As noted in para 2.30, EFAB funding of £2.1m was allocated to the Trust for fire, infrastructure and decarbonisation, for the period 1 April 2023 to 31 March 2025.The decarbonisation schemes identified for EFAB funding for 2023/24 are renewable energy projects at:

- AFSRC Wrexham,
- Blaenau Ffestiniog,
- Cardiff Ambulance Station, and
- Glynneath.

2.53 At the date of audit, all projects remained ongoing and current reporting forecast that each project was to be delivered on time and within budget (see **Appendix B**).

2.54 EFAB funding has also been received for 2024/25 at the Trust. HART, Newtown and Tredegar renewable energy projects, to commence with effect from 1 April 2024, have been selected for this funding.

2.55 Our prior year report noted that NHS Wales organisations were also self-funding decarbonisation initiatives from their discretionary programme; and that it is important that the cost benefit of these schemes is also subject to challenge and scrutiny for inclusion within the overall data. Management confirmed that bids for funding would be managed through the Discretionary Programme Board; but we note that for 2022/23, there were no Trust funded decarbonisation projects given the limited discretionary capital funds available.

Conclusion:

2.56 At the time of audit, projects in receipt of 2023/24 EFAB funding were underway and reported to be delivered within the expected budget and delivery profiles; and EFAB funding has been secured for 2024/25 projects. The approved vehicle replacement programme is also on course to be delivered on time and within budget. Noting the current reported progress of these projects to date, we are providing **reasonable** assurance.

Appendix A: Management Action Plan

Matter Arising 1: Decarbonisation Programme Board: Attendance (Operation)	Impact
The Decarbonisation Programme Board has held four meetings since its inception in January 2023. The terms of reference for the Programme Board list the membership (25 officers named) for attendance. However, from review of the minutes, attendance appears to be a challenge noting the number of apologies and non-attendance recorded: • January meeting – 14 of the 25 named membership attended. There were an additional two officers in attendance who are not named in the terms of reference (Senior Training & Development Lead – Driving; and Fleet Business Manager); • April meeting – 15 of the 25 named membership attended; • June meeting – 11 of the 25 named membership attended; and • August meeting – 14 of the 25 named membership attended. There was one additional officer in attendance who was not named in the terms of reference (Locality Manager South East) For those not in attendance, there was no evidence of an alternative representative. We recognise that the terms of reference have recently been approved, yet the attendance figures suggest that the membership is not appropriately aligned to the requirements of the Programme Board.	Potential risk of: • Inadequate controls to mitigate risks due to lack of ownership or accountability of risks; resulting in failure to achieve mandated reductions in carbon emissions.

Recommendations		Priority
1.1	The named membership in the terms of reference should be reviewed again to ensure reasonable and appropriate representation at the Decarbonisation Programme Board.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
1.1	Noted. The membership will be further reviewed to ensure that quoracy levels outlined within the Terms of Reference are achieved. All teams will be asked to reconfirm their representatives. It is however noted that the attendance is actually good in comparison to other project and programme board meetings, with it never necessarily being expected that all those invited to attend will do so at all meetings, and no issues have arisen in terms of the ability of the PB to discharge its duties due to any attendance issues. This action will be considered closed once the team is assured that meetings have been, and continue to be, quorate and the updated attendance list has been ratified at the Programme Board.	30 April 2024	Decarbonisation Project Manager and Head of Capital Development

Matter arising 2: Delivery of the DAP (Operation)	Impact
The current RAG status of both the delivery against DAP and the Trust's overall confidence of delivering the target reduction in emissions by 2025 are reported to be 'amber'; an improvement against the previous status which was 'red / amber' status and 'red' respectively. Nevertheless, based on the RAG ratings above, there is a risk that the Trust may not meet its carbon reduction targets and the Welsh Government's ambition for carbon neutrality by 2030. The Trust has highlighted that the financial shortfalls will impact on the organisation's ability to make further progress. The Trust is required to complete over 80 actions covering all Trust aspects. These actions are included in the DAP. Additionally, the Trust has specific targeted actions relating to its fleet, many of which are currently rated red – this is one of the Trust's biggest challenges to address noting that fleet accounts for approximately 80% of the Trust's emissions. We recognise that in addition to the fleet challenges there are wider challenges that the Trust faces to the achievement of its Decarbonisation Action Plan which has been effectively reported in the risk register and are subject to routine scrutiny / appropriate mitigating actions. In addition, the Trust is evolving in line with its long-term strategy 'Delivering Excellence' which may result in an increase to staff levels, its estate and its fleet which will have an impact on the organisation's emissions.	Potential risk of: • Failure to meet the mandated carbon reduction targets set out in the NHS Wales Decarbonisation Strategic Delivery Plan.

Recommendations		Priority
2.1	Challenges and risks to the achievement of the objectives within the Trust's Decarbonisation Action Plan, along with any mitigating factors, should continue to be monitored with regular updates provided via the established governance routes through to Trust Board.	**High**

Management response		Target Date	Responsible Officer
2.1	The DAP and Risk Register will continue to feature as standard agenda items on every Decarbonisation Programme Board. Regular reporting will continue to Capital Management Board, Finance and Performance Committee and Trust Board as per the agreements set out. This action is considered closed, as it forms part of BAU practice	N/A	Head of Capital Development

Matter Arising 3: Risk Management (Operation)	Impact
A Decarbonisation Programme Board risk register was initially developed in March 2023 and is monitored via the Trust's Programme Board. It was updated in August 2023 and includes 25 'open' risks. Given the complexity and range of risks within this work, a programme level risk management approach has been adopted. However, we noted the following issues: • The column 'Date Closed / Next Update Due' is incomplete throughout the risk register. Although we recognise that these risks are active risks, we considered that a date for 'next update due' should be recorded to facilitate effective, proactive monitoring of each risk. • Work continues to articulate the level of corporate risk for consideration at Board level. Discussions have been ongoing since July 2023 in respect of the development of risk 542: *Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Plan* for inclusion on the Corporate Risk Register. Further, we also recognise that recent changes to the Trust's requirement to include medical gases within its carbon emissions reporting should be captured within the Trust's risk register. Whilst we appreciate medical gases are not part of the DAP, we note the impact of their inclusion may have on the wider role of NHS organisations in their ability to meet the ambition of public sector carbon neutrality by 2030.	Potential risk of: • Inadequate controls to mitigate risks due to lack of ownership or accountability of risks; resulting in failure to achieve mandated reduction in carbon emissions.

Recommendations		Priority
3.1	The 'Date Closed / Next Update Due' should be completed for each risk.	**Medium**
3.2	Noting the recent requirement to include medical gases within the Trust's carbon emissions, the associated risk should be reflected appropriately	
3.3	The development of risk 542: *Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Plan* should be finalised to ensure the Trust's Corporate Risk Register is appropriately reflective of prevalent risks.	

Agreed Management Action		Target Date	Responsible Officer
3.1	The date closed and next update due will be completed for each risk. This action has now been completed, and this is considered closed. The risk register will be reviewed on a regular basis, and any relevant new risks added as appropriate	N/A: actioned since fieldwork	
3.2	Risk 8 on the current risk register outlines the risk of not being able to compare current emissions to baseline. The item will be updated to reflect the risk of WG further changing the scope of reporting, but will not specifically reference medical gases as this is just one specific example of the risk materialising.	30 April 2024	Decarbonisation Project Manager
3.3	Risk 542 will be finalised for inclusion within the Corporate Risk Register	30 April 2024	Head of Capital Development and Assistant Director of Capital and Estates

Matter arising 4: Funding Strategy (Design)			Impact
Further to our prior year report and the expectation that DAPs should be supported by funding strategies, management advised that an initial 10-year capital cost estimate had been provide to Welsh Government, along with some high-level specific estimates of the costs of delivery of the DAP itself. There has been no further update to this submission. No detailed resource analysis to determine the costs of delivery of the DAP has been undertaken; nor has an options appraisal been prepared and shared with the Board to help visualise the problem of achievement of the Welsh Government targets. This would also help with the development of Risk 542 (see MA3.2).			Potential risk of: • The Trust is not investing sufficient resources to achieve its decarbonisation programme. • Failure to achieve the Welsh Government targets for carbon emissions.
Recommendations			**Priority**
4.1	The Trust should develop a long-term financial model for the financial support required to support the decarbonisation programme to provide assurance to the Board regarding achievement of the Welsh Government targets. A clear timeline should be determined for undertaking this exercise, with progress monitored at a relevant forum.		**High**
Management response		**Target Date**	**Responsible Officer**
4.1	The value of such an overarching exercise at this stage, compared to that previously undertaken and the resource required to do so needs to be considered, and as opposed to the way the Trust has looked to approach this to date. It also needs to be noted that part of the ongoing process to do so is also linked to any initial response from WG to that previously provided and the now confirmed upcoming and updated overall NHS Wales capital prioritisation work that will be progressed through 2024. Again it is not considered good value of resource to further progress anything here until this has now been completed and reported back to us. In the meantime a number of other significant areas of progress continue in relation to this, including the detailed costings undertaken to ensure significant (and greater than could have been expected) funding in relation to EFAB schemes through 2023/24 and 2024/25, along with the detailed decarbonisation impacts being front and centre of all new proposed and planned developments. The cost implications of this and the impact this may have affordability of schemes, either locally through the Trust's	31 March 2025	Executive Director of Finance and Corporate Resources, Head of Financial Business Intelligence and Capital Planning, Head of Capital Development

	discretionary capital funding or nationally via AWCP needs to however also not be underestimated and a balance will always need to be struck in this regard with other competing factors such as operational requirements, staff welfare and safety, etc. Recent Fleet BJCs have also included cost estimates to support, where possible and currently commercially and practically available, the electrification of the Trust's fleet, and the required supporting infrastructure. Examples of where other aspects of this can be further enhanced include the estate retrofit guide, which will be used as a framework to assess the impact and potential cost of estate requirements on a priority basis. This is also linked to any planned further refreshes in the overall Estates Strategy (SOP), high level information will also be used (where available) to determine broad fleet replacement costs including infrastructure. This will similarly be a key part of any proposed rewrite likely to be required through 2024 of the Fleet SOP, again due to current capital funding challenges at a national level but which will provide an opportunity to further consider specific decarbonisation cost within this area of the Trust's plans going forward. Overall, this will give a further indication of estimated total requirements, building on that already undertaken.		

Appendix B: EFAB Funding Tracker 2023/24

Location	Project overview (Proposal Summary)	Current WG Approved Spend Total 2023/24	Current WG Approved Spend Total 2024/25	Current Overall Total Recommendation	Health Board Forecast Spend 2023/24	Health Board Total Forecast	Spend to date	% Spend to date	Staged Reached	Forecast variance from WG approved spend 2023/24	Total Over / Underspend	Overall RAG (Delivery /Prog/£/ Quality)
AFSRC Wrexham - Renewable energy project	Install PV system & battery storage. EV charging infrastructure	£190,800		£190,800	£190,800	£190,800	£14,098	7%	Design	£0	£0	Amber
Blaenau Ffestiniog - Renewable energy project	To install a PV system, battery storage and EV charging infrastructure	£138,000		£138,000	£138,000	£138,000	£12,208	9%	Design	£0	£0	Amber
Cardiff make ready depot - Renewable energy project	To install a PV system and battery storage at the Make ready Depot.	£102,000		£102,000	£102,000	£102,000	£6,329	6%	Design	£0	£0	Amber
Glynneath - Renewable energy project	To install a PV system, battery storage and EV charging infrastructure.	£138,000		£138,000	£138,000	£138,000	£10,767	8%	Design	£0	£0	Amber

Appendix C: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Client Organisation	Welsh Ambulance Services NHS Trust
Audit title	Decarbonisation
Audit reference	WAST_2324_002
Final Report Date	15 February 2024
Auditor(s)	Donna Morgan / Felicity Quance

Would you please take a moment to complete the below questionnaire which will enable us to ensure that we provide a high quality service. Feedback will also be reflected within our key performance information reported to the Audit Committee.

	QUERY (enter "X" alongside)	Yes	No	Partially	n/a	Any further comments
1	**Engagement & Communication** Were you satisfied with the way the audit team engaged with you and colleagues?					
2	**Professionalism** Was the audit conducted in a positive, professional manner and respectful of your work commitments?					
3	**Report** Was the work reported in a clear, constructive way?					
4	**Impact** Was the audit beneficial e.g. providing assurance regarding current arrangements, or supporting improvements?					

What words would you use to describe the audit service you have received? Please feel free to enter up to six words into the boxes below:		

If you have any additional comments or suggestions, please add them below:

Thank you very much for taking time to complete this questionnaire. Please return by email: Osian.lloyd@wales.nhs.uk or post: **Osian Lloyd, Head of Internal Audit, NWSSP Audit & Assurance Services, 4-5 Charnwood Court, Heol Billingsley, Parc Nantgarw, Cardiff, CF15 7QZ**

Serious Adverse Incidents – Joint Investigation Framework

Final Internal Audit Report

February 2024

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-2324-07
Report status:	Final
Fieldwork commencement:	1 September 2023
Fieldwork completion:	15 January 2024
Draft report issued:	26 January 2024
Draft report meeting:	31 January 2024
Management response received:	14 February 2024
Final report issued:	15 February 2024
Auditors:	Osian Lloyd, Head of Internal Audit; Felicity Quance, Deputy Head of Internal Audit; Rhian-Lynne Lewis, Principal Auditor
Executive sign-off:	Liam Williams, Executive Director of Quality and Nursing
Distribution:	Wendy Herbert, Assistant Director of Quality and Nursing; Jane Palin, Assistant Director, Quality & Safety (Interim); Stephen Johnson, Head of Patient Safety, Concerns & Learning; Lucie Jones, Deputy Head of Patient Safety.
Committee:	Audit Committee

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

Acknowledgement:

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

Executive Summary

Purpose

To undertake a review of the Trust's compliance with the joint investigation framework for serious patient safety incidents.

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include areas of non-compliance with Section 4 (Joint Investigation Process) of the NHS Wales National Policy, noting which a review of the internal policy should be undertaken.

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

Report Opinion

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

Assurance summary[1]

Objectives		Assurance
1	Policy and Procedures	Reasonable
2	Training and Supervision	Reasonable
3	Patient Safety Incidents	Reasonable
4	Incident Investigations	Reasonable
5	Monitoring and Reporting	Reasonable
6	Action Plans and Lessons Learned	Reasonable

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Policy review	1	Design	Medium

1. Introduction

1.1 As outlined in the NHS Wales National Policy on Patient Safety Incident Reporting & Management, a patient safety incident occurs when an unintended or unexpected incident could have or did lead to harm for one or more patients or service users receiving NHS-funded healthcare. The process for investigating such incidents is vital to understand and learn from what has gone wrong, to identify and address risk areas and to provide assurance to the Healthcare provider over the quality of patient care, in line with the NHS Wales (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011. Incidents that occurred after 1 April 2023 that meet the following triggers, are also subject to Duty of Candour procedures as set out in the Health and Social Care (Wales) Act 2020.

1.2 All patient safety incidents should be reported through Datix Cymru, part of the Once for Wales Concerns Management System. In 2019, the Trust and all trusts and health boards agreed a joint investigation framework for serious patient safety incidents. The framework sets out the process for escalating serious incidents, including where the main cause is a factor outside of the Trust's control or because of health board hospital handover delays. The Trust identifies cases for escalation through its Serious Case Incident Forum (SCIF). In these cases, the Trust completes an incident referral form and sends it to the appropriate health body for investigation, copying in the Welsh Government's Delivery Unit.

1.3 Due to significant numbers of referrals not being investigated properly or reported nationally, this process was requested to be reviewed by the Emergency Ambulance Services Committee (EASC) and was led by the NHS Wales Delivery Unit. Significant discussion and work occurred over the summer of 2022 to agree the Joint Investigations framework through a Task and Finish Group that had membership from every Health Board, WAST and wider NHS Partners. A key outcome of the process is the requirement for a joint meeting to confirm a serious incident has occurred, confirm if a joint investigation is required and subsequently, which organisation will lead the investigation. Implementation of the process took place through a pilot which reported to EASC and the NHS Wales Delivery Unit.

1.4 The risks considered during the review were:

- Inappropriate investigation arrangements could lead to further patient harm.
- Financial risk from litigation due to patient harm.
- Compromised patient care.

1.5 During the planning of this review management advised that the Datix Cymru used to capture, track and report incidents and investigations has provided some limitations in relation to the investigation process. This has been taken into consideration during the course of our fieldwork.

1.6 The coverage of the review has focused solely on the joint investigation process and arrangements (Section 4 of the NHS Wales Policy). The stage at which the Trust report on National Reportable Incidents (NRIs) has not been considered.

2. Detailed Audit Findings

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

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

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

Objective 1: The Trust has incident management policy and procedures in place which align to the NHS Wales policy.

2.3 The *NHS Wales National Policy (*the NHS Wales policy*) on Patient Safety Incident (PSI) Reporting & Management* provides guidance on incident reporting and the subsequent management and investigation requirements, to ensure a consistent approach across Wales. The policy was updated in April 2023.

2.4 The NHS Wales policy has six supporting sections which provide further detail in relation to the management and reporting of PSIs:

Section 1: Never Events List	*List of reportable patient safety incidents to be classed as Never Events.*
Section 2: Reporting Process	*Guidance for submission of any National Reportable Incidents (NRI) forms to the NHS Wales Executive*
Section 3: Guidance on Specific Incident Types	*Provides clarity around some particular types of incidents which may require national reporting.*
Section 4: Joint Investigation Process (JIP)	*Provides guidance and a structure for joint investigations involving multiple organisations.*
Section 5: Safety II Guidance	*Guidance on applying Safety-II thinking into current incident management practices.*
Section 6: Commissioned Services	*Application of the Policy within commissioned services.*

2.5 Whilst the above are relevant to the wider management of incidents, the focus of our review has been in relation to the Joint Investigation Process (JIP) and the Trust's adherence to such (see audit objectives 3 and 4).

2.6 The Trust has an '*Adverse Incident and Reporting Policy*' in place which was updated in April 2023. It sets out *structure and clarity around the process for reporting, receiving, investigating, responding to and learning from Adverse Incidents (ADI), Near Misses, Hazards and National Reportable Incidents (NRIs)*, including:

- Reporting Process, including passing incidents to other organisations.
- Roles and Responsibilities.
- National Reportable Incidents Serious Case Incident Forum (SCIF).
- Duty of Candour.
- Investigations and Learning; and
- Audit and Monitoring.

2.7 We note that the Trust policy includes limited references to the NHS Wales policy and review of the content noted it does not set out a detailed process for the JIP to align with Section 4 of the NHS Wales policy. While a joint investigation should meet the same standards and requirements of any patient safety incident investigation, there may be logistical differences in terms of how a joint investigation is conducted in practice. See **MA1**

2.8 The Trust have advised us that they have committed to a full policy review, with a view for completion in Autumn 2024, to ensure the alignment of patient safety incidents, health and safety, Datix arrangements and also revision of relevant group reporting arrangements. We acknowledge that the timeline for this review will be subject to the Welsh Government's completion of their review of the Putting Things Right Regulations. Refer to audit objective 4 for review of compliance for joint investigations.

2.9 Our review of Siren did not identify any links to the NHS Wales Policy therefore making it less accessible to staff. See **MA1**

Conclusion:

2.10 The Trust has an internal policy to support local arrangements for incident management and reporting which is available to all staff; and we have identified enhancements required, in respect of the joint investigation process, to ensure alignment to the NHS Wales policy. The NHS Wales Policy provides national guidance on incident management; however, it is not readily available to all members of Trust staff. **Reasonable** assurance has therefore been determined for this objective.

Objective 2: Appropriate training and supervision arrangements are in place for staff undertaking investigations into patient safety incidents.

2.11 The Patient Safety Team (PST) structure consists of the Head of Patient Safety, Concerns and Learning (PSCL), three Investigation Supervising Officers, a Lead Serious Incident Investigator & Advisor and three Patient Safety Managers (PSM) - noting one post was vacant at the date of fieldwork. The team has recently undergone a formal Organisational Change Process (OCP) with six additional posts to be recruited (covering the whole of the Putting Things Right Team).

2.12 We were advised that PSMs typically hold active professional registration as registered Nurses/Midwives or Paramedics and have undergone a BTEC level 7 Advanced Professional Certificate in Investigative Practice. In addition, the one PSM is currently enrolled on the *Leading Patient Safety* course with the Safe Care Collaborative and the Deputy Head of Patient Safety is the Trust lead for the Welsh Risk Pool Enhanced Learning Programme which commenced in September 2023.

2.13 The PSMs are responsible for coordinating and overseeing all PSIs and receive an automated email when a new PSI has been added to Datix Cymru. The PST has developed a procedural guide for team members when reviewing and progressing incidents, which sets out the process from when the Datix Cymru entry is created through to its conclusion. There are experienced members within the team to provide support and mentoring. Investigations, and the wider SCIF portfolio (refer to audit objective 5), are supervised by the Head of PSCL ensuring that all information in relation to incidents is collated and is adequate.

2.14 Upon commencement of employment with the Trust, each employee attends a corporate induction session which includes a section on patient safety delivered by a member of the PST. Coverage includes:

- An understanding of how concerns are managed;
- Identifying when patient safety has (or could have) been affected; and
- An emphasis of the importance of why all patient safety incidents must be reported and investigated (noting it should be seen as a positive, not negative process).

2.15 Patient safety training is also delivered on an ad hoc basis, tailored for specific role progression such as Operational Team Leader and Duty Operation Manager.

Conclusion:

2.16 PSMs hold professional registrations and complete appropriate investigative practice training. A procedural guide is available to assist during investigations and there are experienced members within the team to provide support and mentoring. Appropriate guidance is also shared with all new Trust employees, upon induction, with regard to patient safety incidents. A **reasonable** assurance rating is therefore concluded for this objective.

Objective 3: Patient safety incidents (including nationally reportable incidents) are identified and captured.

2.17 PSIs are defined as *any unintended or unexpected incidents which could have, or did lead to harm for one or more patients receiving NHS-funded care*. Within the Trust they are identified and recorded/reported by:

- Paramedics and Technicians;
- Staff at Clinical Contact Centres;
- Staff at 111 Call Centres;
- Ambulance Care Service;
- Other Trusts / health boards (referred as a joint investigation); and
- Complaints received (that are escalated to incidents as appropriate).

2.18 As documented within audit objective 2, all staff receive patient safety training during their initial induction. Once a PSI is identified, this must be entered on to Datix Cymru. Each PSI is reviewed by the PSMs (including low harm) to ensure that they have been appropriately categorised, with reference to the categories set out in section 6.1 of the Trust's Policy, and to assess if the incident requires escalation.

2.19 In addition to Datix Cymru, serious incidents are recorded on the SCIF action log which is updated to reflect discussion at each SCIF meeting. The Datix Cymru system does not currently have the functionality to code incidents as joint investigations as required by the NHS Policy. The PST, however, does include narrative within the Datix Cymru records to indicate where incidents have been referred under JIF.

2.20 The JIP sets out three key areas that are considered essential to ensure an efficient and effective joint investigation between entities:

Joint Incident Management Meetings	Meetings should be arranged as soon as practicably possible following an incident and it sets out suggested membership/attendance and the frequency of meetings.
Standard Data Set	This has been provided to the Trust and Health Boards by NHS Wales and is used to capture and share information in relation to the incident. This is referred to as a SCIF briefing paper within the Trust, but the formal name is the 'Patient Safety Incident Requiring Joint Review'.
Overview of joint investigation process	This provides NHS bodies in Wales with guidance on how to instigate, progress and conclude a joint investigation.

2.21 The JIP further details 13 steps that Health Boards and Trusts should consider when assessing a PSI for consideration for a joint investigation. We reviewed 22 patient safety incidents that were referred under the joint investigation framework between January and August 2023 (161 in total for this period), to ensure that

expected processes have been followed in line with the NHS Wales policy. The items were selected from the Trust's SCIF action log.

2.22 The Trust was not the lead investigator for any of the items in our sample. We note that, due to the nature of the incidents, i.e. the impact of handover delays at emergency departments on the care provided to patients in the ambulance and the Trust's ability to reach patients out in the community, the Trust will lead on very few investigations.

2.23 A summary of our findings relating to the capture and escalation (section 4: Joint Investigation Process, steps 1 and 2) is as follows, with full details included in Appendix B:

Extract from Joint Investigation Process	Audit Findings
Step 1 *The organisation who identifies that an incident has occurred is responsible for reporting the incident on their local Datix Cymru system in line with local requirements. This should be within one working day of identification of the incident.*	2 cases were identified where there was a delay of more than 10 days between the incident date/notification received from the other organisation and when the Datix Cymru incident was created by the Trust. See **MA2**
Step 2 *In line with the organisation's local processes, the incident will be reviewed in a timely manner to assess the circumstances and determine next steps. It is expected that this review will take place within two working days of the report being made. A routine part of this review will be to consider if a joint incident management meeting is indicated.*	As part of the Trust's local arrangements, a Patient Safety Incident Requiring Joint Review Paper (PSI RJR or SCIF brief) is requested by the PSMs to instigate a review at a SCIF meeting. As per the policy, this is expected to take place within 2 working days of the Datix Cymru incident being raised. Two cases were identified where there were delays of 19 and 27 days, respectively, between the incident date and a SCIF briefing being requested. See **MA2**

Conclusion:

2.24 Patient safety incidents are captured on Datix Cymru and reviewed by the Patient Safety Team. Serious incidents, including those requiring joint investigation, are also recorded on the SCIF action log which is discussed and updated at each SCIF meeting. Timelines within the National Policy in relation to the initial capture and escalation were not adhered to for a small number of incidents in our testing sample. As such, **reasonable** assurance is determined.

Objective 4: Incidents are investigated, quality assured, approved and responded to within required timeframes and in-line with the joint investigation process.

2.25 When an incident is reported on the Datix Cymru system, this will trigger an automated email to the PST and any other relevant divisions across the Trust (e.g. clinical, operational, clinical contact centres etc.) so that all relevant parties are aware that investigations/audits are required. Each division then undertakes a review of their contribution to the incident, i.e. Emergency Medical Service Clinical Contact Centre investigator would listen to the relevant calls, senior

paramedics/locality managers would interview the relevant paramedic/technician and ensure ePCR (electronic patient clinical record) detail is factually correct and complete.

2.26 Once an issue is escalated to SCIF, the Deputy Patient Safety Manager within the PST prepares a briefing paper using a standard form which captures the organisation, Datix Cymru reference, incident date, summary of incident, data from the electronic patient clinical record and hospital turnaround times, thus establishing a timeline of events from the Trust's perspective.

2.27 The briefing paper for the incident is then attached to a SCIF meeting which occur twice weekly. The relevant information is presented at the meeting and where it is determined that another responsible body has contributed to the incident, the Trust refers it to them to lead the investigation under the JIF. This decision is documented and captured within the SCIF action log. The Trust refers a significant proportion of incidents to Health Boards as a result of the handover delays due to over-crowding at emergency departments and broader system pressures.

2.28 During audit fieldwork, we observed a SCIF meeting to further understand the process to identify if an incident should be assessed in line with the JIP as set out in the NHS Wales Policy. We were advised that the lead organisation is usually the Health Board where the patient resides as they are deemed the best place to ensure a patient centered approach.

2.29 The JIP recommends that a joint investigation management meeting (JIMM) is arranged with the relevant Health Board/Trust to discuss the incident and establish next steps. Discussion with the Deputy Head of Patient Safety confirmed that due to the significant volume of incidents referred under the JIF, reflecting the wider system pressures being faced by the NHS, regular weekly meetings are held in place of JIMMs, allowing for multiple incidents to be reviewed.

2.30 We also note that within the Trust, Datix Cymru incidents are closed at the point the incident is referred to a Health Board/Trust as a JIF as from the Trust's perspective, all necessary work has been completed, i.e. the incident discussed with their counterparts and the PSI RJR / SCIF brief has been shared with them. Discussion with the PST established that this is to show that the Trust is no longer the lead on the investigation but will update the record on Datix if further updates are received from the Health Board/Trust. If the Trust did not adopt this approach, then these incidents could remain open on Datix indefinitely.

2.31 The selected sample of incidents was further reviewed to confirm compliance with the remaining JIP steps (as per Section 4 of the NHS Wales policy). A summary of our findings is as follows, with full details included in Appendix B:

Extract from Joint Investigation Process	Audit Findings
Step 4 *The incident should be discussed at the joint incident management meeting to make a joint decision on whether it requires a joint investigation.*	Due to the volume of SCIFs being received, reflecting the wider system pressures being faced by the NHS, formal joint investigation management meetings are not arranged. As a mitigating action, the PSMs meet

Extract from Joint Investigation Process	Audit Findings
	weekly with their relevant health board counterparts to discuss investigations.
Step 5 *Consideration of the lead organisation should be taken on a case by case basis.*	The decision to determine the lead investigating organisation is discussed within the SCIF meetings, and is subsequently documented and captured within the SCIF meeting action log. The lead organisation was agreed in all items in our sample apart from one incident dating back to February 2023 which we couldn't determine if it had been investigated. **See MA2** The Trust was not the lead investigator for any of the items in our sample.
Step 9 *Following the joint decision to undertake a joint investigation, a proportionate investigation will be jointly undertaken by the relevant stakeholders utilising the chosen methodology and within the stipulated timescale. Regardless of the methodology chosen, the joint investigation must include analysis in line with the Yorkshire Contributory Factors Framework (YCFF).*	Trust PSMs meet with their Health Board equivalents on a weekly basis and active investigations are discussed. We note that these meetings are not minuted but the existence of meetings has been confirmed in diaries.
Step 10 *The end product of the joint investigation will be one investigation report which covers all parts of the patient's journey relevant to the incident, incorporating the YCFF analysis, along with identified areas for improvement.* *• It is essential that action is taken to address the identified areas for improvement, consideration should be given to whether this is best addressed through a stand-alone action plan or via a thematic action plan.*	Discussion with the PST has confirmed that the issuing of final investigation reports is not consistent across Wales and as such, feedback from investigations is very limited to allow for learning. **See MA5.** We note that as the Trust leads on so few joint investigations, this is outside of their control.
Step 12 *Once the joint investigation report has been finalised, each NHS Wales stakeholder organisation will:* *• update their Datix Cymru record with the investigation outcomes and contributory factor analysis; and* *• share the outcomes and learning from the investigation within their organisation.*	Within the Trust, Datix Cymru incidents are closed at the point the incident is referred as a JIF as from the Trust's perspective, all necessary work has been completed, i.e. the incident discussed with Health Board colleagues and the PSI RJR / SCIF brief has been shared with them. The PSMs are however able to return to the incident to update and add additional supporting documents, post closure. There were only 3 cases where a final report/closure email had been received and added to Datix Cymru. We do, however, acknowledge, that this is outside the control of the Trust.

Conclusion:

2.32 Serious incidents are investigated internally and escalated at the SCIF to determine whether they require joint investigation. A significant proportion of these incidents are as a result of handover delays at emergency departments, as well as broader system pressures, and are therefore referred to Health Boards to lead the joint investigation. Due to the significant volume of incidents, Trust PSMs meet with their Health Board counterparts on a weekly basis to discuss, instead of convening the Joint Investigation Management Meeting required by the NHS Wales policy. Due to the limited updates received from Health Boards on the status of investigations, the Trust closes the incidents on both Datix and the SCIF action log at the point they are referred to them as lead investigators. As such a **reasonable** assurance rating is determined for this objective.

Objective 5: Monitoring and reporting take place at appropriate forums within the Trust and with external parties.

2.33 The SCIF meeting was established to *undertake a timely, multidisciplinary review of all patient safety incidents which are assessed as causing actual or potential moderate, severe or catastrophic harm to patients*. Following review of the incident and underpinning intelligence surrounding the incident, a view on next steps is taken in terms of the type and level of investigation required.

2.34 The group meets twice weekly and has a diverse membership to include input from all departments involved in an incident. The terms of reference define quoracy as the Chair and four members, which must include a representative from Patient Safety, Emergency Medical Services Coordination & Resourcing, Clinical Directorate and Operations. During the course of the fieldwork, it was identified that attendance at SCIF meetings was not captured and recorded and as such, quoracy could not be confirmed. We note that the Trust responded to this immediately and attendance was captured from this point onwards and further evidence has been provided to confirm that these arrangements are being maintained. We also note that this forum could not proceed without the active involvement from the representatives as no decisions would be able to be taken. With the acknowledgment that this recording of attendance needs to be sustained, we have not raised a recommendation at this report.

2.35 Due to the sensitivity of the matters discussed within the SCIF meetings, we note that minutes are not taken. Rather, the group produces a high-level action log which references all SCIF incidents. This is reviewed at each meeting and updated upon completion of actions.

2.36 A SCIF Alert, Advise, Assure (AAA) report is presented to the Clinical Quality and Governance Group (CQGG) on a monthly basis. This summarises the Trust's current position on matters discussed at SCIF, including joint investigations, the number of open NRI investigations and subsequent themes identified.

2.37 Review of the CQGG terms of reference notes that the membership of the group includes a diverse range of employees, and sub-groups that the group oversees

including the SCIF. Quoracy is defined as five members with one being the Chair or Co-chair. A review of four meetings (June to September 2023) has confirmed quoracy and that meetings are well attended. Following its monthly meeting, CQGG prepares a AAA report to the Executive Management Team (EMT).

2.38 The Quality, Patient Experience and Safety Committee (QuESt) receives a quarterly Putting Things Right report. The last report (presented October 2023) provided an update stating that there were 73 cases reviewed at SCIF during the reporting period, with 39 referred under the Joint Investigation Framework. We note that there is opportunity to provide more detail on the status of joint investigations. **See MA3**

2.39 The Monthly Integrated Quality and Performance Report (MiQPR) presented to QuESt details a range of performance metrics, including an update on the number of cases taken to SCIF during the period and of which, those cases that were referred under the Joint investigation Framework. This MIQPR report will also be presented to the Trust Board, who also receive a report on 'Actions to Mitigate Patient Harm' and underpinning improvement plan.

2.40 During the reporting period August to October 2023, this report identified 46 severe cases of avoidable harm that were referred to Health Boards under the joint investigation framework. While the report also has wider considerations, it includes an action plan setting out arrangements to mitigate avoidable patient harm which is subject to review and scrutiny at Board level.

2.41 External organisations are kept up to date on investigation progress during meetings between the Trust's PSMs and their respective counterparts in relevant organisations. The JIP requires that once an investigation has been completed, a final SCIF briefing paper is emailed to the relevant Health Board/Trust, providing them with the closing decisions of the joint investigation. However, we note that this is not being consistently undertaken across Wales.

Conclusion:

2.42 There is an appropriate internal reporting framework in place, with escalation from the SCIF meeting through to the Clinical Quality and Governance Group and onwards to Executive Management Team, QuESt and Trust Board. Adequate reporting to external parties is also undertaken. The formality of recording the quoracy at the SCIF meetings was addressed during the course of fieldwork, with record of attendance now maintained. Therefore a **reasonable** assurance rating is determined for this objective.

Objective 6: Action plans are in place for lessons learnt from patient's safety incidents and reports are shared across the Trust.

2.43 On completion of an investigation, the Trust is notified of the outcome through the weekly meeting between the PSMs, or via email from the investigating Health Board/Trust. Discussion with the Assistant Director of Quality Nursing noted that where feedback is received it does not typically capture lessons learned. These concerns have also been reported within the MiQPR to both QuESt and Trust Board.

One of the Patient Safety Team's priorities following the recruitment to the new structure is to try and influence system colleagues to identify more meaningful patterns, themes and trends and associated learning opportunities from the Joint Investigation Process, however ultimately oversight of the process and Health Boards actions sits nationally with the NHS Executive not the Trust.

2.44 Discussion with the Head of Patient Safety Team noted that briefing papers, completed for proceeding with the joint investigation process, will identify (if applicable) learning opportunities to mitigate the risk of future patient harm. The SCIF log will also capture any follow up action required.

2.45 Wider organisational learning from investigations is captured within the quarterly Putting Things Right Report that is taken to QuESt. The report also captures themes, learning and outputs from clinical reviews which include failure to examine patient adequately and absence of contact with GP. A summary of the clinical reviews undertaken is also submitted quarterly to the Chief Ambulance Service Commissioner.

2.46 Clinical Notices are also issued to staff which identify areas of good practice or learning. These can be accessed on the Trust intranet but also on the handheld devices within the JRCALC app[1].

2.47 Our high-level review of the SCIF action log showed that positive action was being taken, for example through feedback provided to the staff involved. However, there also appeared to be instances where potential learning had not been addressed. There is therefore further opportunity to undertake a wider review of the learning to ensure key issues and common themes are consolidated and shared Trust-wide. **See MA4**

Conclusion:

2.48 Organisational wide learning is captured and reported to QuESt quarterly. We note that limited feedback is received from the Health Board/Trust where they are the lead on joint investigations; and there are areas of learning identified within the Trust's SCIF action log, in relation to the joint investigation process, which have not been evidenced as addressed. A **reasonable** assurance rating is there for concluded for this objective.

[1] JRCALC (Joint Ambulance Colleges Ambulance Liaison Committee) - an application which allows ambulance services to combine national guidelines with local and regional guidelines and information.

Appendix A: Management Action Plan

Matter Arising 1: Policy Update (Design)		**Impact**
Our review of the Trust's *Adverse Incident and Reporting Policy* has shown that it includes limited reference to the *NHS Wales National Policy on Patient Safety Incident Reporting & Management* and its supporting sections. It does not set out a detailed process for the joint investigation process to align with Section 4 of the NHS Wales policy, which may have resulted in some of the processes not being fully implemented. While a joint investigation should meet the same standards and requirements of any patient safety incident investigation, there may be logistical differences in terms of how a joint investigation is conducted in practice. We do note, however, that the Trust has committed to a full policy review once the Putting Things Right Regulations are updated during 2024. We also note that the NHS Wales policy is not available through the Trust's intranet site.		Potential risk of: • Non-compliance with the NHS Wales policy and Putting Things Right Regulations.
Recommendations		**Priority**
1.1	The Trust's 'Adverse Incident and Reporting Policy' should be reviewed and updated to reflect the requirements set out within the NHS Wales policy.	**Medium**
1.2	To allow accessibility for all members of staff, the NHS Wales policy should be made available on the Trust's intranet site.	

Agreed Management Action		Target Date	Responsible Officer
1.1	The Putting Things Right Team plan was to review relevant policies following the release of the new Putting Things Right Regulations by Welsh Government in May 2024. A recent update from Welsh Government has confirmed that the release will now be Autumn 2024. At which point the review will be undertaken. The Trust has approved policies in respect of incident reporting and management and a Putting Things Right Policy which are included on the intranet site (review dates are both April 2026). Staff also have access to User Guides on the intranet site for Datix Cymru. The All-Wales Patient Safety Policy (NHS Executive) (May 2023) is also due review in March 2024 and will be updated internally when released nationally	30 November 2024 On release from NHS Wales Executive	Assistant Director, Quality & Safety (Interim) *Note: The responsibility for this management action will pass to the newly appointed Head of Putting Things Right once they commence employment at the Trust*
1.2	To be included on the Intranet site.	29 February 2024	Corporate Governance Team

Matter Arising 2: Compliance with NHS Wales Policy (Operation)	Impact
The overview of the joint investigation process is set out within supporting section 4 of the National policy. This establishes 13 steps that Trusts and Health Boards should undertake while considering if an incident requires referral under the Joint Investigation Framework. Our testing of 22 incidents between January and September 2023 has identified three steps within the above process that have not been adhered to across all incidents, which are outlined below (noting a full summary of all 13 steps can be found within Appendix B):	Potential risk of: • Gaps in joint investigation process. • Non-compliance with section 17 of the regulations could result in reputational harm.

Step 1 *The incident should be reported on Datix within one working day of identification of the incident.*	Our review has shown that in 2 cases, there was a delay of more than 10 days between the incident date/when the notification was received from another Health Board/Trust and when the Datix incident was created – There was no narrative included to support this delay.
Step 2 *In line with the organisation's local processes, the incident will be reviewed in a timely manner to assess the circumstances and determine next steps. It is expected that this review will take place within two working days of the report being made*	We note that this timeframe is also stipulated within Regulation 17 of the NHS Wales Regulation (Concerns, Complaints and Redress) 2011 - Delays of between 19 and 27 days were noted in 2 cases between the incident date and the SCIF briefing being requested. There was no narrative included to support this delay within the SCIF action log nor Datix.
Step 5 *Consideration of the lead organisation should be taken on a case by case basis*	From review of the SCIF action log and Datix, we were unable to determine if incident number 10324 had been referred for a joint investigation to Powys Teaching Health Board.

Recommendations			Priority
2.1	To address the requirements of steps 1 and 2 of the Joint Investigation Process, where there is a delay to raising and reviewing an incident on Datix Cymru, appropriate narrative should be included within to support this to ensure a full audit trail is captured.		**Low**
2.2	To address the requirements of step 5 of the Joint Investigation Process, a periodic review of actions not completed within the action log should be undertaken to ensure that records are up to date.		
Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	Patient Safety Team to update the narrative on Datix Cymru as part of business as usual processes.	31 March 2024	Head of Patient Safety, Concerns & Learning.
2.2	Patient Safety Team to undertake a monthly review of the action log.	30 April 2024	Head of Patient Safety, Concerns & Learning.

Matter Arising 3: Putting Things Right (PTR) Reporting (Design)	Impact
The Putting Things Right report is presented to QuESt at each quarterly meeting and includes an update on the number of incidents presented at SCIF and those subsequently referred to Health Boards and Trusts under the joint investigation framework (JIF). However, we note that there could be some enhancements to the data provided to facilitate completeness of reporting, including: • Reference to the number of joint investigations where the Trust is the lead investigator. • Noting the areas of non-compliance from our testing (see **MA2**), highlight any exceptions in terms of Trust compliance with the JIF process. • Number of final joint investigation reports returned from other Health Boards and Trusts in the period.	Potential risk of: • Incomplete disclosures within the report

Recommendations		Priority
3.1	To facilitate completeness of reporting, consideration should be given to the enhancement of the SCIF/JIF data included at the Putting Things Right report.	**Low**

Agreed Management Action		Target Date	Responsible Officer
3.1	The Putting Things Right Report will include additional process measures in respect of the Joint Investigation Framework within the Quarter 4 Report (January – March 2023/24)	30 April 2024	Head of Patient Safety, Concerns & Learning

Matter Arising 4: Learning from investigations (Design)			Impact
The Patient Safety Team review all patient safety incidents to assess whether they require escalation to SCIF for further investigation. A log is prepared to capture decisions made following a SCIF meeting and any follow up action required. Our high-level review of the SCIF action log showed that positive action was being taken, for example through feedback provided to the staff involved. However, there also appear to be instances where potential learning had not been addressed. There is also an opportunity to undertake a wider review of the learning identified at this stage of the investigation, primarily through the detail provided on the briefing papers prepared for joint investigation, to ensure key issues and common themes are consolidated and disseminated to relevant staff. We recognise that in the absence of feedback on each incident from the relevant Health Boards / Trusts, this process cannot be optimally implemented.			Potential risk of: • The Trust is not learning from serious incidents to prevent future recurrence.
Recommendations			**Priority**
4.1	The Trust should consider the opportunity to consolidate key issues and areas of learning and disseminate Trust-wide to minimise reoccurrence.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
4.1	The Trust has been engaged in the All Wales Enhancing Learning Programme since September 2023 and this includes the roll out of an all-Wales framework for learning from events (including but not limited to incidents). This programme includes membership from all health boards, trusts and health bodies and considers internal and wider system learning. The capability to extract themes and trends from the SCIF log has already been set up by the new PTR Coordinator. This data and information will inform the PTR Quarterly Report.	Milestones Scoping exercise 31 March 2024 Internal approval of the Framework 30 June 2024	Deputy Head of Patient Safety. Head of Patient Safety, Concerns & Learning

Appendix B: Trust compliance with the Joint Investigation Process

Overview of joint investigation process (NHS Wales Policy: Section 4)	Internal Audit Conclusions	Issue ✗ No Issue ✓	Internal Audit Recommendation
Step 1 *The organisation who identifies that an incident has occurred is responsible for reporting the incident on their local Datix Cymru system in line with local requirements. This should be within one working day of identification of the incident.*	This step has been reviewed on a case by case basis across the sample of 22 incidents - 2 cases were identified where there was a delay of more than 10 days between incident date/notification received from other Health Boards/Trusts and when Datix Cymru incident created (Case references 10627 and 10575).	✗	Datix Cymru incidents should be raised within one working day in order to align with the NHS Wales Policy. Where there is a delay, appropriate narrative should be included within Datix Cymru /SCIF action log to support this.
Step 2. *In line with the organisation's local processes, the incident will be reviewed in a timely manner to assess the circumstances and determine next steps. It is expected that this review will take place within two working days of the report being made. A routine part of this review will be to consider if a joint incident management meeting is indicated.* *Where a joint incident management meeting is indicated, the identifying organisation will initiate the joint review process with organisations relevant to the incident. This includes:* *• identifying potential stakeholder organisations required for the joint incident management meeting;* *• making stakeholder organisations aware of the circumstances of the incident, and of the indication for joint review and requesting relevant data to be collated ahead of the joint incident management meeting; and* *• ensuring that the incident is discussed at a joint incident management meeting in a timely manner. This is expected to take place as soon as possible and usually within two weeks of identification*	As part of the Trusts local arrangements, a Patient Safety Incident Requiring Joint Review Paper (PSI RJR - also known as a SCIF brief) is requested by the PSMs to instigate a review at a SCIF meeting. This section of the policy states that this should happen within 2 days of notification of the incident. However delays 19 and 27 days were noted in 2 cases between the incident date and a SCIF briefing being requested - no explanation to support the delay was included in the narrative within Datix nor the SCIF action log.	✗	The Trust should ensure reasons for delays within Datix Cymru /action log to ensure a full audit trail is captured.

Overview of joint investigation process (NHS Wales Policy: Section 4)	Internal Audit Conclusions	Issue ✗ No Issue ✓	Internal Audit Recommendation
of the incident, recognising that there may be occasions where this timescale is exceeded due to complexity.			
Step 3. *To support discussions in relation to the incident, the data described in the standard dataset should be made available, where possible, to all parties involved in the joint incident management meeting. However, not having all the data should not prevent the discussion taking place.*	The standard dataset for the Trust is the SCIF briefing which is used across Wales to summarise the incident – The formal document name is Patient Safety Incident Requiring Joint Review (PSIRJR) or SCIF briefing paper as referred to by the Trust. We also note that other Health Boards send Datix Cymru printouts when referring an incident to the Trust under the joint investigation framework. A PSI RJR was present for each incident within the SCIF working papers.	✓	N/A
Step 4. *The incident should be discussed at the joint incident management meeting to make a joint decision on whether it requires a joint investigation.* *● If the decision is that the incident does not require a joint investigation, then the rationale for this decision should be documented as part of the minutes for the joint incident management meeting. Consideration must be given to whether an individual organisation should carry out an investigation under PTR.* *● If the decision is that the incident does require a joint investigation, then the following points should be discussed and agreed (the below may be used as the template for an agenda, if helpful):* *o Clarity on what the incident is, as well as the outcome* *o Consideration of the level of harm arising from the incident (using the current knowledge available) as this will inform and influence actions under PTR*	Due to the volume of SCIFs being received, reflecting the wider system pressures being faced by the NHS, formal joint investigation management meetings are not arranged. As a mitigating action, the PSMs meet weekly with their relevant health board counterparts to discuss investigations.	✓	Consideration should be given to review the process to ensure all steps here are considered and included to allow for a complete and accurate joint investigation.

Overview of joint investigation process (NHS Wales Policy: Section 4)	Internal Audit Conclusions	Issue ✗ No Issue ✓	Internal Audit Recommendation
o Scope and Terms of Reference for the joint investigation *o Investigation methodology to be used and expected timescales for completion (30, 60, 90 or 120 days)* *o Roles and responsibilities of all organisations involved in joint investigation* *o Agreement of who will be the lead organisation, with responsibility for acting as the Single Point of Contact for the patient, service user or person acting on their behalf* *o Decision on any national reporting requirement (NRI)* *o Decision on any other external reporting that may be required* *o Plan to support staff who have been involved in the incident* *o (if needed) plan for coordination with other concerns processes e.g. complaints, inquest* *o Safeguarding considerations* *o Media and communications considerations*			
Step 5. *Consideration of the lead organisation should be taken on a case by case basis. When deciding the lead organisation, consideration should be given to factors such as:* *•the patient must be put at the centre of the investigation so the primary consideration needs to be, which organisation will be best placed for the benefit of the patient or service user and any person acting on their behalf to undertake the lead role which will include acting as the single point of contact for the patient/family;* *•what the actual incident is and where it occurred, which may be different to where harm and/or the incident was identified***.**	The decision to determine the lead investigating organisation is discussed within the SCIF meetings, and is subsequently documented and captured within the SCIF meeting action log. The lead organisation was agreed in all items in our sample apart from one incident dating back to February 2023 which we couldn't determine if it had been investigated (incident reference 10324). The Trust was not the lead investigator for any of the items in our sample.	✗	We recommend that a periodic review of actions marked as not completed within the action log is undertaken to ensure that records are kept up to date.

Overview of joint investigation process (NHS Wales Policy: Section 4)	Internal Audit Conclusions	Issue ✗ No Issue ✓	Internal Audit Recommendation
Step 6 *All NHS Wales organisations involved in the joint investigation will raise an incident on their local Datix Cymru system, clearly coding this as a joint investigation with the relevant reference details for the other organisations for cross-matching purposes.* *Non-NHS Wales organisations should give consideration to their own local recording requirements.*	Our review confirmed that a Datix incident had been created for each PSI that we reviewed. We note that the current Datix Cymru system does not allow for coding of a joint investigation but that the comments entered by the PST, includes narrative to indicate that the incident has been referred under JIF.	✓	N/A
Step 7. *Should the incident meet the threshold for national safety incident reporting, the lead NHS Wales organisation will undertake any national reporting requirement, taking into account the guidance provided in Section 15 of the Policy on incidents occurring in commissioned services.*	Only one NRI report was made to the Trust which was received from CTM for incident 10625.	✓	N/A
Step 8. *The lead organisation will engage the patient, service user or person acting on their behalf in line with the requirements of PTR and the Duty of Candour. For incidents where moderate harm or above has resulted, this will include proactively making contact with the patient, service user of person acting on their behalf at the earliest appropriate opportunity, and engaging them in the investigation process, including understanding events from their perspective and ensuring any of their questions are taken into consideration as part of the investigation. Involvement of the patient, service user or person acting on their behalf should be undertaken throughout the investigation process.*	This information is not captured within Datix Cymru nor the action logs. Discussion with PST has confirmed that this is a key aspect of the role of the team.	✓	N/A
Step 9. *Following the joint decision to undertake a joint investigation, a proportionate investigation will be jointly undertaken by the relevant stakeholders utilising the chosen methodology and within the stipulated timescale. Regardless of the methodology chosen, the joint*	Trust PSMs meet with their Health Board equivalents on a weekly basis and active investigations are discussed. We note that these meetings are not minuted but the existence of meetings has been confirmed in diaries.	✓	N/A

Overview of joint investigation process (NHS Wales Policy: Section 4)	Internal Audit Conclusions	Issue ✗ No Issue ✓	Internal Audit Recommendation
investigation must include analysis in line with the Yorkshire Contributory Factors Framework (YCFF).			
Step 10. *The end product of the joint investigation will be one investigation report which covers all parts of the patient's journey relevant to the incident, incorporating the YCFF analysis, along with identified areas for improvement.* *• It is essential that action is taken to address the identified areas for improvement, consideration should be given to whether this is best addressed through a stand-alone action plan or via a thematic action plan.*	Discussion with the PST has confirmed that the issuing of final investigation report is not consistent across Wales and as such, feedback from investigations is very limited to allow for areas of learning. We note that as the Trust lead on so few joint investigations, this is outside of their control. Discussion with the PST has shown that this is to show that the Trust is no longer the lead on the investigation, but will update the Datix Cymru incident as and when updates are received from Health Boards - if the Trust did not close the Datix incident, these cases could remain open indefinitely.	✓	N/A
Step 11. *The joint investigation report will be submitted through the governance and quality assurance mechanisms for sign off as agreed at the strategy meeting.*	A summary of all cases is taken through from SCIF to CQGG via AAA report under incident reporting. This has been captured and documented under audit objective 5.	✓	N/A
Step 12. *Once the joint investigation report has been finalised, each NHS Wales stakeholder organisation will:* *• update their Datix Cymru record with the investigation outcomes and contributory factor analysis; and* *• share the outcomes and learning from the investigation within their organisation.*	Within the Trust, Datix Cymru incidents are closed at the point the incident PSIRJR / SCIF briefing paper has been shared and the investigation is referred as a JIF to the relevant Health Board, as from the Trust's perspective all necessary work has been completed.	✗	We recommend that the Trust develop a process to follow up on joint investigations where a final report has not been received from the Health Board.

Overview of joint investigation process (NHS Wales Policy: Section 4)	Internal Audit Conclusions	Issue ✗ No Issue ✓	Internal Audit Recommendation
	Discussion with the PST has established that this is to show that the Trust is no longer the lead on the investigation, but will update the record on Datix Cymru if further updates are received from Health Boards. If the Trust did not adopt this approach, then these incidents could remain open on Datix indefinitely. The PSMs are, however, are able to return to the incident to update and add additional supporting documents post closure. There were only 3 cases where a final report/closure email had been received and added to Datix Cymru. We do, however, acknowledge, that this is outside the control of the Trust.		
Step 13. *In addition to the above, the lead organisation will:* *• if the incident was nationally reported, complete any outcome requirements associated with the notification, including sharing the contributory factor analysis at a national level; and* *• complete any relevant PTR requirements in line with the organisation's governance processes, including engaging with the patient, service user or person acting on their behalf about the final investigation report.*	As part of the testing, whilst the Trust was the lead investigator for two incidents, neither resulted in a NRI. Arrangements are in place within the Trust to capture and report on NRIs within the Trusts usual governance process, which we were advised would also apply to outcomes from joint investigations.	✓	Whilst there is a PTR report prepared by the Trust, enhancements have been recommended to expand on the data reported in respect of SCIF/JIF investigations.

Appendix C: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Strategy Development

Final Internal Audit Report

February 2024

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-2324-006
Report status:	Final
Fieldwork commencement:	28 August 2023
Fieldwork completion:	23 January 2024
Draft report issued:	25 January 2024
Draft report meeting:	29 January 2024
Management response received:	14 February 2024
Final report issued:	14 February 2024
Auditors:	Osian Lloyd, Head of Internal Audit; Felicity Quance, Deputy Head of Internal Audit; Donna Morgan, Audit Manager
Executive sign-off:	Rachel Marsh, Executive Director of Strategy, Planning & Performance
Distribution:	Alexander Crawford, Assistant Director of Planning & Transformation; James Houston, Head of Strategy Development; Estelle Hitchon, Director of Partnerships & Engagement; Heather Holden, Head of Transformation
Committee:	Audit Committee

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

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

Executive Summary

Purpose

A review of the arrangements in place to support the development of the Trust's strategic ambitions. To include a review of the process in place to manage strategic decision making and how these are communicated throughout the organisation.

Overview

An overall reasonable assurance has been determined.

The key matters requiring management attention include:

- Delays to the Engagement Framework Delivery Plan; and
- Opportunities to improve how the Trust measures and reports progress.

We recognise that the Trust's long-term strategy has been subject to regular review with commitment to its objectives recently re-confirmed by the Board. However, noting the current juncture of the strategy, consideration should be given to refresh to account for Trust developments post approval and following the Covid-19 pandemic.

See Appendix A for further details.

Other recommendations are within the detail of the report.

Report Opinion

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

Assurance summary[1]

Objectives		Assurance
1	Legislative Obligations	Reasonable
2	Development of Strategic Ambitions	Reasonable
3	Stakeholder Engagement	Reasonable
4	Monitoring and Reporting	Reasonable

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
2	Engagement Framework Delivery Plan	3	Operation	Medium
3	Reporting and monitoring of delivery and progress	4	Design	Medium

1. Introduction

1.1 In March 2019 the Welsh Ambulance Services NHS Trust ('the Trust') approved a long-term strategy, Delivering Excellence, which set out a vision for the service in Wales up to 2030. Following this, the Trust has developed and continues to evolve strategic ambitions for an integrated set of service offers for the people of Wales over the next 3-5 years. The Strategic Plan is designed around supporting the delivery of relevant national strategies and policies, including:

- Wellbeing of Future Generations Act;
- 'A Healthier Wales';
- 'Six goals for urgent and emergency care'; and
- Emergency Ambulance Services Commissioners (EASC) commissioning intentions.

1.2 In 2021/22 the Trust identified a seven-stage framework of strategy development to support the continued development and enrichment of the Trusts Long Term Strategic Framework and Strategic Ambitions.

1.3 The Trust's Integrated Medium-Term Plan (IMTP) sets out, over a three-year cycle, the priorities to move the Trust towards realising its long-term strategic ambitions. These are then scheduled into a delivery plan and taken forward by one of the seven Transformation Programme Boards which monitor and regularly report their progress and status to the Trust Board via the Strategic Transformation Board.

1.4 The potential overarching risk associated with this subject area is delivery of the Trust's strategic objectives could be jeopardised by ineffective planning arrangements.

2. Detailed Audit Findings

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

	Recommendation Priority			
	High	Medium	Low	Total
Control Design	-	2	-	2
Operating Effectiveness	-	1	1	2
Total	-	3	1	4

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

Objective 1: The Trust's strategy and associated objectives address the requirement of the Welsh Government and Commissioners.

2.3 The Trust developed its Long-Term Strategy (LTS) titled '*Delivering Excellence, Our Vision for 2030'* in 2017/18, in line with Welsh Government requirements to have a strategic document setting out the longer-term ambitions.

2.4 As part of the engagement process, the Commissioners (Emergency Ambulance Services Committee[1]) were involved in key stakeholder meetings during the development of the Strategy. The Strategy was endorsed by EASC in 2019 (see **objective 3** for further details on engagement). The LTS was approved by the Trust Board in March 2019, although we note that it was not submitted to Welsh Government.

2.5 The Strategy outlines the Trust's ambition to move away from being a traditional ambulance and transport service and sets out how it plans to achieve this. The following three ambitions were identified in line with the Welsh Government's objectives, specifically 'A Healthier Wales':

1. *Helping patients and staff to stay healthy;*
2. *Helping patients more easily access our services at the right time; and*
3. *Providing the right care in the right place, wherever and whenever it is needed.*

2.6 Four enablers were identified to support the successful implementation of the Strategy:

1. *Continue to provide the best care possible, outcomes and experience to our patients;*
2. *Enable our people to be the best that they can be;*
3. *Ensure the design and infrastructure of the organisation are at the forefront of innovation and technology; and*
4. *Whole system partnership and engagement.*

2.7 Regular high-level reviews of the LTS have taken place at the Strategic Transformation Board. Noting that broad objectives were outlined in the Strategy, the Trust has reviewed and reconfirmed its commitment to these at a recent Board Development session.

2.8 However, noting that the LTS is approaching its fifth year, the Strategy and Planning Team considers that a refresh at its mid-point would be beneficial, to account for developments that have occurred since Covid, the recent development of the 'Inverting the Triangle' service model[2], and the wider integrated model proposed which would also include Emergency Medical Services (EMS), Non-

[1] Emergency Ambulance Services Committee (EASC) is the joint Committee of the seven health boards in Wales and has the responsibility for planning and securing sufficient ambulance services for the population.

[2] Inverting the Triangle is the Trust's service model outlining the Trust's vision of altering its traditional service model and how it will manage demand differently. This includes increasing telephone consultations and expanding the provision of treatment in the community with the aim of reducing the levels of ambulance conveyance to hospital.

Emergency Patient Transport Services (NEPTS) and Integrated Care (111 and the clinical support desk). See **MA1**.

2.9 The Strategy also includes its 'golden threads' which links the Trust's processes and systems to its goals. The Strategy is organised into key projects of work and sets out the Trust's priorities, which form the basis for the three-year IMTPs to deliver the Trust's ambition to transform and improve services. It also underpins annual directorate delivery plans and is aligned to the EASC commissioning intentions for EMS, NEPTS and 111.

2.10 Delivery of the IMTP is therefore one of the main drivers for service change, and it states the strategic objectives from the LTS to maintain alignment. The Trust's IMTP has consistently been endorsed by Welsh Government each year; the most recent version having been approved in September 2023 based on accountability conditions issued by the Director General.

2.11 A paper was presented to the Finance and Performance Committee in November 2023 to outline the progress and actions required to develop the next iteration of the Trust's IMTP for 2024-27.

2.12 The aims for achieving an approved plan were reported as follows:

- *Refresh of the current 3-year IMTP with a focus on how the Trust is working towards its strategy, whilst also maintaining control of its spend in the challenging financial environment;*
- *To be clearer about the milestones across the whole period in years 1,2 and 3 – this is the direction set by the Board and Welsh Government;*
- *Ensure the IMTP meets the needs of patients, colleagues and the wider public and WAST's people; and*
- *That it showcases the Trust's commitment to delivering its statutory obligations and commissioning intent.*

2.13 As highlighted in the Audit Wales Structured Assessment (2023) for the Trust, the Board intends to ensure the IMTP 2024-27 has increased clarity on what the Trust is seeking to deliver in years two and three.

Conclusion:

2.14 The Trust's Long-Term Strategic Framework, IMTP and associated objectives are aligned to the requirements of the Welsh Government and Commissioners. Although we recognise that the Board has confirmed that the Strategy remains fit for purpose as it approaches its fifth year, the Strategy and Planning Team is looking to undertake an exercise to refresh its stated ambitions regarding the future service model and so we have raised a recommendation to support this. Accordingly, we have assigned **reasonable** assurance to this objective.

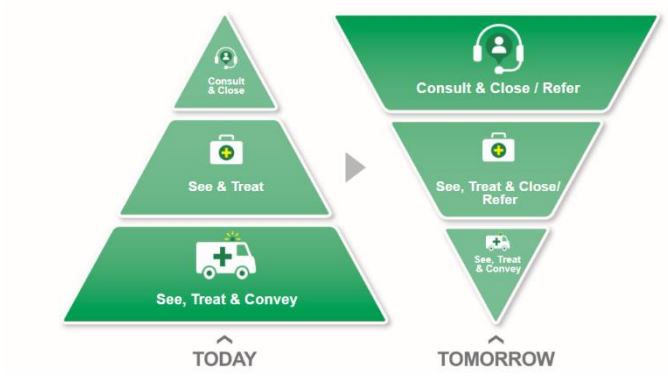
Objective 2: Mechanisms are in place to support the continued development of strategic ambitions.

2.15 As recognised by Audit Wales in their Structured Assessment report, corporately, the Trust has a good approach for developing strategies and plans and there is alignment between the LTS and the IMTP. Appropriate Board scrutiny of those strategies was also evident (see **objective 1** for details on the development of the LTS), and the Strategic Transformation Board (STB) oversees delivery (refer to **objective 4** on the reporting framework in place).

2.16 A high-level review of the LTS was undertaken and reported to the September 2023 Executive Leads away day. A report was also presented outlining progress in delivering the ambitions. Management advised that these sessions are not formally minuted.

2.17 The Strategy and Planning Team's desire to refresh the LTS demonstrates the Trust's ongoing commitment to the continued development of its strategic ambitions. See para 2.5 and **MA1**.

2.18 We note that one of the Trust's main drivers for service change is through the 'Inverting the Triangle' (ITT) model for EMS:



2.19 Noting that this model has been developed in recent years, this is not currently expressly stated in the approved LTS. However, we accept that this aligns to the principles of providing the right care in the right place, wherever and whenever it is needed. We acknowledge that work is continuing to build on the ITT concept and the Trust is starting to develop a broader and more integrated model of care that brings the core services closer together (EMS, NHS111 and NEPTS).

2.20 It is reported that full transformation of the service offer will not be possible in one step noting that this will be a significant change to how the service has operated in recent times. Consultation with PricewaterhouseCoopers (PwC) is ongoing at the Trust for the development of the Strategic Case for Change (specifically the 'Inverting the Triangle' service model).

2.21 We noted that in addition to the LTS, there are a number of other strategies / plans in place at the Trust that need to be aligned to support the achievement of the Trust's strategic aims, including, but not limited to the Clinical Strategy, People and Culture Plan and Digital Strategy.

Conclusion:

2.22 Appropriate mechanisms are in place for the development and ongoing scrutiny of strategic objectives. Consultation for the development of the Strategic Case for Change, including the 'Inverting the Triangle' and the wider integrated service models proposed, is currently ongoing. The Strategy and Planning Team's desire to undertake a refresh of the Long-Term Strategy demonstrates the Trust's ongoing commitment to the continued development of its strategic ambitions. Accordingly, we have assigned **reasonable** assurance to this objective.

Objective 3: There is appropriate involvement and engagement with stakeholders for the identification and communication of service change strategies.

2.23 A stakeholder engagement document for the long-term strategic framework for ambulance services in Wales was issued in 2017. When initially developed, Trust undertook a series of large engagement events across Wales to collaborate with external partners and key stakeholders to identify the opportunities and expectations for the strategy. This included Commissioners, Health Board clinical and management leads, blue light partner organisations and patient/volunteer groups. There was also proactive engagement with the public via a range of events facilitated by the Trust's Patient Engagement and Community Involvement Team. All stakeholders were actively encouraged to share comments and feedback. The Trust captured the feedback in various excel sheets and collated the results in a PowerPoint that informed the strategic objectives in the LTS.

2.24 The Trust also has an Engagement Framework in place that focuses on the Trust's commitment to its LTS and particularly the transformation of emergency medical services. The Board approved the Framework at its July 2022 meeting and the associated delivery plan at its January 2023 meeting.

2.25 The Framework is regularly reviewed and is currently on its third iteration. However, at the November 2023 People and Culture Committee it was reported that *'…the Engagement Framework delivery plan is currently being revised in respect of both timelines and specifics to align with the further emerging broader strategy work (the move from inverting the triangles to transforming care more broadly)'*. See **MA2**.

2.26 It was reported that although timescales have been revised, work was underway to reprofile timescales and provide opportunities for systemised engagement. See **MA2**.

2.27 The Trust is currently working with the Consultation Institute to review its Engagement Delivery Plan to develop this work into a more formal document. A series of workshops are planned up until March 2024. We have been advised that the Trust is currently working to a target of April 2024, at which point, the plan will be complete.

2.28 The following phases are planned under the revised framework:

- Phase 1 - key stakeholder[3] engagement.
- Phase 2 - staff (including trade unions) / volunteer engagement.
- Phase 3 - pre-engagement public.
- Phase 4 - engagement on options.
- Phase 5 - consultation on preferred option (*note: at the date of reporting, no explicit decision had been made if 'formal consultation' is required*).

2.29 Wider stakeholder engagement is undertaken via a number of different Boards / Groups which support delivery of the strategy, taking forward key initiatives / improvement actions, including:

- EASC Committee and EASC Management Group;
- 111 Programme Board;
- Welsh Government Six Goals for Urgent and Emergency Care;
- Integrated Commissioning Action Plans (ICAPS) with health boards;
- Community Health Councils (Llais); and
- Representation at most Regional Partnership Boards.

2.30 A workshop was held in November 2023 with members of staff to discuss the Strategic Case for Change, including the 'Inverting the Triangle' service model and also the potential opportunities for the wider integration of services. Employees also had the opportunity to learn more about what the Trust is doing moving forward and what it is looking to achieve at the recent CEO Roadshows.

Conclusion:

2.31 Engagement with stakeholders for the identification and communication of service change was evident for the Trust's Long-Term Strategy at several consultation events held throughout Wales. Noting that there have been delays to the delivery of the engagement framework delivery plan, and the uncertainties around its delivery, but recognising that the Trust is currently working to a target date of April 2024 for completion of its Engagement Framework, we assign this objective as providing **reasonable** assurance.

Objective 4: There is regular monitoring and reporting of strategy development status, and it is subject to appropriate review and scrutiny.

2.32 There is a defined reporting framework in place at the Trust. The STB maintains a focus on strategic ambitions, overseeing and managing the implementation of the strategic framework. See **Appendix B**.

[3] Stakeholders include Health Board partners (including clinical and management leads from unscheduled care, primary and community services), Public Health Wales, Community Health Councils, Local Authority Partners, representatives from the Voluntary Sector, Welsh Government, Older People's Commissioner for Wales, Children's, Future Generations Commissioners and 'Blue Light' partners.

2.33 It is accountable to the Finance and Performance Committee and focuses on assuring IMTP delivery and its alignment with the LTS.

2.34 The Finance and Performance Committee receives quarterly IMTP progress updates, including the status of each delivery programme. We note that the report contains details, including the status of the actions, progress made since the previous report as well as work to be completed. The most recent report highlighted that the status of the IMTP delivery and enabling programmes are rated amber or green / amber.

2.35 We also noted that item 424 at the Trust's corporate risk register – *Prioritisation or availability of resources to deliver the Trust's IMTP* is currently RAG rated 'red'. It is reported that '*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.'*

2.36 There are a number of Programme Boards sitting under STB. These coordinate the below strategic delivery programmes and provide quarterly written assurance reports, including progress against agreed delivery milestones:

- EMS Operations Programme;
- Ambulance Care Programme;
- Clinical Transformation Programme;
- Gateway to Care Programme; and
- Financial Sustainability Workstreams.

2.37 In addition to the STB, a Transformation Steering & Assurance Group (TSAG) has been embedded to oversee delivery of the EMS service level strategy 'Inverting the Triangle'.

2.38 An Integrated Strategic Planning Group is also in operation. This Group provides an internal mechanism to bring together intelligence from engagement with health boards via ICAPs and other associated work streams into the organisation which help to drive delivery of aspects of the strategy and service transformation.

2.39 Periodic Board Development sessions are held with Non-Executive Directors (NEDs) and the Executive Management Team (EMT). Strategy forms a key area of focus and discussion at these sessions.

2.40 We noted that a review of the governance arrangements for STB and the transformation programmes was undertaken during quarter 4 of 2022/23 to identify opportunities to strengthen and improve their functioning. The following groups were disbanded following the review:

- The Board Strategic Advisory Group, established in 2021 with the aim of providing dedicated 'informal thinking and discussion space'. No terms of reference were developed for this former group; and

- The Strategy Development Working Group which was established to allow for strategic discussion. We were advised that following four cycles of meetings, it was determined that this group duplicated the work of other groups / boards.

2.41 The Trust plans to transition to a strategic Board Assurance Framework that reflects more closely the Trust's strategic objectives against its LTS. We have also noted a commitment to alternate the order of the STB agenda between 'Strategic Forward View' and 'IMTP Programme Delivery'. This demonstrates the intention to focus on the Trust's commitment to deliver its LTS by 2030, in addition to its short-term obligations as outlined in its IMTP. The planned refresh of the LTS (see **MA1**), could present an opportunity to highlight progress against the ambitions and outcomes to date. See **MA3.**

2.42 Many of the IMTP deliverables are being managed through the Trust's main service focused programmes (IMTP Delivery Programmes). Benefits and associated measures of success for key programmes of work / objectives are outlined in the IMTP.

2.43 However, there may be an opportunity to further review and refresh how the Trust measures and reports progress on an ongoing basis. This is consistent with the Audit Wales Structured Assessment report which highlighted that reporting tends to focus on the status of actions; noting that there are opportunities to enhance the report to understand whether these are having the intended impact in terms of outcome achievement. A draft 'benefits realisation plan' is in development. This process is to be embedded and undertaken across all programmes / work streams. This exercise remained ongoing at the time of audit. See **MA3**.

2.44 We also noted one instance in April 2023 where there was an issue with the sign off of a report at the STB due to the meeting not being quorate. The work around for this to avoid further delays was to circulate the reports to individuals outside of the meeting to obtain sign off virtually.

2.45 In respect of reporting arrangements, we note that Strategy Highlight Reports are issued frequently (every six weeks) by the Strategy Team. These reports include updates on the EMS Transformation Programme ('Inverting the Triangle' service model).

Conclusion:

2.46 Internal monitoring and reporting controls are in place for providing assurance at the Trust, however we considered that the completion and embedding of the benefits realisation plan would enhance monitoring arrangements at the Team. Reporting of performance issues and outcomes would be beneficial and could be implemented alongside the proposed refresh of the LTS. Accordingly, we have provided **reasonable** assurance in this area.

Appendix A: Management Action Plan

Matter Arising 1: Review of the Long-Term Strategy (Operation)	Impact
The Trust developed its Long-Term Strategy (LTS) 'Delivering Excellence Our Vision for 2030' in 2017/18, in line with Welsh Government requirements to have a strategic document setting out their longer-term ambitions. Regular high-level reviews of the LTS have taken place at the Strategic Transformation Board. Noting that broad objectives were outlined in the Strategy, the Trust has reviewed and reconfirmed its commitment to these at a recent Board Development session. However, noting that the LTS is approaching its fifth year, the Strategy and Planning Team considers that a refresh at its mid-point would be beneficial to account for developments that have occurred since Covid, the recent development of the 'Inverting the Triangle' service model, and the wider integrated model proposed which would also include EMS (Emergency Medical Services), NEPTS (Non-Emergency Patient Transport Services) and Integrated Care (111 and the clinical support desk).	Potential risk of: • Strategic ambitions are not met as the Long-Term Strategy does not reflect current practices and developments.

Recommendations		Priority
1.1	A refresh of the Long-Term Strategy shall be considered, clearly outlining the aspects of the long-term strategy that require updating, and specifying the new developments to be included.	**Low**

Agreed Management Action		Target Date	Responsible Officer
1.1	Aligned to the continued development of the future clinical service model taking place in Q1 to Q2, a clear recommendation shall be presented to ELT and respective groups outlining the specific requirements (if required) to refresh the Long-Term Strategy document.	December 2024	Director of Strategy Planning & Performance and Head of Strategy Development/

Matter Arising 2: Engagement Framework Delivery Plan (Operation)	Impact
The Trust has an Engagement Framework in place that focuses on the Trust's commitment to its Long-Term Strategy, and particularly the transformation of emergency medical services. The Board approved the Framework at its July 2022 meeting and the associated delivery plan at its January 2023 meeting. The Framework is regularly reviewed and is currently on its third iteration. However, at the November 2023 People and Culture Committee it was reported that *'…the Engagement Framework delivery plan is currently being revised in respect of both timelines and specifics to align with the further emerging broader strategy work (the move from inverting the triangles to transforming care more broadly)'*. It was reported that although timescales have been revised, work was underway to reprofile timescales and provide opportunities for systemised engagement. The Trust is currently working with the Consultation Institute to review its Engagement Delivery Plan to develop this work into a more formal document. A series of workshops are planned up until March 2024. We have been advised that the Trust is currently working to a target of April 2024, at which point, the Engagement Delivery Plan will be complete. The following phases were planned under the revised framework: • Phase 1 - key stakeholder engagement. • Phase 2 - staff (including trade unions) / volunteer engagement. • Phase 3 - pre-engagement public. • Phase 4 - engagement on options. • Phase 5 - consultation on preferred option (*note: at the date of reporting, no explicit decision had been made if 'formal consultation' is required*).	Potential risk of: • Inadequate involvement and engagement with stakeholders for the identification and communication of service change strategies.

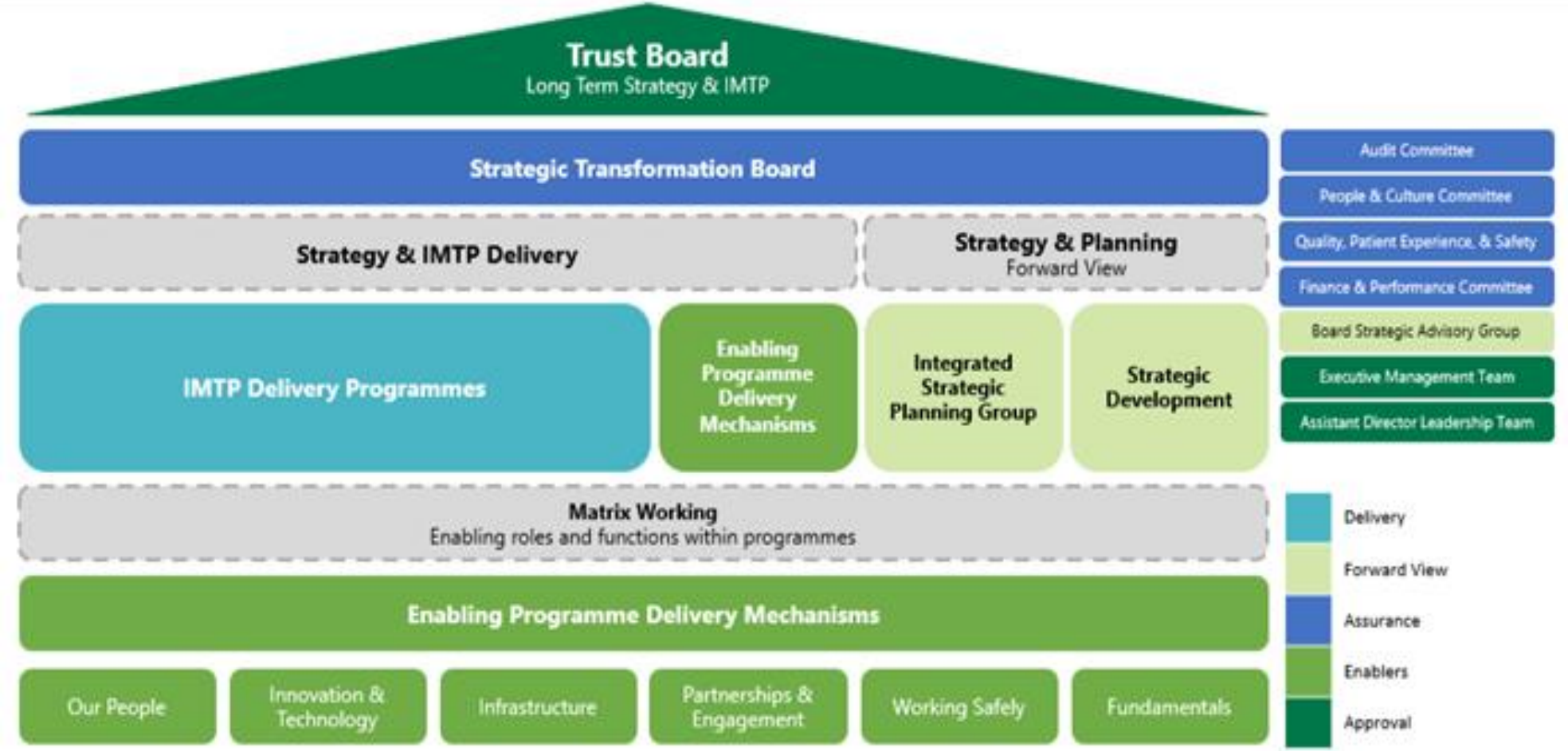
Recommendations			Priority
2.1	The Trust should complete the work to revise engagement framework delivery plan and monitor its implementation.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	1. Continue work with the Consultation Institute and internal leads to revise and finalise the Engagement Delivery Plan. The revised plan will provide further detail of the key phases of engagement, purpose and approach of the engagement activities with re-profiled timescales for delivery.	June 2024	Director of Partnerships & Engagement
	2. Commence implementation of the Engagement Delivery Plan (as per the approach set out and agreed timescales in the revised and approved plan).	June 2024	
	3. Build in clear periods of 'pause and reflect' following each phase of engagement to monitor progress and delivery reporting into TSAG / ELT.	June 2024* *('Pause and Reflect process to continue throughout the lifespan of the Engagement Delivery Plan	

Matter arising 3: Reporting and Monitoring of Delivery and Progress (Design)	Impact
There is a defined reporting framework in place at the Trust. The STB maintains a focus on strategic ambitions, overseeing and managing the implementation of the strategic framework. See Appendix B. It is accountable to the Finance and Performance Committee and focuses on assuring IMTP delivery and its alignment with the LTS. The Finance and Performance Committee receives quarterly IMTP progress updates, including the status of each delivery programme. We note that the report contains details, including the status of the actions, progress made since the previous report as well as work to be completed. The most recent report highlighted that the status of the IMTP delivery and enabling programmes are rated amber or green / amber. The Trust plans to transition to a strategic Board Assurance Framework that reflects more closely the Trust's strategic objectives against its LTS. We have also noted a commitment to alternate the order of the STB agenda between 'Strategic Forward View' and 'IMTP Programme Delivery'. This demonstrates the intention to focus on the Trust's commitment to deliver its LTS by 2030, in addition to its short-term obligations as outlined in its IMTP. The planned refresh of the LTS (see MA1), could present an opportunity to highlight progress against the ambitions and outcomes to date. Many of the IMTP deliverables are being managed through the Trust's main service focused programmes (IMTP Delivery Programmes). Benefits and associated measures of success for key programmes of work / objectives are outlined in the IMTP. However, there may be an opportunity to further review and refresh how the Trust measures and reports progress on an ongoing basis. This is consistent with the Audit Wales Structured Assessment report which highlighted that reporting tends to focus on the status of actions; noting that there are opportunities to enhance the report to understand whether these are having the intended impact in terms of outcome achievement. A draft 'benefits realisation plan' is in development. This process is to be embedded and undertaken across all programmes / work streams. This exercise remained ongoing at the time of audit.	Potential risk of: • The Trust does not achieve the ambitions set out in its long-term strategy; and • The Trust is not able to demonstrate that strategic delivery programmes are having the intended impact.

Recommendations		Priority
3.1	The benefits realisation plan should be completed to facilitate monitoring of progress against the achievement of the ambitions set out in the Long-Term Strategy – Delivering Excellence: Vision 2030.	**Medium**
3.2	The Trust should also consider opportunities to enhance reporting to demonstrate that strategic delivery programmes are having the intended impact in terms of outcome achievement.	

Management response		Target Date	Responsible Officer
3.1	Draft Benefits Realisation Framework underway. To be finalised and approved in Q1/Q2 FY2024/25, in order to facilitate consistent and standardised approach to developing and monitoring of all Trust ambitions, including the Long-Term Strategy – Delivering Excellence: Vision 2030	September 2024	Assistant Director of Planning and Head of Transformation
3.2	1. Undertake a review of the internal programme delivery structures to determine the optimal delivery and monitoring structure. 2. Implement changes to the programme structures (identified following the initial review). 3. Aligned to the Benefits Realisation Plan, respective benefits and outcomes to be mapped and regularly monitored as part of the refreshed programme arrangements	June 2024 September 2024 September 2024	Assistant Director of Planning and Head of Transformation

Appendix B: Governance for Strategy Development



Appendix C: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Retention of Staff

Final Internal Audit Report

February 2024

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-2324-16
Report status:	Final
Fieldwork commencement:	14 November 2023
Fieldwork completion:	22 January 2024
Debrief meeting:	22 January 2024
Draft report issued:	23 January 2024
Management response received:	12 February 2024
Final report issued:	14 February 2024
Auditors:	Osian Lloyd, Head of Internal Audit; Felicity Quance, Deputy Head of Internal Audit; Ross Hughes, Principal Auditor
Executive sign-off:	Angela Lewis, Director of People & Culture Directorate
Distribution:	Liz Rogers, Deputy Director of People & Culture; Julie Stokes, Head of People Services; Peter Brown, Head of Service (111)
Committee:	Audit Committee

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

Acknowledgement:

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

Executive Summary

Purpose

To evaluate and determine the adequacy of the systems and controls in place within the Trust in relation to staff retention.

Overview

We have issued reasonable assurance on this area, noting that the Trust have identified that there were shortfalls in the retention process and are introducing new initiatives across the organisation, including the moving on interview process, to strengthen arrangements.

In response to the attrition rates noted within the 111 service, we have also considered the initiatives that have been implemented to enhance retention.

The matters requiring management attention include:

- Finalisation and ratification of the 'Moving on Interview' process, with a clear timetable for its roll out; and
- Evaluation of the effectiveness of the initiatives that have recently been introduced to improve staff retention;

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

Report Opinion

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

Assurance summary[1]

Objectives		Assurance
1	Strategies and Policies	Reasonable
2	Retention Initiatives and Outcomes	Reasonable
3	Exit Interviews	Limited
4	Reporting and Analysis	Reasonable

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Implementation of the 'Moving on Interview' process.	1, 3	Operational	Medium
2	Effectiveness of initiatives	2	Operational	Medium

1. Introduction

1.1 The retention of staff is a key issue for the NHS. Whilst focus may be given to the workforce supply to create a recruitment pipeline, it is important that both new and existing staff are supported and encouraged to remain with the Trust. Good staff retention levels will be the result of a combination of actions including, for example, supporting new starters, having development and career plans in place and developing organisational cultures and values.

1.2 The Trust's Integrated Medium-Term Plan (IMTP) 2023-26 highlights the following workforce challenges:

- *Focussing on retention of our people to reduce the demand on attracting new candidates.*
- *Maintaining the national 111 service and improving 111 retention.*

1.3 The People and Culture Committee minutes for March 2023 notes that the People and Culture Plan 2023-26 and the Trust's IMTP Deliverables identifies emerging priorities such as building on the employee experience to attract and retain a diverse workforce, developing a recruitment and retention plan that supported all roles in the organisation, and continuing to build an effective employee brand while improving the effectiveness and application of the Trust's internal people processes.

1.4 As highlighted in Audit Wales's Review of Workforce Planning Arrangements report (November 2023): *in line with broader NHS Wales, since the pandemic, the Trust has been experiencing higher levels of turnover within its operations department. The increased turnover was particularly the case with within its 999 and 111 call-answering staff, due to the challenging working environment. The Trust has also seen a general increase in staff leaving within 6-12 months of recruitment.* The Trust is performing mid-table when comparing staff turnover rates across all Health Boards and Trusts in Wales for 2022-23.

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

- The Trust is unable to consistently operate in a safe manner due to insufficient staff;
- Additional costs incurred by the Trust as a result of requiring potential overtime / agency staff or via additional recruitment campaigns;
- Impact on staff morale and wellbeing from increased workloads due to reduction in resource;
- Potential negative impact on the Trusts reputation;
- Continued reduction in the Trusts workforce including loss of key talent, as a consequence of retention issues not being monitored and relevant action not being taken; and
- Failure to capitalise or reap the benefits of development investment in individuals.

2. Detailed Audit Findings

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

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	-	-	-	-
Operating Effectiveness	-	4	-	4
Total	-	4	-	4

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

Objective 1: There are relevant strategies, policies and plans in place to outline the approach to staff retention.

2.3 As per para 1.2, retention of staff is flagged as a workforce challenge within the Trust's IMTP.

2.4 To help address this challenge, the Trust has developed a People & Culture Plan 2023 – 2026 (see para 1.3), approved by Trust Board (May 2023) 'with a commitment to creating an environment that *attracts, retains and develops exceptional talent and expertise*'. The plan focuses on three key areas:

- Culture – the way the Trust achieves its purpose.
- Capacity – the resource needed to achieve its purpose.
- Capability – the skills needed to achieve its purpose.

2.5 The People and Culture Plan includes a high-level action plan where in year 1 it looks to '*build on the employee experience to attract and retain a diverse workforce*.' Targets and milestones to deliver this plan are captured within the Directorate Plan. There are circa 80 actions included and the most recent progress report shows that the directorate is on track to achieve those which relate to staff retention. Monitoring of the progress against the actions is undertaken via the People and Culture Directorate Business meeting.

2.6 For further details on performance metrics to monitor progress against the People & Culture Plan, see audit objective 4.

2.7 The Trust has a 'Policy on Pre-Exit Interviews' available via its SharePoint site. The Policy was approved by the Trust Board in July 2004 and was due for review in July 2007. However, this review had not been undertaken. The review of the policy remained overdue because there was a proposal to develop an all-Wales approach to exit interviews which then did not materialise. See **MA1**

2.8 The People Services Team carried out a deep dive exercise into the exit interview process in September 2022. The outcome of this review highlighted limited data being held and an inconsistent approach applied across the Trust.

2.9 The issues identified were attributed to the following factors:

- Exit interviews are not compulsory and not all leavers want to complete one. (noting they will always be optional).
- Managers do not always approach leavers to complete an exit interview, with no prompts or reminders to do so.
- Exit interviews are paper based and not always shared centrally with the People Services Team by the manager.

2.10 In response to these findings, the Trust has developed a new procedure - the Moving on Interview (MOI) process. This will supersede the Pre-Exit Interview Policy and is intended to provide a better understanding of staff experience (See objective 3 for further details on the Moving on Process). This process encourages meaningful conversations between employees and their line manager; however, employees can also complete the questionnaire independently.

2.11 The MOI process has been piloted in three areas (111 Service and Powys EMS and Hywel Dda EMS), to test and evaluate it before rolling out across the organisation and has incorporated aspects of the People and Culture Plan (see para 2.4). The new procedure will apply to all staff, including those who move internally within the Trust. See **MA1**

Conclusion:

2.12 We note that the current pre-exit interview policy for the Trust has surpassed its review date by some time, however we recognise that steps are already underway to introduce a local Moving on Interview Process noting the lack of progress to develop an approach nationally. The recently implemented People & Culture Plan 2023-2026 outlines the Trust's intentions to retain and develop the workforce and progress is monitored via the People and Culture Directorate Business meeting. We therefore assign **reasonable** assurance to this objective.

Objective 2: Initiatives are in place that align to agreed strategies and plans, and outcomes are reviewed.

Organisation wide initiatives

2.13 As noted above, staff retention is highlighted as a challenge within the Trust's IMTP, particularly since the Covid-19 pandemic, with turnover exceeding 11% for the months between May 2022 and October 2022. The Trust has therefore looked to implement initiatives to improve the retention rate within the organisation. At the date of fieldwork, it was noted that a number of the initiatives are either still in their development stage, being piloted or still in their infancy including:

- **HIVE** – In October 2023, the Trust implemented the use of this software which allows the issue of short surveys to gather quick, confidential, real-

time information on potential challenges or issues within the organisation; allowing remedial action to be taken in a timely manner. To date the Trust has issued and closed one survey, with information being issued to the Organisational Development team for analysis. We acknowledge that the People Service team will assess the impact and benefit of the tool towards the end of the agreement.

- **Cultural Early Warning Score (CEWS)** – The development of a new toolkit for managers which is a cultural health check diagnostic. The toolkit assesses the cultural health of the team based on assigning a high/medium/low rating for sickness levels, wellbeing referrals, turnover rates, formal disciplinaries and other culture, capacity and capability indicators, and will be repeated over time to measure impact on any changes implemented. At present the toolkit is being piloted in Emergency Medical Dispatch and the People & Culture Team with the intention for further pilots in the 111 Service (January 2024) prior to roll out across the organisation by the new financial year.

2.14 Established mechanisms that have been running for a number of years include:

- **CEO Staff Roadshows** - The Trust has put on multiple roadshow events across Wales where the Trust's employees have the opportunity to engage with the Executive Team face-to-face to learn more about what the Trust is doing moving forward and what it is looking to achieve. The latest roadshow was held in November 2023 with circa 420 staff members registered to attend; and
- **WAST Live** - Staff can pre-submit questions to the Executive Team, which are then answered via a live stream. It also updates staff across the organisation on important issues, priorities, performance, challenges and subjects of interest.

2.15 We also acknowledge that the Trust have a number of other interventions, organisation-wide, to help support retention of staff, including culture reviews within individual teams; Freedom to Speak Up Safely; Sexual Safety Guiding Principles; Occupational Health support; and compassionate practices. We have, however, not reviewed these initiatives in detail during the course of our fieldwork.

<u>111 Service Initiatives</u>

2.16 During discussions with the senior staff within the Trust, we were informed that the 111 service has historically been an area with higher staff turnover levels. The Head of Service has undertaken work to support staff and improve retention within the service and we sought to determine the impact of such during the course of our fieldwork.

2.17 **111 Conversations** - Senior Management throughout the Trust shadowed 111 call handlers for initial 111 conversations (165 in total by the end of the initiative) to better understand the challenges being faced in their role. The conversations gave the call handlers an opportunity to relay issues, concerns or suggestions which would impact the longevity of their employment with the service.

Improvements implemented to date include around the working environment, culture, staff rosters and clearer career progression structures.

2.18 **Our Shared Success Framework** - a recommendation that came from the 111 conversations was that the employees wanted to know if they were doing a good job. Weekly face-to-face meetings between the call handler and supervisor are now held to review performance against a framework of indicators created by the service.

2.19 **Investment in Individuals** – to address the trend of staff leaving within 6-12 months with reasons cited including the poor quality of upfront training or to seek further education for a more clinical setting (nursing), the 111 service has introduced an initiative that gives the opportunity to acquire a NVQ in dealing with contact centre operations via Gower College. This allows career pathways to be built within the Trust. Management also advised that improvements have been made to initial training so that employees are better aware of the role and its requirements from the outset.

2.20 **111 Clinicians** – a deep dive (June 2023) into attrition levels noted that many clinicians left their post within 6 months of employment due to a lack of support after induction; they missed face-to-face contact with the patients; and there were issues with rostering. To address these issues, changes have been made including implementation of a new clinician framework of support, development and continued learning; a blend of observation shifts or rotational roles; increase in Continued Professional Development (CPD) - including the opportunity of undertaking postgraduate qualifications (MSc / PhD); and the introduction of an 'Academic Corner' in contact centres and on SharePoint, featuring academic achievements, advice, support and guidance.

2.21 It was noted that the majority of these initiatives are currently within their infancy and at this moment in time it is too early to undertake analysis to ascertain their effectiveness in retaining staff. However, there will be benefit to the Trust in completing this exercise in due course. See **MA2**

Conclusion:

2.22 The Trust has a number of initiatives in place to improve the retention of staff, however we recognise that many are currently being piloted or in their infancy and will take time to fully embed. From the review of the work undertaken, to date, within the 111 service we can see that these are having a positive effect, especially with the call handlers and clinicians; and consideration should be given to replication Trust-wide. Therefore, we assign **reasonable** assurance to this objective.

Objective 3: There is an effective leavers process in place that is clearly defined and there are tools available to support managers to process a leaver.

2.23 As outlined in objective 1, the Trust undertook a deep dive into its current Pre-Exit Interview policy. The exercise identified only 8% of leavers, during the timeframe reviewed, had shared a pre-exit interview centrally, meaning no meaningful

analysis could be undertaken to better understand the reasons for leaving. It was highlighted that this doesn't necessarily mean exit interviews were not undertaken and held locally. It was also noted that the pre-exit interview forms were paper based so any analysis that could be undertaken had to be done manually, which is inefficient and time consuming.

2.24 The Trust has therefore modernised its approach to engage with leavers, via the 'Moving on Interview' (MOI) process (see para 2.10). An electronic questionnaire has been created via Microsoft Forms which, on completion, is issued centrally to the People Services Team who can then share with the relevant team / manager as appropriate.

2.25 The questionnaire forms the basis of engagement work and to help understand the employees' experience throughout their employment with the Trust. The main areas of focus within the questionnaire are: 'Learning and Development', 'Working Relationships', 'Wellbeing' and 'Equality Monitoring'.

2.26 Individuals are encouraged to complete the questionnaire with their manager. Due to the form being electronic, they also have the option to do so by themselves and anonymously if preferred. The form can be accessed via a desktop or on a smart device via a QR code.

2.27 The data collated from the pilot scheme (see para 2.11) which took place between February and July 2023 highlighted an increase in the return rate from 8% to 56%. During the pilot the Trust's People Services Team had to manually collate the data to produce analysis within a highlight report.

2.28 The highlight report focused on the main themes and trends raised by leavers, whether leaving the Trust or moving to a new role within the organisation. This included pursuing further education, career development and progression, mental health and wellbeing, and shift patterns, and was presented to the August 2023 People and Culture Committee (see objective 4 below).

2.29 Going forward, the Trust has secured support from Digital Health and Care Wales (DHCW) to create a dashboard that will form the basis of ongoing regular reporting. We understand that the production of the dashboard will be automated, avoiding the time and effort involved with collating the data manually, and that DHCW are also looking to incorporate functionality that will allow individual directorates to analyse data specific to them, thus allowing the Trust and individual directorates to undertake proactive actions towards making the Trust a more attractive place to work and therefore reduce staff turnover. We were informed at the date of fieldwork closure that the dashboard has been developed and will be available imminently. We have therefore not raised a recommendation on this basis.

2.30 To assist in the development and implementation of the MOI process, the People Services Team has created an action plan. Whilst our review confirmed that it outlined the required actions and responsibility, it was noted that timescales for its roll out across the Trust have yet to be set. **See MA1**

2.31 As noted under audit objective 1, prior to the MOI process being rolled out across the Trust, the People Services Team is creating a process and guidance document

to guide managers and staff when completing the MOI. We were informed that the document will also include a link to 'working in confidence' which will allow the user to share any issues or concerns around harassment or bullying that the individual might not feel comfortable discussing in the MOI. In addition to the document, the team are also looking to create bitesize training sessions for managers and a FAQ document to support the process. **See MA1.**

Conclusion:

2.32 Although the new MOI process has yet to be implemented across the Trust, with no set date for its rollout, we recognise that positive steps have been taken in introducing the process to the organisation. The intention is that the new process will modernise exit interviews for leavers and supply the Trust with increased data for analysis to identify any trends or issues. However, noting that the process has currently only been piloted across three areas and managers' training has yet to be developed, we assign **limited** assurance for this objective.

Objective 4: Data is collected and analysed in relation to staff turnover rates plus other relative data such as exit interviews, PADR compliance, and staff engagement and staff surveys. The outcomes of which are analysed and reported on to facilitate effective monitoring of staff retention trends.

2.33 As noted under audit objective 3, to date, data from the pilot MOI process has been collated and analysed manually by the People Services Team; with the development of an automatic solution being undertaken by DHCW.

2.34 A review of People & Culture Committee (P&CC) papers identified that an Integrated Quality & Performance Report (MIQPR) is issued to each Committee meeting, as well as the Finance and Performance Committee and Board meetings. Part of the MIQPR focuses on Health and Wellbeing of the employees within the Trust including sickness absence indicators, staff turnover rates, equality and diversity, statutory & mandatory compliance and PADR completion.

2.35 In addition to the MIQPR, the following reports have been presented to P&CC:

- November 2022 – report on Exit Interviews
- May 2023 –update on the MOI process.
- August 2023 - a cultural themes and trends report, which provided analysis of the data from the MOI pilot.
- November 2023 – first quarterly People and Culture Plan metrics update providing a high-level indication of the impact of the plan under its three core headings (culture, capacity and capability). The report includes metrics on staff survey completion, staff turnover and PADR compliance.

2.36 In addition, we were informed that staff turnover rates are presented at the Executive Leadership Team. The Trust is also in the process of developing directorate level scorecards which will include a summary of key workforce metrics, in line with an action included in the Quality & Performance Management Framework work plan. The Workforce Transformation and Planning Team has

recently developed a highlight report on workforce data which is shared via the Integrated Technical Planning Group, and People Business Leaders are also available to support and provide further information to Directorates as requested.

2.37 The Audit Wales Review of Workforce Planning Arrangements report highlighted that: *The Trust does not routinely benchmark its workforce performance metrics with other health bodies in Wales. Its performance benchmarking with other ambulance trusts is infrequent. The Trust should introduce regular workforce benchmarking with similar organisations and use this to inform relevant groups and committees on its performance and efficiency and to identify and share good practice.* We have therefore not raised a recommendation at this report.

Conclusion:

2.38 There is sufficient reporting on turnover rates within the Trust, including via the People and Culture Committee, with a further introduction to the reporting recently via the People and Culture Plan Metrics report. The Trust is also in the process of producing directorate level scorecards and has recently developed workforce highlight reports. As recommended by Audit Wales, the Trust should undertake more regular benchmarking of its workforce performance metrics with similar organisations. We therefore assign **reasonable** assurance to this objective.

Appendix A: Management Action Plan

Matter Arising 1: Implementation of the Moving On Interview Process (Operation)		Impact
The Trust's Pre-Exit interview policy was due to be reviewed in July 2007, however, this was not undertaken due to work being undertaken to implement an All-Wales approach. Due to lack of progress at a national level, the Trust undertook a deep dive into the process, from the results the Trust is looking to introduce a new 'Moving on Interview' (MOI) Process to supersede the policy. The MOI has been piloted in three areas of the Trust (111 Service and Powys and Hywel Dda EMS), but from review of the action plan created by the People Services Team, there is no clear timescale in which the process will be rolled out more widely across the organisation. This was in part reliant on external support to develop dashboard reporting which we understand will be made available imminently. The Team is also looking to create bitesize training sessions for managers and a FAQ document to support the process.		Potential risk of: • Continued reduction in the Trust's workforce including loss of key talent, as a consequence of retention issues not being monitored and relevant actions not being taken.
Recommendations		**Priority**
1.1	The 'Moving on Interview' process should be finalised and approved in accordance with Trust procedure.	**Medium**
1.2	The Trust should identify and confirm a clear timescale for the roll out of the 'Moving on Interview' process across the organisation.	
1.3	The Trust should look to develop an appropriate training package to assist managers in the use of the new Moving on Interview Process.	

Agreed Management Action		Target Date	Responsible Officer
1.1	The structure of the interview will be finalised shortly. The team are still exploring opportunities to generate automatic triggers for managers and staff rather than relying on managers remembering to ask a colleague to complete.	31 March 2024 30 June 2024	Deputy Director of People and Culture
1.2	Dates will be added to the action plan	31 March 2024	Deputy Director of People and Culture
1.3	Guidance for managers on using the process developed and signed off	30 April 2024	Deputy Director of People and Culture

Matter Arising 2: Effectiveness of Retention Initiatives (Operation)			Impact
The Trust has introduced a number of initiatives in place to improve the retention of staff. At the date of fieldwork, it was noted that a number of these are either still in their development stage, being piloted or still in their infancy. As a result, it is too early to undertake analysis to ascertain the effectiveness of the initiatives in retaining staff.			Potential risk of: • Continued reduction in the Trusts workforce including loss of key talent, as a consequence of retention issues not being monitored and relevant actions not being taken.
Recommendations			**Priority**
2.1	The Trust should undertake, and report to an appropriate forum, an evaluation of the initiatives introduced to determine their impact and effectiveness in retaining staff.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	An evaluation report will be developed in association with the 111 senior team. It is noted that not all initiatives are appropriate for other areas of the organisation based on role types, culture differences and different pressures.	30 September 2024	Deputy Director of People and Culture & Head of Service 111 Wales

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

NHS 111 Wales Service Commissioning Arrangements

Final Advisory Review Report

December 2023

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-2324-04
Report status:	Final
Fieldwork commencement:	2 October 2023
Fieldwork completion:	7 November 2023
Draft report issued:	10 November 2023
Draft report meeting:	14 November 2023
Management response received:	12 December 2023
Final report issued:	13 December 2023
Auditors:	Osian Lloyd, Head of Internal Audit; Felicity Quance, Deputy Head of Internal Audit; Lisa Harte, Internal Audit Manager
Executive sign-off:	Rachel Marsh, Executive Director of Strategy, Planning & Performance
Distribution:	Hugh Bennett, Assistant Director of Commissioning & Performance
Committee:	Audit Committee

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

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

Executive Summary

Purpose	The objective of this review was to assess the effectiveness of the new commissioning arrangements and structures for the NHS 111 Wales service, to ensure there is a sustainable and improved patient quality experience provision with appropriate resourcing and finance mechanisms.
Report opinion	This is an **advisory review** therefore we have **not provided an assurance rating**. We have identified learning and provided suggestions for opportunities to strengthen and improve the current commissioning arrangements (see Appendix A). Limitations to the scope of our review and associated risks are detailed in Appendix B.

Overview

The arrangements put in place for the national NHS 111 Wales service are still evolving and the improvements identified as part of the review will assist in strengthening the current framework for delivery but will also provide focus when inputting into the design of arrangements effective from April 2024 (see para 1.5). Putting in place a robust mechanism to capture post-implementation learning will form a key aspect of this to confirm that the expected outcomes and benefits have been achieved, and identify any lessons learnt.

Roles and accountabilities of partners are currently unclear within the latest draft version of the National Collaboration Agreement, which remains unsigned by the Trust. We have been unable to obtain a copy of the previous signed version, to confirm responsibilities, escalation and funding arrangements, or the finalised versions of the terms of reference to clarify roles and responsibilities for the Joint Operational & Performance Group, Finance Group or National Urgent Primary Care GP (OOH) Forum.

A governance structure for NHS 111 Wales has been established and we have evidenced an appropriate level of discussion and scrutiny of agenda items has been undertaken from our review of meeting minutes. Enhancements noted to further strengthen arrangements include ensuring that there is effective oversight of key discussions arising within the groups and forums in the structure; providing clarification on the process where matters should be referred to for escalation; and putting in place a robust mechanism to ensure that conflicts of interest are appropriately declared and recorded.

There is frequent performance reporting on the NHS 111 Wales service delivery to Welsh Government, the Trust's Board and its various committees; and opportunities have also been identified to strengthen reporting of the commissioning arrangements, including to the Strategic Transformation Board. Within the NHS 111 Wales governance structure, to comply with the Commissioning Framework, the Trust supplies a provider report and monitors progress on the commissioning intentions (see Appendix C). During quarter 4, the Trust is due to report progress against the care standards and core requirements and work is ongoing to develop national quality indicators.

Review of the NHS 111 Wales commissioning arrangement has noted that it would benefit from having a designated strategy to assist with developing a sustainable service provision, which would help to enable the appropriate identification of longer-term funding. Currently, key areas such as the roster review (to assess the demand and capacity of the service) and the website development have been impeded due to a lack of funding and resource. However, we note that development of the strategy is the responsibility of the Commissioner.

Key strategic, financial, and reputational risks have been identified and are escalated appropriately, but the commissioning risks that are recorded on the Trust's Corporate Risk Register need to be amended to incorporate the NHS 111 Wales commissioning arrangements.

1. Introduction

1.1 During 2015/16, NHS Wales, supported by Welsh Government, confirmed their intention to collaborate and implement a NHS 111 Service across Wales. A 111 National Programme Board oversaw the implementation of the model, which integrates the telephone service provided by NHS Direct Wales (a core service of the Welsh Ambulance Services NHS Trust ('the Trust')) and Urgent Primary Care (GP out-of-hours) provided by health boards. The national rollout of the programme was completed in March 2022.

1.2 Now the national NHS 111 service has been fully implemented across Wales, a new commissioning framework ('Quality & Delivery Assurance (Commissioning) Framework') has been developed, which details the role of the Trust, as a provider organisation, in the delivery of the NHS 111 Wales services, e.g. call handling and clinical assessment functions. It aims to improve the delivery of urgent primary care by providing a single access point to help patients get urgent help when they need it, as well as reducing service inefficiency and improving access to health information and advice. Quality & Delivery standards have been designed to provide assurance on the service quality provided.

1.3 The NHS 111 Wales Service is closely aligned to Goal 2 (signposting people with urgent care needs to the right place, first time) of the Welsh Government's 'Six Goals for Urgent and Emergency Care 2021-2026' ('Six Goals Programme'). The Programme aims to support improvement in the urgent and emergency care system and contributes to the delivery of the Minister for Health and Social Care's priorities.

1.4 The Trust's Integrated Medium-Term Plan (IMTP) 2023-2026 sets out in strategic objective 1 ('for providing the right care or advice, in the right place, every time') the need to focus on improving clinical metrics and patient experience within NHS 111 Wales. This includes setting out a clear 'quality & delivery commissioning framework' for the service, improving performance and patient experience, and continued development of the 111 Wales website.

1.5 A review commissioned by Welsh Government ('*Independent Report into a review of National Commissioning Functions*' May 2023), concluded that the national commissioning arrangements currently undertaken by the Welsh Health Services Commissioning Committee (WHSCC), The Emergency Ambulance Services Committee (EASC) and the National Collaborative Commissioning Unit (NCCU) should be combined into a single entity and form a single Joint Committee. While the NHS 111 Wales Service commissioning arrangement was not part of the original scope, the review recommended that the new body should be responsible for commissioning this service. The Trust's Chief Executive is on the NHS Implementation Board to provide input on the development of new arrangements.

2. Detailed Audit Findings

Objective 1: There is an appropriate framework designed for the commissioning arrangement that covers the aims, principles and outcomes that will be achieved, the roles and accountabilities of each partner; and is adequately supported by procedures.

2.1 A Quality & Delivery Assurance (Commissioning) Framework for the NHS 111 Wales service has been approved by both the National Director (NHS 111 Wales) and the Trust's Chief Executive. This details the objectives and principles of the NHS 111 Wales Service, provides an overview of governance arrangements, but is primarily focused on outlining the performance mechanisms for providing assurance on the quality of service provided.

2.2 The Commissioning Framework refers to the National Collaboration Agreement (the Agreement) that was developed to support the rollout of the NHS 111 Wales National Programme across health boards. It details that the Agreement, "*sets out principles of collaboration, roles and responsibilities for NHS Wales organisations who deliver elements of NHS 111 Wales.*" Partners were initially given until March 2023 to provide feedback on the revised version of the Agreement with the expectation that the Interim NHS 111 Wales Board would approve the finalised version in May 2023.

2.3 Terms of reference for the Interim NHS 111 Wales and Urgent Primary Care (Out of Hours) Board detail that one of their core delivery priorities is, "*ensure an 'NHS 111 Wales National Collaboration Agreement' for NHS 111 Wales is agreed by all stakeholders.*"

2.4 The Trust has not signed the latest version as more clarity was needed in relation to roles and responsibilities; and we were unable to obtain a copy of a previous signed version of the Agreement to confirm roles and accountabilities of each partner. The latest version of the Agreement has been discussed with the Commissioners and also at Executive Leadership Team (ELT) in April 2023, but it has not been amended (see **Matter Arising 1**).

2.5 The commissioning arrangements did not require any specific documented policies and procedures to be put in place, but a core requirement of the Commissioning Framework is for the Trust to ensure that "*policies and procedures are in place to support staff in the carrying out their duties*". From our review of the SharePoint intranet site, three operational procedures have missed their review dates (Clinical Safety Plan - due 21/05/22; Fire Evacuation Procedure 111 NHS Wales VPH 1st Floor Clinical Contact Centre – due 18/11/22; and a Standard Operating Procedure for the Management of NHS Direct Wales/111 Service and Ambulance Calls during Planned System Outage or System Failure - due 11/07/21). There were also three business impact analysis documents (for business continuity planning within the NHS 111 Wales) dated February 2017 that did not detail a review date.

2.6 The Head of 111 Service confirmed that two of these operational procedures were currently being reviewed (Clinical Safety Plan and Fire Evacuation Procedure), but

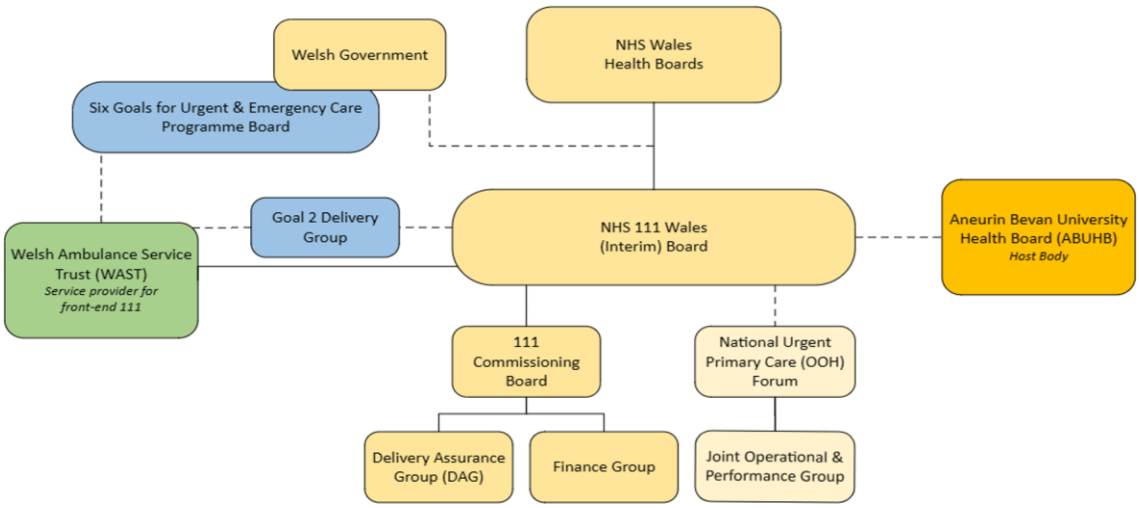
the other documents were no longer 'live' (see **Matter Arising 2**). The Operations Directorate have recently put in place a document tracker to record the review dates of key procedures to strengthen arrangements going forward. We note that policy reviews have been impacted by the Covid-19 pandemic across the Trust.

2.7 It remains early days in terms of embedding the NHS 111 Wales commissioning arrangements, and while there have been opportunities to reflect through Board development days and inputting into the independent review commissioned by Welsh Government, there is no robust mechanism to capture post-implementation learning including the views of operational staff involved (see **Matter Arising 3**). This would be beneficial in terms of focussing on the development of the new arrangements that will take effect from April 2024 (see para 1.5).

Objective 2: Decision-making structures are clear and transparent, with due regard given to potential and perceived conflicts of interest which risk compromising the integrity of decision-making.

2.8 The Commissioning Framework details the following governance structure for NHS 111 Wales:

NHS 111 Wales Governance Structure



2.9 The revised version of the draft Agreement also details the above governance framework, but only includes as appendices the draft terms of reference for some of the boards and forums. We have not been able to obtain finalised versions of the terms of reference for the Joint Operational & Performance Group, Finance Group or National Urgent Primary Care GP (OOH) Forum (see **Matter Arising 1**). While we understand that the Trust does not have responsibility for the administration of governance arrangements, it should ensure that it has received finalised versions of terms of reference to clarify roles and responsibilities and ensure appropriate oversight.

2.10 Our review focussed on the commissioning element below the NHS 111 Wales (Interim) Board (111 Commissioning Board, Delivery Assurance Group (DAG), and Finance Group). The level of discussion and scrutiny of agenda items was evident from our review of meeting minutes for both the 111 Commissioning Board and DAG. Meeting minutes are not taken for the Finance Group, so we are unable to ascertain the key outcomes arising from their discussions (see **Matter Arising 4**).

2.11 The 111 Commissioning Board receives regular updates on the financial position and commissioning arrangements, and DAG reporting included performance and workforce metrics and complaints, but at some meetings, there were verbal updates provided rather than written reports due to staff pressures, which would need to be approved by the Chair. However, we note that arrangements are embedding, and written reports are increasingly being provided.

2.12 Governance arrangements could be strengthened by providing clarification on the process where matters should be referred to for escalation. The draft Agreement details escalations and disputes, but this version remains unsigned (see para 2.4). Terms of references for the groups and forums, that were available for audit review, do not cover the escalation process although DAG carries out regular highlight reporting to the 111 Commissioning Board that provides an opportunity to capture this information (see **Matter Arising 4**).

2.13 There is also no process for dealing with perceived conflicts of interest to ensure that they are declared appropriately and recorded. The independent review commissioned by Welsh Government (see para 1.5) identified that some Chief Executives were placed in a difficult position of being both a commissioner and provider and therefore have a potential conflict of interest. The independent review recommended that substantive declarations of interests should be stated at the start of committee meetings where issues could directly affect the organisations involved. Therefore, we have not replicated a recommendation in this report. There is a similar issue within the NHS 111 Wales service commissioning arrangement noting that Aneurin Bevan University Health Board continues to host the National 111 team as commissioner, but also provides the Clinical Support Hub. This will be addressed by the new commissioning body being in place from next year.

Objective 3: 111 commissioning arrangements are being reported on and embedded within the Trust core processes, e.g. IMTP

2.14 Elements of the NHS 111 Wales Service form part of the remit of several executive directors within the Trust. A RACI (Responsible, Accountable, Consulted, and Informed) document is in place to detail roles and responsibilities amongst executive directors for activities within the service. The Executive Director of Strategy, Planning & Performance is responsible for the commissioning arrangement and the collaboration agreement (roles and responsibilities and schedules).

2.15 Commissioning arrangements have been detailed within the Trust's IMTP 2023-26, which refers to the Commissioning Framework. Trust Board reporting (27 July 2023) also noted that the new governance arrangements began in May 2023.

2.16 The Commissioning Framework details commissioning intentions (see Appendix C) that have been designed to deliver service improvements and these were shared with the Gateway to Care Programme Board (that reports into the Strategic Transformation Board) in June 2023. A report was submitted to Finance & Performance Committee (18 September 2023) on the outcome of the national review of commissioning functions (see para 1.5).

2.17 However, while there is frequent reporting to the Trust Board and various committees on risks and the performance metrics with the NHS 111 Wales service delivery, progress with delivering the commissioning arrangements has only been reported if it forms part of the IMTP delivery. The plan was for the commissioning intentions to be included in quarterly reporting to the Strategic Transformation Board (STB), but this has not always happened and is recognised as an area for improvement (see **Matter Arising 4**). Management has advised that proposed annual reporting for 2023-24 will incorporate compliance with the standards and commissioning intentions.

Objective 4: Performance is monitored appropriately with clear standards and benchmarking.

2.18 The Commissioning Framework details the quality assurance arrangements for assessing service delivery, including the commissioning intentions; care standards and core requirements provide assurance on the quality and safety of service delivery.

2.19 Commissioning intentions (see Appendix C) are reported quarterly to DAG and the 111 Commissioning Board. The latest progress report (October 2023) detailed 18 actions with none having a red RAG status; 8 recorded as amber; 9 green; and one action had been closed. Of the amber rated actions, four had missed their timescales and these were impacted because of delays with the system implementation or roster reviews. We note that the commissioning intentions for 2024-25 have been drafted and are currently with the Trust for consultation.

2.20 The Trust is due to report progress against the care standards and core requirements during Quarter 3 using the self-assessment templates provided although this has been postponed until Quarter 4 due to staff capacity issues. Additionally, there is also a bi-monthly 111 WAST provider report. The latest report (20 September 2023) provides the 111 Commissioning Board with an overview of current quality and performance within the service. Key reporting points note that call answering performance was improving but highlighted concerns about capacity and service resilience into the winter. The report also details that a 111 Measures Task & Finish Group has been established, with representation from the Six Goals Programme, the Trust and Digital Health and Care Wales (DHCW) to focus the development of National 111 Quality Indicators as required by Welsh Government. As work is ongoing to take this forward, we have not raised a recommendation.

2.21 Welsh Government representatives attend the NHS 111 Wales (Interim) Board as well as the bi-monthly Integrated Quality, Planning and Delivery (IQPD) meeting where performance and service developments are discussed. There is also regular

oversight and monitoring of performance within the NHS 111 Wales service through reporting to the Quality, Patient Experience & Safety Committee (QuEST), People & Culture Committee, Performance & Finance Committee, and the Board.

2.22 The report presented to QuEST (31 October 2023) outlined progress with performance in August and September 2023:

Top Monthly Indicators	Target 2023/24	2 Year Average	August 2023	September 2023	RAG
NHS 111 Call Handling Abandonment Rates	<5%	15.0%	3.2%	3.4%	G
111 Clinical Triage Call Back Time	90%	96.7%	99.2%	99.0%	G
NHS 111 % of Total Calls Answered in Welsh	Increasing Trend	0.44%	0.92%	0.88%	G
NHS 111 Dental Calls	To Be Determined	5,877	7,603	6,750	TBD

2.23 The report also noted that staff sickness absence reduced within the service, continuing a longer-term trend in this direction; and 65.4% of calls were answered within 60 seconds during September 2023, although this remains significantly below target (95%). The following remedial actions were identified to address this:

- The Commissioners have agreed to fund 198 WTE call handlers in 2023/24 but is currently 21.25 FTE short of establishment. The Trust is aiming to address this in quarter three.
- Improving sickness absence in line with an IMTP aim of reducing to 6%.
- Carrying out a roster review, in collaboration with the 111 commissioners, to ensure that capacity is aligned to demand, but the review has been impacted by funding.
- Reviewing the use of the Clinical Advice Line (for call handlers requiring clinical advice while on a call to the patient).

2.24 Evidence was provided of regular performance reporting operationally, e.g., there is a fortnightly group that reports into the Operations Directorate Performance Group, which replicates the information reported to the various committees. A Learning Experience Group has recently been established to enable further analysis of performance data and to identify themes and trends and the performance framework is currently being revised.

2.25 A revised audit tool has been developed to monitor the performance of calls and the quality of the advice provided, but, at the date of audit fieldwork, had not been implemented. Management advised they were awaiting a decision on the 111 Wales triage and clinical assessment platform required within the NHS 111 Wales Service, as this may already have an integrated audit tool.

2.26 Complaints can come from three main sources – Putting Things Right, when the caller is on the phone, and from other healthcare professionals. Any negative feedback is reported to the line manager and to the operational Quality Assurance Group and DAG. The latest report (September 2023) noted that there had been a decrease in the number of concerns raised (ten concerns were raised in June 2023 and this has reduced each month to only one concern being raised in September 2023).

2.27 The report presented to QuEST (31 October 2023) detailed the outcomes from patient experience surveys for September 2023 (based on four responses):

111	Benchmark	Score
Do you feel your call to 111 Wales was helpful?	85	66
Did you follow the advice given to you by NHS Direct Wales?	85	100
Would you consider using NHS 111 Wales again	85	100
Overall experience of NHS 111 Wales Online today	57.14% Good	14.29% Poor
Overall experience of Integrated Care (NHS 111 Wales telephone line only) today	100% Good	0% Poor

2.28 Benchmarking of performance has been carried out but is at an early stage. At the date of audit fieldwork, due to concerns over data sharing, discussions were ongoing as part of a wider review within the Trust on utilising benchmarks.

Objective 5: Key strategic, financial, and reputational risks have been identified and are regularly monitored.

Risk Management

2.29 There are no specific risks in relation to the NHS 111 Wales Service commissioning arrangement or service delivery recorded on the Trust's Corporate Risk Register (CRR). However, there are two risks in relation to commissioning that need to be amended to incorporate the 111 Service (see **Matter Arising 5**):

- Risk 458 – *A confirmed commitment from EASC and/or Welsh Government is required in relation to funding for recurrent costs of commissioning*; and
- Risk 100 - *Failure to persuade EASC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience.*

2.30 The Risk Management & Board Assurance Framework report presented to Trust Board (28 September 2023) notes that work continues to consider the development of a risk that includes the triage and clinical assessment platform, symptom checkers, website, clinical workforce training and funding, and may

require inclusion on the CRR in future. This has been highlighted at both Gateway to Care Programme Board and ELT.

2.31 There is also periodic risk reporting at 111 Commissioning Board, and 111 risks are also recorded on the Gateway to Care Programme Board's risk register. Progress with updating the programme's risk register has been impacted by resourcing issues and we note that some risks have not been updated since October 2022 (see **Matter Arising 5**).

2.32 Service risk registers also record risks in relation to NHS 111 Wales service delivery and evidence was provided demonstrating that risks had been appropriately escalated, where required.

Sustainable Service

2.33 The delivery and sustainability of the national service model that will link services delivered by NHS 111 Wales with Urgent Primary Care services is noted as a key objective within the draft National Collaboration Agreement; but development of the NHS 111 Wales Service has been impacted in some areas.

2.34 While performance is improving (see para 2.20), the planned roster review (see para 2.23) has been paused due to funding issues, and the website development and symptom checker have been impacted by both funding and resourcing issues (see para 2.30).

2.35 The Patient Experience & Community Involvement Bi-Annual Report (April - September 2023), presented to QuEST (31 October 2023), outlined the outcomes of a website experience survey, which 195 people completed between April and September 2023. It was reported that *53% of respondents could not easily find information on the NHS 111 Wales website and 49% of people rated their overall experience of using the website as 'Poor' or 'Very Poor'*. It further conveyed the risks posed with the website content not being updated and no ongoing assurance processes for clinical content, including the online symptom checkers.

2.36 Strategic workforce planning has been identified as a commissioning intention (see Appendix C) as part of the Commissioning Framework and is at an early stage; although management advised that the project plan details that work will be completed by Quarter 4 (2023/24). The Head of Workforce Planning, who is assisting with developing the NHS 111 Wales service workforce plan, sits on the Integrated Technical Planning Group, which assesses the wider impact of decisions to the Trust. The Group is chaired by the Assistant Director of Commissioning & Performance who was a facilitator at a session in November 2023 on horizon scanning as part of workforce planning for the NHS 111 Wales service.

2.37 There has been a focus on NHS 111 Wales staff recruitment and retention. The Head of Workforce Transformation chairs the 111 People and Culture Group, which has been looking at making rostering more agile, in line with flexible working requests, and developing a multi-disciplinary team. Innovative recruitment campaigns have also been carried out using social media. There is limited data corporately to understand why people are leaving the Trust and a 'Moving on

Interview' process has been developed to address this (this will be explored as part of our Recruitment and Retention audit within the 2023/24 Internal Audit plan). However, the report presented to DAG (16 June 2023) provided a high-level overview of staff retention within the service and identified themes in relation to rostering, not having face-to-face contact with patients and support after training in the first year of practice.

2.38 Further support for staff during their first year of practice is currently being developed. There is a structured induction and training programme in place with self-directed learning through accessing a dedicated library and reflective practice opportunities where clinicians work through a patient scenario. A training matrix is currently being developed recording the skills required for each role in the service compared to the training the Trust provides.

2.39 While the NHS 111 Wales service is included in the Trust's IMTP 2023-26, there is no separate strategy to assist with longer term planning (aligned to the timescales of the Goal 2 priorities, referred to in the Six Goals Programme (see para 1.3). This would ensure that appropriate funding is allocated for the delivery and transformation of the service. However, we note that the strategy would have to be developed jointly with the Commissioner and therefore, no recommendation has been made.

Financial Resources

2.40 The Commissioning Framework refers to a cost and recovery finance methodology for 2023/24, which will remain in place until such time that a consistent future service model has been jointly agreed. While there is reference to funding arrangements within the latest draft National Collaboration Agreement, it has not been signed by the Trust (see para 2.4) and we have not been able to obtain further documentation to outline more explicitly the funding arrangements and ensure that costs can be recovered where necessary (see **Matter Arising 1**).

2.41 The cost and recovery finance methodology removes the risk of overspending as NHS 111 Wales Service costs are forecasted at the start of the financial year, and the Finance Group, as part of the NHS 111 Wales Governance structure (see para 2.8) meet monthly to agree costs incurred by the Trust that will be invoiced to the Commissioner. Historically, the Trust has been underspending because of recruitment and retention challenges. However, we were informed that the methodology, which differs from the block contract/resource envelope commissioning approach for Emergency Medical Service (EMS) and Non-Emergency Patient Transport Service (NEPTS), is limiting the Trust in being able to develop the 111 service, e.g., assessment of capacity so staff can be effectively rostered to meet demand, proactively undertake website development, etc.

Appendix A: Management Action Plan

Matter arising 1: Clarity over Roles and Responsibilities (Operation)	Impact
111 Commissioning Board meeting minutes (28/02/23) note that, "*within the existing agreement, there had been a commitment to update and refresh the Collaboration Agreement when the national programme had concluded and 111 moved to a national operational service*." Both the draft National Collaboration Agreement and the Commissioning Framework detail that, "*all Parties acknowledged and agreed there would be an opportunity to reassess the existing collaboration arrangements once the programme rollout had concluded, however, there was an expectation that the majority of the existing agreement would remain extant and apply to a nationally recognised model*." The Commissioners had met with board secretaries on revisions to the existing agreement with an initial feedback deadline of 17th March 2023. 111 Commissioning Board meeting minutes (18/04/23) record that no response had been received from the Trust. Reporting to Executive Leadership Team (ELT) on the 19 April 2023 noted that the Interim NHS 111 Wales Board were seeking to approve the Agreement at their meeting at the end of May, but there was a need to have greater clarity over roles and responsibilities of partners detailed within the Agreement and the Clinical Governance Framework section within Schedule 1 (the Trust's Delivery of NHS 111 Wales Call handling & Clinical Nurse Triage) had not been completed. ELT agreed that comments in relation to the Agreement would be conveyed in writing to the Commissioners. The Agreement remains unsigned by the Trust. We requested a copy of the previous version of the Agreement to ascertain what was detailed within there on the roles and accountabilities of each partner. However, this was not provided by the conclusion of our review. The draft National Collaboration Agreement details that the Commissioners will receive funding directly from Welsh Government and a proportion will be transferred to the Trust in relation to "*the initial front end call handling/ nurse clinical assessment element of the service along with proportionate costs for additional operational and technical support including education and training for staff*". For any additional funding, the 111 Board may request financial investment for transformational activities. However, we have not been able to obtain further documentation to outline more explicitly the funding arrangements while the latest version of the Agreement remains unsigned. The Commissioning Framework details the NHS 111 Wales governance structure, but we were unable to obtain finalised versions of the terms of references for forums and groups within the structure (draft copies were provided for the National Urgent Primary Care (Out of Hours) Forum, Finance Group, and the Joint Operational & Performance Group). While we understand that the Trust does not have responsibility for the administration of the governance	Potential risk of: • Unclear roles and responsibilities could result in poor decision making and a lack of accountability and oversight. • Resources being used inefficiently if partners duplicate in their undertaking of roles and responsibilities

arrangements, it should ensure that it has final version of the terms of reference to confirm roles and accountabilities and that decision making is appropriate at each level of the governance structure.

Recommendations		Priority
1.1	Noting that roles and responsibilities will have changed since the national NHS 111 Wales service has been implemented, roles and responsibilities should be clearly detailed within the National Collaboration Agreement and signed by both parties (Commissioner and Trust). Opportunities should be provided for partners to reflect on their roles and functions regularly so that the Agreement can be amended to reflect any changes.	**N/A – this is an advisory review**
1.2	A copy of the previous signed version of the National Collaboration Agreement should be retained in a central location and monitored to ensure roles and responsibilities are fulfilled.	
1.3	The Trust should ensure that it has finalised versions of the terms of reference for forums and groups where it participates within the NHS 111 Wales governance structure.	

Management response		Target Date	Responsible Officer
1.1	A new Joint Commissioning Committee will come into effect from 01/04/24. The Trust wants to wait and see what develops in this space rather than commit time to a document that could cease on the 31/03/24.	01/04/24	Executive Director of Strategy, Planning & Performance
1.2	The previously signed version will apply until the new version is agreed, so the Trust will seek to obtain and retain a copy until recommendation 1.1 is enacted.	31/12/23	Executive Director of Strategy, Planning & Performance
1.3	The responsibility for up-to-date terms of references rests with 111 commissioners, but the Trust will collaborate with commissioners and seek to ensure all relevant terms of reference are updated. The Trust will feedback to commissioners on the National Urgent Primary Care (Out of Hours) Forum and the Joint Operational & Performance Group) but considers these outside of the formal commissioning arrangements.	31/01/24	Executive Director of Strategy, Planning & Performance

Matter arising 2: Out-of-date policies and procedures (Operation)	Impact
While no specific policies and procedures were required by the NHS 111 Wales commissioning arrangement, our review of policies and procedures relating to the operational delivery against the commissioning intentions noted the following issues: • the Clinical Safety Plan – records a review date of 21st March 2022 (the document tracker notes the date as 21 May 2022); • the Fire Evacuation Procedure 111 NHS Wales VPH 1st Floor Clinical Contact Centre – is dated 18/11/21 and does not detail a review date, but the document tracker records this as 18/11/22; • there are three business impact analysis documents (Thanet House, Vantage Point House, and Snowdon House) that are dated 2017 but do not record a review date; and • the '*Standard Operating Procedure for the Management of NHS Direct Wales/111 Service and Ambulance Calls during Planned System Outage or System Failure*' records a review date of 11/07/21. The Head of the 111 Service explained that both the Clinical Safety Plan and the Fire Evacuation Procedure are currently being reviewed and the other documents are old versions. We note that Audit Wales ('*Structured Assessment 2022 – Welsh Ambulance Services NHS Trust'* (January 2023)), which included reviewing the Trust's governance arrangements, has highlighted a wider issue across the Trust with policy reviews being impacted by the Covid-19 pandemic and the capacity of the Office of the Board Secretary. A policy prioritisation exercise has since been undertaken by the Trust, which has resulted in a programme of work being established to bring the organisation's key policies up to date.	Potential risk of: • Outdated arrangements which are not compliant with legislation and cause confusion to staff.

Recommendation		Priority
2.1	Management should ensure that all operational policies and procedures that relate to NHS 111 Wales service delivery, are updated as soon as possible.	**N/A – this is an advisory review**
2.2	Once approved, policies and procedures should be circulated to all staff.	

	Management response	Target Date	Responsible Officer
2.1	The Clinical Safety Plan and the Fire Evacuation Procedure are currently being reviewed and the other documents are old versions. The reviews will be completed and the old versions of policies removed and replaced.	29/02/24	Assistant Director of Operations (Integrated Care)
2.2	Updated policies to be placed on Siren and accompanied by Siren communications and more direct staff briefings, where appropriate e.g. fire evacuation procedure.	29/02/24	Assistant Director of Operations (Integrated Care)

Matter arising 3: Post-Implementation Learning (Design)	Impact
There have been opportunities to reflect on current commissioning arrangements, e.g., discussions at executive director level, Strategic Transformation Board, Gateway to Care Programme Board, etc. However, there needs to be a robust mechanism to capture these reflections in one place and to encapsulate the views of staff involved with the operational service delivery. This would be beneficial to determine not only benefit realisation and lessons learnt, but also assist with providing input to the new commissioning arrangements that will take effect from April 2024.	Potential risk of: • Lack of organisational learning in respect of service delivery or being able to effectively input into the development of new commissioning arrangements.

Recommendation		Priority
3.1	Develop a mechanism to enable post-implementation learning of benefits, lessons learnt and impact to service delivery to be completely captured.	**N/A – this is an advisory review**

Management response		Target Date	Responsible Officer
3.1	Proceed with the planned "time out" for Executives who interface with the commissioning arrangements, 111 Senior Leadership Team and other Assistant Directors/Heads of Service who support the commissioning arrangements.	29/02/24	Executive Director of Strategy, Planning & Performance

Matter arising 4: Governance Oversight (Operation)	Impact
While we acknowledge that the governance arrangements for the national NHS 111 Wales service are embedding, the following gaps have been identified to ensure that the Trust has adequate oversight: • A signed version of the previous National Collaboration Agreement could not be provided by the conclusion of our review to confirm effective oversight of its content, agreed roles and responsibilities of each partner and escalation arrangements (see **MA1**). • Key outcomes arising from meetings of the Finance Group are not documented. • We were unable to establish the level of oversight of the Joint Operational and Performance Group and the National Urgent Primary Care GP (OOH) Forum as meeting minutes and reports were not provided (however, we understand that these groups do not form part of the commissioning element of the governance structure). • Progress against performance measures detailed in the Commissioning Framework are not reported within the Trust. It was planned for commissioning intentions to be included in quarterly reporting to the Strategic Transformation Board (STB), but this has not always happened. This has been recognised as an improvement as part of the Quality & Performance Framework and detailed on the workplan for Audit Committee (30 November 2023).	Potential risk of: • Unclear governance and reporting arrangements leading to a lack of accountability and oversight.

Recommendation		Priority
4.1	Key outcomes from meetings that Trust employees attend on commissioning arrangements should be appropriately recorded and reported to ensure that there is appropriate oversight of key discussions held.	**N/A – this is an advisory review**
4.2	Progress with delivering the commissioning framework should be reported within the Trust.	
4.3	The Trust should obtain written confirmation of the escalation process to be followed within the current governance structure.	

	Management response	Target Date	Responsible Officer
4.1	Action notes/minutes for the Finance Group are the responsibility of 111 commissioners. The Trust will discuss with 111 commissioners and seek a formal record of each meeting.	31/12/23	Director of Finance and Corporate Resources
4.2	The Trust does report progress on the commissioning framework i.e. commissioning intentions, but recognises that internal reporting is more intermittent. Re-establish regular reporting of the commissioning intentions (every quarter) to the Trust's Strategic Transformation Programme Board.	31/01/24	Executive Director of Strategy, Planning & Performance
4.3	A letter will be collaboratively drafted and agreed between the 111 Board Chair and Trust CEO to formalise the informal escalation arrangements that do currently exist.	31/01/24	Executive Director of Strategy, Planning & Performance

Matter arising 5: Risk Management (Design)	Impact
Any risks associated with a commissioned arrangement should be captured in the Trust's risk register. Funding and resourcing limitations have been highlighted that are impacting the NHS 111 Wales service development in line with the Trust's ambitions, however this isn't currently captured within the two risks on the Trust's Corporate Risk Register that relate to commissioning: • Risk 458 – A confirmed commitment from EASC and/or Welsh Government is required in relation to funding for recurrent costs of commissioning. • Risk 100 – Failure to persuade EASC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience. The Risk Management & Board Assurance Framework report presented to Trust Board (28 September 2023) notes that work continues to consider the development of a risk that includes the triage and clinical assessment platform, symptom checkers, website, clinical workforce training and funding, and may require inclusion on the CRR in future. This has been highlighted at both Gateway to Care Programme Board and ELT. NHS 111 Wales risks are also recorded on the Gateway to Care Programme Board's risk register, but its review has been impacted by resourcing issues, and some risks showed a review date of October 2022.	Potential risk of: • Risks are not identified and managed effectively and impact adversely.

Recommendation		Priority
5.1	The Trust's Corporate Risk Register should be amended to capture risks relating to the NHS 111 Wales commissioned arrangement or service delivery.	**N/A – this is an advisory review**
5.2	The Gateway to Care Programme Board's risk register should be reviewed and updated to ensure that the risks documented remain current and there are appropriate mitigating controls in place.	

Management response		Target Date	Responsible Officer
5.1	The Trust's Corporate Risk Register commissioning risks to be updated to reflect that 111 is now also a commissioned service.	31/01/24	Executive Director of Strategy,

			Planning & Performance
5.2	Gateway to Care Programme Board's risk register to be reviewed and updated.	31/01/24	Executive Director of Strategy, Planning & Performance

Appendix B: Terms of Reference

Scope and Objectives

Scope	To assess the effectiveness of the new commissioning arrangements and structures for the 111 service, to ensure there is a sustainable and improved patient quality experience provision with appropriate resourcing and finance mechanisms. The review will examine the following areas: 1. There is an appropriate framework designed for the commissioning arrangement that covers the aims, principles and outcomes that will be achieved, the roles and accountabilities of each partner; and is adequately supported by procedures. 2. Decision-making structures are clear and transparent, with due regard given to potential and perceived conflicts of interest which risk compromising the integrity of decision-making. 3. 111 commissioning arrangements are being reported on and embedded within the Trust core processes, e.g. Integrated Medium-Term Plan (IMTP). 4. Performance is monitored appropriately with clear standards and benchmarking. 5. Key strategic, financial, and reputational risks have been identified and are regularly monitored.

Limitation of scope

Limitations to scope	The review is limited to assessing the effectiveness of arrangements from the Trust's perspective. The Gateway to Care Programme will not be considered in detail as this was covered in our audit of IMTP Delivery (final report issued February 2023) nor did we assess the delivery of new digital platforms as this is planned within the ICT Contract Management audit.

Associated Risks

Associated risks	• Ineffective arrangements resulting in wasted resources, failure to deliver strategic objectives, poor patient experience, and a lack of value for money; and • Failure to deliver required service levels resulting in patient harm

Appendix C: Commissioning Intentions 2023-24:

Agreed commissioning intentions detailed within the Commissioning Framework

Commissioning intentions focus on delivering service improvements which will improve staff and patient experience and overall service performance - supported by a suite of actions. WAST will work collaboratively with the National NHS 111 Wales team, through the Delivery Assurance Group (DAG), to deliver its Commissioning Intentions. WAST will be required to develop action plans with key activities and timelines to deliver the following Commissioning Intentions:	
Ci.1 - Optimise performance, improve outcomes & ensure value for money by further developing the WAST service model.	
Ci.1A	Undertake a review of the current model using evidence of effectiveness to establish 'what good looks like' for NHS 111 Wales
Ci.1B	Develop the model to reduce the number of hand-offs, consider the concept of 'one & done'
Ci.1C	Review the current workforce skill mix and ratios of non-clinical vs clinical staff based on future service models and UK benchmarking
Ci.1D	Evaluate roles that have been created as pilots and report on the impact & outcomes achieved
Ci.1E	Consider the opportunities for creating enhanced roles – enhanced call handler, autonomous nurse practitioner, in the future delivery model
Ci.1F	Support the National Programme for Urgent & Emergency Care (Goal 2) transformational workstreams, specifically the development of 'Enhanced Clinical Pathways': • Urgent Dental - Map out the existing pathways for HBs (4) and review in the context of developing a National Urgent Dental Pathway to support all HBs • Palliative Care pathway development
Ci.2 - Enhance performance through the improvement of call abandonment rates (Step 2).	
Ci.2A	Undertake a review of calls to understand disposition/outcomes including self-care rates, number of touchpoints and flows into OOH
Ci.2B	Undertake a review of abandonment after 60 secs to understand at what point in the call, abandonments are occurring
Ci.2C	Review IVR messaging to determine which messages have greatest impact in diverting calls to website /other services
Ci.2D	Review the correlation of days/ times to peaks in demand and levels of staffing rostered during those times and undertake the necessary action to ensure staffing meets demand patterns
Ci.3 - Staff experience a great place to work, where they are engaged and their wellbeing is promoted (Core Requirement 6).	

Ci.3A	Develop a strategic workforce plan to ensure effective workforce planning arrangements are in place with the capacity to meet service demand. Ensure the plan links to wider National workforce plans
Ci.3B	Ensure workforce planning arrangements are in place to identify staffing requirements and action plans such as recruitment & training plans to meet those requirements
Ci.3C	Undertake a workforce & training review to establish where training can be more efficient and effective
Ci.3D	Undertake a rostering review and ensure effective rostering practices are implemented to ensure shift fills, rota management and rostering to levels of demand
Ci.3E	Develop a staff education & training matrix to ensure staff are appropriately trained, educated & qualified to undertake their role and deliver the services provided
Ci.3F	Ensure the requirement to work predominantly out of hours, is a key feature in contractual agreements
Ci.3G	Review sickness absence rates and undertake the necessary action to ensure sickness absence is in line with National targets
Ci.3H	Monitor turnover rates and undertake exit surveys to identify the reasons why staff leave the service

.

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

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Vehicle Replacement Programme
Final Internal Audit Report

February 2024

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:	SSU-WAST-2324-01
Report status:	Final Report
Fieldwork commencement:	11th August 2023
Fieldwork completion:	10th October 2023
Draft reports issued:	21st November 2023 & 31st January 2024
Management response received:	12th February 2024
Final report issued:	15th February 2024
Auditors:	NWSSP Audit & Assurance: Specialist Services Unit
Executive sign-off:	Chris Turley, Executive Director of Finance & Corporate Services
Distribution:	Lee Brooks, Executive Director of Operations
	Judith Bryce, Assistant Director of Operations, National Operations & Support
	Navin Kiala, Deputy Director of Finance & Corporate Resources
	David Holmes, National Fleet Manager
	Andrea Davies, Project Manager
	Edward Roberts, Head of Financial Business Intelligence & Capital Planning
	Joanne Williams, Head of Capital Development
	Richard Davies, Assistant Director of Capital & Estates
	Trish Mills, Board Secretary
Committee:	Audit Committee

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

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

Disclaimer notice - please note

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

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

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

Executive Summary

Purpose

The Trust undertakes a cyclical refresh of its fleet of vehicles. This includes both emergency, and non-emergency ambulances as well as specialist support vehicles.

The audit was undertaken to evaluate the processes and procedures put in place by the Trust to support the management and control of the ongoing procurement of replacement vehicles.

Overall Audit Opinion and Overview

A ten-year Strategic Outline Programme commencing in 2017/18 was endorsed by Welsh Government in 2018. A 2021 refresh (also endorsed by Welsh Government), profiled requirements as £94m for 642 vehicles over the remaining 6 years of the programme.

Business Justification Cases are presented to Welsh Government for annual funding based on current circumstances and prices, within the context of the overall programme.

The refresh was found to be a mature process with good understanding of the key factors determining refresh frequency (e.g. expiry of warranties).

Recommendations have therefore been made in context of the general robustness of the overall approach.

Key issues raised within the audit included the need to:

- ensure compliance with Standing Orders for Trust Board approval of contracts;
- enhance reporting and review of the procurement strategy to ensure best value;
- ensure procurement and contractual arrangements obtain best value from strategic partnering;
- detail variances to programme at business cases;
- demonstrate optimal vehicle procurement numbers; and
- better align the project management and business case processes with best practice.

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

An overall **reasonable assurance** has been determined.

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	Strategic planning & approvals	Substantial
2	Programme management	Reasonable
3	Procurement	Limited
4	Financial monitoring & reporting	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	Priority
1	Project controls should be reviewed for appropriate compliance with Prince2 principles	2	Medium
4.1	The various aspects of the procurement strategy should include: (a) enhanced narrative within the business case; & (b) evaluation and approval by appropriate parties to confirm that it remains optimal (as detailed within the business case for approval) e.g. to affirm that it best aligns procurement and contractual arrangements to obtain best value from strategic partnering.	*3*	Medium
4.2	Allocated duties for dialogue and negotiation on the costs and price of the specification should be delineated between procurement and project officers at the Project Initiation Document.	*3*	Medium
5.1	Contracts should be discretely authorised in accordance with Standing Orders.	*3*	High
5.2	Pre-tender Estimates and variance commentary should be utilised to inform tender evaluations.	*3*	Medium
6	Business Justification Cases should show investment to date against plans of the Strategic Outline Programme, including variance commentary (for both vehicle numbers and values).	*4*	Medium

1. Introduction

1.1 This audit forms a part of the 2023/24 operational plan agreed with the Trust.

1.2 The audit was undertaken to evaluate the processes and procedures put in place by the Trust to support the management and control of the ongoing procurement of replacement vehicles. A programme business case provides a framework within which to plan annual needs.

1.3 The annual replacement programme is subject to annual financial allocation requests submitted via discrete business cases. For the purposes of this audit, these are referred to as projects.

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

- Risks may not be appropriately prioritised, and investment may not appropriately directed;
- Management arrangements may be poorly established leading to a loss of control over key time, cost, and quality aspects;
- The client brief may not be met;
- Local and national requirements may not be adhered to; and
- Approved plans may not appropriately consider the potential to positively impact decarbonisation.

2. Detailed Audit Findings

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

Strategic planning & approvals: *To obtain assurance that there was an established and approved strategy to the overall replacement programme, integrated with the approved Integrated Medium-Term Plans and annual plans; and that decarbonisation and other emerging priorities have been adequately assessed within the strategies.*

2.2 A Demand and Capacity Review had been conducted to inform a ten-year Strategic Outline Programme (SOP) for refresh of the ambulance fleet. Annual plans derived from this were contained within call-off Business Justification Cases (BJCs), presented to Welsh Government for specific funding. These plans, in turn were integrated with the (three year) Intermediate Medium Term Plan (IMTP) of the Trust, with Board approval of SOP, BJC's and IMTP.

2.3 A Fleet SOP Delivery Group was in place to oversee production of required documents for the refresh programme, supported by an appropriate range of sub-groups and expertise.

2.4 Accordingly, **substantial assurance** has been determined in relation to strategic planning and approvals.

Programme management: *To confirm appropriate programme management arrangements, including client defined requirements, adoption of project management tools, and commissioning arrangements.*

2.5 The Programme was overseen by an experienced National Fleet Manager, being a national lead in this area. A dedicated project manager undertook operational management of procurement and was supported by specialist procurement officers and an administrator.

2.6 The Project Initiation Document (PID) outlined how the project would be managed according to Prince2 best practice principles (a government standard for project management).

2.7 Accordingly, the programme benefitted from a:

- Project Initiation Document;
- Project Plan;
- Risk Register;
- Issues Register;
- Decisions Register;
- Communications Plan; and
- Benefits Realisation document.

2.8 In accordance with Prince2, roles were also allocated for those commissioning the project, those delivering, and the end Users. However, duplication in allocated officers was observed, and accordingly there was a need to review the allocation and operation of these roles in accordance with Prince2 customer / supplier accountabilities (**MA 1**).

2.9 There was also a need for the Project Board to allocate tolerances (of time and cost etc.) to the Project Manager, to enable them to manage by exception (**MA 1**).

2.10 A core part of Prince2 is management by stages, with periodic reviews of the investment to direct progression. It was evident that a reduction in the number of such stages (to annual review) would make the process more manageable and effective (**MA 1**).

2.11 This would also facilitate effective Stage reporting and (annual) evaluation of project controls. This should include the evaluation of allocated risk contingencies to inform future funding requirements (**MA 1**). However, in context, both outcomes and performance were well understood e.g. the performance of the parties was thoroughly assessed in evaluating tenders, and any late deliveries were known.

2.12 One element utilised within Prince2 is the formal adoption and utilisation of a user specification - which also serves as a basis of change (and cost) control. A detailed specification was evidenced, with changes on-going throughout the year. A listing was provided of dates that changes were submitted / notified to the Project Board (the FSDG). However, while management have commented that there is de-facto

approval, it has been recommended that minuted or signed User approval is formally documented (**MA 3**).

2.13 There was an associated need to update the Project Initiation Document to reflect all controls that are currently operating any revised controls adopted as a result of this audit, and also to specify User sign off at commissioning (**MA 1**).

2.14 While noting the above recommendations, the basic process of managing and requesting funding for refresh was a mature one and well understood e.g. that ongoing costs of retention escalate significantly once warranties expire. A **reasonable assurance** has therefore been determined in relation to programme management.

Procurement: *To obtain assurance that the procurement of vehicles (and adaptation) complied with established local and national procurement requirements; and that decarbonisation and other emerging priorities have been adequately considered at the procurement approach.*

2.15 Procurement comprised of sourcing chassis and fit-out / conversion suppliers of vehicles of various types. Of these, the largest volume was that of emergency ambulances (circa £10m p.a.), for which there had been a long-standing preferred supplier.

2.16 The project benefitted from:

- comprehensive specifications for both the chassis and conversion;
- extensive User involvement;
- use of collaborative procurement frameworks to derive best value;
- comprehensive and contract award assessments;
- official sign-off of recommended suppliers;
- expert procurement support;
- call-off Purchase Orders; and
- a defined quality acceptance process.

2.17 During the audit, it was also confirmed that procurement arrangements were being added to the draft 2024/25 business case, including the specification of contractors. However, it has been recommended that the expansion of the narrative to further explain choices made would enhance the review of processes in line with Prince2 principles (e.g. including derivation and use of a Pre-tender Estimates and review of outcomes) (**MA 4**).

2.18 As noted, certain procurement arrangements were of a long-term partnering nature. In the case of emergency ambulances, the chosen supplier was stated to be the only one able to provide chassis of sufficient load bearing weight. They also supplied enhanced vehicle features, extended warranty, and roadside servicing with specialist parts. Accordingly, the Trust had invested in specialist tooling for servicing and repairs at its depots, specific to this brand.

2.19 Noting this, there was a need to ensure that procurement and contractual arrangements best reflected these relationships and obtained best value from strategic partnering e.g. engaging in appropriate dialogue in relation to the long-term partnering and any specifications which could be modified or omitted to optimise supply chain costs (**MA 4**).

2.20 The National Fleet Manager had actively engaged in procurement partnering negotiations with other Trusts. However, allocated duties for dialogue and negotiation on the costs and price of the specification (as permitted under the procurement frameworks) were not delineated between procurement and project officers at the Project Initiation Document (for clarity and assurance of effective engagement) (**MA 4**).

2.21 Purchase Orders were authorised by the Chief Executive Officer (CEO) (with delegated authority to contract to £500k). Two sampled Purchase Orders were valued at £2,122,320 and £3,042,200 respectively. However, Standing Orders required Trust Board approval of contracts exceeding £500k. Feedback to the audit highlighted Trust Board approval of the Business Justification Case (BJC), and its associated procurement values. However, contractual arrangements were made subsequently, and therefore its approval could not represent approval of specific contracts. While subsequent narrative was provided to the Trust Board of procurement arrangements, their authorisation of specific contractual arrangements was not evidenced (**MA 5**).

2.22 Noting this breach of Standing Orders, **limited assurance** has been determined in relation to procurement arrangements.

Financial reporting and monitoring: *To obtain assurance that appropriate controls operated, including monitoring of in-year expenditure and overall budget.*

2.23 Both long term and annual budgets were formally approved via the business cases.

2.24 There was therefore formal reporting and approval of budgets and their derivation both by the Trust and Welsh Government.

2.25 In-year financial monitoring was also undertaken by the Head of Financial Business Intelligence & Capital Planning and published to Welsh Government.

2.26 Prince2 requires Stage evaluation i.e. the outcome of a project / programme Stage should inform future progression e.g. in this case no ambulances were funded by Welsh Government in 2020/21. This is informative to understand current business case requests as profiled against previously agreed programmes. It can also help understand if any shortfalls in procurement arose from price variations etc. However, the refresh of the Strategic Outline Programme (SOP) only updated forward requirements. While BJCs narrated the 2020/21 funding shortfall, they did not report out-turn data against the prior plans with variance commentary (**MA 6**).

2.27 While noting this matter, recognising approved financial budgets and on-going monitoring, **reasonable assurance** was determined in relation to financial reporting and monitoring.

Appendix A: Management Action Plan

Matter Arising 1: Project Management (Design)	**Impact**
The Project Initiation Document stated that it sought to utilise *"a tailored project management methodology based on Projects in Controlled Environments (Prince2)"* i.e. the government recommended project management methodology. There are several aspects of current arrangements which could benefit from review against Prince2 methodologies including: • effective representation of the Supplier, Customer, and Executive roles within the project management structure; • delegated financial tolerances to project managers for stage / annual delivery; and • end stage reports to review project controls, benefits realised, and lessons learnt etc. (e.g. the adequacy of project contingency).	Potential risk that: • Best practice methodologies are not effectively applied

Recommendations		**Priority**
1	Project controls should be reviewed for appropriate compliance with Prince2 principles including: • effective representation of the Supplier, Customer, and Executive roles within the project management structure; • delegated financial tolerances to project managers for stage / annual delivery; • End-stage reports to review project controls, benefits realised, and lessons learnt, etc.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
1	Agreed to be reviewed, noting that the agreed and stated approach is to a pragmatic approach and the application of an overarching Prince2 methodology.	30th June 2024	FSDG Chair and Project Manager

	The FSDG Terms of Reference and the Project Initiation Document for future projects will be reviewed with particular consideration being given to project controls including allocation of roles and responsibilities and delegated tolerances to provide clarity, with the outcome of the review being documented and any agreed changes implemented. End stage / project reporting will be reviewed and developed in line with project timescales. Further narrative will be developed in the Project Initiation Document for future projects to provide clarity on such reporting. This will all be reviewed through the FSDG, at which point this action will be considered closed.		

Matter Arising 2: Optimal procurement quantity (Design)			**Impact**
Prince2 methodology requires reporting against targeted benefits i.e. the measurable improvement, resulting from an outcome that is perceived as an advantage by one of the stakeholders. Collation of data for the assessment of benefits was also a requirement of the funding approval letter from Welsh Government in April 2023. A table of costs and benefits of chosen replacement numbers was set out at the Strategic Outline Programme, and annual call-offs within business case were derived from this. However, at annual business cases for specific call-off, while benefits analysis demonstrated that new vehicles were more beneficial than older vehicles, the incremental benefit of new vehicles was not set against the additional costs of purchase. It was difficult therefore to determine the optimal annual replacement numbers from information provided to at the annual business cases and associated presentations. Future business cases should also report performance against prior benefit targets to better inform investment decisions.			Potential risk that: • Benefit measures do not sufficiently inform decisions.
Recommendations			**Priority**
2	The benefit of additional purchases should be contrasted to the associated costs of retention at business cases.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
2	Agreed. Benefits realisation monitoring will continue as part of project review. Further data and analysis relating to vehicle replacement versus retention will continue to be developed and included as part of this monitoring.	30th June 2024	Head of Financial Business Intelligence & Capital Planning and Project Manager

	Consideration will be given to the relevance of including information on benefits realisation (performance versus targets) in future business cases where appropriate. It should be noted that the agreed vehicle life cycles are identified in the SOP and then drawn down into the annual business cases, and this determines the optimal numbers. In addition, the prioritisation process which had to be undertaken for 2023/24 due to restricted funding took into account the cost of retention versus replacement for the various vehicle types in deciding what vehicles to progress.		

Matter Arising 3: User sign-off (Operation)	**Impact**

Prince2 requires Users to agree a product configuration as a defined baseline for delivery acceptance, and from which change control authorisations are required.
 	
Accordingly, the Project Initiation Document stated that:
• *"all vehicle specifications are approved by Project Board"; and that*
• *"changes from the agreed baseline specification ..are formally approved by Users."*
 	
<u>User sign-off</u>
Minuted sign-off was not evidenced. The National Fleet Manager presented User requirements and change requests to the Project Board.
 	
The model and supplier selection was also presented at Project Board by the Senior Supplier (National Fleet Manager), rather than the Senior User.
 	
While Users were involved in assessing supplier tenders (including conformance to specification), the complexity of this meant that each assessor could score with differing subjective key criteria of desired specification.
 	
While management have commented that there is de-facto User approval of the specification, it has been recommended that minuted or signed User approval is always formally documented.
 	
<u>Quality - Final acceptance</u>
 	
The PID also required sign-off against the agreed specification via a:
• *"schedule of visits to vehicle converters in-build to confirm compliance with vehicle specification"* and a *"final User-acceptance sign-off visit…managed by the Fleet Operational Lead (*Senior Supplier*) and Commissioning Lead*.
  ○ *Quality Method - Approved suppliers, contract documentation, pre-build meetings, inspections.*
  ○ *Quality Check - Fleet sign off / ICT sign off / TU Partner representative sign off".*
	Potential risk that:
	
	• User requirements are not appropriately specified.

This inspection and acceptance by technical staff was not evidenced. Similarly the nature of their interaction with the Supplier; User / commissioning leads; Vehicle Working Group; and the Project Board in formal sign-off was not defined.			
Recommendations			**Priority**
3.1	The process of agreement of specification by relevant parties should be specified at the Project Initiation Document e.g. as involving parties such as the Vehicle Working Group and the Project Board, and user sign-off of requirements / minimum performance specifications.		**Low**
3.2	Inspections by technical staff should be formally documented and advised to the Senior Supplier, User, and commissioning leads as part of the quality acceptance process.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	Agreed. The process of specification agreement will be further developed and documented, and narrative included in the Project Initiation Document for future projects. A visual process map will also be included.	30th June 2024	Project Manager
3.2	Agreed. The inspection and quality acceptance process will be developed and documented and ratified by the FSDG.	30th June 2024	Project Manager

Matter Arising 4: Procurement Strategy (Operation)	**Impact**
A key part of project management is the procurement strategy, and accordingly it is recommended by NHS Wales investment guidance for post project review. Accordingly, the 2023/24 draft business case included narration of the procurement choices, including the chosen contractors. These were largely structured around the use of national frameworks (e.g. as provided by the Crown Commercial Service - CCS). However, there remains the potential to further develop this narration to better inform scrutiny parties as to the rational for such choices, and to assist evaluation of outcomes e.g. (by vehicle type): • The potential for volume discounts based on wider partnering with common core specifications (e.g. European partners); • contractual options e.g. annual framework call-off v longer term / strategic partner arrangement; • optimal split of work between chassis and fit-out contracts; • derivation & use of Pre-tender Estimate; • lifecycle & support costs; and • dialogue with the supplier (e.g. over specification & key cost drivers). Regarding this latter point – presently the Trust pass the specification (circa 100 pages) to Procurement Services who obtain a market price from the supplier. However, price negotiation is expressly permitted by the CCS framework. Procurement Services may not have sufficient expertise relating to the specification to participate in dialogue relating to any inclusions within the specification that may be causing the supplier particular cost (and which perhaps could be modified, deleted, or provided by an alternative). However, the Project Initiation Document did not specify any involvement in such dialogue for either the Trust or Procurement Services in order to obtain best market value. During the audit, management confirmed that narration of the procurement strategy had been enhanced at the draft 2024/25 business case proposal to include: • exclusion of a lease option due to capital funding requirements; and • confirmation that tender options are considered against framework options.	Potential risk that: • best value is not obtained from procurement arrangements.

However, noting the above considerations, further expansion of the narrative would enhance review of processes. The National Fleet Manager stated that the chosen model (as adapted) was unique to Wales, and that any potential for home nations partners to drive volume of the basic chassis was currently provided via participation of Scotland in the CCS framework. Evidence was also provided, where collaboration and options outside this framework has also been utilised to obtain best value (via negotiated price based on additional volume). The National Fleet Manager stated that the present chassis supplier for Emergency Vehicles was preferred on an on-going basis due several key factors, including: • load bearing weight; • longer life vehicles (circa 2 years); • preferred chassis size; • roadside assistance with specialist parts; • extended warranty (or mileage warranty); and • investment by the supporting servicing and repair shops in dedicated equipment Noting these factors, it was apparent that the relationship was one of long-term strategic partnering. However, contractual arrangements were based on one-year call-off based on annual funding, rather than a supply arrangement negotiated on a longer-term basis. Noting the range of considerations, as previously noted, further expansion of the narrative would further enhance review of processes in line with Prince2 principles.	
Recommendations	**Priority**
4.1 The various aspects of the procurement strategy include: (a) enhanced narrative within the business case; & (b) evaluation and approval by appropriate parties to confirm that it remains optimal (as detailed within the business case for approval) e.g. to affirm that it best aligns	**Medium**

	procurement and contractual arrangements to obtain best value from strategic partnering.	
4.2	Allocated duties for dialogue and negotiation on the costs and price of the specification should be delineated between procurement and project officers at the Project Initiation Document.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
4.1	Agreed. The current narrative describing the procurement strategy will be further detailed within future business cases to better facilitate evaluation of the procurement strategy.	At future business case compilation – next one expected by Dec 2024	National Fleet Manager and Project Manager
4.2	Agreed. Narrative on roles and responsibilities relating to procurement dialogue and negotiation will be developed and included in the Project Initiation Document for future projects.	At future PID development as part of project delivery – anticipated to be June 2024	Project Manager

Matter Arising 5: Contracts (Operation)	**Impact**

The audit sought to establish whether:

- contracts of appropriate content were in place prior to procurement; and
- contract award evaluation reports had been appropriately authorised and informed by Pre-tender Estimates (in accordance with the procedures and guidance of the Crown and Commercial Services framework utlised by WAST and procurement best practice).

The audit found the following in relation to contractual arrangements:

Re: Procurements of approved 2022/23 Business Justification Case (BJC)						
Contracts	**2022/23 BJC Target No.**	**Value £'m**		**In-date Framework (Y/N)**	**In-date contract (Y/N)**	**Evaluation (Y/N)**
Emergency Ambulances (EA)	51	3.1	Chassis	Y	Y	Y
		3.8	Fit-out	Y	Y	Y
Car Based & Rapid Response Vehicles (CBRV) / (RRV)	23	0.8	Chassis	Y	Y	Y
		0.7	Fit-out	Y	Y	Y
Non-Emergency Private Transport Service (NEPTS)	37	0.9	Chassis	Y	Y	Y
		1.3	Fit-out	Y	Y	Y
Specialist HART	0		Chassis	N/A - Not progressed / BJC updated		
			Fit-out			

** Note – equipping, contingency and project costs are additional to the above*

Potential risk that:

- There is breach of Standing Orders;
- Longer term liabilities may not be adequately addressed until the main contract is finalised and executed agreeing specific requirements of the works;
- The Trust may be exposed to increased risk/liabilities.

Standing Orders require contracts to be authorised as follows:

Authorisation by	Value
Budget holder	< £10,000
Service lead or Board Secretary	< £50,000
Relevant Executive	< £100,000
Chief Executive Officer	< £500,000
Trust Board	> £500,000

While "*guiding principles*" permit Board delegation, they also state that "*everything is retained by the Board unless it is specifically delegated.*" No such specific delegation was identified in respect of this matter.

Prior to contract award, a Pre-tender Estimate is a management tool that allows the Trust to consider the potential costs involved - and can be used as a benchmark for tender returns in determining Value for Money. Pre-tender Estimates are a requirement for Shared Services procurements (noting that the procurement process was undertaken in partnership with NWSSP: (Shared Services) Procurement Services, and is also recommended best practice for infrastructure procurement. While they were not utilised in this case, they could usefully be derived and adjusted from base model market price (e.g. the basic model as supplied in volume to the U.S.A.). Variance commentary is then added to the evaluation to inform approval.

Contractual arrangements were stated as following the business case (BJC), and therefore approval of the business case did not represent approval of specific contracts.

Specific contract under the frameworks were effected by means of quotations (agreed by the National Fleet Manager) followed by a Purchase Order at the agreed prices.

Purchase Orders were authorised by the Chief Executive Officer (CEO), noting the need for an individual officer to authorise a Purchase Order. Two sampled Purchase Orders were valued at £2,122,320 and

£3,042,200 respectively (i.e. above the delegated limits of the CEO and requiring authorisation by the Trust Board). However, while subsequent narrative was provided to the Trust Board of general arrangements, authorisation of all and specific contractual arrangements by the Trust Board was not evidenced. In context, the Trust Board had approved both the overall programme, and annual business cases outlining purchasing requirements. Updates were also provided to the Trust Board retrospectively outlining some of the key contractual arrangements. NWSSP (Shared Services) Procurement (Procurement Services), were also involved in expediting contractual arrangements in accordance with NHS Wales Procurement regulations. A national framework was utilised to procure both chassis and conversion and has been consistently utilised for some years as a mechanism to assure best value. (However, as at **MA 4**, there was a need to narrate the full procurement strategy to better inform the Trust Board as to such conclusions).			
Recommendations			**Priority**
5.1	Contracts should be discretely authorised in accordance with Standing Orders.		**High**
5.2	Pre-tender Estimates and variance commentary should be utilised to inform tender evaluations.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
5.1	Agreed. Noting that the current approach is across the Trust and not specific to fleet procurement, the Trust's Standing Orders and Standing Financial Instructions have been reviewed with regards to contract award approvals and delegated authority. As a result, a proposal to add an additional mechanism to ensure discrete Trust Board contract approval together with an amendment to the narrative relating to delegated authority for purchase order approvals will be presented to the March 2024	April 2024	Executive Director of Finance & Corporate Services and Trust Board Secretary

	Audit Committee and Trust Board meetings for consideration and approval and for subsequent implementation. Such proposals will mitigate this recommendation.		
5.2	Agreed - Pre-tender estimates and variance commentary will be utilised for future tender evaluations.	At future business case compilation	Head of Financial Business Intelligence & Capital Planning and National Fleet Manager

Matter Arising 6: Monitoring (Operation)			**Impact**
While refresh of the Strategic Outline Programme (SOP) only updated forward requirements, it did not report outcomes against the prior plans with variance commentary. By way of example, no funding was provided in 2020/21 due to financial impact of the Covid pandemic. In subsequent years, inflation differed significantly from original assumptions. As a result, the 2021/22 BJC referenced *"a re-profiling of vehicle replacements due to funding not being available for the 2020/21"*. Subsequently, the Finance & Performance Committee were advised in May 2023, that the 2023/24 BJC *"continued to include an element of "catch up" / smoothing of vehicle replacements following the inability of any fleet funding to be made available to the Trust in the 2020/21 financial year."* However, full 10 year re-profiling against the original SOP was not reported at the BJCs. A variance table would enhance understanding of current requests (including contingencies), as compared to the originally approved SOP.			Potential risk that: • Investment decisions are not appropriately informed.
Recommendations			**Priority**
6	Business Justification Cases should show investment to date (planned and approved) against plans of the Strategic Outline Programme, including variance commentary (for both vehicle numbers and values).		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
6	Agreed. A review of the existing data and narrative contained in previous business cases relating to SOP proposals will be further undertaken and consideration will be given to providing further information in future business cases as appropriate.	At future business case compilation	National Fleet Manager

Appendix B Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Electronic Patient Clinical Record: Clinical Compliance

Final Internal Audit Report

February 2024

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-2324-08
Report status:	Final
Fieldwork commencement:	23 October 2023
Fieldwork completion:	16 January 2024
Debrief meeting:	12 January 2024
Draft report issued:	25 January 2024
Management response received:	12 February 2024 & 15 February 2024
Final report issued:	15 February 2024
Auditors:	Osian Lloyd, Head of Internal Audit; Felicity Quance, Deputy Head of Internal Audit; Johanna Butt, Principal Auditor
Executive sign-off:	Andy Swinburn, Director of Paramedicine
Distribution:	Duncan Robertson, Assistant Director of Clinical Development; Kevin Webb, Head of Clinical Intelligence & Assurance; Ffion Timmins, Digital Systems Product Specialist; Keith Dorrington, Clinical Lead (ePCR)
Committee:	Audit Committee

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

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

Executive Summary

Purpose

To review the operational deployment of the electronic Patient Clinical Record being developed and assess compliance.

Overview

We have issued reasonable assurance on this area.

Management attention is required in respect of oversight of training completion. The number of staff self-certifying training completed is higher than the number of views for some of the individual training module pages.

Development is also required noting the current limitations in reporting, and associated accuracy and data quality.

Our overall assurance is based on where we would reasonably expect the Trust to be one year post implementation, recognising that a new system needs time to embed and mature.

This audit review does not provide assurance on the physical handover of patients at hospital sites or any delays with off-loading patients that contribute to handover delays.

Report Opinion

		Trend
Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	N/A - no previous report

Assurance summary[1]

Objectives		Assurance
1	Procedure notes in place	Substantial
2	Appropriate training	Reasonable
3	ePCR completion	Reasonable
4	Management information	Limited
5	EASC Clinical indicators	Reasonable

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Training self-certification	2	Operation	Medium
2	Limitations and accuracy of reporting	3, 4, 5	Design	High

1. Introduction

1.1 From October 2015 to March 2022, the Welsh Ambulance Services NHS Trust ('the Trust') generated an average of 400,000 patient clinical records a year, which were captured as handwritten notes, using the 'digipen'. From April 2022, electronic Patient Clinical Record (ePCR) technology provided by Terrafix's TerraPACE software was implemented Trust wide. It enables staff to capture information on an iPad, reducing paper, improving the accuracy of notes and enabling real-time information to be shared with healthcare partners.

1.2 The ePCR system delivers a digital patient records solution for the Trust and facilitates a more structured approach to clinical handovers. It includes access to appropriate medical information to inform on-scene decisions, and captures the treatment and medication received by the patient. It allows the Trust to exchange and report information electronically prior to a patient's arrival at hospital to better facilitate the required course of treatment. Senior clinicians providing remote advice to clinicians, whilst attending a patient, can also access the ePCR system in real-time and record their advice as part of the record.

1.3 Whilst the ePCR system offers a more structured approach, significant handover delays outside hospital emergency departments remains as one of the highest scoring risks on the Trust's Corporate Risk Register. There is recognition that this is a complex and system wide issue which results in access to definitive care being delayed and impacts on the Trust's ability to provide a safe and effective service.

1.4 The risks considered for this audit were:

a. Patients are significantly delayed in ambulances outside emergency departments;

b. Access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised; and

c. Patients potentially coming to harm and a poor patient experience.

1.5 In 2017-18 we undertook an audit of 'Handover of care at Emergency departments', to provide the Trust with assurance that operational procedures were compliant with the Welsh Health Circulars issued by Welsh Government, which provided 'Limited' assurance. A follow-up review was undertaken in 2018-19 which provided 'Reasonable' assurance. This review does not duplicate that audit and does not provide assurance on the physical handover of patients at hospital sites or any delays with off-loading patients that contribute to handover delays.

1.6 Further, we have not tested access rights to the TerraPACE system or that these are subject to regular review to ensure appropriateness.

2. Detailed Audit Findings

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

	Recommendation Priority			
	High	Medium	Low	Total
Control Design	3	-	-	3
Operating Effectiveness	-	4	-	4
Total	**3**	**4**	**-**	**7**

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

Objective 1: There are procedure notes in place on the use of the ePCR.

2.3 The Trust has a dedicated electronic Patient Clinical Records (ePCR) intranet page. Within this page, procedure notes are available, which form part of the training materials. These provide guidance to staff on the completion of the ePCR (noted under audit objective 2) for handover of the patient to the receiving health body. Review of the procedure notes confirmed that they include step by step instructions and screen shots of how to complete the ePCR.

2.4 Furthermore, the TerraPACE application also has a user manual and a 'help' section installed. There is also a training mode section on the application for staff to familiarise themselves with the application. In addition, a Frequently Asked Questions (FAQ) document has been produced to supplement the procedure notes.

2.5 Updates in respect of ePCR are communicated, as and when required, on the Trust's intranet via Clinical Notices; Digital Notices; Newsletters; and TerraPACE Application Release notes.

Conclusion:

2.6 There are sufficient resources on the Trust's intranet in respect of ePCR completion, including procedure notes and a 'frequently asked questions' document. Updates to the system are communicated on these pages. The TerraPACE application also has a user manual and training mode. Noting this, we have assessed this objective as **substantial** assurance.

Objective 2: Staff using ePCR have been identified and have received appropriate training.

2.7 The Trust has identified that a total of 2,115 staff, mainly from the Emergency Medical Service (EMS) and Ambulance Care staff groups, are required to complete the TerraPACE training.

2.8 Training is included on the learning portal linked on the Trust's intranet site. There is a two-step approach to training:

1. completion of all relevant training modules; and
2. self-certification on ESR.

2.9 Management advised that eight hours Continual Professional Development (CPD) is provided to complete the training modules. However, there is no requirement to complete a test in ESR before self-certifying. See **MA1**.

2.10 We requested an ESR report which showed that as at 19/10/23, 2,005 (94.8%) had self-certified that they had completed the training, as shown in the table below:

	Required	Achieved	Compliance %
Total Ambulance Care (all localities)	268	243	90.67%
Total EMS (all localities)	1782	1701	95.45%
020 Education & Development L6 (PZ02)	14	14	100.00%
020 National Operations & Support - Volunteer Management L6 (DZ05)	6	6	100.00%
020 Resilience/Business Continuity L6 (DZ03)	45	41	91.11%

2.11 There are a total of 18 training modules and each one has its own page on the intranet. We compared the total number of views on each page against the number of staff self-certifying that they had completed the training. This confirmed that the total number of views for the last 10 modules were lower than the number of staff that had self-certified as completing the training. For full details of the number of views against each training module, refer to Appendix B.

2.12 Management advised that a generic login was provided for full access to the training environment before implementation. The application is designed to be intuitive, where some individuals may not have completed formal training but have used demo accounts to familiarise themselves with the application. As a result, ESR compliance may exceed training module views due to the opportunities for the workforce to tailor their approach to learning the application, reflecting a diversity of learning styles.

2.13 Not all modules need completion as they are tailored to each user, which are a blend of standard and hospital users. Multiple users can access pages simultaneously, facilitating group learning rather than on an individual basis, which would apply to Emergency Medical Technician (EMT) training, and group sessions provided at the time of implementation. However, the method of delivery of training completed is not currently captured / recorded when self-certifying on ESR. See **MA1**.

2.14 From our review of the training pages, we considered many of these modules to be lengthy, which could explain the drop off in views for the latter modules. Consequently, there may be opportunity to streamline the amount of narrative included. However, we also acknowledge the management advice in para 2.12 on the various methods in which training is delivered. See **MA1**.

Conclusion:

2.15 Whilst the overall training compliance is reported at 94.8%, the number of views on the majority of training modules was lower than the number of individuals that have self-certified on ESR as completing the training. We acknowledge that there are a number of ways that training can be delivered, however this is not currently captured on ESR. We note that a number of the mandatory data fields include pre-defined options (see objective 3) and there are detailed procedure notes and sufficient 'help' functionalities available should the need arise (see objective 1). There is also opportunity to streamline the training content. Noting this, we have assessed this objective as **reasonable** assurance.

Objective 3: The ePCR is completed for every patient contact, in accordance with the operating procedures, and information is shared with healthcare partners as appropriate.

2.16 When creating a new patient record, there are a number of data fields that require a minimum criteria, these being patient name, address, date of birth, patient observations and summary. These fields are required to ensure that the data recorded meets the Trust's expectations in respect of patient information and data storage and retrieval. Patient details are required to enable a Welsh Demographics Service (WDS) lookup to match the patient demographics. There are also predefined options that must be completed as a minimum requirement for patient handover, clinical response feedback, conveyance decision and a dropdown list of hospital sites for conveyance.

2.17 Once a patient record is completed and closed, it is stored on a secure database within the Trust's IT Infrastructure. The record is saved from the point it was initially created, thus allowing multiple Trust clinicians to work on the same record during an incident.

2.18 Via a web-based portal, access is provided to hospital staff, which will allow them to view ePCRs of incoming patients, once the hospital destination has been selected on the vehicle mobile device screen by WAST clinicians. For example, when an ambulance crew has left the scene and is 'on route' to a hospital, staff at the unit will be able to access the patient record and condition report in real time prior to their arrival. Any changes that are made to the record whilst transporting the patient, for example the administration of drugs or other treatments, will also be visible. The hospital unit cannot edit records on the system - they can only view records of patients who are on route to, or have been treated by that unit.

2.19 All NHS Wales emergency departments and selected sites have access to ePCR via the web-based portal. In addition to these, the following eight English hospital sites also have access via the web-based portal: Countess of Chester Hospital; Royal Shrewsbury Hospital; Hereford County Hospital; Princess Royal Hospital Hereford; University North Staffordshire City (Stoke) Hospital; Walton Centre Fazackerley; Liverpool Heart and Chest Hospital; and Southmead Bristol Hospital. Patient records and reports can also be viewed by primary, secondary and other care

providers. A Standard Operating Procedure is in place (Clinical Notice 15/2022) for any conveyance to a non-ePCR enabled site.

2.20 Following closure of the ePCR, we were informed that the ambulance summary report is transferred to the Welsh Clinical Record Service (WCRS) and can be viewed on the Welsh Clinical Portal (WCP).

2.21 An ePCR must be completed for all patient interactions, but with some exceptions. At the date of the fieldwork, Community First Responders (CFRs) were not required to complete an ePCR. However, at the date of reporting we were informed that this requirement has now been rolled out. CFRs use a reduced version of the primary application, which synchronises together in the background. The Falls Response Teams are also currently implementing this version. However, St John Ambulance do not use ePCR for the patient. The Emergency Medical Retrieval and Transfer Services (EMRTS) use their own system, rather than TerraPACE, to complete the patient record should they arrive at the scene first.

2.22 We understand that improvement work is under way to improve awareness of the need to complete an ePCR for every patient encounter, including interfacility transfers. In addition, we were informed that the Trust is currently undergoing a review to understand the scale of where partner agencies have taken over care of a patient, or where an interhospital transfer with accompanying clinicians have been undertaken.

2.23 The Trust has developed a power BI ePCR compliance dashboard, this provides 'live' information on completed ePCRs, for further details on the use of this dashboard, refer to audit objective 4.

Conclusion:

2.24 WAST clinicians are required to complete an ePCR for every patient contact. Third party responders such as St John Ambulance are exempt as they complete their records on paper and a review is currently being undertaken to understand the scale of these. A number of data fields must be completed as a minimum criteria requirement, and these include pre-defined options. All receiving locations in Wales, along with a number of neighbouring English hospitals, have access to view the records of patients who are on route or have previously been treated by that location in real time. Noting this, we have assessed this objective as **reasonable** assurance.

Objective 4: Management information relating to the completion of ePCR is regularly reported and monitored, and issues investigated and escalated where necessary.

2.25 Previously, all data reported from the digipen was validated, although there was a time lag between recording and uploading the information. The ePCR captures significantly more data, 800 tables compared to 11 under the digipen, and this is available in real time (within the hour). This presents significant potential benefits to the Trust although it does pose a challenge around how it validates this volume of information.

2.26 A decision was taken by the Digital Directorate to report Clinical Indicators (CIs) based on the raw data inputted directly by clinicians on scene. This led to the development of mechanisms to provide assurance around data quality including the compliance / exception reports and the introduction of the clinical data assurance audits (see paras 2.39 and 2.40).

2.27 The completion rates of the ePCR are regularly reviewed by the Trust's Clinical Intelligence & Assurance Group (CIAG), which meets monthly. We reviewed the agendas and papers for this group from March 2022 to date which confirmed that standard agenda items to this group included, but not limited to:

1. *Clinical Indicator Data (AQI): Caveats for agreement;*
2. *Clinical Indicator Plan;*
3. *Clinical Indicator Reporting Dashboard;*
4. *Current Indicator Review;*
5. *ePCR Clinical Data Requests; and*
6. *the ePCR Dashboard.*

2.28 Review of the minutes confirms that the Trust has undertaken work to review and assess data quality to identify and drive improvements. Notably, the development of the Power BI ePCR Compliance and Clinical Indicator Reporting dashboards.

2.29 The compliance dashboard includes reporting on the number of incidents with incomplete patient records. We were informed a review of the data highlighted that the majority relate to records which are automatically closed if they are not updated for eight hours (due to the absence of a disposition code being entered) and a smaller number to community first responders and St John Ambulance who are operating on paper records. Further ePCR Clinical Data Assurance 'deep dives' have been undertaken as detailed within audit objective 5.

2.30 We note that these dashboards are still evolving and contain a number of caveats. We were provided with the ePCR compliance dashboard for the period 04/01/2023 to 14/06/2023. This showed that the ePCR had not been fully completed for 21% of the total attended incidents (116,321). For incidents responded to out of WAST area, up to 44% are indicated as not being fully completed (see para 2.29). We were also informed that circa 150-175 ePCRs are auto closed per day. The Trust recognises the need to create capacity to look at these in more detail. See **MA2**.

2.31 Where requested, updates from this group have been provided to Quality, Patient Experience and Safety Committee (QuEST), the most recent being the Clinical Indicator (CIs) performance report in October 2023, which are also reported to the Emergency Ambulance Services Committee (EASC), was shared (also refer to audit objective 5).

2.32 We note that, at the date of reporting, the TerraPACE Tenant Structure is currently under construction. This will allow Senior Clinicians to monitor their individual team compliance to ensure optimal patient care is delivered and identify training needs in both a reactive and proactive manner. **See MA2**.

2.33 Whilst there are further improvements required, including software upgrades to enhance the user interface with the aim of improving care bundle compliance, the Trust has recognised these and is already working towards implementing these improvements with the primary focus being data quality to date.

Conclusion:

2.34 A reporting framework is in place through CIAG and onwards to QUEST. Issues arising to date include ePCR data quality, which is essential for improved clinical indicator performance (see also audit objective 5), and limitations to the reporting from the dashboards. Work is ongoing to upgrade the software to facilitate improved data quality which requires time to fully embed. Noting this, we have assessed this objective as **limited** assurance.

Objective 5: There is improved performance against the Emergency Ambulance Services Committee (EASC) clinical indicators.

2.35 CIs are captured and reported to monitor clinical inputs or processes that affect patient outcomes. It is not a direct measure of quality but should be used to draw attention to issues that may need to be reviewed, reduce variations and bring about improvements in care for patients.

2.36 The Trust's vision for the future recognises that there is always room for improvement in patient care, quality and outcomes. To support this, the Clinical Intelligence & Assurance Team has developed a set of CIs and care bundles for a number of clinical conditions, the outcomes of which will be used to measure clinical performance, including clinical handover.

2.37 CIs were published until November 2021 using data from the 'digipens'. CI collection and reporting changed following the introduction of the ePCR within the Trust, and was suspended between December 2021 and March 2022 to focus on its rollout. From April 2022 clinical indicator data for Stroke and Fractured Neck of Femur were published from ePCR data, with other clinical indicators (ST-elevation myocardial infarction (STEMI), Hypoglycaemia and Return of Spontaneous Circulation (ROSC)) coming online following quality assurance checks. The published ambulance service indicators detail the following compliance since the rollout of ePCR (first full publication November 2022), compared with the final publication from digipen data:

Standard	Nov-21	Nov-22	Mar-23	Dec-23	Target
ROSC	10.90%	15.90%	14.00%	17.60%	None set
Stroke	98.40%	80.20%	72.20%	75.30%	95%
STEMI	85.70%	51.30%	46.30%	40.60%	95%
Hypoglycaemia	91.80%	43.10%	46.60%	51.20%	95%
Fractured #NOF	88.70%	67.40%	59.50%	61.80%	95%

2.38 The Trust papers presented to EASC have indicated the improved performance in compliance has not yet materialised since the use of ePCR. Our review of the CIAG papers noted that due to the predicted fall in clinical indicator compliance whilst the new system for creating clinical records becomes embedded, a risk has been

raised with an associated action plan internally. The risk is based on intelligence from other UK ambulance services and is predicated on the transition from validated to raw data. Management advised that this was not considered a high enough risk for inclusion on the Trust's Corporate Risk register (CRR), however, the risk is being monitored by the CIAG.

2.39 The Trust is now reporting performance against CIs using a PowerBI dashboard. This compliance dashboard is reviewed monthly by the CIAG. Due to the decision made to report on CIs using directly inputted ePCR data, the Clinical Intelligence & Assurance Team has undertaken a series of deep dive (ePCR Clinical Data Assurance') audits to determine if reporting generated from the ePCR system provides an accurate picture of the clinical care provided to patients. These audits have informed an improvement plan and future decisions on the quality of data required for reporting (see para 2.36). The following Clinical Data Assurance audits have been undertaken:

1. Fractured Neck of Femur (#NOF) Clinical Indicator (2022);
2. Stroke Clinical Indicator (2022);
3. STEMI Clinical Indicator (2022);
4. Hypoglycaemia Clinical Indicator (2022); and
5. ROSC at Hospital - Clinical Indicator (2022).

2.40 The results of these data quality deep dives shown in the table below demonstrates that the system isn't accurately reporting the Trust's compliance with care bundles, and that manual auditing gives a more accurate clinical picture of the care provided: (see **MA2**)

Standard	Compliance derived from raw ePCR data (%)	Compliance derived from audit (%)	% difference in reported compliance
Fractured NOF	67.2	83.4	+16.2
Stroke	72.1	91.2	+19.1
STEMI	25.2	66.7	+41.5
Hypoglycaemia	47.8	86.8	+39.0
ROSC	18.7	21.6	+2.9

2.41 We were informed that upgrades to the system, some of which were requested as a result of the above audits, were introduced in December 2023. This update included, but not limited to, user interface changes to the Hypoglycaemia, STEMI, Stroke & NOF care bundles and to enhance data completeness and CI compliance. We also understand that system change requests are logged by the Trust and are appropriately approved before submission, including consideration of funding requirements. We were also advised that Terrafix are required to deliver upgrades in a timely manner in line with the with the contractual arrangements.

2.42 It is expected that these updates will improve the accuracy of CI performance figures. Management advised that, in the meantime, a group has been set up, reporting to CIAG, that will determine which elements of the record will be flagged for completion (if missing or not recorded) at ePCR closure. Additionally, it has

been reported in the 'ePCR Clinical Data Assurance' audits (see para 2.38) that a re-audit will take place when the TerraPACE user interface has matured. See **MA2**.

Conclusion:

2.43 The introduction of the ePCR has not yet shown an improvement in the performance against the CIs presented to EASC. However, clinical data assurance audits are being undertaken to measure compliance and these inform required software updates to improve data quality and reporting accuracy. It is too soon to see what impact this will have on CI performance and care bundle compliance. However, recognising the steps the Trust is taking to address the completeness of information to assess performance, **reasonable** assurance has been determined at this objective.

Appendix A: Management Action Plan

Matter Arising 1: Training self-certification (Operation)	Impact
The Trust has identified that 2,115 staff are required to complete the TerraPACE training to assist in the use/completion of the ePCR. At the time of our review there was a compliance rate of 94.8%, with 2,005 having self-certified that they had completed the training (there is no requirement to complete a test in ESR before successfully self-certifying). There are a total of 18 training modules and each one has its own page on the intranet. We compared the number of total views of each page against the number of staff self-certifying that they had completed the training. This confirmed that the total number of views for the last 10 modules were lower than the number that had self-certified as completing the training (for full details of the number of views against each training module, refer to Appendix B). We understand that ESR compliance may exceed training module views due to opportunities to tailor the approach to learning the application e.g., through group sessions being held. The method of delivery is currently not captured when self-certifying completion on ESR; and such would provide more informed challenge for those training modules with lower-than-expected completion, such as obstetrics Our review of the training pages also highlighted opportunity to streamline as many of these modules were very detailed and include lengthy narrative, which could explain the drop off in views for the latter modules whilst also recognising that not all modules need completion as they are tailored to each user.	Potential risk of: • Staff who have not undertaken the full training package may not be accurately completing ePCR entries, leading to a lack of comprehensive understanding regarding appropriate ePCR recording methods.

Recommendations		Priority
1.1	To confirm accuracy of the self-certification compliance rate, management should consider capturing the method of training delivery on ESR.	**Medium**
1.2	Management should obtain feedback from staff to improve the training materials.	
1.3	Management should consider including a test in ESR to confirm competency before successfully self-certifying.	

1.4	Whilst we acknowledge there are different methods of training delivery, management should review lower viewed training modules, to confirm that the completed ePCRs are compliant with expectations in this area.	

Agreed Management Action		Target Date	Responsible Officer
1.1	For future training, the method of instruction will be captured as part of the ESR sign-off process (for example, classroom based, individual learning using the training materials, one to one instruction using the training zone in the application).	30 June 2024 (end of Q1 24/25)	Assistant Director for Clinical Development
1.2	We will design a survey via the ePCR Clinical Reference Group (CRG) for ePCR users to explore the reasons for this and how training materials might be improved to enhance ePCR completion.	30 June 2024 (end of Q1 24/25)	Assistant Director for Clinical Development
1.3	At the ePCR CRG WAST will discuss including a test to assess understanding at the completion of training.	30 June 2024 (end of Q1 24/25)	Assistant Director for Clinical Development
1.4	Through the ePCR Clinical Reference Group (CRG) we will review the lower viewed modules as set out in Appendix B of this report. This will build on knowledge discussed at the most recent ePCR CRG where a small audit has identified that the obstetric section is not being completed. However, we currently have only opened access to the Welsh GP Record (WGPR) for our cohort of Advanced and Senior Paramedics. The pathways section of the ePCR is not currently live and requires testing prior to going live, which explains the disparity reported in these sections of Appendix B.	30 September 2024. (end of Q2 24/25)	Assistant Director for Clinical Development

Matter Arising 2: Limitations and accuracy of reporting (Design)	Impact
Due to the significant increase in the volume of data being captured in the ePCR system, a decision was taken to report Clinical Indicators (CIs) based on the raw data inputted directly by clinicians on scene. This led to the development of mechanisms to provide assurance around data quality including the compliance / exception reports and the introduction of the clinical data assurance audits. We note that the compliance and CI reporting dashboards are still evolving and contain a number of caveats. We were provided with the ePCR compliance dashboard for the period 04/01/2023 to 14/06/2023. This showed that the ePCR had not been fully completed for 21% of the total attended incidents (116,321). For incidents responded to out of WAST area up to 44% are indicated as not being fully completed. We were also informed that incomplete records included those incidents that were automatically closed by the system after eight hours of inactivity due to the absence of a disposition code being entered. We were also informed that circa 150-175 ePCRs are auto closed per day. The Trust recognises the need to create capacity to look at these dashboards in more detail, and is looking to implement the tenant structure to allow Senior Clinicians to monitor their individual team compliance and to identify training needs. The Clinical Intelligence & Assurance Team has also undertaken a series of deep dive ('ePCR Clinical Data Assurance') audits to determine if reporting generated from the ePCR system provides an accurate picture of the clinical care provided to patients. The results of these data quality deep dives show that the system isn't accurately reporting the Trust's compliance with care bundles. These exercises inform required software updates to improve data quality and reporting accuracy, and there are plans to perform re-audits when the TerraPACE user interface has matured.	Potential risk of: • Sub optimal quality of data limits the Trust's ability to accurately report on the care delivered to patients.

Recommendations		Priority
2.1	The Trust, with continued support from Terrafix, should address the limitations and caveats relating to the dashboard reports to ensure that they provide robust information on all incidents.	**High**
2.2	Management should ensure the tenant structure is developed to provide data at both a team and individual level to assist in identifying training needs and drive improvement in ePCR compliance.	

2.3	The Trust should continue with its programme of Clinical Data Assurance audits to inform further upgrades required to the system to improve data quality and the accuracy of care bundle compliance reporting.	

Agreed Management Action		Target Date	Responsible Officer
2.1	We will review the compliance dashboards and amend the nomenclature used and recommend changes to the presentation of the data to ensure consistency and understanding. However, this is dependent on the capacity of Health Informatics to complete the work.	30 September 2024. (end of Q2 24/25)	Assistant Director for Clinical Development
2.2	Reporting into CIAG, we will set up a Task and Finish Group to write the plan to deliver the dashboards against the Tenant Structure. This is a complex piece and requires input from multiple directorates. It is also dependent on the capacity within teams to deliver the dashboards, therefore the output of the T&F might be a business case jointly developed between the Digital and Clinical Directorates to outline the resources required and what this would cost to deliver.	30 September 2024. (end of Q2 24/25)	Assistant Director of Clinical Development and nominated Digital Directorate Lead.
2.3	Clinical Audit Programme for 2024/25 has been agreed at CIAG and presented for approval to the February 2024 QuEST meeting. This is ongoing work and does not require a specific action as it is central business for the CIAT.	N/A – completed since fieldwork (February 2024)	

Appendix B: Training Module Completion

	Page views as at 26/10/23)	ESR: Training compliance achieved	ESR training compliance achieved v training page views
Section 1 – General:			
Module 1.1 – General overview of the TerraPACE system	5888	2005	3883
Module 1.2 – Accessing the System, User Credentials and Signing on	3855	2005	1850
Module 1.3 – Reporting faults	2979	2005	974
Section 2 – TerraPACE Application:			
Module 2.1 – Accessing Patient Record and Cooperative Working	3708	2005	1703
Module 2.2 – Generation of new Patient Records	2722	2005	717
Module 2.3 – Navigation around the TerraPACE App	2839	2005	834
Module 2.4 – Data Entry, Modification and Deletion	2367	2005	362
Module 2.5 – Report Completion and Mandatory Fields	2271	2005	266
Module 2.6 – Patient Management and Consent	1954	2005	-51
Module 2.7 – Primary Survey, Observations and Examinations	1997	2005	-8
Module 2.8 – Patient History	1836	2005	-169
Module 2.9 – Cardiac Arrest and ROLE	1968	2005	-37
Module 2.10 – Trauma and Road Traffic Collisions	1737	2005	-268
Module 2.11 – Obstetrics	1594	2005	-411
Module 2.12 – Safeguarding	1996	2005	-9
Section 4 – Welsh GP Clinical Record:			
Module 4.1.1 – WGPR	461	2005	-1544
Module 4.1.2 – WGPR Part 2	279	2005	-1726
Section 5 - NHS Directory of Services:			
Module 5.1 – NHS DOS	359	2005	-1646

Appendix C: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Archwilio Cymru
Audit Wales

Audit Committee Update – Welsh Ambulance Service NHS Trust

Date issued: February 2024

Document reference: 4047A2024

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.

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

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

Contents

Audit 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 the Trust's 2022-23 Financial Statements	Audit work is complete, and our closing 'Audit of Accounts Report' has been issued. The accounts were certified by the Auditor General on 28 July 2023, and laid with the Senedd shortly afterwards.
Independent Examination of the Charitable Fund's 2023-24 Financial Statements	The Independent Examination of the Charity's annual report and accounts has been completed, and the Auditor General certified the accounts on 29 January. They were filed with the Charity Commission on the same day, prior to the statutory deadline of 31 January.
Audit of the Trust's 2023-24 Financial Statements	The Auditor General wrote to NHS bodies on 5 February 2024 to confirm an audit certification deadline for 2023-24 accounts of 15 July 2024. We will discuss specific arrangements for the audit of the Trust's accounts in due course.

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 or completed

Topic	Focus of the work	Current status and Audit Committee consideration
Review of Unscheduled Care	This work will examine different aspects of the unscheduled care system in three parts: • Part One: Flow out of hospital • Part Two: accessing unscheduled care • Part three: national arrangements and leadership structures.	Blog and data tool published in 2022 Part One: Commenced clearance for regional reports Parts 2 and 3 to begin shortly.
Workforce planning	The review examined how local and national workforce planning activities are being taken forward to manage those risks and address short-, medium- and longer-term workforce needs.	Complete. Reported to Audit Committee in November 2023.
Structured Assessment 2023 - core	This work will review the following core areas: • Board and committee cohesion and effectiveness; • Corporate systems of assurance; • Corporate planning arrangements; and	Complete. Reported to Audit Committee in March 2024.

Topic	Focus of the work	Current status and Audit Committee consideration
	• Corporate financial planning and management arrangements. This work will also include a review of the arrangements that are in place to track progress against previous audit recommendations. This allows the audit team to obtain assurance that the necessary progress is being made in addressing areas for improvement identified in previous audit work. It also enables us to more explicitly measure the impact our work is having.	
Structured Assessment – deep dive into financial efficiencies	In addition to the core structured assessment work, we will also undertake “deeper dive” work in a specific area. We had initially identified digital transformation as the deeper dive topic for 2023. However, given the financial challenges facing the NHS at present, we are looking to now focus our deep dive work in health boards on financial savings / cost improvement plans. The focus of this work is currently being developed and further details will be shared in due course.	Underway. Fieldwork planned for March 2024. Anticipated to report to Audit Committee in May 2024.

Exhibit 3 – Planned work not yet started or revised

Topic	Focus of the work	Current status
Follow up Review of Quality Governance Arrangements	This work will examine progress made in response to previous audit recommendations during the original review of quality governance arrangements, which was reported to the Audit Committee in September 2022.	Not yet started. Planned to begin in March 2024.

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 The next Good Practice event will be on 'Transatlantic Conversations – Parallels in Homelessness' on 7 March 2024. We have also published several resources, including on the themes of 'Integrity in the Public Sector' and 'Strategy to Action: How digital makes a difference to everyday lives.' Further details of resources and future events are available on the GPX website.

NHS-related national studies and related products

6 The Audit Committee may 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 **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
Corporate Joint Committees – commentary on their progress	November 2023
NHS Wales Workforce data briefing	September 2023
Approaches to achieving net Zero across the UK	September 2023
NHS Wales Finances Data Tool	September 2023

Additional information

8 Exhibit 4 provides information on corporate documents published by Audit Wales since the last committee update. Links to the documents on our website are provided.

Exhibit 4 – Audit Wales corporate documents

Title	Publication date
Fee scheme for 2024-25	January 2024
Equality Report 2022-23	November 2023

Audit Wales

24 Cathedral Road

Cardiff CF11 9LJ

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

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

Archwilio Cymru
Audit Wales

Structured Assessment 2023 – Welsh Ambulance Services NHS Trust

Audit year: 2023

Date issued: November 2023

Document reference: 3991A2024

This document has been prepared as part of work performed in accordance with statutory functions.

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

We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

Mae'r ddogfen hon hefyd ar gael yn Gymraeg. This document is also available in Welsh.

Contents

Summary report

About this report

1 This report sets out the findings from the Auditor General's 2023 structured assessment work at the Welsh Ambulance Services NHS Trust (the Trust). Our structured assessment work is designed to help discharge the Auditor General's statutory requirement under section 61 of the Public Audit (Wales) Act 2004 to be satisfied that NHS bodies have made proper arrangements to secure economy, efficiency, and effectiveness in their use of resources.

2 Our 2023 Structured Assessment work took place at a time when NHS bodies were still responding to the legacy of the COVID-19 pandemic as they look to recover and transform services and respond to the additional demand in the system that has built up during the pandemic. Furthermore, health bodies are also dealing with a broader set of challenges associated with the cost-of-living crisis, the climate emergency, inflationary pressures on public finances, workforce shortages, and an ageing estate. More than ever, therefore, NHS bodies and their Boards need to have sound corporate governance arrangements that can provide assurance to themselves, the public, and key stakeholders that the necessary action is taken to deliver high-quality, safe, and responsive services, and that public money is spent wisely.

3 The key focus of the work has been on the Trust's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically, with a specific focus on Board transparency, cohesion, and effectiveness; corporate systems of assurance, corporate approach to planning, and corporate approach to financial management. We have not reviewed the Trust's operational arrangements as part of this work.

4 Our work has been informed by our previous structured assessment work, which has been developed and refined over a number of years. It has also been informed by:

- Model Standing Orders, Reservation and Delegation of Powers
- Model Standing Financial Instructions
- Relevant Welsh Government health circulars and guidance
- The Good Governance Guide for NHS Wales Boards (Second Edition)
- Other relevant good practice guides

We undertook our work between July 2023 and October 2023. The methods we used to deliver our work are summarised in **Appendix 1**.

5 We also provide an update in this report on the Trust's progress in addressing outstanding recommendations identified in previous structured assessment reports in **Appendix 2**.

Key findings

6 Overall, we found that **the Trust demonstrates a focus on improving its arrangements for governance, planning and finance. However, significant operational pressures, inefficiencies caused by handover delays, reliance on non-recurrent savings and lack of available funding is limiting its ability to transform services**.

Board transparency, effectiveness, and cohesion

7 **We found that Board and Committee arrangements are effective, however the Trust has a significant backlog of policies due for review, and there is scope to make some improvements to other areas of administrative governance.**

8 The Board remains committed to public transparency. Meetings are livestreamed, there are opportunities for the public to ask questions in advance of meetings and private/closed meeting actions are reported in public Board papers. The Trust publishes most meeting papers in advance of meetings. However, to further increase the transparency of Board business, the Trust should publish unconfirmed Board and committee minutes sooner, and a written version of the Chair's Report should be provided. The Trust has a significant backlog of policies that are overdue for review. However, it has developed a realistic and prioritised plan to review key policies and to improve its process for maintaining written control documents.

9 The Board and committees operate well, supported by up-to-date terms of reference and cycles of business. Meetings are well-chaired, and members provide meaningful contribution to support, scrutinise, and seek assurance on areas of performance. Papers are generally of a good standard and there is ongoing work to encourage more succinct presentations of key risks and issues. Patient and staff stories are key features of board and committee agendas that are highly valued forms of intelligence to set the tone of meetings. Work continues to enable and encourage members to make greater use of board member visits to allow members to triangulate intelligence from board and committee meetings with their observations. There will be some changes to the membership of the Board over coming months due to Non-Executive Director turnover. The Trust has taken reasonable and well-considered action to manage these changes.

Corporate systems of assurance

10 **We found that the Trust is strengthening its corporate systems of assurance, however there is more to do in key areas including the BAF and handling concerns and incidents. Operational performance continues to be extremely challenging due to increased demand and wider system pressures.**

11 The Trust maintains reasonable arrangements for managing and overseeing corporate risks. It continues to progress its risk transformation programme with several actions expected to be complete by April 2024. There are factors beyond

the Trust's control which contribute significantly to its highest risks and the Trust demonstrates a commitment to collaborating with partners to establish a shared understanding and response to these risks. The Trust has been developing its Board Assurance Framework since 2022. However, there needs to be greater Board and committee focus on the risks to the achievement of the Trust's strategic objectives.

12 The Trust maintains reasonable performance management arrangements, however operational performance remains extremely challenged due to increased demand, wider system pressures and the consequential inefficiencies created. The Trust has taken positive steps to improve its quality governance arrangements, including work to prepare for the requirements under the new Health and Social Care (Quality and Engagement) Act (2020). However, timeliness of response to concerns has deteriorated due to increased demand and capacity issues. Arrangements for tracking audit recommendations are strengthening, with greater clarity on the closure of actions and the impact achieved.

Corporate approach to planning

13 **We found that the Trust has a good corporate approach to developing strategies and plans, but plans do not include SMART milestones and delivery reports do not provide enough clarity on whether intended outcomes are being achieved.**

14 The Trust's arrangements for producing and overseeing the development of strategies and plans are reasonably sound. The Trust continues to produce Integrated Medium-Term Plans (IMTPs) as a vehicle for achieving its long-term strategic ambition. The IMTP again received approval from Welsh Government and the Trust strengthened its engagement of staff when developing its 2023-2026 plan. However, the Trust should ensure that all actions set out in the IMTP are SMART with measurable outcomes and clear delivery milestones. The Trust needs to strengthen reporting of delivery of the IMTP by increasing the focus on outcomes and impact achieved, rather than focussing solely on activity.

Corporate approach to managing financial resources

15 **We found that the Trust demonstrates strong financial performance, a good approach to financial planning and appropriate Board and committee oversight. However, the reliance on non-recurrent savings schemes, operational inefficiencies caused by handover delays and lack of available additional funding may limit the Trust's ability to support its service modernisation plans.**

16 The Trust continued its good financial track-record of meeting its financial objectives and duties both for 2022-23 and the rolling three-year period of 2020-21 to 2022-23. As of month seven (October) 2023-24, the Trust is again on track to

achieve its financial duties, which is significant given the incredibly challenging current financial challenges facing NHS Wales.

17 The Trust has robust arrangements for financial planning, which clearly identifies key risks and issues. The risks include a lack of clarity around availability of recurrent funding for ambulance staff who were originally recruited to address winter service pressures in 2022 using short-term funding.

18 The Trust had a savings gap at the time of approving its financial plan but was able to identify the necessary savings to meet this gap by month four. However, we have concerns about the level of non-recurrent savings within the Trust's plan and how this may impact the Trust in future years.

19 Inefficiencies such as ambulance handover delays and difficulties accessing additional funding limit the Trust's ability to pursue transformational change and service modernisation. Last year, we highlighted that the notional cost of handover delays was £50 million, and those delays continue to remain high. This inefficiency inhibits the ability of the Trust to redeploy its resource to support preventative treatment in the community and reduce ambulance conveyancing to hospital. We will also be considering arrangements for delivering financial efficiencies as part of our audit programme early in 2024.

Recommendations

20 **Exhibit 1** details the recommendations arising from our work. These include timescales and our assessment of priority. The Trust's response to our recommendations is summarised in **Appendix 3**.

Exhibit 1: 2023 recommendations

Recommendations
Transparency of Board and committee business R1 Opportunities exist to further enhance the transparency of Board and Committee business. The Trust should: a) provide a written Chair's Report to each Board meeting. (**Medium Priority**) b) review and publish unconfirmed minutes of committee and Board meetings within 14 days of the meeting. (**Medium Priority**)
Public access to key strategies and plans R2 The Trust should publish key plans on the Trust website, including the most recent IMTP and the People and Culture Plan. (**High Priority**)

Recommendations

Clarity of IMTP objectives/actions

R3 We found that the Trust's IMTP does not include SMART actions, many do not include a specific measurable outcome and it is also unclear in the IMTP which year each action is due for delivery. However, delivery milestones are set out elsewhere. The Trust should ensure all actions set out in future IMTPs are SMART by specifying measurable outcomes and delivery milestones. (**High Priority**)

Oversight of IMTP delivery

R4 Whilst there have been recent improvements to the reporting of IMTP progress to Committee and Board, there is scope to provide better clarity on whether the actions delivered have achieved the intended impact. The Trust should ensure all plan delivery progress reports include information about the impact achieved. (**High priority**)

Oversight of Savings plans

R5 The Trust does not clearly specify in its finance plans and reports whether savings schemes are recurrent or non-recurrent. To strengthen oversight of savings, the Trust specify whether schemes are recurrent or non-recurrent in its financial plans and reports. (**High Priority**)

Detailed report

Board transparency, effectiveness, and cohesion

21 We considered whether the Trust Board conducts its business appropriately, effectively, and transparently.

22 We found that **Board and Committee arrangements are effective, however the Trust has a significant backlog of policies due for review, and there is scope to make some improvements to other areas of administrative governance.**

Public transparency of Board business

23 We considered whether the Board promotes and demonstrates a commitment to public transparency of board and committee business. We were specifically looking for evidence of:

- board and committee meetings that are accessible to the public;
- board and committee papers are publicly available in advance of meetings;
- board and committee business and decision-making is conducted transparently; and
- board and committee meeting minutes are publicly available in a timely manner.

24 We found that **The Trust is committed to operating transparently but there are opportunities to increase public access to Board business**.

25 The Trusts holds Board meetings in-person and broadcasts live online via Facebook. Recorded meetings are available on YouTube shortly after meetings. The Trust provides appropriate signposting and guidance to enable members of the public to access meetings and submit questions to the Board. Given that members of the public can observe meetings virtually from any location, the Trust now holds each of its Board meetings in Cardiff rather than rotating meetings around Wales. This reduces lost work time to travel for most Board members. Committee meetings are virtual rather than in-person. Although not broadcast live, members of the public can request to observe committee meetings virtually.

26 The Trust altered its Standing Orders in May and September 2023, including altering the requirement to publish papers for both Board and committees from ten days in advance to seven days in advance. The Office of the Board Secretary has issued guidance and support to all directorates on the process and timelines for submitting papers for board and committee meetings. These changes, together with the establishment of clear cycles of business and timely agenda setting meetings, is improving the compliance of publishing Board and committee papers by the agreed deadline (see **Appendix 2**, **Recommendation 1a 2022**). Reasonable exceptions include finance reports to the Finance and Performance Committee, which are not uploaded in advance due to the need to present the most up-to-date position.

27 The Trust minimises the use of private (closed) meetings, reserving these for confidential and sensitive matters only. When the Board takes decisions in private, it reports those in the following public session alongside any Chair's Actions taken since the previous meeting. The Trust is reducing the use of Chair's Actions and when they do occur, public reporting of those is sufficiently detailed (see **Appendix 2**, **Recommendation 1b 2022**).

28 We have also noted a general decrease in the number of verbal presentations without accompanying papers. This supports good governance as it allows Board members to read papers in advance. However, we do note that the Chair's Report provided at each Board meeting is a verbal update. The Trust should seek to provide the Chair's Report in a written format as well as a verbal presentation (**Recommendation 1a**). This is important given that the Trust does not publish minutes of committee and board meetings until confirmed at the following meeting. To increase the transparency of Board business, and enable timely public access, the Trust should publish unconfirmed minutes within 14 days of the meeting, once reviewed by the committee chair and lead executive (**Recommendation 1b**).

Arrangements to support the conduct of Board business

29 We considered whether there are proper and transparent arrangements in place to support the effective conduct of Board and committee business. We were specifically looking for evidence of:

- a formal, up-to-date, and publicly available Reservation and Delegation of Powers and Scheme of Delegation in place, which clearly sets out accountabilities;
- formal, up-to-date, and publicly available Standing Orders (SOs) and Standing Financial Instructions (SFIs) in place, along with evidence of compliance; and
- formal, up-to-date, and publicly available policies and procedures in place to promote and ensure probity and propriety.

30 We found that **while there are proper and transparent arrangements to support the effective conduct of Board and committee business, the Trust has a significant backlog of policies that are overdue for review**.

31 The Audit Committee and Board annually review the Trust's Standing Orders, including the Standing Financial Instructions and Scheme of Reservation and Delegation. This ensures they remain up-to-date and aligned to the organisational structure. The Scheme of Reservation and Delegation clearly set out accountabilities within the Trust. Amendments to Standing Orders made in 2023 ensure they now reflect the requirements of the Health and Social Care (Quality and Engagement) (Wales) Act 2020. Officers clearly explained the changes made to Standing Orders at the Audit Committee and Board in May and September 2023 and ensured the latest approved version was publicly accessible.

32 The Trust is strengthening its approach for registering declarations of interests and recording gifts and hospitality. Its new Standards of Business Conduct policy, approved by the Board in July 2023, sets out clear expectations. During summer 2023, the Trust issued revised guidance to staff. We note, however, that the number of submissions remains low, which may mean it will take time to embed the new arrangements. The Board Secretary routinely reviews gifts and hospitality submissions issuing advice and guidance where needed.

33 At present only the Board and Executive Leadership Team are required to submit declarations of interest, although we understand that the Trust intends to broaden this requirement to include further senior decision makers in 2024. Both the Register of Declarations of Interest for the Board and Executive Leadership Team and the Register of Gifts, Hospitality and Sponsorship are now publicly available on the Trust's website (see **Appendix 2**, **Recommendation 1c 2022**).

34 In 2022, we highlighted concerns about timely policy review. In August 2023, the Trust reported that only 14% (13 out of 93) of its policies were within review date. While this remains a clear concern, the Trust has developed a robust and prioritised plan to address this significant backlog, including an urgent review of its policy on policies. In the longer-term, the Trust also intends to strengthen its process for developing written control documents. The Trust's Audit Committee is routinely and appropriately monitoring progress of all work to improve the timing of policy reviews.

Effectiveness of Board and committee meetings

35 We considered whether Board and committee meetings are conducted appropriately and effectively. We were specifically looking for evidence of:

- an appropriate, integrated, and well-functioning committee structure in place, which is aligned to key strategic priorities and risks, reflects relevant guidance, and helps discharge statutory requirements;
- Board and committee agendas and work programmes covering all aspects of their respective Terms of Reference as well being shaped on an ongoing basis by the Board Assurance Framework;
- well-chaired Board and committee meetings that follow agreed processes, with members observing meeting etiquette and providing a good balance of scrutiny, support, and challenge; and
- committees receiving and acting on required assurances and providing timely and appropriate assurances to the Board.
- clear and timely Board and committee papers that contain the necessary / appropriate level of information needed for effective decision making, scrutiny, and assurance.

36 We found that **in general, Board and committee meetings are conducted appropriately and effectively**.

37 The Trust has an integrated and well-functioning committee structure which aligns to and provides good coverage of key strategic priorities and risks. The Trust has a broadly effective approach for committee agenda setting which involves the chair, committee lead director and secretariat. During 2022-23, all committees reviewed their terms of reference and 'cycles of business'[1] to ensure full coverage of their remit and to ensure their responsibilities are discharged. We also note that the Trust's Academic Partnership Committee, originally established to achieve University Trust status, has expanded its remit to have a broader focus on research and innovation.

38 Our recent observations indicate that committee chairs manage meetings well, encouraging member discussion and identifying issues for timely and effective escalation to the Board. During 2023, issues escalated to Board included out of date policies, poor Putting Things Right[2] response times and continuing concerns relating to the impact of operational pressures on patient care and staff wellbeing.

39 The Board and its committees generally receive good quality information to support effective scrutiny, support, and challenge. Papers are available in advance of meetings, and their quality is generally good. However, some papers are lengthy, which is reflected in feedback in committee self-assessments and comments from committee members. Recent guidance from the Office of the Board Secretary on concise report writing should help to support improvements in this area. Additionally, the Trust could also use post-meeting reflections, agenda setting meetings and board development sessions to reflect on progress to improve papers and clarify expectations.

40 In our Structured Assessment 2022, we commented that non-executive directors needed to improve scrutiny so that they are assured that the Trust is taking all necessary actions to address areas of poor service quality. The Trust carefully considered and reflected upon this feedback, including by inviting us to observe more committee meetings and provide committee-specific feedback. Our recent observations found improved and well-balanced constructive challenge. Examples include discussion of stakeholder engagement results and the Trust's annual review of performance metrics used for the Trust's regular performance monitoring.

Board commitment to hearing from patients/service users and staff

41 We considered whether the Board promotes and demonstrates a commitment to hearing from patients/service users and staff. We were specifically looking for evidence of the Board using a range of suitable approaches to hear from patients/service users and staff.

[1] Committee 'cycles of business' refer to the programme of work committees have oversight for during the year, including items they have a statutory duty to oversee.

[2] Putting Things Right is the process for raising concerns or complaints in NHS Wales

42 We found that **the Trust makes effective use of staff and patient stories and is strengthening its approach to make use of board visits**.

43 The Trust continues to make good use of patient and staff stories to assist Board and committee members' understanding of the experiences of service users and staff. Our observations indicate that Board and committee members highly value these stories, and they prompt further discussion and usefully set the tone for meetings. In our 2022 Structured Assessment, we raised the need for the Trust to identify the action it can take to address issues identified in patient experience reports. Our work this year indicates that there is more to do (see **Appendix 2**, **Recommendation 2, 2022**).

44 It is important that Board members also have access to information outside of formal meetings to enable them to triangulate information and hear directly from patients and staff. The Board approved a Standard Operating Procedure for Board member visits in May 2023. The Trust is establishing a reporting process and planning the next round of visits, including ensuring appropriate geographic and organisational coverage.

Board cohesiveness and commitment to continuous improvement

45 We considered whether the Board is stable and cohesive and demonstrates a commitment to continuous improvement. We were specifically looking for evidence of:

- a stable and cohesive Board with a cadre of senior leaders who have the appropriate capacity, skills, and experience;
- the Board and its committees regularly reviewing their effectiveness and using the findings to inform and support continuous improvement; and
- a relevant programme of Board development, support, and training in place.

46 We found that **the Trust is taking appropriate action to maintain Board stability and cohesion and there is a commitment to continuous improvement.**

47 Since our previous Structured Assessment, the Board has been largely stable, with only one change in membership, a new Director of Digital. However, over the coming months the Trust anticipates several changes to its non-executive director membership with some reaching the end of their fixed term appointment.[3] While recruitment activity is ongoing, the Trust has been constrained during 2023 by

[3] We also note that the Trust's Executive Medical Director is due to retire in December 2023. Whilst the post of Executive Medical Director will not be replaced, the Director of Paramedicine will hold the executive portfolio from 1 January 2024. The Clinical Services Directorate will include two part time Associate Medical Director positions, one for an Acute Care Specialist and one for a Primary Care Specialist. They will report to the Executive Director of Paramedicine.

having to wait several months for a direct Ministerial appointment for its new Vice Chair. To cover this vacancy, the Board has appointed an existing non-executive director as interim Vice Chair from December 2023 to September 2024.

48 The Trust has prepared well for its board member recruitment by analysing its board member skill-mix to identify where it may need to secure additional specific experience. It also has a comprehensive induction programme which incorporates learning from the experiences of the most recent Board appointments.

49 The Board and committees regularly review their effectiveness via annual self-assessments. This work included a self-assessment of compliance with the Corporate Governance in Central Government Departments: Code of Practice 2017. Findings from the 2023 round were reported to the Board, including a summary of strengths and areas for improvement identified by members. Feedback showed members were happy with committee agendas and the process for escalating concerns to the board but would like to see improvements such as reducing the length of committee papers and greater focus on outcomes. As discussed in **paragraph 39**, the Trust is already demonstrating action to address this feedback.

50 The Trust's bi-monthly board development programme provides formal briefings and open discussions about strategy and performance. Recent topics include organisational strategy, board maturity and collaboration with other emergency, 'blue light' services. The Trust is developing a medium-term board development programme with the intention of becoming a high-performing Board. It intends to roll out the new programme in 2024, once it has filled all non-executive director positions.

Corporate systems of assurance

51 We considered whether the Trust has a sound corporate approach to managing risks, performance, and the quality and safety of services.

52 We found that **the Trust is strengthening its corporate systems of assurance, however there is more to do in key areas including the BAF and handling concerns and incidents. Operational performance continues to be extremely challenging due to increased demand and wider system pressures.**

Corporate approach to overseeing corporate and strategic risks

53 We considered whether the Trust has a sound corporate approach to identifying, overseeing, and scrutinising corporate and strategic risks. We were specifically looking for evidence of:

- an appropriate and up-to-date risk management framework in place, which is underpinned by clear policies, procedures, and roles and responsibilities;

- the Board providing effective oversight and scrutiny of the effectiveness of the risk management system;
- the Board providing effective oversight and scrutiny of corporate risks;
- an up-to-date and publicly available Board Assurance Framework (BAF) in place, which brings together all the relevant information on the risks to achieving the organisation's strategic priorities / objectives; and
- the Board actively owning, reviewing, updating, and using the BAF to oversee, scrutinise, and address strategic risks.

54 We found that **the Trust has reasonable arrangements for overseeing corporate risks, but it needs to reframe the BAF as a tool that brings together all relevant information on the risks to achieving strategic objectives**.

55 The Audit Committee continues to appropriately oversee the Trust's corporate risk management arrangements. The Trust's arrangements for developing and maintaining its corporate risk register appear to be working well. The Assistant Director Leadership Team routinely review the corporate risk register prior to committee and Board oversight. Our observations of committee and Board meetings indicate that discussions frequently focus on the Trust's most concerning risks. This includes red and amber performance, quality of care and outcomes, financial performance and workforce, matters, such as sickness absence.

56 The Trust recognises that several of its key risks are not wholly within its sphere of control. Management of key risks specifically relating to ambulance response times and related harm relies on close partnership working to identify and implement risk mitigating actions. The Trust discusses its highest scoring risks regularly with external stakeholders. This includes peer networks such as the Directors of Nursing and Chief Operating Officer groups, the All-Wales Chief Executive's forum and with Welsh Government. Despite these discussions, and the Trust's actions to mitigate risks, often the overall level of risk isn't reducing.

57 The Trust has a significant programme of work to further progress its risk transformation programme by April 2024. The Trust is working to develop a new risk management policy along with underpinning staff guidance on the organisation's approach and available support to manage operational risks. Work to improve the consistency of risk management and escalation is underway. This includes delivery of virtual risk training sessions with key groups in the organisation, including the Assistant Directors' Leadership Team and Operational Heads of Service. By April 2024, the Board also intends to develop risk appetite statements.

58 The Trust's Board Assurance Framework (BAF) maps the organisation's corporate risks against the deliverables of its IMTP. The Trust regularly updates its BAF and reports this to the Board and specific risks allocated to each committee. However, the BAF is focussed on the corporate operational risks, and therefore limits the extent that it provides a framework for assurances on achievement of the Trusts strategic objectives. We also observed little Board and committee discussion on

the BAF. The Trust plans to develop the BAF by April 2024 to focus on the risks relating to achieving the Trust's strategic objectives.

Corporate approach to overseeing organisational performance

59 We considered whether the Trust has a sound corporate approach to identifying, overseeing, and scrutinising organisational performance. We were specifically looking for evidence of:

- an appropriate, comprehensive, and up-to-date performance management framework in place, underpinned by clear roles and responsibilities; and
- the Board and committees providing effective oversight and scrutiny of organisational performance.

60 We found that **whilst the Trust has reasonable performance management and monitoring arrangements, operational performance continues to be extremely challenging.**

61 The Trust's Performance and Quality Framework, approved in March 2022, is comprehensive and sets out clear roles and responsibilities for staff. The Quality and Performance Management Steering Group oversees the ongoing development of the framework which includes trialling and reviewing best approaches for effectively incorporating the new requirements placed by the Duty of Quality and Duty of Candour. Despite this, operational performance remains extremely challenged due to increased demand, wider system pressures and the consequential inefficiencies. Together, these challenges are leading to avoidable patient harm.

62 The Trust reports its performance in Monthly Integrated Quality and Performance Reports which it provides to every committee and Board meeting. Despite consistent performance issues the Board continues to provide challenge and scrutiny that seek to encourage improvement. The Trust reviewed its approach for performance reporting in May 2023. This led to an improved and more rounded set of performance metrics. The Trust implemented its electronic Patient Clinical Record system during 2022-23. Once embedded, this system should enable the Trust to better link delivery activity to patient outcomes.

Corporate approach to overseeing the quality and safety of services

63 We considered whether the Trust has a sound corporate approach to overseeing and scrutinising the quality and safety of services. We were specifically looking for evidence of:

- corporate arrangements in place that set out how the organisation will deliver its requirements under the new Health and Social Care (Quality and Engagement) Act (2020);
- a framework (or similar) in place that supports effective quality governance; and

- the Board and relevant committee providing effective oversight and scrutiny of the quality and safety of services.

64 We found that **the Trust is focussing on service quality, with good committee oversight, however performance for incidents and concerns has deteriorated and additional staff are required to enable the Trust to ensure compliance with the new Duty of Candour**.

65 The Board approved its Quality Strategy in 2021, and it is due for review in 2024. Its Quality, Patient Experience and Safety Committee (QuESt) continues to appropriately review key quality information, focussing on the high level of risk of patient harm. This includes increases[4] in the numbers of incidents, concerns and coroner's requests and regular regulation 28 reports[5]. As of September 2023, the Trust reported a backlog of 200 concerns, due to capacity constraints and increasing number of complaints. The QuESt Committee is applying constructive challenge, support, and it is escalating concerns such as these to the Board.

66 The Trust has reviewed its arrangements to deliver new requirements under the Health and Social Care (Quality and Engagement) Act (2020). It undertook a self-assessment against the governance, leadership and accountability domains of the Health and Care Standards 2015. The Trust has identified a £300,000 staffing resource shortfall needed to enable the Trust to fully respond to the requirements of the Duty of Candour. At the time of our fieldwork, the Trust was considering options to fund this resource requirement.

Corporate approach to tracking recommendations

67 We considered whether the Trust has a sound corporate approach to overseeing and scrutinising systems for tracking progress to address audit and review recommendations and findings. We were specifically looking for evidence of appropriate and effective systems in place for tracking responses to audit and other review recommendations and findings in a timely manner.

68 We found that **the Trust is strengthening its systems for tracking responses to audit recommendations**.

69 The Trust is seeking to improve how it monitors implementation of internal and external audit recommendations. The Trust is working with Digital Health Care Wales to develop an automated tracker system for March 2024. This should reduce the manual work required to keep the tracker up to date. In the meantime, the Trust has developed an interim tracker which provides clear information on actions which it closed during the previous quarter and revised dates for actions,

[4] During Quarter 2 of 2023-24 the Trust received 285 incidents, 58 concerns, 183 coroner's requests and three regulation 28 reports.

[5] Regulation 28 Reports are issued by coroners to an individual, organisations, local authorities or government departments and their agencies where they believe that action should be taken to prevent further deaths.

where required. The Trust has also developed an audit guide to explain the role of audit, the mechanism for developing management responses to audit recommendations, and responsibilities for maintaining the audit tracker. These actions have also increased understanding of the purpose of audit work as well as the oversight role of each committee for their respective trackers. Focussed work has enabled the Trust to close and substantially reduce the number of outstanding recommendations on its audit tracker.

Corporate approach to planning

70 We considered whether the Trust has a sound corporate approach to producing strategies and corporate plans and overseeing their delivery.

71 We found that **the Trust has a good corporate approach to developing strategies and plans, but plans do not include SMART milestones and delivery reports do not provide enough clarity on whether intended outcomes are being achieved.**

Corporate approach to producing strategies and plans

72 We considered whether the Trust has a sound corporate approach to producing, overseeing, and scrutinising the development of strategies and corporate plans. We were specifically looking for evidence of:

- a clear Board approved vision and long-term strategy in place which are future-focussed, rooted in population health, and informed by a detailed and comprehensive analysis of needs, opportunities, challenges, and risks;
- an appropriate Board approved long-term clinical strategy;
- appropriate and effective corporate arrangements in place for developing and producing the Integrated Medium-Term Plan (IMTP), and other corporate plans; and
- the Board appropriately scrutinising the IMTP and other corporate plans prior to their approval.

73 We found that **the Trust has a good corporate approach for developing strategies and plans and they receive appropriate Board scrutiny**.

74 The Trust continues to pursue the ambitions and vision outlined in its long-term strategic framework (the Framework) titled ‘Delivering Excellence, Our Vision for 2030’ and the supporting Clinical Strategy 2020-2025. These strategic documents explain the Trust’s vision of altering its traditional service model and how it will manage demand differently. This includes increasing telephone consultations and expanding the provision of treatment in the community with the aim of reducing the levels of ambulance conveyance to hospital.

75 During 2023, the Trust has reflected on the Framework, and in a board development session, the board reviewed and re-confirmed its continued

commitment to the strategic objectives. The Trust will soon become a listed organisation under the Wellbeing of Future Generations (Wales) Act 2015 and will then also need to set well-being objectives in accordance with the sustainable development principle.

76 The Trust's Integrated Medium-Term Plan (IMTP) 2023-26 met Welsh Government requirements and secured Ministerial approval. The Trust demonstrated a good approach for internal and external engagement to support IMTP development. This included Trust senior leaders, the Chief Ambulance Services Commissioner and Health Board partners to ensure the plan was well informed and aligned to the broader health system. There were also increased levels of engagement with the Trust's staff (see **Appendix 2, Recommendation 3**). The Finance and Performance Committee and the Board had appropriate opportunities to review the draft IMTP before formally scrutinising the Plan in the March 2023 Board meeting. The Emergency Ambulance Services Committee also discussed and noted the IMTP in March 2023.

77 In terms of wider planning arrangements, the Board approved the delayed People and Culture Plan in May 2023. To inform its development of the People and Culture Plan, the Trust effectively engaged with staff, trade union representatives, non-executive directors, and other stakeholders, including peer Workforce and Organisational Development Directors, and other UK ambulance services. In addition, the Board approved the Delivery Plan to accompany the Trust's refreshed Engagement Framework in February 2023. This sets out the way in which the Trust will continue to inform, communicate, engage with and influence key partners (see **Appendix 2, Recommendation 4**). We note that neither the most recent IMTP nor the People and Culture Plan are yet published on the Trust's public website (**Recommendation 2**).

Corporate approach to overseeing the delivery of strategies and plans

78 We considered whether the Trust has a sound corporate approach to overseeing and scrutinising the implementation and delivery of corporate plans. We were specifically looking for evidence of:

- corporate plans, including the IMTP, containing clear strategic priorities/objectives and SMART[6] milestones, targets, and outcomes that aid monitoring and reporting; and
- the Board appropriately monitoring the implementation and delivery of corporate plans, including the IMTP.

[6] Specific, measurable, achievable, relevant, and time-bound

79 We found that **plans do not contain SMART actions and progress reports on their delivery do not provide enough clarity on whether intended outcomes are being achieved**.

80 The Trust's Long-Term Strategic Framework is now nearly five years old. Whilst the Board reviewed and confirmed the ongoing relevance of the objectives set out in the Framework in 2022, it is now seeking to evaluate the delivery progress to date and plans to report this early in 2024. In addition, while no significant issues were highlighted in relation to the Trust's IMTP 2023-26 development process for this year, the Board intends to ensure the IMTP 2024-27 has increased clarity on what the Trust is seeking to deliver in years two and three.

81 The IMTP 2023-26 contains five delivery programmes including Emergency Medical Service operations and four enabling programmes, including financial sustainability workstreams. The IMTP 2023-26 sets out what the Trust hopes to deliver. However, the actions in the IMTP 2023-26 are not all SMART, many actions do not contain specific measurable outcomes and it is unclear which year each action is due for delivery (**Recommendation 3**). However, Delivery Assurance Reports that set out IMTP delivery progress to the Finance and Performance Committee include delivery milestones for each action. The delivery milestones should be explicit within the IMTP to aid readers in their understanding of when IMTP actions are intended to be completed.

82 Directorates generally manage their respective corporate enabling programmes. However, strategic delivery programmes are co-ordinated and monitored by transformation boards that feed into the Strategic Transformation Board. The Strategic Transformation Board receives quarterly written assurance reports for each delivery programme, including progress against agreed delivery milestones. However, we note that the Strategic Transformation Board does not routinely consider performance, which should be a key tool to understand whether the delivery programmes are achieving the intended impact, or whether a different course of action may be necessary.

83 The Finance and Performance Committee and Board receive quarterly IMTP progress updates. It is positive to note that the delivery reports now contain richer information than previous reports which reported only whether actions were on track or not. In particular, the Finance and Performance Committee now receives a significant amount of detail showing the progress of each delivery programme. However, we note that reports continue to focus primarily on the status of actions, rather than the outcome achieved (**Recommendation 4**).

Corporate approach to managing financial resources

84 We considered whether the Trust has a sound corporate approach to managing its financial resources.

85 We found that **the Trust demonstrates strong financial performance and a good approach to planning with appropriate Board and committee oversight. However, the reliance on non-recurrent savings schemes, operational inefficiencies caused by handover delays and lack of available additional funding may limit the ability to support the Trust's service modernisation plans**.

Financial objectives

86 We considered whether the Trust has a sound corporate approach to meeting its key financial objectives. We were specifically looking for evidence of:

- the organisation meeting its financial objectives and duties for 2022-23, and the rolling three-year period of 2020-21 to 2022-23; and
- the organisation being on course to meet its objectives and duties in 2023-24.

87 We found that **the Trust has continued its good financial track-record and is currently on course to meet its objectives and duties for 2023-24**.

88 The Trust continued to maintain a good record of meeting its financial duties in 2022-23, recording a small surplus of £62,000, and achieving breakeven over the rolling three-year period 2020-23. The Trust spent its capital expenditure in line with the plans and public sector payment policy was on track.

89 As of month seven (October), 2023-24, the Trust is reporting a small surplus of £108,000 and forecasting a year-end breakeven position. However, capital expenditure plans are not yet finalised. The Trust is also facing greater financial challenges than in previous years. The Trust has been awaiting confirmation of recurrent funding for the additional frontline staff recruited during 2022 which were required to manage winter pressures. The Trust received £3 million to cover the additional staff pay costs in 2022-23 but has been unclear as to whether Welsh Government or Commissioners would provide the recurrent full-year costs, amounting to £5.7 million in 2023-24. The Trust has been in frequent contact with Welsh Government and, as of month seven, Welsh Government confirmed £3.5m of funding for 2023-24. The Trust is forecasting meeting the remaining funding gap through over-delivery of savings schemes and use of a contingency reserve.

Corporate approach to financial planning

90 We considered whether the Trust has a sound corporate approach to overseeing and scrutinising financial planning. We were specifically looking for evidence of:

- clear and robust corporate financial planning arrangements in place;
- effective financial arrangements in place which enable the Board to understand cost drivers and how they impact on the delivery of strategic objectives;
- the Board appropriately scrutinising financial plans prior to their approval;
- sustainable, realistic, and accurately costed savings and cost improvement plans in place which are designed to support financial sustainability and service transformation; and
- the Board appropriately scrutinising savings and cost improvement plans prior to their approval.

91 We found that **the Trust has a robust corporate approach to financial planning, however, the reliance on non-recurrent savings schemes may create significant financial challenges in future years and costly operational inefficiencies caused ambulance handover delays may limit the ability to transform services.**

92 The Board and Finance and Performance Committee scrutinised the Trust's financial plan as part of its IMTP 2023-26 in March 2023. The financial plan appropriately identifies the current financial challenges and risks, including the lack of clarity for funding additional frontline staff (see **paragraph 89**) and inflationary pressures. The Trust is aware of its cost drivers, which again for 2023-24 included the significant inflationary costs for power and fuel, digital licenses and non-recurrent savings brought forward from 2022-23. Against this context, the financial plan reasonably sets out areas that the Trust is prioritising for funding, and the Trust sought to agree all changes with commissioners.

93 At the time of approving the financial plan for 2023-24, the Trust had a £6 million funding gap. The Trust identified £3.5 million of savings by March 2023, with the Board proceeding at risk until month four, when the remaining saving schemes were fully identified and formed. As of month seven (October), 2023-24 the Trust has achieved savings of £4.3 million against its year-to-date target of £3.7 million.

94 Currently, the Trust does not explicitly specify whether its savings schemes are recurrent or non-recurrent. Going forward, financial plans should focus on financially sustainable service models to reduce reliance on short term 'cost control' fixes (**Recommendation 5**). We have previously highlighted risks around the Trust's reliance on vacancy management to achieve savings. It has increased its non-operational staff vacancy savings target from £907,000 in 2022-23 to £2.6 million in 2023-24. As of month seven, the Trust was overachieving against the savings plan by £45,000 having achieved £228,000. In addition, the Trust is also seeking to control the level of staff overtime allocation. These are short-term

solutions that may create further pressures or prompt additional agency spending to compensate for unplanned resource gaps over the winter.

95 In addition, in our 2022 Structured Assessment we described how handover delays amounted to inefficiencies costing £50 million in 2021-22, and handover delays remain unacceptably high in 2023. Operational pressures and associated inefficiency mean that the Trust is limited in its ability to transform and modernise its workforce according to the Trust's longer-term ambitions.

Corporate approach to financial management

96 We considered whether the Trust has a sound corporate approach to overseeing and scrutinising financial management. We were specifically looking for evidence of:

- effective controls in place that ensure compliance with Standing Financial Instructions and Schemes of Reservation and Delegation;
- the Board maintaining appropriate oversight of arrangements and performance relating to single tender actions, special payments, losses, and counter-fraud; and
- the organisation's financial statements for 2022-23 were submitted on time, contained no material misstatements, and received a clean audit opinion.

97 We found that **the Trust has sound arrangements in place to oversee and scrutinise financial management**.

98 The Trust's financial systems and controls continue to operate effectively. As mentioned in **paragraph 31**, the Audit Committee and the Board reviewed the Standing Financial Instructions in May and September 2023. The Trust's Audit Committee appropriately oversees and scrutinises information on losses and special payments in its public session, and counter-fraud activity, procurement controls and single tender actions in the private session of each meeting. The programme of Internal Audit work during the previous year (to the time of reporting) has not identified any significant concerns relating to financial or budgetary control. No significant financial control issues have been reported to the Audit Committee this year.

99 The Trust submitted good quality draft financial statements for 2022-23 for audit within the required Welsh Government timeframe. Our audit identified no material or uncorrected misstatements. Following Board approval of the accounts, we issued an unqualified audit opinion on 25 July 2023.

Board oversight of financial performance

100 We considered whether the Board appropriately oversees and scrutinises financial performance. We were specifically looking for evidence of:

- the Board receiving accurate, transparent, and timely reports on financial performance, as well as the key financial challenges, risks, and mitigating actions; and
- the Board appropriately scrutinising the ongoing assessments of the organisation's financial position.

101 We found that **the Trust provides timely and accurate reports on financial performance to committee and Board, however reporting could be clearer to strengthen assurance and scrutiny**.

102 There is regular oversight of financial spending and saving performance at both executive and Board level. The Trust regularly submits finance reports to the Strategic Transformation Board, the Executive Leadership Team, and the Finance and Performance Committee.

103 In September 2023 the Trust reflected on the increasing public sector financial challenges and their impact on NHS Wales. As a result, the Trust expanded its financial sustainability programme reporting to the Finance and Performance Committee. Our Board and committee observations shows that Board members understand the current financial situation and provide appropriate scrutiny as well as supporting improvements where possible.

104 Financial reports during 2023 have included a mix of PowerPoint presentations containing the most up-to-date position to the Finance and Performance Committee, followed by a written report to the following Board meeting. Whilst both the PowerPoint presentations and the subsequent written reports highlight the most current financial situation and associated risks, the written reports presented to Board provide greater detail and clarity. As highlighted in **paragraph 26,** due to timing, finance presentations are not consistently shared ahead of Finance and Performance Committee meetings, which means members cannot prepare in advance. While this approach is understandable, the Trust should remain mindful that verbal presentations provide the necessary clarity and detail to support the presentations to enable members to understand and scrutinize key issues. In addition, as discussed in **paragraph 93** the Trust does not currently make clear within finance reports which of its savings are recurrent or non-recurrent.

Appendix 1

Audit methods

Exhibit 2 below sets out the methods we used to deliver this work. Our evidence is limited to the information drawn from the methods below.

Element of audit approach	Description
Observations	We observed Board meetings as well as meetings of the following committees: • Audit Committee; • Finance and Performance Committee; • Quality, Experience and Patient Safety Committee; • People and Culture Committee; and • Academic Partnerships Committee.
Documents	We reviewed a range of documents, including: • Board and Committee Terms of Reference, work programmes, agendas, papers, and minutes; • key governance documents, including Schemes of Delegation, Standing Orders, Standing Financial Instructions, Registers of Interest, and Registers of Gifts and Hospitality; • key organisational strategies and plans, including the IMTP; • key risk management documents, including the Board Assurance Framework and Corporate Risk Register; • key reports relating to organisational performance and finances; • Annual Report, including the Annual Governance Statement;

Element of audit approach	Description
	• relevant policies and procedures; and • reports prepared by the Internal Audit Service, Health Inspectorate Wales, Local Counter-Fraud Service, and other relevant external bodies.
Interviews	We interviewed the following Senior Officers and Independent Members: • Chief Executive Officer; • Chair; • Board Secretary; • Chair of Audit Committee; • Chair of Academic Partnerships Committee; • Executive Director of Strategy, Planning and Performance; • Executive Director of Finance & Corporate Resources; and • Director of Partnerships and Engagement.

Appendix 2

Progress made on previous-year recommendations

Exhibit 3 below sets out the progress made by the Trust in implementing recommendations from previous structured assessment reports.

Recommendations from 2022	Description of progress
Administrative governance R1 We have identified opportunities for the Trust to further increase transparency by strengthening administrative governance by: a) Ensuring the timely publication of committee papers in advance of meetings and minutes following the end of meetings to the Trust website; b) Enhancing the recording of chair's actions and decisions taken in private session, for example by identifying the costs and delivery risks relating to decisions made; c) Providing the declarations of interest, gifts, and hospitality as a specific document available to be publicly viewed; and d) Reconsidering receiving all counter fraud information within the private session of the audit committee.	a) **Superseded by R1b 2023.** While there has been increase in the number of papers published in advance of meetings, the Trust continues to only publish meeting minutes once they have the committee has approved at the following meeting, which is two to three months later. b) **Complete.** There has been a clear reduction in the use of Chair's Actions during 2023, as well as improvements to the way these are reported to the Board. Reporting of Chair's Actions provide sufficient detail including assurance that the Trust appropriately followed governance and process requirements. c) **Complete.** The Trust's register of declarations of interest and register of gifts, hospitality and sponsorships are accessible via the Trust website. d) **Complete.** The Trust has considered reporting its counter fraud activity within the public session of the audit committee, however, has decided not to.

Recommendations from 2022	Description of progress
Patient experience reporting R2 Improve quarterly patient experience reporting to QuESt by ensuring a balance of both positive and negative feedback and providing information on what is being done to address the negative themes arising in the report.	**In progress.** While the Trust does report negative feedback received within its patient experience reports, there is little narrative on actions in place or planned to address any issues identified. While generally negative feedback requires actions by other organisations, in areas within the Trust's control, such as ensuring timely translation services, we would expect to see further narrative on the actions the Trust will take to improve.
Staff involvement in the development of future key plans R3 The Trust should take steps to ensure its key strategic plans, including the IMTP, are developed with, and informed by its staff.	**Complete.** The process for developing the IMTP 2023-26 involved more staff engagement than in 2022-25. The Trust recognises that this should be an ongoing feature of IMTP planning.
Develop engagement delivery plans R4 While the Trust has recently refreshed its high-level engagement framework, it should seek to urgently publish and progress detailed plans to support it in providing external in relation to unscheduled care system pressures.	**Complete.** The Board approved the Engagement Framework phased delivery plan at the January 2023 meeting.
Ensure evaluation of effective staff wellbeing services R5 While the Trust has introduced a programme of services to support staff wellbeing, it is not currently undertaking sufficient evaluation and review to ensure these are meeting the needs of staff. The Trust should introduce a regular process to evaluate its staff wellbeing services, such as via pulse surveys or participant questionnaires. This evaluation should inform long-term investment decisions for such services.	**Complete.** The Trust worked with Swansea University to conduct a wellbeing survey and a report of the survey results was shared with the Trust's Executive LeadershipTeam in February 2023. The report contained insight into the wellbeing services offered by the Trust as well as suggested areas for further focus.

Appendix 3

Organisational response to audit recommendations

Exhibit 4: Trust response to our audit recommendations

Ref	Recommendations	Organisational response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R1	**Transparency of Board and committee business** Opportunities exist to further enhance the transparency of Board and Committee business. The Trust should: a) provide a written Chair's Report to each Board meeting. (**Medium Priority**) b) review and publish unconfirmed	(a) Agreed. A written Chair's Report will be provided to each Board meeting effective the January 2024 Board meeting (b) Agreed that minutes should be drafted and approved by the Chair and Executive Lead within 14 days. However, these are not final until approved by the Board/Committee. To facilitate transparent and timely communication, it is proposed that the AAA report from the Committee Chair to the Board is published within 14 days of the meeting. These AAA reports provide a summary of the meeting and gives the attendance and agenda items also.	To commence in January 2024 and ongoing thereafter To commence in January 2024 and ongoing thereafter	Trish Mills, Board Secretary Trish Mills, Board Secretary

Ref	Recommendations	Organisational response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	minutes of committee and Board meetings within 14 days of the meeting. (**Medium Priority**)			
R2	**Public access to key strategies and plans** Publish key plans on the Trust website, including the most recent IMTP and the People and Culture Plan. (**High Priority**)	Agreed – these are both now on the website	Completed	Trish Mills, Board Secretary
R3	**Clarity of IMTP objectives/actions** We found that the Trust's IMTP does not include SMART actions, many do not include a specific measurable outcome and it is also unclear in the IMTP which year each action is due for	The IMTP is a three year plan. Assurance on delivery of the plan in year is to the Finance and Performance Committee and the Board via the Strategic Transformation Board. These in year actions will be SMART and wherever possible specify measurable outcomes and delivery milestones.	May 2024 reporting to Finance and Performance Committee	Rachel Marsh, Executive Director of Strategy, Planning and Performance

Ref	Recommendations	Organisational response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	delivery. However, delivery milestones are set out elsewhere. The Trust should ensure all actions set out in future IMTPs are SMART by specifying measurable outcomes and delivery milestones. (**High Priority**)			
R4	**Oversight of IMTP delivery** Whilst there have been recent improvements to the reporting of IMTP progress to Committee and Board, there is scope to provide better clarity on whether the actions delivered have achieved the intended impact. The Trust should ensure all plan delivery progress reports include information about the	Agreed. Consideration will be given as to how this can best be achieved, and this will be taken forward into the 2024/25 reporting processes.	June 2024	Rachel Marsh, Executive Director of Strategy, Planning and Performance

Ref	Recommendations	Organisational response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	impact achieved. (**High priority**)			
R5	**Oversight of Savings plans** The Trust does not clearly specify in its finance plans and reports whether savings schemes are recurrent or non-recurrent. To strengthen oversight of savings, the Trust specify whether schemes are recurrent or non-recurrent in its financial plans and reports. (**High Priority**)	Agreed Whist not always specifically called out in the main report, the Trust is required to provide a monthly financial return to WG that details recurrent schemes. The latest return is provided as an appendix to every financial report. Consideration will be given to more explicitly calling some of this out in the main body of the report. Recognising the current and future climate for the public sector and the NHS specifically, the organisation has instigated a strategy of pursuing a Financial Sustainability Program to identify increases in recurrent savings schemes via two separate working group lenses of Achieving Efficiency and Income Generation in mitigation. This should also allow for greater clarity of the split between recurring and non-recurring savings within future financial plans. It is inevitable however that an element of any in year delivery of financial balance will include an element of non-	March 2024	Chris Turley, Executive Director of Finance & Corporate Resources

Ref	Recommendations	Organisational response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
		recurrency, whether that be spend or savings.		

Audit Wales

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

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

AGENDA ITEM No	**9**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**5**

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

MEETING	Audit Committee
DATE	1st March 2024
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 principal risks and an update on the risk management transformation programme.

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

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

4. The principal risks are updated as at 7th February 2024 and each of the risks have been reviewed during this reporting period in line with the agreed schedule detailed at Annex 3. Focus has been given to the risk ratings, controls, assurances, gaps, and mitigating actions.

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

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

7. As reported at the last Board meeting; **Risk 139** *Failure to Deliver our Statutory Financial Duties in accordance with legislation* has achieved its target risk score of 8 (2x4). The risk has reduced in score from 16 (4x4) and will remain on the CRR and continue to be monitored in month and it is expected that the risk score will increase in the next financial year due to the challenging financial climate.

8. **Risk 594** *The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death* was increased in score from 15 (3x5) to 20 (4x5) along with Risk 163 *Maintaining Effective and Strong Trade Union Partnerships* from 16 (4x4) to 20 (5x4).

9. The title of **Risk 424** was amended to include a reference to revenue, capital and staff capacity and now reads *Resource availability (revenue, capital, and staff capacity) to deliver the organisation's Integrated Medium-Term Plan (IMTP).*

10. The summary description of **Risk 201** *A loss of stakeholder confidence that damages the Trust's reputation* has been strengthened in the last review along with controls, assurances and actions..

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

12. Notwithstanding, a detailed review, discussion and challenge takes place with the Executive Leadership Team (ELT) and Assistant Director Leadership Team (ADLT) on these risks monthly.

13. The Risk Transformation Programme enters its third and final year as set out in the 2024/25 IMTP. External support has been commissioned to support the team to progress the programme advising on best practice in areas such as the strategic BAF, risk appetite and exploring options for digitising the BAF. The programme will see the delivery risk management training for the Board and across the organisation building on bespoke sessions already on offer to staff groups, risk leads and directorates.

14. The Risk Management Policy is before the Audit Committee for approval ahead of endorsement at Trust Board. Risk Management guidelines are available for staff, and procedures will be finalised for publication along with the Policy following Board endorsement on 28 March 2024.

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

(1) Note the review of each principal risk including ratings and mitigating actions.
(2) Note the reduction in risk score of Risk 139 to the target score of 8.
(3) Note the increase in risk score of Risk 594 from 15 to 20.
(4) Note the increase in risk score of Risk 163 from 16 to 20.
(5) Note the amendment to the summary description of Risk 201
(6) Note the amendment to the title of Risk 424.
(7) Note the update on the Risk Management Transformation Programme.
(8) Approve the Risk Management Policy.

KEY ISSUES/IMPLICATIONS
The key issues and implications are set out in the Executive Summary above.
REPORT APPROVAL ROUTE
Each of the Principal Risks have been or are due to be considered by the following Committees, as relevant to their remit, during the forthcoming reporting period: EMT (07 February 2024) Finance & Performance Committee (19 March 2024) Trust Board (28 March 2024)

REPORT ANNEXES
SBAR report. Annex 1 - Summary table describing the Trust's Principal Risks. Annex 2 – Scoring Matrix Annex 3 – Frequency of Risk review Annex 4 - Board Assurance Framework Appendix 1 – Risk Management Policy

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

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

SITUATION

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

BACKGROUND

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

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

ASSESSMENT

4. The summary of the Trust's 14 principal risks is set out in Annex 1 with the full risk detail including controls, assurances, gaps and mitigating actions contained within the Board Assurance Framework (BAF) in Annex 4.

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

Principal Risks

6. Each of the risks have been reviewed during this reporting period in line with the agreed review schedule detailed at Annex 3. Focus has been given to each of the risk ratings and the mitigating actions identified and taken to ensure that risks achieve their target score. This is in addition to the regular review of controls, assurances, and any gaps.

7. Specifically, The Trust's highest rated Risks 223 *the Trust's inability to reach patients in the community causing patient harm and death* and Risk 224**:** *significant handover delays outside A&E departments impacts on access to definitive care being delayed and affects the trust's ability to provide a safe and effective service*, scoring 25, remain unchanged because of sustained and extreme

pressure across the Welsh NHS urgent and emergency care system which is negatively impacting on patient flow leading to avoidable patient harm and death. These risks continue to be regularly dynamically reviewed and closely monitored by management, Board Committees, at the Trust Board meetings as well as at internal forums.

8. As reported to the January 2024 Trust Board, whilst good progress has been made on the actions that the Trust can control, the extreme pressure continues. As a result, the likelihood is that the levels of avoidable harm will continue. That does not mean that the Trust is not continually seeking additional actions to mitigate these risks and the actions are articulated in the avoidable harm paper that the Board receive at each meeting.

9. Several updates have been made to the controls and assurances in relation to Risk 223 and 224 during this period and these are highlighted on the BAF to address gaps in assurance.

10. These two risks have been reviewed closely in conjunction with each other to ensure the synergy between them both and ensure that they reflect the actions from the avoidable harm paper in the same way.

11. Additionally, these risks will be considered further as to how the Trust can approach them by applying the risk appetite methodology as part of the Risk Management Improvement Programme and the most efficient and effective way of managing them internally.

12. Risk 160 *High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service*, whilst good progress is being made to reduce sickness absence, a decision has been made to keep the risk rating under review and work has been undertaken to strengthen the controls, assurances and mitigating actions during the last review.

13. Risk 163 *Maintaining Effective & Strong Trade Union Partnerships* – It was recognised that there would need to be a period of healing across the organisation following the industrial action in 2023. Since this has ended, there has been a significant focus placed on maintaining effective and strong trade union relationships at all levels. Whilst this has helped to improve communication and understanding of different styles and approaches there is still work to do particularly in relation to clarity of roles, openness and building trust. Several issues are currently being discussed where concerns have been raised by the TUs in relation to progressing respect and resolution processes due to dissatisfaction with management response.

14. On this basis, the score has increased from 16 (4x4) to 20 (5x4). Work has been undertaken to draw out and strengthen the mitigating actions and seek to reduce the score.

15. In relation to Risk 201 *A loss of stakeholder confidence that damages the Trust's reputation*, whilst it is acknowledged that the rating for this risk remains high and has been static for some time given the status, the Trust is not able to de-escalate it. This risk is reviewed by the People and Culture Committee at each meeting and a deep dive was held at the last meeting in November 2023 and it was a topic of discussion at the ELT away day in December 2023.

16. As a result of these discussions, the risk summary description has been strengthened as follows:

IF there is an inability of the Trust to deliver its core services because of system or organisational pressures

THEN there will be a loss of stakeholder confidence in the Trust

RESULTING IN a lack of stakeholder support for the Trust's long term strategic vision, a failure to deliver its strategic ambition, damage to reputation and increased external scrutiny.

17. This more closely describes the difficulties in being able to progress the Trust's long term strategic ambition because of lack of stakeholder confidence and support. Additional controls and mitigations have been articulated to support this change during the detailed review in January 2024.

18. As reported to the January 2024 Trust Board, Risk 594 *The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death* has increased in from 15 (3x5) to 20 (4x5) which reflected the Health Board's declining to include the testing of plans to release ambulances in a recent mass casualty exercise. Additionally, the Trust was unable to fulfil its PDA as part of the Manchester Arena Inquiry recommendation due to ambulance being delayed at hospital and Health Boards being unable or unwilling to release them in three out of four scenarios. The lack of assurance led to the increased risk score. Since then, the Health Board's have agreed to put their own policies in place to ensure that ambulances are released in the event of a civil contingency event. The risk score will be reviewed in the next reporting period.

19. The risk title has been amended on Risk 424 from Prioritisation or Availability of Resources to Deliver the Trust's IMTP to *Resource availability (revenue, capital and staff capacity) to deliver the organisation's Integrated Medium-Term Plan (IMTP)*.

Additional work will be undertaken to ensure that the change is reflected in the controls, assurances, and mitigating actions.

20. Risk 458 *A confirmed commitment from EASC and/or Welsh Government* is required in relation to funding for recurrent costs of commissioning, the risk is linked to 139; however, the score remains unchanged currently.

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

22. Risk 543 *Major disruptive incident resulting in a loss of critical IT systems* - Most mitigating actions are complete on Risk 543; however, the score remains unchanged as further reviews of the CE assessor and CRU reports are required to identify any further actions that need to be undertaken.

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

24. Risks 100 *Failure to persuade EASC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience* and Risk 283 *Failure to implement the EMS Operational Transformation Programme* remain unchanged and are not due for review again until April 2024.

25. As reported at the last Board meeting; Risk 139 *Failure to Deliver our Statutory Financial Duties* in accordance with legislation has achieved its target risk score of 8 (2x4). The risk has been considered in conjunction with the level of financial risk detailed in the Trust's financial monitoring returns submitted to Welsh Government. The score has shown to improve in year as a result, in part due to the Trust being able to resource the remaining cost of the Emergency Medical Service (EMS) staff increase itself in year, whilst further confirmation and assurance has been received from Welsh Government on any pay award funding due. In addition, a recent letter from Welsh Government confirmed that the Trust does not need to contribute anything further to the wider NHS Wales deficit reduction plan or will see any further reduction in its income to do so, providing further confidence that for this financial year, the risk has reduced. It must be noted that even though the level of risk has reduced during this year, the current challenging financial climate for all public sector organisations means that the risk will remain elevated as focus turns towards financial planning for the new

financial year, for example, recurrent funding will still need to be agreed with Commissioners for 2024/25 for the 100 wte EMS staff.

26. Because of this, the risk will remain on the CRR and continue to be monitored in month and it is expected that the risk score will increase in the next financial year.

Development of New Principal Risks

27. Work continues to consider and develop potential new Risks for inclusion on the CRR in the following areas:

a) 111 Service Risks including Symptom Checkers, Website, Clinical Workforce training and funding.
b) Decarbonisation Risk (overarching the programme risks).
c) Covid-19 Inquiry risk.
d) Charity Risks.
e) Volunteer Fundraising Risk.
f) Clinicians delivering treatments outside their scope of practice.
g) Information Governance Risk.
h) Digital Risks.

Risk Management Policy

28. The Risk Management Policy has been developed and is before the Audit Committee for approval ahead of endorsement at Trust Board on 28 March 2024. A procedural document will be finalised to support the delivery of the Policy following publication. The Policy replaces the Trust's Risk Strategy.

Risk Management Transformation Programme

29. The Trust embarked upon a risk management transformation programme during 2023/24 to further strengthen and positively impact the development of the Trust's future strategic ambition and provide clarity on the risks that would prevent us from achieving our organisational objectives.

30. Areas of focus for the risk management improvement programme plan this year were to deliver a risk management framework as a key enabler of our long-term strategy and decision making and build on the positive risk culture embedded during 2022/23 which saw the re-articulation of the Trust's principal risks.

31. The programme will enter its third and final year, as set out in the 2024/25 IMTP, and will predominantly focus on the design and delivery of a strategic BAF that reflects more closely the Trust's strategic objectives against its long-term strategy – Delivering Excellence: Vision 2030. This will be aligned to a series of strategic risks and see the development of a suite of risk appetite statements as well as exploring

options for a future digital BAF. External support has been commissioned to advise the team on best practices in these areas and draft the road map into 2024/25.

32. A programme of training and education will be developed and delivered on both the risk management framework and the BAF during 2024/25 and build on the bespoke sessions already on offer to staff groups, risk leads and directorate business meetings.

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

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

(1) Note the review of each principal risk including ratings and mitigating actions.
(2) Note the reduction in risk score of Risk 139 to the target score of 8.
(3) Note the increase in risk score of Risk 594 from 15 to 20.
(4) Note the increase in risk score of Risk 163 from 16 to 20.
(5) Note the amendment to the summary description of Risk 201
(6) Note the amendment to the title of Risk 424.
(7) Note the update on the Risk Management Transformation Programme.
(8) Approve the Risk Management Policy.

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)** →
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	Director of Workforce & Organisational Development	**20 (5x4)** ↑ **16 (4x4)**

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		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.		
201 PCC	A loss of stakeholder confidence that damages the Trust's reputation	**IF** there is an inability of the Trust to deliver its core services because of system or organisational pressures **THEN** there will be a loss of stakeholder confidence in the Trust **RESULTING IN** a lack of stakeholder support for the Trust's long term strategic vision, a failure to deliver its strategic ambition, damage to reputation and increased external scrutiny	Director of Partnerships & Engagement	**20 (4x5)** →
594 FPC	The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death	**IF** a major incident or mass casualty incident is declared **THEN** there is a risk that the Trust cannot provide its pre-determined attendance as set out in the Incident Response Plan and provide an effective, timely or safe response to patients **RESULTING IN** catastrophic harm (death) and a breach of the Trust's legal obligation as a Category 1 responder under the Civil Contingency Act 2004.	Director of Operations	**20 (4x5)** ↑ **15 (3x5)**
424 FPC	Resource availability (revenue, capital, and staff capacity) to deliver the organisation's Integrated Medium-Term	**IF** resources are not forthcoming within the funding envelope available to WAST (link to risk 139)	Director of Strategy Planning and Performance	**16 (4x4)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
	Plan (IMTP)	**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		
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)** →
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	Director of Digital Services	**15 (3x5)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		THEN there is a risk of a significant information security incident **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		
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)** →
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	Director of Strategy Planning & Performance	**12 (3x4)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		staff and key outcomes within the IMTP not being delivered		
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)** →
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	**8 (2x4)** ↓ **16 (4x4)**

Annex 2 - Risk Scoring Matrix

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

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

Annex 3 - Frequency of Risk Review

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

Annex 4 – Board Assurance Framework

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	17/01/2024	TREND	25 (5x5)
		Date of Next Review:	14/02/2024	➡	

IF significant internal and external system pressures continue	THEN there is a risk of an inability and/or a delay in ambulances reaching patients in the community	RESULTING IN patient harm and death

	Likelihood	Consequence	Score
Inherent	4	5	20
Current	5	5	25
Target	2	5	10

IMTP Deliverable Numbers:

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

Risk Commentary Q3 2023/24

The risk score remains constant at 25 (almost certain & catastrophic). Internal and external assurances remain weak as there remains a daily risk of actual patient harm and death because of the Trust not being able to reach patients in the community. **The Trust continues to receive Prevention of Future Death Reports (Regulation 28) from Coroners across NHS Wales. The Trust has received 6 reports since April 2023, including 1 report in quarter 3 2023/4. 5 of these reports directly relate to system pressures with the coroners raising concerns about delays in responding to patients in the community and handover of care delays at emergency** departments. In **November** 2023, over **20,126** hours were lost **and 22,756 in December 2023.** Only Cardiff & Vale University Health Board has demonstrated material improvement and is a positive outlier. The impacts on patients waiting for extended periods of time both in the community and then outside emergency departments is well documented (AACE Delayed Hospital Handovers: Impact assessment of patient harm, 2021) and includes pressure damage, acute kidney injury, deconditioning, poorer outcomes, and extended recovery times. Delays across the system continue to be the focus of patient safety incidents, complaints, Coronial enquires and redress / claims. The effectiveness of our controls in many areas are dependent on external partners acknowledging and having ownership of the risk across the urgent and emergency care system. Key to moving the position is to continue to work in collaboration influencing system partners, being present and engaging in key conversations, whilst continually seeking opportunities internally to swiftly identify and mitigate the risks within our control and share those with relevant system partners that we cannot control. Of note, recent data analysis highlights the increased levels of red activity which has doubled since the pre covid period, plus an average increased on scene time of circa 10 minutes. Both measures are reflective of an increasingly challenged system with WAST crews fully exploring admission avoidance alternatives.

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

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

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

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	17/01/2024	TREND	25 (5x5)
		Date of Next Review:	14/02/2024	➡	

IF significant internal and external system pressures continue	THEN there is a risk of an inability and/or a delay in ambulances reaching patients in the community	RESULTING IN patient harm and death

	Likelihood	Consequence	Score
Inherent	4	5	20
Current	5	5	25
Target	2	5	10

	setting to mitigate the risk. ELT has therefore agreed to grow the APP numbers further this year, redirecting existing operational spend to bolster APP growth.
9. Clinical Safety Plan	9. Clinical agreement – agreeing escalation to higher levels, ODU dashboard, AACE paper through National Director of Operations group. **In December 2023, Version 2.21 of the Clinical Safety Plan was released. The subsequent reduction in the demand is the assurance which is dynamically monitored via ODU.**
10. Recruitment and deployment of CFRs	10. CFR numbers have grown during 2022/23 which alongside a cleanse of the volunteer database has realised 500 current active volunteers with an ambition to recruit a further 100 by end of Q4. Response data indicates that our CFRs are reaching more patients, especially those with life threatening conditions in 8 minutes compared to this time last year. Numbers of CFR's, percentage of contribution to performance a governance framework is in place. Monitoring through AD 1:1's and volunteer highlight report (IMTP).
11. ETA scripting	11. The ETA Dashboard is a tactic that was signed off by ELT. The dashboard supports scripting analysed by comparing with real time data. ETA performance is reviewed weekly at SLT weekly performance meeting. The effect of the ETA scripting results in cancellations of ambulances which is monitored through algorithmic review process.
12. Clinical Contact Centre (CCC) emergency rule	12. Emergency Rule is incorporated into CSP 999 levels.
13. National Risk Huddle	13. This is a tactic contained in REAP ratified through SPT and EPT. Daily risk huddles are recorded, and documented actions are shared with stakeholders and progress monitored via the ODU.
14. Summer/Winter initiatives	14. Monitoring through SLT and STB. Senior Planning Team (SPT) is now stood up for the duration of Winter 2023/24.
15. CHARU implementation	15. Recruitment of 153 WTE has continued; To lift further, a trial of a rotational model is due to be trialled in Aneurin Bevan Health Board area.
16. Clinical Model and clinical review of code sets	16. Reported through CPAS and DCR Review reporting through CQGG
17. Remote clinical support enabling discharge at scene	17. Strategic Transformation Board – IMTP deliverable; Providing support to the Community Welfare Responders (CWR) initiative and supporting CFRs to discharge at scene with current non conveyance rates for CFRs in excess of 40%
18. Trust Board paper (28/07/22) detailing actions being taken to mitigate the risks (see actions section for details of specific work streams being progressed to mitigate this risk)	18. Formally documented action plan – actions captured are contained within and monitored via the Mitigating avoidable harm paper from PIP.
19. Information sharing	19. Information Sharing: Patient Safety Reports, Chief Operating Officer (COO) Data Pack, Immediate Release Declined (IRD) Reports.
20. Completed EMS Roster Review	20. Helps to ensure that we have the maximum available capacity to respond to dispatch to 999 calls received in a timely manner. Monitor production against the rosters weekly at performance meeting and that provides a level of UHP as a percentage.
21. Delivered a reduction in the number of multiple **vehicle** attendances dispatched to red calls	21. This will increase vehicle availability generally across the Trust and is monitored through SLT weekly performance meeting.
22. Transfer of Care	22. WAST has clearly articulated to the Health Board COOs the risk associated with delayed handovers. Consequently, work has commenced to withdraw WAST staff from portering duties on hospital premises, cease the practice of ED swaps and cease the use of WAST equipment in EDs across Wales. Please refer to the following documents: i) Letter to COO Handover Delays 30.03.2023 ii) Letter to COO Handover Delays iii) WAST – Transfer of Care Brief
23. **Virtual Ward – Connect Support Cymru**	23. Multi phased approach commenced in Dec 2022 with St John Ambulance Cymru virtual ward responder, a digital and telehealth platform, and a Community Welfare Responder model to enhance community resilience. • Phase 1 delivered through St John Ambulance Cymru • Funding also obtained through external grant funding to pilot a volunteer phase. which went live mid-October with twelve teams piloting the approach. Early results look promising and the ambition to upscale is being explored with a focus on CSD capacity. Whilst the pilot tests the approach with existing CFRs, the ambition is to introduce a new volunteer role to which we will recruit new volunteers.

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	17/01/2024	TREND	25 (5x5)
		Date of Next Review:	14/02/2024	➡	

IF significant internal and external system pressures continue	THEN there is a risk of an inability and/or a delay in ambulances reaching patients in the community	RESULTING IN patient harm and death

	Likelihood	Consequence	Score
Inherent	4	5	20
Current	5	5	25
Target	2	5	10

24. **ARA – Acute Release Area - GUH**	**24. Live until 31st March 2024**
25. **WAST Serious Clinical Incident Forum (SCIF) is in place to discuss patient safety incidents, learning and improvement actions to prevent future harm, working in collaboration with Health Boards / NHS Wales Executive Delivery Unit under the Joint Investigation Framework which was formalised in the National Patient Safety Policy in May 2023. Sharing of potential case of serious avoidable harm/death with Health Boards for investigation when response delay associated with system congestion is the primary cause. CNO and CMO plus peer group and COOs regularly updated on patient safety incidents. Patient safety reporting and escalation through the Serious Clinical Incident Panel (SCIF), Patient Safety Highlight Reports, Health Board specific reports in place with escalation through WAST governance framework.**	**25. Patient safety reporting and escalation through the Serious Clinical Incident Panel (SCIF), Patient Safety Highlight Reports, Health Board specific reports in place with escalation through WAST governance framework.**
26. **WAST membership of the working group (Executive Director of Quality & Nursing) to reform the Framework for the Investigation of Patient Safety Serious Incidents (SIs) national investigation framework with system partners. Chaired by the Deputy Chief Ambulance Commissioner and commenced in August 2022.**	27. **Workshop with system partners in place with executive directors of nursing attendance and to date is working well with good engagement from health board colleagues. Following the last meeting on 25.01.2023 it was agreed that sub-groups would be formed to meet more frequently to gather themes / evaluation / develop more consistency which would include aligning the outputs / outcomes with the 'Six Goals for Urgent and Emergency Care' work.**
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Acknowledgement and acceptance of risk by Health Boards and balancing the risks across the whole system	1. Improvement in handover delays across Cardiff and Vale and more latterly across AB have led to improved handovers at Eds. This has now been sustained for some months across C&V in a phased programme of improvement with no delays in excess of 2 hours. Programme of improvement underway in AB, commencing at 4hour tolerance with a plan to reduce over time. In other Health Boards, there remains little or no controls, with variation in both handovers and risk levels across Health Boards. An extraordinary incident declared by WAST on 22 October 2023 as direct result of system risk associated with handover delays at Morrison hospital has increased focus on handover delays with external partners and across the media. Some plans are in train (detailed in actions) following a meeting with Swansea Bay COO to include mobile imaging, pathways to bypass ED and a pod solution ahead of winter.
2. Blockages in system e.g., internal capacity within Health Boards which affect patient flow	
3. Local delivery units mirroring WAST ODU	
4. Handover delays link to risk 224	
5. There is an ambition that no handover should exceed 4 hours and for lost hours to handover to be reduced by 25% but given the track record over last 12 months there is a low confidence in attaining this.	The majority of Health Boards have failed to deliver on this ambition; With the exception of Cardiff and Vale University Health Board, the remaining 5 Health Boards with acute Trusts that were required to deliver on this target, have failed to do so.
6. Handover Improvement Plans agreed between WAST and Health Boards	12. Handover Improvement Plans have been replaced by Integrated Commissioning Action Plans (ICAPS) and are subject to review with EASC; However, it is noted that previous plans did not demonstrate sufficient improvement in reducing handover delays (see above)
18. Access to Same Day Emergency Care (SDEC) for paramedic referrals	18. This forms part of the handover improvement plans in place with Health Boards; however, assurance is limited given that the **uptake** is low (less than 1% of **total demand**). There is an inconsistency in approach from Health Boards on eligibility and availability; The national Once for Wales acceptance criteria has not been uniformly deployed by Health Bards across Wales.
Please note that the gaps listed are not WAST's and are therefore outside of the control of WAST	

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Exploring Rural model options (Paused during Pandemic Response) – subject to funding through IMTP. Now refreshed to wider rural model opportunities to include recruitment of CFRs. Additional funding has been sourced to increase posts within the volunteer function.	Assistant Director of Operations EMS / Assistant Director of Operations – National Operations & Support	Superseded	Rural model superseded by Action 9 below (Recruitment and deployment of CFRs)

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	17/01/2024	TREND	25 (5x5)
		Date of Next Review:	14/02/2024	➡	

IF significant internal and external system pressures continue	THEN there is a risk of an inability and/or a delay in ambulances reaching patients in the community	RESULTING IN patient harm and death

	Likelihood	Consequence	Score
Inherent	4	5	20
Current	5	5	25
Target	2	5	10

2. Leading Change Together (forum to progress workforce related work streams jointly with TUPs)	ADLT Sub-Group	30.09.22 - Superseded	
3. Recruit and train more Advanced Paramedic Practitioners – Value Based Healthcare Fund bid for up to 50 WTE (I) [Source: Action Plan presented to Trust Board 28/07/22]	Director of Paramedicine / Director of People & Culture	Extended to March 2024	WAST has attempted to secure additionality within its APP numbers, as the evidence illustrates a dramatic impact upon ED avoidance with more people being managed within the community. At this stage, no additional funds have been secured. However, it remains the case the prospective APPs are completing their education and could be deployed into the operational setting to mitigate the risk. ELT has therefore agreed to grow the APP numbers further this year, redirecting existing operational spend to bolster APP growth.
4. Transition Plan (I) [Source: Action Plan presented to Trust Board 28/07/22]		Superseded	
5. Overnight Falls Service extension (I) [Source: Action Plan presented to Trust Board 28/07/22]	Assistant Director of Quality & Governance / Head of Quality Improvement	Ended March 2023	The temporary extension of the SJAC contract for overnight provision was evaluated, demonstrating on available evidence a positive performance impact over the period of operation (Jan-April 2023). The evaluation report was presented to EMT on 5 April 2023. The contract extension (as a temporary arrangement) ceased on 5 April 2023. Falls service enhanced day and night provision remains in place and utilisation of resources is reviewed at weekly performance meetings by Operations SLT.
6. New 2023 EMS Demand and Capacity (roster) review	Assistant Director of Planning & Performance	March 2024	ORH modelling underway. Initial findings January 2024, full report to Trust Board and EASC in March
7. Swansea Bay Winter actions	Assistant Director of Operations, EMS	December 2023	Some plans are in train following a meeting with Swansea Bay COO to include mobile imaging, pathways to bypass ED and a pod solution ahead of winter.
8. Mental Health response pilot	Assistant Director of Operations, EMS	**Not yet Active.**	Pilot to commence in Aneurin Bevan Health Board area Nov 2023
9. Connected Support Cymru – is initially designed to utilise NHS and voluntary-sector resources and responders to enable patients to be supported in their own home whilst waiting for an urgent healthcare need to be managed. The service will employ digital health technologies to connect patients, communities and clinicals to achieve better health outcomes. The initiative will improve patient experience and safety, while supporting the healthcare system in directing patients to the right pathway at an appropriate time for their care need. It is expected this will help reduce unnecessary demand upon Emergency Departments.	Assistant Director of Quality Governance		Multi phased approach commenced in Dec 2022 with St John Ambulance Cymru virtual ward responder, a digital and telehealth platform, and a Community Welfare Responder model to enhance community resilience. Phase 1 delivered through St John Ambulance Cymru, **with further funding by the commissioner for a further phase via SJAC.** Funding also obtained through external grant funding to pilot a volunteer phase. which went live mid-October with twelve teams piloting the approach. Early results look promising and the ambition to upscale is being explored with a focus on CSD capacity. Whilst the pilot tests the approach with existing CFRs, the ambition is to introduce a new volunteer role to which we will recruit new volunteers.
10. Maximise the opportunity from Consult and Close – stretch to 17%			Trust ambition is to attain 17% Consult and Close rate, with an improvement plan in place to achieve this. The Trust has however already achieved the inclusion of Mental Health Practitioners in CSD, a key contributor to the achievement of Consult and Close rates. **Consult and Close compliance remains around 14%. Action plan activities therefore continue with a review of triage processes which may lead to shorter triage durations, along with increase in staffing, which**

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	17/01/2024	TREND	25 (5x5)
		Date of Next Review:	14/02/2024		

IF significant internal and external system pressures continue	THEN there is a risk of an inability and/or a delay in ambulances reaching patients in the community	RESULTING IN patient harm and death		Likelihood	Consequence	Score
			Inherent	4	5	20
			Current	5	5	25
			Target	2	5	10

			together will enable more triages to take place, thus increasing the percentage of consult and close to 17%.
11. Development of new model of care	Head of Strategy Development	2024/25	Development of the model remains ongoing
12. Development of the pathway which connects mental health users connecting via the 999 system to 111 Press 2 services	Assistant Director of Operations, Integrated Care	March 2024	Development of the model remains ongoing
13. Palliative Care Paramedic Unit	**Assistant Director of Operations**	**January 2024**	**Reducing demand via APPs – 15th January Start.**
14. Audit Wales investigation of Urgent and Emergency Care System: Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time?	**CEO**	**Q4 2023-2024**	• **Conducted in three phases Audit Wales will independently investigate and report on patient flow out of hospital: access to unscheduled care services and national arrangements (structure, governance, and support)** • **WAST will proactively support this work and offer best practice examples from other jurisdictions that can support benchmarking and improvement activities.** • **Expected outcomes in 2023/24.**
Winter Ambulance Handover Improvement Plan Meetings	**Executive Director of Operations**	**February 2024 (six weeks duration)**	• **Weekly meetings set up with Welsh Government, NHS Executive, CASC and the Health Board COOs. All parties (including WAST) to provide updates on actions being taken to alleviate and improve handover delays. WAST to update on C&C, CWR, red dispatch and local updates from EMS HOS on initiatives.**

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:	17/01/2024	TREND	25 (5x5)
		Date of Next Review:	14/02/2024	➡	

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

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

IMTP Deliverable Numbers:

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

Risk Commentary Q3 2023/24

The risk score remains constant at 25 for quarter 3 2023/24 (almost certain & catastrophic). Internal and external assurances remain weak as there remains a daily risk of actual patient harm due to handover of care delays. **There were 1,888 patient handovers in October 2023 which were over 4 hours.** The target was originally to have zero by September 2022. **In November 2023 over 20,126 hours were lost and 22,756 were lost in December 2023** Cardiff & Vale University Health Board has demonstrated material improvement and is a positive outlier. The impacts on patients waiting for extended periods of time both in the community and then outside emergency departments is well documented (AACE Delayed Hospital Handovers: Impact assessment of patient harm, 2021) and includes pressure damage, acute kidney injury, deconditioning, poorer outcomes, and extended recovery times. Delays across the system continue to be the main focus of patient safety incidents, complaints, coronial enquires and redress / claims. **The Trust continues to receive Prevention of Future Death Reports (Regulation 28) from Coroners across NHS Wales. The Trust has received 6 reports since April 2023, including 1 report in quarter 3 2023/4. 5 of these reports directly relate to system pressures with the coroners raising concerns about delays in responding to patients in the community and handover of care delays at emergency departments**. The effectiveness of our controls in many areas are dependent on external partners acknowledging and having ownership of the risk across the urgent and emergency care system. Key to moving the position is to continue to work in collaboration influencing system partners, being present and engaging in key conversations, whilst continually seeking opportunities internally to swiftly identify and mitigate the risks within our control and share those with relevant system partners that we cannot control. WAST CEO and Directors have ensured that system safety and avoidable harm remain a live topic of discussion in all relevant forums and continue to seize opportunities as they emerge that can contribute to mitigating avoidable harm. The Joint Investigation Framework in place to review incidents across the system is now approved and included in the recently published National Policy on Patient Safety Incident Reporting & Management (May 2023). Themes from system partners following review of incidents remains the consequences of high escalation levels in acute care and crowded emergency departments.

Improvement actions led by Welsh Government and system partners include:

a) Right care, right place, first time Six Goals for Urgent and Emergency Care - A policy handbook 2021–2026. Goal 4 'Improving ambulance patient handover, ensuring no one arriving by ambulance at an Emergency Department waits more than 60 minutes from arrival to handover to a clinician – (Welsh Government) ***by the end of April 2025***
b) NHS Wales eradicates all emergency department handover delays more than 4 hours (LHB CEOs) ***revised to March 2023/24.***
c) Alternative capacity equivalent to 1,000 beds project (LHB CEOs) – 678 additional beds delivered, a significant achievement, but short of the target of 1,000.
d) Investigation of Urgent and Emergency Care System: Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time? (Audit Wales)
e) Implement nationwide approach to emergency department 'Fit 2 Sit' (Welsh Government: Chief Medical Officer and Chief Nursing Officer).

CONTROLS	**ASSURANCES**
	Internal Management (1st Line of Assurance)
1. WAST Serious Clinical Incident Forum (SCIF) is in place to discuss patient safety incidents, learning and improvement actions to prevent future harm, working in collaboration with Health Boards / NHS Wales Executive Delivery Unit under the Joint Investigation Framework which was formalised in the National Patient Safety Policy in May 2023. Sharing of potential case of serious avoidable harm/death with Health Boards for investigation when response delay associated with system congestion is the primary cause. CNO and CMO plus peer group and COOs regularly updated on patient safety incidents.	1. Patient safety reporting and escalation through the Serious Clinical Incident Panel (SCIF), Patient Safety Highlight Reports, Health Board specific reports in place with escalation through WAST governance framework.
2. WAST membership of the working group (Executive Director of Quality & Nursing) to reform the Framework for the Investigation of Patient Safety Serious Incidents (SIs) national investigation framework with system partners. Chaired by the Deputy Chief Ambulance Commissioner and commenced in August 2022.	2. Workshop with system partners in place with executive directors of nursing attendance and to date is working well with good engagement from health board colleagues. Following the last meeting on 25.01.2023 it was agreed that sub-groups would be formed to meet more frequently to gather themes / evaluation / develop more consistency which would include aligning the outputs / outcomes with the 'Six Goals for Urgent and Emergency Care' work.
3. WAST and system compliance with National Standards - 15-minute handover (NHS Wales Hospital Handover Guidance v2 (May 2016)	3. Monthly Integrated Quality and Performance Report, Health Informatics reports, APP dashboard on app use by Consultant Connect and shared at local and corporate meetings regarding patient safety and handover of care position across NHS Wales and NHS England.
4. WAST Clinical Notice in place - Escalating a clinical concern with a deteriorating patient outside the Emergency Department (11.02.2021). National Early Warning Score (NEWS) trigger of 5 or above for escalation to hospital clinicians. NEWS data available via EPCR (electronic patient care record).	4. NEWS data now available via ePCR and escalation system in place via local managers and the Operational Delivery Unit.

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:	17/01/2024	TREND	25 (5x5)
		Date of Next Review:	14/02/2024	➡	

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

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

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.
7. Regional Escalation Protocol and Resource Escalation Action Plan (REAP). Proactive and forward-looking weekly review of predicted capacity and forecast demand. Deployment of predetermined actions dependant on assessed level of pressure. Consideration of any bespoke response/actions plans in the light of what is expected in the coming week. WAST has updated the REAP in advance of winter, including revised triggers (higher) for handover lost hours.	7. The Senior Leadership Team convenes every Tuesday as the Weekly Performance Meeting to review performance and demand data, and review/assign REAP Levels as appropriate. Dynamic escalation is via the Strategic Command structure. **REAP has undergone an annual review with v4.1 released in November 2023.**
8. Staff from WAST, Health Boards and third sector organisations assisting to meet patient's Fundamentals of Care as best they can in the circumstances.	8. Confirmed through Healthcare Inspectorate Wales (HIW) workshops and Health & Care Standards self-assessment process and Putting Things Right Quarterly Reports to Clinical Quality Governance Group and QuEST
9. 24/7 operational oversight by ODU with dynamic **Clinical Safety Plan** review and system escalation as required. Realtime management and escalation of risks and harm with system partners. Triggering and escalation levels within CSP to best manage patient safety in the context of prevailing demand and available response capacity. Monitoring, escalation and reporting of extreme response or handover delays.	9. Shift reports from ODU & ODU Dashboard received by Executive Management Team (EMT), Senior Operations Team (SOT) and On-Call Team at start/end. Realtime management and escalation of risks and harm with system partners. Triggering and escalation levels within CSP to best manage patient safety in the context of prevailing demand and available response capacity. Monitoring, escalation and reporting of extreme response or handover delays. **In December 2023, Version 2.21 of the Clinical Safety Plan was released. The reduction in the demand is the assurance which is dynamically monitored via ODU.**
10. Gold/Strategic, Silver/Tactical and Bronze/Operational 24 hour/ 7 day per week system to manage escalation plans.	10. Shift reports from ODU & ODU Dashboard received by EMT, SOT and On-Call Team at start/end. **On Call cover is reviewed weekly at SLT Performance Meetings.**
11. Escalation forums to discuss reducing and mitigating system pressures.	11. Daily risk huddles are recorded, and documented actions are shared with stakeholders and progress monitored via the ODU.
12. WAST Education and training programmes include deteriorating patient (NEWs), tissue viability and pressure damage prevention, dementia awareness, mental health.	12. Monthly Integrated Quality and Performance Report (October 2023 overall 76% - Safeguarding and dementia awareness remains over 91%.
13. Clinical audit programme in place.	13. Clinical audit programme in place (dynamic document) with oversight from the Clinical Quality Governance Group and QuEST.
14. Workshop set up by the Deputy Chief Ambulance Commissioner to respond to the findings in the Health Care Inspectorate Wales (HIW) Report *Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover* (undertaken 2021). WAST has senior representation at this meeting. – assurance is that HIW approve and sign off WAST elements and Health Board elements of recommendations.	14. Workshop set up by the Deputy Chief Ambulance Commissioner to respond to the findings in the Health Care Inspectorate Wales (HIW) Report Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover (undertaken 2021). WAST has senior representation at this meeting. A collective response from WAST and Health Boards is being overseen by EASC.
15. Escalation of patient safety concerns by Trust Board: featured in provider reports to the Emergency Ambulance Committee (EASC); been the subject of Accountable Officer correspondence to the NHS Wales Chief Executive; numerous escalations to professional peer groups initiated by WAST Directors; and coverage at Joint Executive Meetings with Welsh Government. 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	15. Monthly Integrated Quality and Performance Report, CEO Reports to Trust Board including 'Actions to Mitigate Avoidable Patient Harm Report' (last presented to Trust Board November 2023) and Board sub-committee oversight and escalation through 'Alert, Advise and Assure' reports.

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:	17/01/2024	TREND	25 (5x5)
		Date of Next Review:	14/02/2024	➡	

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

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

eradicate ambulance patient handover delays of more than four hours and reduce the average ambulance time lost per arrival by 25 per cent (from the October 2021 level) have been set. It should also confirm the target dates for the achievement of these targets."	
16. Implementation of Duty of Quality, Duty of Candour, and new Quality Standards requirements in April 2023.	16. Welsh Government Road Map in place (soft launch) with milestones for organisations – baseline assessment and monthly updates (RAG ratings) in place with Trust Board oversight. The current internal assessment overall as of **December** 2023 is 'Implementing and operationalising'. The Trust has representation on the All Wales Duty of Candor Implementation Group and is actively engaged in developing resources. From April 2024 the Trust will publish an annual quality report and compliance with Duty of Candour. Operational oversight occurs at the Quality Management Group and Executive oversight is via the Clinical Quality Governance Group.
17. Clinical Support Desk First in place	17.
18. Summer/Winter initiatives	18. **Monitoring through SLT and STB. Senior Planning Team (SPT) is now stood up for the duration of Winter 2023/24.**
	External Sources of Assurance Management (1st Line of Assurance)
	1. Monitoring and oversight of the Ambulance Quality Indicators (AQIs) including handover of care timeliness and Commissioning Framework by the Chief Ambulance Services Commissioner (CASC), the Emergency Ambulance Services Committee (EASC) including the Integrated Commissioning Action Plans (ICAPS) and Joint Executive Team (JET) meetings with Welsh Government (I&E).
	2. Healthcare Inspectorate Wales (HIW) 'Review of Patient Safety, Privacy, Dignity and Experience whilst waiting in Ambulances during Delayed Handover' Report and system wide improvement plan with working group in place with WAST senior representation. Oversight by HIW and EASC
	3. Duty of Quality and Duty of Candour readiness returns assessment by Welsh Government.
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Lack of capacity in the Putting Things Right Team to deliver across the functions due to competing priorities resulting from sustained system pressures.	1.
2.	2. Implementation of the revised Joint Investigation process remains in pilot stage with good engagement seen by system partners. Several overdue patient safety investigations remain presenting a risk to patient safety across the system. The Trust has 38 overdue nationally reportable incident investigations. Shared system learning from the Joint Investigation Framework is currently limited with no new learning identified to date.
3. Lack of implementation and holding to account regarding the NHS Wales of the Handover Guidance v2 and recognition of the patient safety risks pan NHS Wales.	3. 15-minute handover target is not being achieved pan-Wales consistently and has led to a substantial growth in emergency ambulance handover lost hours. In October 2023, 23,232 hours were lost with 1,888 +4 hour delayed patient handovers.
4. Variation in responsiveness at Emergency Departments to the escalating concerns regarding patients' NEWS.	4. Strengthening of patient safety reports and audit processes as e PCR system embeds.
5. Variation pan Wales / England as position not implemented across all emergency departments*.	5. New Quality Management System in development which will include monitoring of the new Quality Standards & Enablers and underpinning governance structure.
6. National steer required to confirm the accountability arrangements regarding patients in ambulances outside of the emergency departments. The seven Local Health Boards (LHBs) in Wales are responsible for planning and securing delivery of primary, community, secondary care services, and also the specialist services for their areas.	6. HIW approve and sign off WAST elements of recommendations.
	External Gaps in Assurance 1. Lack of escalation and response to AQIs by the wider urgent care system and regulators

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

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:	17/01/2024	TREND	25 (5x5)
		Date of Next Review:	14/02/2024	➡	

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

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

1. Handover checklist implementation – Nationally WAST Quality Improvement (QI) Project	WAST QI Team (QSPE)	• TBC – Paused	• Timeframes awaited via Emergency Department Quality & Delivery Framework (EDQDF).
2. Implement patient safety dashboards (live and look back data) triangulating quality metrics / KPIs and performance data sourcing health informatics resource.	Assistant Director of Quality & Nursing	• Q4 2023/24	• Incremental improvements to quality and safety data and information to enable triangulation / collective intelligence at Trust and system level. • Access to ePCR data (NEWS) now available. Work on-going with Health Informatics regarding patient safety and health board dashboards.
3. Continued Health Board interactions – my next patient (boarding), patient safety team dialogue – proactive conversations with Health Board Directors of Quality & Nursing.	Executive Director of Quality & Nursing	• Monthly and as required.	• Monthly meetings continue to be held and networking through EDoNS.
4. Recruit and train more Advanced Paramedic Practitioners – Value Based Healthcare Fund bid for up to 50 WTE	Director of Paramedicine	• Q4 2023/24	• WAST has attempted to secure additionality within its APP numbers, as the evidence illustrates a dramatic impact upon ED avoidance with more people being managed within the community. At this stage, no additional funds have been secured. However, it remains the case the prospective APPs are completing their education and could be deployed into the operational setting to mitigate the risk. ELT has therefore agreed to grow the APP numbers further this year, redirecting existing operational spend to bolster APP growth.
5. Overnight falls service extension	Executive Director of Quality & Nursing	• 31.03.2024	• Night Car Scheme extension agreed to 31 March 2024 (2 regional resources) • Utilization rates continue to be monitoring. Nighttime falls assistance 64% Utilisation (Apr 2023 -Jun 2023); Nighttime falls assistance 66% Utilisation (July – Oct 2023); Daytime utilisation sustained: July -August 58%. September- October 58% utilisation. • Optima modelling has now been completed. The modelling clearly identifies that the level two falls' vehicles are the more effective resource. The modelling has identified an estimated need of 48 (38 day and 10 overnight) falls vehicle level 2 12 hours shifts. The modelling is now being built into the strategic (five year) demand & capacity review.
6. Duty of Quality, Duty of Candour and new Quality Standards implementation from April 2023 with development of a Quality Monitoring System supporting monitoring and oversight systems in place and embedded.	Executive Director of Quality & Nursing	• Q3 2023/24	• Monthly updates to progress against actions following the baseline assessment and readiness returns. • RL Datix Dashboards and KPIs under development nationally. • Key policies updated and approved. • Participation in the All Wales Duty of Candour implementation group by Patient Safety Team – monthly.
7. Connected Support Cymru is initially designed to utilise NHS and voluntary-sector resources and responders to enable patients to be supported in their own home whilst waiting for an urgent healthcare need to be managed. The service will employ digital health technologies to connect patients, communities and clinicals to achieve better health outcomes. The initiative will improve patient experience and safety, while supporting the healthcare system in directing patients to the right pathway at an appropriate time for their care need. It is expected this will help reduce unnecessary demand upon Emergency Departments.	Executive Director of Quality & Nursing	• Q3 2023/24	• SJAC funded ended on 31 October 2023. • Proof of concept using WAST CFR volunteers as CWRs is underway. Grant funding is being used to put in place roles and processes to recruit and train to new volunteer role. • This eyes on support to CSD clinicians, by volunteers, is producing positive results, with early data suggesting a 35% consult & close rate for the cohort of patients covered by the pilot. • The business case has now been completed and can be made available to key stakeholders. Now awaiting business case approval. • The CWR will be modelled as part of the options being considered by the current EMS demand & capacity review.
8. Organisational change process (OCP) of Putting Things Right Team (PTR) to enable increased capacity across all functions to manage increasing complexity and demands.	Executive Director of Quality & Nursing	• Q4 2023/24	• OCP commenced 25.09.2023 and the consultation period has concluded with the final new structure confirmed. Next steps are to recruit to vacant positions which has commenced. It is anticipated that all positions will be filled by **May** 2024 (taking notice periods into account).
9. Connect with All Wales Tissue Viability Network to explore strengthening the current investigations into harm from pressure damage across the whole patient pathway.	Assistant Director Quality & Nursing	• Q4 2023/24	• Positive meeting held in August 2023 as planned with the Chair of the TVN network. Next steps are for the Patient Safety Team to attend a TVN leads meeting to discuss opportunities for collaborative

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:	17/01/2024	TREND	25 (5x5)
		Date of Next Review:	14/02/2024	➡	

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

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

			working and data / information sharing. Date to be confirmed and there has been good engagement from Health Board Tissue Viability Nurses. Workshop date confirmed in January 2024.
10. Audit Wales investigation of Urgent and Emergency Care System: Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time?	CEO	• Q4 2023/24	• Conducted in three phases Audit Wales will independently investigate and report on patient flow out of hospital: access to unscheduled care services and national arrangements (structure, governance, and support) • WAST will proactively support this work and offer best practice examples from other jurisdictions that can support benchmarking and improvement activities. • Expected outcomes in 2023/24.
11. Internal Audit to undertake a review of Serious Adverse Incidents & Joint Investigation Framework	Executive Director of Quality & Nursing	• Q4 2023/24	• Internal audit in progress. Delays due to sickness in the internal audit team.
12.Winter Ambulance Handover Improvement Plan Meetings	**Executive Director of Operations**	• **February 2024 (six-week duration)**	• **Weekly meetings set up with Welsh Government, NHS Executive, CASC and the Health Board COOs. All parties (including WAST) to provide updates on actions being taken to alleviate and improve handover delays. WAST to update on C&C, CWR, red dispatch and local updates from EMS HOS on initiatives.**
13.Swansea Bay Winter actions	**Assistant Director of Operations, EMS**	• **December 2023**	• **Some plans are in train following a meeting with Swansea Bay COO to include mobile imaging, pathways to bypass ED and a pod solution ahead of winter.**

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:	17/01/2024	TREND	20 (5x4)
		Date of Next Review:	14/02/2024	➡	

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

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

IMTP Deliverable Numbers:

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

Risk Commentary

Sickness absence remains one of the key challenges for the organisation. Whilst there has been a significant reduction in absence levels over the past 18 months, rates remain higher than desired and therefore a continued focus on supporting good attendance at work is needed by both managers and the People and Culture team. Increased pressures on our people like handover delay, missed breaks and cost of living impact on health and wellbeing. As we move into winter, we also see increased absence due to respiratory illness and Covid. The outcome of this is to maintain the risk at a score of 20 and review the level at the end of Q4 2023/24.

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

Risk ID 160	High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service	Date of Review:	17/01/2024	TREND	20 (5x4)
		Date of Next Review:	14/02/2024	➡	

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

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

18. Stress risk assessments- identify measures that can be taken to address issues	18. Reference to the assessments during attendance management line manager training and to the TUS 28/11/2023 OH to lead on a refresh of stress risk assessments use
19. Sickness statistics are reported to SLT, SOT, People & Culture Committee, Trust Board and the CASC	19. Sickness forms part of Workforce Scorecard to People & Culture Committee and is also supported by PCC deep dives into sickness. Reporting is also shared with CASC and EASC. Discussions on sickness are reported in minutes and AAA to Board
20. External agencies support e.g., St John Ambulance, Fire and Rescue- if needed at times of increased demand pressure	20.
21. Monthly reviews of colleagues on Alternative duties	21. Action plans arising from meetings with colleagues implemented through monthly diarised meetings
22. Manager guidance on managing Alternative duties	22. Evidence of managers guidance in place and referenced in attendance management training
23. Monthly report on absence to ELT and report to every meeting of People & Culture Committee via the Workforce Report and provision of deep dives when requested.	23.
24. Sickness audits for localities- provides additional level of detail	24. Audits carried out and actions taken forward
25. Additional support for areas with higher-than-average absence – emphasis is on understanding reasons and developing action plans	25. Dedicated meetings taking place and support from people services for areas with absence with local plans in place to address specific issues
26. Review of top 100 cases -carried out monthly	26. Provides a focus on cases with a clear focus on support and making sure there are plans attached to each case.
27. Deep dives on specific issues and reasons for absence	27. Enables wider consideration of additional measures that may be adopted and identifies themes and keeps focus on absence management e.g. – mental health and causes 28/11/23 Recognition of the impact of employee experience and workplace conditions and link to absence. **Reported to ELT for information**
28. Implementation of the Managing Attendance Project 2022-23 completed and ongoing activities maintained	28. **BAU evaluating for delivery**
29. Implementation of Behaviours Refresh Plan completed	29. **BAU evaluated for delivery**
30. 2023 10-point action plans shared with EMT for assurance and RAG rated to track progress quarter	30. Offers assurance to ELMT on the activities and measures in place. Figures on absence are being reported monthly to ELT which is reflected in the minutes and AAA reports
31. Work in Confidence system implemented and Freedom to Speak Up Month in October 2023 focused attention on this	31. External Management (2nd Line of Assurance)
32. Actions from Audit of Nov 22 **completed**	32. **Audit actions completed**
33. Strengthen Freedom to Speak Up Arrangements policy and advice and roll out of platform for raising concerns (in relation to Freedom to Speak Up Arrangements) (Having additional mechanisms in place for individuals to speak up potentially reducing work related stress and anxiety which is a key reason for absence)	33. Monitor FTSU concerns and they are dealt with in agreed timeframes and assessed whether absence related to mental health and anxiety reduces.
34. Create a Manager and Staff training plan for Freedom to Speak Up Arrangements	34. Monitored through numbers of FTSU concerns raised and continual promotion via Comms and Roadshow Events.
35. **Health and Wellbeing Steering Group in place**	35. Agendas, minutes etc.
36. **Actions identified from the Managing Attendance Audit implemented**	36. Underway and now BAU – we need to say what this means by way of assurance
37. **PADR review undertaken and now including wellness questions**	37. PADRs undertaken and questions asked
	Independent Assurance (3rd Line of Assurance)
	1b. Internal Audits scheduled through Shared Services Partnership. Last audit on attendance was November 2022 and the last actions from this due at the end of December 2023. (last audit November)
	2. Audit Wales – Taking Care of the Carers report in October 2021
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
(a) Consistency and Application in Managing Attendance at Work Policy	There are other factors that impact on sickness which can't be controlled
1. 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	1. 9, 10 and 19 Absence data is not updated in a timely manner into ESR by managers

Risk ID 160	High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service	Date of Review:	17/01/2024	TREND	20 (5x4)
		Date of Next Review:	14/02/2024	➡	

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

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

1 – 22 Education and communication with managers about resources available and how to implement it e.g., stress risk assessments

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Scrutinising on a monthly basis all long term sickness absence case to ensure there is a tailored, individual action plan which identifies interventions that will support a return to work as soon as reasonably possible.	Deputy Director of People & Culture	**Ongoing**	**Discussion on levels of long term sick absence is undertaken in a variety of forums including EASC, ELT and PCC**
2. Develop guidance and training for line managers to equip them with the confidence and skills to have meaningful and sensitive conversations related to attendance.	Deputy Director of People & Culture	**Ongoing (training new managers)**	**Measured through ongoing participation in development sessions and feedback from TU regarding management handling of absence cases.**
3. Accountability meetings on attendance management between People Services and senior ops managers to ensure this issue is given sufficient focus on priorities.	Deputy Director of People & Culture	Ongoing action	**Assurance – meetings taking place and active discussions on operational areas experiencing high levels of absence**
4. Senior Ops Managers have accountabilities sessions on attendance management with their Heads of Service.	ADOs Operations	Ongoing action	**Assurance – meetings taking place and active discussions on operational areas experiencing high levels of absence**
5. Case studies developed on examples of areas of business where attendance management has improved significantly to share learning across WAST	Deputy Director of People & Culture	31/05/24	**Case studies published and discussed at leadership meetings and evidence of good practice adopted**
6. Review of top 100 cases by **the wider People & Culture Team** on a monthly basis (**Wellbeing, OCC Health, People Services)**	Deputy Director of People & Culture	Ongoing	**Understanding within the wider People & Culture Directorate of cases and action plans clearly identified**
7. Connect to other Ambulance sector organisations to identify additional interventions they have implemented to address attendance management, share learning and consider whether to adopt in WAST	Deputy Director, People and Culture	30/06/24	**Discuss at P&C Business Meeting and share at ELT/PCC with recommendations.**
8. Ensure that the specific issues associated with muscular skeletal conditions is discussed regularly at the H&S Committee and relevant additional interventions are identified	AD Q&N	Ongoing	**It is on the agenda and outcomes are available for discussion at H&SC**
9. Targeted culture change reviews are undertaken in areas of the business where levels of absence are high and other metrics such as turnover indicates concerns. Alongside this these areas are also experiencing significant change.	Director of People & Culture	Ongoing	**Culture review action plans are produced and taken forward. Sick absence in these areas is evaluated and monitored to assess whether reductions are achieved.**
10. Implementation of new approach to regularly checking in with staff. Piloting a simple conversation framework for Managers to use with their staff on a monthly basis which provides a focus on wellbeing, goals and personal development.	AD of Wellbeing	To commence 30/05/24	**Evaluation of pilot after 6 months to assess if there has been a reduction in sick absence in specific areas where this approach has been adopted.**

Risk ID 163	Maintaining Effective & Strong Trade Union Partnerships	Date of Review:	17/01/2024	TREND	20 (5x4)
		Date of Next Review:	14/02/2024		

				Likelihood	Consequence	Score
IF the response to tensions and challenges in the relationships with TU partners is not effectively and swiftly addressed and trust and (early) engagement is not maintained	**THEN** there is a risk that TU partnership relationships increase in fragility and the ability to effectively deliver change is compromised	**RESULTING IN** a negative impact on colleague experience and/or services to patients	**Inherent**	5	3	15
			Current	5	4	20
			Target	4	3	12

IMTP Deliverable Numbers:

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

Risk Commentary

This risk is regularly reviewed. Work is underway to seek to improve partnership working and an action plan has been created to deliver this. The engagement structures below WASPT are in place and running. The Deputy Director of P&C is currently writing a workshop session with TU partners to deliver to managers are TU reps across the organisation and a second session for senior TUPs and senior managers to improve the understanding of the challenges for both groups. Individual relationships with TUPs are quite good. However, there is a further prospective risk as discussions on pay commence for 2024/25 which are out of the gift of WAST but may result in further tension and industrial action if an offer made is not accepted by the trade unions. This is in the context of the current financial pressures for Welsh Government who are seeking to make significant savings. At a local level there are challenging issues to be managed such as USH payments for those off sick and EMT 2-3, demand and capacity reviews, industrial injury appeals and changes to the workforce profile by increasing APPs. Some of these issues are escalating and **may** likely result in R&R processes**.** When there are discussions on one area then there appears to be difficulty disengaging different issues.

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

Risk ID 163	Maintaining Effective & Strong Trade Union Partnerships	Date of Review:	17/01/2024	TREND	20 (5x4)
		Date of Next Review:	14/02/2024	➡	

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

	Likelihood	Consequence	Score
Inherent	5	3	15
Current	5	4	20
Target	4	3	12

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Proposed externally facilitated mediation session(s) building on the IPA workshops and specifically to address the thorny issue of what happens when we fail to agree.	Deputy Director of People & Culture	Completed 12/01/23	Rearranged date 24.08.22 due to COVID in ACAS facilitators. First ACAS sessions delivered in June. Joint ACAS session with TUPs and Senior Team delivered on 24.08.22. Awaiting report from ACAS advised they are finalising by 23.09 and will forward week of 26th Sept. Draft plan in development to capture actions from the meeting. Actions from the ACAS recommendations will be added on receipt. Report received in October. Action plan developed and shared with TUs. Implementation underway
2. Refresh of engagement programme post Industrial Action and establish work	Deputy Director of People & Culture	30/08/23 Underway and work ongoing. Plan delivery to be completed in 2024. However, this will be subject to the national picture.	Plan agreed and being monitored via WASPT. Draft training development underway in partnership with TUPs **– list of training needs shared from TUPs.** Principles on engagement being developed (in part from the training) and as a result the partnership statement will be updated.

Risk ID 201	A loss of stakeholder confidence that damages the Trust's reputation	Date of Review:	18/01/2024	TREND	20 (4x5)
		Date of Next Review:	14/02/2024	➡	

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

	Likelihood	Consequence	Score
Inherent	4	5	20
Current	4	5	20
Target	3	5	15

IMTP Deliverable Numbers:

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

Risk Commentary Q3 2024/25

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

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

GAPS IN CONTROLS	GAPS IN ASSURANCE
1. The delivery plan is currently under review and is subject to further agreement	1.
2. Managing the narrative of the media	2.
3. Strategic collaboration – further work needed to formalise opportunities	3.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Review of 2022 Engagement Framework Delivery Plan in conjunction with the Consultation Institute to reflect revised strategic ambition	Director of Partnerships & Engagement	31/03/24	Board development planned 22/02 on reputation
2. Reputation audit year two planned	Director of Partnerships & Engagement	Q4/Q1 23/24 24/25	
3. Roll out of the revised Engagement Framework Delivery Plan	Director of Partnerships & Engagement	From Q1 24/25	

Risk ID 201	A loss of stakeholder confidence that damages the Trust's reputation	Date of Review:	18/01/2024	TREND	20 (4x5)
		Date of Next Review:	14/02/2024	➡	

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

	Likelihood	Consequence	Score
Inherent	4	5	20
Current	4	5	20
Target	3	5	15

4. Reputation Audit deep dive on findings to be presented at Board Development	Director of Partnerships & Engagement	Q1 2024/25

RISK ID 594	The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death	Date of Review:	17/01/2024	TREND	20 (4x5)
		Date of Next Review:	14/02/2024	➡	

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

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

IMTP Deliverable Numbers: TBC

EXECUTIVE OWNER	Director of Operations	ASSURANCE COMMITTEE	Finance & Performance Committee

Risk Commentary Q3

The challenges across the unscheduled care system **November 2023, over 20,126 hours were lost and 22,756 in December 2023. Only Cardiff & Vale University Health Board has demonstrated material improvement and is a positive outlier**. There is a direct correlation with ambulance availability and high levels of resources unavailable due to protracted waits at hospital E.Ds. Several incidents declared have failed to provide sufficient on the ground assurance that vehicles would be released. Health Boards have declined to incorporate testing of vehicle release into a recent mass casualty exercise. Further, a recent workshop undertaken by the EPRR team as part of the Manchester Arena Inquiry assurance process which has tested our ability to fulfil the PDA in North and South Wales, both in and out of hours, has confirmed that we would only meet the PDA in one of these four mass casualty scenarios.

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1. Immediate release protocol	1. The Immediate Release Protocol is a Nationally agreed NHS Wales protocol. Refusals by Health Boards are Datixed by WAST and compliance report provided weekly to the DG for Health & Social Services.
2. Resource Escalation Action Plan (REAP)	2. The Senior Leadership Team convenes every Tuesday as the Weekly Performance Meeting to review performance and demand data, and review/assign REAP Levels as appropriate. Dynamic escalation via Strategic Command structure. **REAP has undergone an annual review with v4.1 released in November 2023.**
3. Regional Escalation Protocol	3. Daily conference calls to agree RES levels in conjunction with Health Boards
4. Incident Response Plan	4. The Incident Response Plan has been ratified via EMT
5. Mutual Aid arrangement with NARU	5. AACE National Policy on mutual aid in place
6. Clinical Safety Plan	6. CSP adopted by EMT and operational; reviewed annually by SLT **in December 2023, Version 2.21 of the Clinical Safety Plan was released. The reduction in the demand is the assurance which is dynamically monitored via ODU.**
7. Operational Delivery Unit 24/7 cover	7. Shift reports from ODU & ODU Dashboard received by Exec, SOT, and On-Call Team at start/end of shift and cover review at weekly performance meeting
8. In hours and out of hours command cover	8. Civil Contingency requirement as set out in the Command Policy and Incident Response Plan. Cover review at weekly performance meetings
9. Notification and Escalation Procedure	9. Published procedure in operation, reviewed 3 yearly by SLT
10. Continued escalation of risk to partners and stakeholders	10. Referenced by the Executive Director of Operations in correspondence sent to health board Chief Operating Officers dated 30 March 2023. It was further emphasised at the face-to-face COO Peer Group meeting on 14 April 2023.
	External Independent Assurance N/A

RISK ID 594	The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death	Date of Review:	17/01/2024	TREND	20 (4x5)
		Date of Next Review:	14/02/2024	➡	

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

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

11. **CEO letter to Health Boards dated 3 Jan 2023, and DOO letter to Chief Operating Officers dated 30 March 2023 to seek assurance on plans.**	**11. Acknowledgement and acceptance of risk by HBs and balancing the risk across the whole system. Improvement in handovers in C&VHB and ABUHB. This has been sustained form some months across C&V in a phased programme of improvement with no delays more than 2 hours. Programme of improvement underway in ABUHB commencing at 4-hour tolerance with a plan to reduce over time. In other HBs there remains little or no controls with variation in both handovers and risk levels across HBs.**
12. **Health boards are asked to provide assurance of existing and tested plans to immediately reduce emergency ambulances on incident declaration.**	**12. All Health Boards responded with assurance of plans except BCU.**
13. **Multi Agency Exercise to be arranged.**	**13. This exercise has taken place although Health Boards declined to incorporate vehicle release plans**
14. **Meeting with Welsh Government to outline this risk; WG agreed to write to HBs seeking assurance from EPRR leads in HBs on the ability to clear EDs and release vehicles. WG agreed to incorporate testing into the forthcoming mass casualty exercise, and a timeframe for vehicle release was proposed by WAST with 30% of vehicles released within 10 minutes of an incident declaration, 50% within 20 minutes and 100% within 40 minutes.**	**14. WG have confirmed that they have written to HB EPRR leads.** **Health Board COOs approved the proposals for vehicle release as outlined.**
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
Despite the controls listed, the single most limiting factor in providing a pre-determined response in line with the Incident Response Plan is the lost capacity due to hospital handover delays. In this area, WAST has no control. – link to CRR 223 on CRR.	The Trust is not assured that Hospital sites have plans in place that are trained and tested to release ambulances effectively and immediately in the event of an incident declaration.
	Following two incidents (Pembroke Dock Ferry fire on 11th February 2023 and the Swansea gas explosion on 13 March 2023), The Trust is not assured by the effectiveness of assurances given by Health Boards (responses provided following correspondence from WAST CEO – formal returns received from LHBs except BCU). Despite these two incidents being lower-level incident declarations where the pre-determined attendance was met, the experience does not add confidence to the ability to release all resources from hospitals which would support assurance. Further testing of the pre-determined attendance levels has been undertaken as part of the Manchester Arena Inquiry recommendations; This tested the Trust's ability to fulfil the PDA in North Wales and South Wales in the event of a mass casualty scenario both in hours and out of hours. This simulation concluded that in three of these four scenarios, the Trust would be unable to fulfil the PDA. **A further declared major incident at Treforest Industrial Estate in December 2023 following an explosion, failed to release resources from Morriston Hospital, Wales's dedicated burns unit (formal debrief still to be conducted).**

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Review of Manchester Arena Inquiry	Assistant Director of Operations	**March 2024**	This programme of work is underway, and a workshop has confirmed that the PDA would be unable to be met in three out of four simulated mass casualty scenarios. **The financial case associated with MAI is planned to be familiarised with ELT and EASC during Jan and Feb 2024, with the final outline case to ELT in March 2024.**
2. Further correspondence to Welsh Government to seek assurance of testing plans following recent mass casualty exercise where Health Boards declined to incorporate vehicle release plans	Assistant Director of Operations	**January 2024**	**Correspondence with Welsh Government remains ongoing**

Risk ID 424	Resource availability (revenue, capital, and staff capacity) to deliver the organisation's Integrated Medium-Term Plan (IMTP)	Date of Review:	17/01/2023	TREND	16 (4x4)
		Date of Next Review:	14/02/2024	➡	

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

IMTP Deliverable Numbers: All

EXECUTIVE OWNER	Director of Strategy, Planning & Performance	**ASSURANCE COMMITTEE**	Strategic Transformation Board and Finance and Performance Committee

Risk Commentary
Risk score remains currently at 16 as some outstanding gaps in controls and, linked to risk 458, some continued risk with regards to recurrent funding. There are also currently sickness & vacancies in the Transformation team resulting in gaps to support delivery of key workstreams and delivery of mitigations listed in this BAF, however these are in the recruitment and managing attendance processes.
IMTP planning for 2024-2027 underway to refresh our priorities for the next three years, taking into account the external context in which the Trust is working.
This risk will therefore remain under review as we put further controls in place but also taking account of the new commissioning landscape, financial context and our strategic developments.

CONTROLS	**ASSURANCES**
	Internal **Management (1st Line of Assurance)**
1. Prioritisation of IMTP deliverables	1. Prioritisation 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 **Path Framework** (PPF)	6. PowerPoint pack detailing **Project Path Framework**
7. Regular engagement with key stakeholders	7. Stakeholder Engagement Framework
8. Financial Sustainability Programme – savings and income work streams	8. FSP programme highlight reports
	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.~~	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 PP**F**	Head of Transformation	Extended from 31.03.23 – To 31.06.23 and then to 30.09.23 in line with milestone for delivery Extend to 31.12.23 in line with timescales for sign off. Extend to 31.01.24 in line with timescales for sign off. **Extend to end of Feb in line with next STB.**	Currently (January 2023) working through delivery structures for 2023-26 which will inform the PPM review – changed checkpoint date to 31.06.23. Workshop held in Q1 and Q2 to develop new Project Path Framework. Milestone for delivery in Q3. Planning Framework approved by STB on 04.07.2023 which sets out the Project Path framework at a high level. Project Path Framework presented at ISPG on 27.10.23 and is scheduled for approval at STB on 27.11.23. STB reviewed the Project Path Framework and generally good feedback but some alterations to be made and brought back to STB in January 2024 for approval.

Risk ID 424	Resource availability (revenue, capital, and staff capacity) to deliver the organisation's Integrated Medium-Term Plan (IMTP)	Date of Review:	17/01/2023	TREND	16 (4x4)
		Date of Next Review:	14/02/2024	➡	

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

	Likelihood	Consequence	Score
Inherent	4	4	16
Current	4	4	16
Target	1	4	4

			Further finalisation required; approval deferred to STB meeting 26.02.24.
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. Further extend to 31.06.23 and then to 30.09.23 in line with milestone for delivery Extend to 31.12.23 as priorities have taken precedence but there is work ongoing in this space. Extend to 29.02.24 as other priorities have taken precedence but there is work ongoing in this space. **As above extend to end of Feb.**	Reviewed action and extended checkpoint date further as approach being developed for next iteration of IMTP. Work ongoing. Workshop held in Q1 and Q2 to develop new Project Path Framework. Milestone for delivery in Q3 as part of Project Path Framework. Work continues with the Commissioning and Performance Team to align performance metrics with programme/IMTP deliverables. An evaluation methodology is being trialled with Swansea University to look at benefits realisation of small, agile projects and PDSA cycles. Work continues this but will be rolled out as part of the PPF.
4. A formal approach to service change to be developed providing secure recurrent funding with commissioners (link to risk 458)	Director of Finance	31.12.22 – checkpoint date 31.06.23 and then to 30.09.23 Extend to 31.12.23. **As above extend to end of Feb.**	Extend checkpoint date to 31.03.2023 on basis of new financial allocations for 2023 to be worked through with Commissioner. A business case panel process has been developed and trialled as part of the development of the project path framework and is factored into the IMTP planning cycle, to give finance colleagues a timelier view of potential developments into the next 3-year cycle. Extended in line with the roll out of PPF as the business case process is within that framework, however it has been utilised to review the recent CSC Business Case and was found to be helpful and supportive – albeit the model for developing business cases needs to be reviewed further to make the actual output more streamlined

Risk ID 458	A confirmed commitment from EASC and/or Welsh Government is required in relation to funding of recurrent costs of commissioning services to deliver the IMTP and/or any additional services	Date of Review:	17/01/2024	TREND	16 (4x4)
		Date of Next Review:	14/02/2024	→	

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

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

IMTP Deliverable Numbers:

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

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

CONTROLS	**ASSURANCES**
	Internal **Management (1st Line of Assurance)**
1. Financial governance and reporting structures in place	1. Risk is reviewed quarterly at FPC, and a report is submitted bimonthly to Trust Board
2. Financial policies and procedures in place	2.
3. Setting and agreement of recurrent resources	3.
4. Budget management meetings	4. Diarised dates for budget management meetings. If an area is in financial deficit, the meeting would be at least once a month. If the area is in balance or surplus, the meeting would be quarterly.
5. Budget holder training	5. Diarised dates for budget holder training
6. Annual Financial Plan	6. Submission to Trust Board in March annually
7. Regular financial reporting to EFG & FPC in place	7. Diarised dates for EFG and FPC with full financial reports
8. Regular engagement with commissioners of Trust's services	**External** **Management (1st Line of Assurance)** 1. Accountability Officer letter to Welsh Government 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 monthly	**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.	Executive Leadership Team	31.3.24	Update: 23/24 Recurrent funding remains an issue for the 100 WTE £6m funding from commissioners. In addition, discussions continue with commissioners to ensure WAST continue to obtain funds in relation to 111 on a spend and recover basis.
2.Develop a Value Based Healthcare system approach with commissioners. This would mean that funding would flow more seamlessly between organisations and would go some way to mitigating the risk of not receiving recurrent funding.	Deputy Director of Finance	31.3.24	Update: Work to identify the PROMS & PREMS evaluation criteria for Emergency based services via the Value-Based Healthcare working group continues.

Risk ID 260	Significant and Sustained Cyber Attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems	Date of Review:	17/01/2023	TREND	15 (3x5)
		Date of Next Review:	14/02/2024	➡	

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

IMTP Deliverable Numbers:

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

Risk Commentary

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

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

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:	17/01/2023	TREND	15 (3x5)
		Date of Next Review:	14/02/2024	➡	

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

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

NHS Wales Cyber Response Unit independent view of Network and Information Systems (NIS) Directive compliance within last 4 – 5 months (covering controls 1 -,3 – 11, 13 – 14

GAPS IN CONTROLS	GAPS IN ASSURANCE
1. Lack of understanding and compliance with policy and procedures by all staff members	1.
2. No organisational information security management system in place	3. SIRO in place and ISMS evolving in line with refresh of Trust information Security Policy
3.	
4. Departments do not communicate in a timely manner with Digital Services around putting in new processes, new projects, and procurement and this has a cyber security, information governance and resource impact	

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Establish Cyber and Information Security KPIs	Director of Digital Services	31.03.23 complete	KPI format agreed and will be produced from Q1 2023-24 with a retrospective annual report produced for 2022-23.
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 - Complete	Exercise reports being drafted.
5. Formalise Cyber Incident Response Plan	Head of ICT	30.06.23 – complete	Cyber Incident Response Plan adopted, and CRU Assessment conducted during May 2023 with report expected by end June 2023.
6. Implement Meta Compliance Policy Solution	Senior ICT Security Specialist	30.06.23 – Complete Checkpoint Date 31.03.2024	Additional learning modules purchased, and both will be rolled out from Q1 2023-24. Drive up staff compliance of IG & Cyber training
7. Cyber Improvement Plan	**Senior ICT Security Specialist**	**Next checkpoint date 31.03.2024**	**Implementation of Cyber Improvement Plan actions ongoing and reported into IGSG**

Risk ID 543	Major disruptive incident resulting in a loss of critical IT systems	Date of Review:	17/01/2024	TREND	15 (3x5)
		Date of Next Review:	14/02/2024	➡	

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: TBC

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

Risk Commentary

The risk remains static as work continues to migrate services to the new infrastructure. In addition, controlled cut over of key systems to backup sites was undertaken during this quarter. Maintenance works has been undertaken by estates on power systems supporting key ICT sites which will provide additional assurance for sites in the event of incoming mains disruption. Further desktop exercises are being considered to test both department BCP and ICT recovery plans. Internal audit has completed an audit on ICT system resilience which was rated as reasonable assurance. Work will be undertaken to address the recommendations.

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. 04/08/23 – New back-up system ordered with the aim of implementation before the end of Nov23.
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. 04/08/23 – Ongoing continual update of servers and replacement of out-of-date equipment
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 • WAST_2324-14 Internal Audit review of ICT Technical Assurance – Reasonable 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 extend to 30.06.23 now complete	Suite of exercise available via BC teams' channel.
2. Exercise template report which shows recommendations to be created	North Resilience Manager	31.12.22 extend to 30.06.23 now complete	Joshua and Joshua 2 reports produced and circulated.
3. Cyber Essentials assessment to be completed.	Head of ICT	30.06.23 Extend to 31.03.24 - ongoing.	Evidence submitted to assessor – further works required to meet requirement. Implementation of action plan in response to CRU Cyber assessment recommendations
4. Implement recommendations of IA Technical resilience audit	Head of ICT	30.06.2024	Implementation of **the 4** recommendations from the internal audit technical resilience

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:	17/01/2024	TREND	15 (3x5)
		Date of Next Review:	14/02/2024	→	

IF	THEN	RESULTING IN
significant internal and external system pressures continue	there is a risk of a significant deterioration in staff health and wellbeing within WAST	increased sickness levels, staff burnout, poor staff and patient experience and patient harm

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

IMTP Deliverable Numbers: TBC

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

Risk Commentary

The ongoing system challenges remain with long handover delays which are likely to worsen again as we head into winter pressures. Work on reducing shift overruns continues with various pilots being run to test viable options which could be implemented. Front line operations had little respite over the summer months.

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
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. 28/11/23 Health and Wellbeing Strategy coming to a close in 2024 and new plan with emphasis on workplace experience being developed in line with the All Wales framework proposals and the People and Culture Plan 2023-2026.
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. Network supported by Assistant Psychologist and TRiM lead. 28/11/23
7. WAST Keep Talking (mental health portal) and Sway on the Intranet	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.
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. 28/11/23 NHS Wales Staff Survey has just closed with results due in the new year.
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 People and culture 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 People and Culture 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.
20. Procure a pulse survey tool to benchmark how colleagues are feeling and get feedback on the employee experience	20. HIVE went live in September 2023.
	External - Independent Assurance - Audit Wales – Taking Care of the Carers report in October 2021
GAPS IN CONTROLS	**GAPS IN ASSURANCE**

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:	17/01/2024	TREND	15 (3x5)
		Date of Next Review:	14/02/2024		

IF	THEN	RESULTING IN
significant internal and external system pressures continue	there is a risk of a significant deterioration in staff health and wellbeing within WAST	increased sickness levels, staff burnout, poor staff and patient experience and patient harm

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

	4. Reporting on wellbeing training take up
11. Need to increase the education and communication with managers about stress risk assessments. Presentation developed and shared with people services. Delivery dates being agreed in conjunction with Health and Safety.	Lack of awareness about staff wellbeing services
	Effects of REAP 4 affecting the ability of staff to engage with staff health and wellbeing services. Important to recognise the consistent reports of the impact of culture on wellbeing.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Restart the Health and Wellbeing Steering Group (link to risk 160)	Assistant Director Inclusion, Culture and Wellbeing	Completed 03.08.23 Group paused due to two key vacancies. Completed 26/10 /23. Steering Group in place 28/11/2023 CLOSED	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. 03/08/23 - Head of workplace Wellbeing due to be in post in October and OH Manager about to go to advert. No capacity within the team to restart the group. 26/10/23 Head of Workplace Wellbeing in Post, OH Manager starting in December. Steering Group arranged for first week of December.
2. Increase the education and communication with managers about stress risk assessments	Head of Health & Safety	Completed	This is part of the IOSH Managing Safety Training BAU. 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:	17/01/2024	TREND	12 (3x4)
		Date of Next Review:	10/04/2024		

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

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

IMTP Deliverable Numbers: 2, 3, 4, 6, 11, 14, 29, 34

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

Risk Commentary

The ambition is appropriate levels of patient safety and good working conditions for our staff. Clearly neither of these are currently being achieved in the emergency ambulance care pathway as evidenced by the long waits, shift overruns and volume of concerns and reportable incidents. The Trust is currently commissioned on the assumption of 6,000 hours of handover lost hours, with current levels **at 23,000 (Dec-23)**. EASC has an ambition to achieve 12,000 handover lost hours by the beginning of quarter four 2023/24, which looks very unlikely, but even if it was achieved, it would still be double what the EMS rosters are predicated on. The Trust is not fully funded on these rosters either. The Trust is not fully funded for the CHARU roster lines, with an identified shortfall of -89.5 FTEs. The Trust has made the decision to transfer staff from emergency ambulance roster lines to CHARU roster lines, which is almost complete, but does not add more staff. Similarly, the Trust has made the decision **(delivered)** to recruit another intake of APPs, an additional 16 FTEs, but this is also being funded through internal movements, with a planned **temporary relief gap to fund these internal movements**.

The 2023 EMS Demand & Capacity Review is live with an estimated completion date of **March 2023 EASC**. This strategic review will enable the Trust to articulate the type and level of resource that optimises response and conveyance to deliver appropriate levels of patient safety and good working conditions for our staff i.e., the ambition. Health boards are clearly under substantial financial pressures, so whether EASC can then support the ambition as articulated by the review, remains to be seen. The Trust **have provided senior external stakeholders with five key areas that it is focused on, as detailed in the Patient Harm Mitigations report to Trust Board (25/01/24) with health boards being asked to do the same.**

If further funding is not forthcoming, post the 2023 EMS Demand & Capacity Review, the risk may need to be revise its score upwards.

CONTROLS	ASSURANCES
	Internal & External Management (1st Line of Assurance)
1. EASC/WAST Forward Plan for EMS and NEPTS in place and monitored at EASC meetings	1. Minutes of meetings and a standard agenda item
2. EASC and its 2 sub-committees established as a forum to discuss WAST's strategy	2. Minutes of meetings and a standard agenda item
3. Weekly catch up between CASC/CEO	3. Meetings are diarised every week
4. Collaboration between EASC and WAST on specific projects e.g. Amber Review, EMS Operational Transformation Programme, Ambulance Care Programme	4. Representatives are co-opted onto meetings and frequency is between 3–6 weeks. Set agendas with NCCU reps co-opted.
5. Monthly CASC Quality and Delivery Meeting established	5. Formal meeting with agendas, minutes, and action logs available.
6. Patient Safety information e.g. Appendix B incidents, weekly/monthly patient safety reports produced	6. These reports supplied to Director of Quality and Nursing in Health Boards and other senior stakeholder's fortnightly
7. Programme structure has been established for 'inverting the triangles' including EASC	7. **This is now an established programme of work with the Trust making an offer to the system via the Six Goals Programme in January 2024**.
	External Management (1st Line of Assurance) 1. Plans go to every bi-monthly meeting 2. Meet bi-monthly and agendas, minutes, and action logs available
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. EASC meetings focus largely on EMS and cursory note of NEPTS	1. NEPTS is covered in the WAST Provider Report to EASC.
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. Actioned but has lapsed due to capacity and resourcing in NCCU team. **The Trust is currently meeting every two weeks connected to the development the IMTP**.
3. WAST's ability to influence hospital handover delays (this is outside of the Trust's control and a Health Board responsibility)	3. Ministerial direction on handover reduction **with significant pressure being applied to health boards through the NHS Leadership Board and NHS Executive accountability arrangements.**

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:	17/01/2024	TREND	12 (3x4)
		Date of Next Review:	10/04/2024		

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

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

4. Funding does not flow in a manner to balance demand with capacity (outside of WAST's control)

4. Strategic demand and capacity review being undertaken with output due to be reported to EASC in **Mar**-24, **with initial findings already shared.**

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Agree and influence EASC/Health Boards that sufficient funding to be provided to WAST	CEO WAST	02/08/23 Checkpoint Date	30.09.22 Additional £3m provided for +100 FTEs into Response by 23/01/23. 12/01/23 Recurrent funding for the +100 not secure. 02.05.23 Recurrent funding still not secure. 28.07.23 Funding secure for 23/24, but not recurring. **18.01.24 Offer being made to the system in January 2024 via the Six Goals Programme.**
2. Agree and influence EASC/Health Board of the need for significant reduction in hospital handover hours	CEO WAST	02/08/23 Checkpoint Date	30.09.22 4-hour handover backstop agreed and -25% reduction in handover from October 2021 baseline. 12/01/23 There has been a significant worsening picture. 02.05.23 Continued worsening picture with almost 29,000 lost in March 2023. 28.07.23 There has been some reduction, but levels remain extreme. **18.01.24 NHS Leadership Board is increasing accountability and focus of health board handover reduction actions**.
3. Increased understanding of NEPTS by EASC	**Executive** Director of Strategy Planning and Performance	02/08/23 Checkpoint Date	30.09.22 "Focus on" session in May 2022 EASC and NCCU represented on Ambulance Care Programme Board. 12/01/23 F&P Deep Dive made available to NCCU. 02.05.23 Continued attendance by NCCU at Ambulance Care Transformation Programme. 28.07.23 EASC want WAST to develop a LTS for NEPTS, which will increase the focus on it. **18.01.24 Ambulance Care strategy sessions held as part of the inverting the triangle programme and IMTP development held**.
4. Governance meeting between NCCU and WAST to manage the commissioner provider interface	Assistant Director Commissioning & Performance	02/08/23 Checkpoint Date	30.09.22 Meeting in place and meeting regularly. 12/01/23 Meetings continue. 02.05.23 These have lapsed due to pressures and sickness absence in the NCCU. HB to reboot, subject to ability of NCCU to undertake. 28.07.23 Availability remains a challenge, but there is regular informal dialogue between WAST and NCCU. **18.01.24 This specific meeting remains lapsed, but the Trust is currently meeting every two weeks with the NCCU on the development of the IMTP.**
5. Utilising the engagement framework to engage with the stakeholders	Director of Partnerships & Engagement AD Planning & Transformation	02/08/23 Checkpoint Date	30.09.22 Significant engagement through roster review briefings. 12/01/23 Engagement on roster review largely concluded, with some political interest continuing in a few areas. 02.05.23 Continued interest from various stakeholders as the roster review concludes. 28.07.23 New engagement manager appointed linked to inverting the triangle work. **18.01.24 The Trust is currently still working with PWC on the information that will drive engagement, but as above an offer being made to the system in January 2024.**

Risk ID 283	Failure to implement the EMS Operational Transformation Programme	Date of Review:	17/01/2024	TREND	12 (3x4)
		Date of Next Review:	10/04/2024	➡	

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

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

IMTP Deliverable Numbers:

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

Risk Commentary

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

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

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. Now every 6 weeks as the programme largely delivered.	1. Minutes and papers of Implementation Programme Board.
2. Executive sponsor and Senior Responsible Owner (SRO) for programme in place.	2. Project Initiation Document (PID) detailing structure and minutes of Implementation Programme Board. PID is up to date.
3. Programme Manager and Programme support office in place (for delivery of the programme).	3. Same as 2 above.
4. Programme risk register.	4. Highlight reports showing key risks reported to STB every 6 weeks.
5. Assurance meetings held with Strategic Transformation Board (STB) every 6 weeks and with CEO every 3 weeks.	5. Highlight reports presented to STB every 6 weeks.
6. Programme budget in place (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.
	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. The PID has been updated for 2023/24 and reflects the budget, commissioning intentions and IMTP.

Risk ID 283	Failure to implement the EMS Operational Transformation Programme	Date of Review:	17/01/2024	TREND	12 (3x4)
		Date of Next Review:	10/04/2024	➡	

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

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

2. System pressures – patient handover delays at hospitals (link to risks 223 & 224)	2. No prompts from STB for programme PID or risk register updates. The SRO continues to provide the HLR, but the PID needs to be signed off by the Executive Sponsors. This can be done outside of STB.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Increase in engagement on the specifics of change through facilitation mechanisms	Assistant Director – Commissioning & Performance	**02.08.23 Checkpoint Date**	30.09.22 Significant engagement through roster review project. 12/01/23 Largely complete. 02.05.23 There remains some minor engagement as the project concludes. 18.01.24 The main o/s action here is engaging with the TU partners on the evaluation of the roster review. A draft evaluation has been written up and will be shared with TU partners this quarter.
2. More capacity requested (transition plan)	Assistant Director of Planning & Transformation	**02.08.23 – Checkpoint Date**	30.09.22 Transition plan not funded, but +100 FTE agreed. 12/01/23 Recurrent funding not secure. 02.05.23 this has not been forthcoming, and handover lost hours are offsetting all the gains that the Trust has made. 03.08.23 More capacity unlikely within current financial pressures, but Trust has recently started the next iteration of the strategic EMS Demand & Capacity Review. 18.01.24 Trust currently making an offer to the system via the Six Goals Programme.
3. Engage with key stakeholders to reduce handover delays	CASC	**02.08.23 – Checkpoint Date**	30.09.22 Reduction commitments agreed, but trend is still upwards. 12/01/23 Extreme and upward trend. 02.05.23 handover hours remain extreme. 28.07.23 Increasing focus through ICAP meetings, with C&V showing notable progress and early signs of progress in some other health boards. 18.01.24 Significant increase in health board accountability and focus via the NHS Leadership Board.
4. Reduce abstractions in particular sickness absence	Deputy Director of Workforce & OD	**02.08.23 Checkpoint Date**	30.09.22 Sickness absence reducing, but abstractions high linked to sickness, but also training abstraction linked to the +100. 12/01/23 Abstractions have reduced, but still very high. Sickness is reducing and on trend to achieving the 10% Mar-23 target. High abstractions linked to internal movements caused by internal recruitment. 02.05.23 the Trust achieved 7.99% in Feb-23, but levels are higher in Operations. Continued focus into 2023/24 to reach 6% by 31/03/23. 28.07.23 Abstractions, which includes sickness now less than 35% with benchmark to 30%. 18.01.24 Abstractions were 31% in November 2023. They did increase in December.
5. Engage with Assistant Director of Planning and Transformation on process for PID updates	Assistant Director – Commissioning & Performance	**02.08.23 Checkpoint Date**	30.09.22 HoT recruited and now started. Initial contact made with HoT. PID is up to date. 12/01/23 PID has been further updated but requires sign off by the SRO and STB. 02.05.23 PID has been updated but needs to be signed off by Executive Sponsors. 28.07.23 PID updated and programme aligned to new arrangements required by HoT. **18.01.24 PID up to date.**

Risk ID 139	Failure to deliver our Statutory Financial Duties in accordance with Legislation	Date of Review:	17/01/2024	TREND	8 (2x4)
		Date of Next Review:	10/04/2024		

IF the Trust does:	THEN there is a risk that	RESULTING IN
• 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)	the Trust will fail to achieve all its statutory financial obligations and the requirements as set out within the Standing Financial Instructions (SFIs)	potential interventions by the regulators, qualified accounts, and impact on delivery of services and reputational damage

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

IMTP Deliverable Numbers:

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

Risk Commentary Q3 2023/24

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

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

Risk ID 139	Failure to deliver our Statutory Financial Duties in accordance with Legislation	Date of Review:	17/01/2024	TREND	8 (2x4)
		Date of Next Review:	10/04/2024		

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

IF the Trust does:
- not achieve financial breakeven and/or
- does not meet the planning framework requirements and/or
- does not work within the EFL and/or
- fails to meet the 95% PSPP target and/or
- does not receive an agreement with commissioners on funding (linked to 458)

THEN there is a risk that the Trust will fail to achieve all its statutory financial obligations and the requirements as set out within the Standing Financial Instructions (SFIs)

RESULTING IN potential interventions by the regulators, qualified accounts, and impact on delivery of services and reputational damage

GAPS IN CONTROLS	GAPS IN ASSURANCE
• Lack of formalised service contracts between Commissioner and WAST as a commissioned body	4. None identified.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Continuing negotiations with Commissioners	Director of Finance and Corporate Resources/ Director of Strategy Planning and Performance	31/03/24 – Checkpoint Date	In line with the recent WAST financial position and monthly monitoring letter sent to WG, WAST can resource the cost of the EMS staff itself. In addition, discussions continue with commissioners to ensure WAST continue to obtain funds in relation to 111 on a spend and recover basis.
2. Embed a transformative savings plan and ensure organisational buy in	ADLT and Savings subgroup	31/03/24 – Checkpoint Date	The Financial Sustainability workstreams that were launched in May 2023 have now been rebranded as the Financial Sustainability Program (FSP) and the work of the program underpins the need of the organisation to deliver transformative savings via the Achieving Efficiencies and Income Generation subgroups. WAST is currently over delivering against its savings plan.
3. Embed value-based healthcare working through the organisation	Executive Leadership Team and Value Based Healthcare Group	31/03/24 – Checkpoint Date	Work to identify the PROMS & PREMS evaluation criteria for Emergency based services via the Value-Based Healthcare working group continues.
4. WIIN support for procurement, savings, and efficiencies	WAST Improvement and Innovation Network group	31/03/24 – Checkpoint Date	WIIN ideas are regularly communicated across to the Achieving Efficiencies subgroup of the FSP.
5. Foundational economy, Decommissioning, and procurement to mitigate social and economic wellbeing of Wales	Estates, Capital and Fleet Groups, NHS Wales Shared Services Partnership	31/03/24 – Checkpoint Date	The organisation utilises the NWSSP Shared Services Procurement framework to ensure contracts tendered provide best value for money while ensuring criteria within the tender docs ask bidders to highlight their ability to serve the aims of FE, Decommissioning, Decarbonisation and social as well as the economic wellbeing of Wales.

Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services
NHS Trust

GIG CYMRU NHS WALES

Risk Management Policy

Policy Number:	107	**Version No:**	V0.12	**Supersedes:**	V0.11
Date of Approval:		**Review Date:**	Annually from date of approval	**Impact Assessments Completed:**	Yes
Classification of Document:	Corporate	**Type of Document:**	Policy	**Approved by:**	Trust Board
Brief Summary of Document:	The Risk Management Policy sets out the roles and responsibilities for risk management and the Board Assurance Framework				
Scope:	This Policy applies to all staff that are directly employed by WAST and encompasses Non-Executive Directors, bank staff, contractors, and all those that it has legal responsibility for such as students and trainees.				
To be read in conjunction with:	Risk Management Guidelines (October 2023) Board Assurance Framework Guidance (April 2023)				
Owned By	Trust Board				
Policy Lead: **Trade Union Lead:**	Julie Boalch Hugh Parry	**Job Title:**	Head of Risk/Deputy Board Secretary Trade Union Partner		
Director:	Trish Mills	**Job Title:**	Board Secretary		

Version Control Sheet

Version	Date	Author	Summary of Changes
0.1	31/07/22	Julie Boalch	New Policy
0.2	08/09/22	Julie Boalch	Minor amendments following Policy Group discussion
0.3	08/01/23	Julie Boalch	Review and amendment of whole Policy following consultation period
0.4	10/01/23	Julie Boalch	Further redrafting based on comments received in consultation.
0.5	23/10/23	Marinela Stoicheci	Review of sections
0.6	31/10/23	Julie Boalch	Prepare draft 2.5 for onward review and governance
0.7	17/11/23	Trish Mills	Review of sections
0.8	15/12/23	Julie Boalch	Formatting, enhancing three lines of defence model, risk appetite and statements section, the BAF section and adding Duty of Quality to introduction and BAF section. Updated auditing and monitoring section.
0.9	19/12/23	Julie Boalch	Front cover, who policy applies to, to be read in conjunction with, 3.4 included monitoring, treatment and acceptance of risk, updated 3rd line of defence definition
0.10	04/01/24	Julie Boalch	Minor update following Policy Group i.e. Trist instead of Trust. No material changes
0.11	13/02/24	Julie Boalch	Version control updated to reflect new policy. Section on strategic objectives strengthened to align to LTS.
0.12	21/02/24	Julie Boalch	Separated out the Risk reporting structure from the Roles and Responsibilities section 6. Created a new section 7.
Keywords	Risk, Risk Appetite, Risk Management, Risk Assessment		

Impact Assessment Reviews

Area	Date of Review	Name of Reviewer
EqIA / Welsh Language	30/08/22	Julie Boalch, Melfyn Hughes, Hugh Parry
EqIA / Welsh Language	02/12/23	Julie Boalch, Hugh Parry, Kathryn Cobley

Policy Approval Route

Meeting Title	Meeting Date	Purpose/Outcome
Policy Group	08/09/22	Review prior to consultation
Policy Group	23/01/23	Review post consultation
Policy Group	04/01/24	Review following further update
Trade Union Partners Team	TBC	Recommend for approval
Assistant Directors Leadership Team	TBC	Recommend for approval
Executive Leadership Team	TBC	Recommend for approval
Audit Committee	01/03/24	Recommend for approval
Trust Board	28/03/24	Approval

Disclaimer
If the review date of this document has passed, please ensure that the version you are using is the most up to date either by contacting the document author or by emailing AMB_Policies@wales.nhs.uk

CONTENTS

1. INTRODUCTION AND AIM

Risk is inherent in everything we do to deliver high quality services. Effective and meaningful risk management remains as important as ever in taking a balanced view to managing opportunity and risk (HM Government, Orange Book, 2020).

The Welsh Ambulance Services NHS Trust (WAST) governing documents, the Standing Orders, set out the requirements that the Board shall set out explicitly, within a Risk and Assurance Framework, how it will be assured on the conduct of Trust business, its governance, and the effective management of the organisation's risks in pursuance of its aims and objectives. It shall set out clearly the various sources of assurance, and where and when that assurance will be provided, in accordance with any requirements determined by the Welsh Ministers.

The Trust is also guided by its legal responsibility outlined in the Health and Social Care (Quality and Engagement) (Wales) Act 2020 to ensure that there is an effective quality management system embedded across all areas of the Trust.

Risk is a vital component of this quality management system, and, in line with the Health and Care Quality standards 2023, the Trust has a responsibility to prioritise and implement a Risk Management Framework that enables the identification and monitoring of risks, and where possible, reduces or prevents risks to safety and ensuring it delivers a safe and high quality service.

The Trust is fully committed to fulfilling its obligations under the Duty of Quality by setting the highest standard of quality in everything it does, by embedding quality in its decision making and in managing the risks associated in the delivery of its services.

The purpose of this policy is to set out the roles and responsibilities for risk management and internal control at WAST and to maintain a robust risk management framework that ensures risks are effectively addressed.

It will:

- Set out the approach to risk management within the Risk Management Framework.
- Set out respective responsibilities for strategic and operational risk management for the Board and staff throughout the organisation.
- Ensure that risk management is an integral and positive part of the Trust's culture.
- Ensure that the Trust meets its legal obligations in respect of risk management.

- Minimise the impact of risks, adverse incidents, and complaints by effective risk identification, prioritisation, treatment, and management.
- Maintain a risk management framework, which provides assurance to the Board that strategic and operational risks are being managed effectively.

2. SCOPE

This Risk Management Policy applies to all staff that are directly employed by WAST and encompasses Non-Executive Directors, bank staff and contractors and all those that it has legal responsibility for.

It is intended to cover all the potential risks that the organisation could be exposed to and must be read in conjunction with the Risk Management Guidelines (October 2023) Procedure and the Board Assurance Framework Guidance (April 2023) that have been produced as subordinate adjuncts to this Policy.

3. RISK MANAGEMENT

3.1. What is Risk Management

Risk Management improves performance, encourages innovation, and supports the achievement of the Trust strategic objectives.

It consists of a defined series of steps which help us understand risks and their impact. It is the process of assessment, analysis, and management taken to minimise the likelihood of a risk materialising and reducing the potential impact it may have if it does.

Good risk management awareness and practice at all levels is a critical success factor for the Trust and needs to be seen as integral in every function, service, and area.

3.2. Types of Risk

Strategic Risks are those risks that could impact upon the delivery of the Trust's strategic objectives as outlined in its long-term strategy, Delivering Excellence 2030, and which need to be raised and monitored by the Executive Leadership Team (ELT) and the Board.

Principal (Corporate) Risks are risks that are escalated to the Corporate Risk Register (CRR) from the Directorate Risk Register (DRR) dependent on scoring or whether they are cross directorate risks Plan and require a corporate response. These are reviewed and monitored by the Assistant Directors Leadership Team (ADLT), the ELT, Board Committees, and the Board.

Operational (Service and Directorate) Risks are key risks that could affect the quality, safety or delivery of services and are managed by individual Directorates and their local teams. If necessary, these can be escalated through the risk reporting structure for inclusion on the CRR.

Project risks are risks that could cause doubt about the ability to deliver a project on time, within budget and to quality. These are monitored and reported through the Project and Programme Boards.

3.3. Recording and Reporting

The purpose of risk recording and reporting is to enable the Trust to manage risk and mitigating actions as well as communicate risk management activities and outcomes across the organisation, provide information for decision making, meet governance requirements and support the Board in meeting its responsibilities.

It is important that risks are included on a register in order that they can be escalated if necessary and managed at higher level.

3.4. Risk Appetite

The Trust recognises, as a healthcare provider, that risks will inevitably occur while providing the right care and treatment to patients at the right time, as well as in enabling and empowering our staff, managing its finances and resources, and striving to continue to be a quality driven and innovative service.

Risk appetite is defined as the amount and type of risk that the Trust is prepared to take in pursuit of its strategic objectives. It enables the Trust to strike the balance between innovation or opportunities and the threats that are an inevitable part of delivering any service.

The Trust's Risk Appetite should be aligned to its long-term strategy (Delivering Excellence 2030) to enable the organisation to prioritise those risks that are most relevant to achieving its objectives.

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

This will be achieved by considering the external and internal environments that it operates in, by establishing a positive risk culture and ensuring a robust risk management framework is in place to monitor, manage and mitigate risk. The result will be the provision of a framework for managers to operate within that includes a risk-based approach to decision making at all levels of the organisation.

Decisions on accepting risks may be influenced by the following:

- The likely consequences are insignificant and/or the risk has a very low possibility of occurring.
- A higher risk consequence is outweighed by the chance of a much larger benefit if the risk is appropriately managed.
- The potential financial costs of minimising the risk outweigh the costs that would arise if the risk event occurred.
- Treating the risk may lead to further unacceptable risks in other ways.
- It is reasonable to accept a risk that under normal circumstances would be unacceptable if the risks or all other alternatives, including doing nothing, is even greater.

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

The Trust may accept some risks if the cost of mitigation is too high or if the risk is deemed to be within acceptable limits. In such circumstances, ongoing monitoring is essential to detect any changes and prompt a reassessment of the risk.

3.5. Board Assurance Framework

The Board Assurance Framework (BAF) is an integral part of the system of internal control and contains the strategic risks It summarises the controls and assurances that are in place, any gaps in these and the actions to mitigate them. The BAF provide a basis upon which the Board will identify, monitor, and evaluate risks which impact upon its strategic objectives.

The BAF is a key source of evidence that links the Trust's strategic objectives to risk and assurance, and one of the tools that the Board will use in discharging its overall responsibility for internal control.

It will be developed through the following key steps:

- The Board agrees its strategic objectives, as set out in the Long Term Strategy, which are delivered through the Integrated Medium Term Plan (IMTP process) and aligned to the BAF.

- The ELT, with the support of the Head of Risk/Deputy Board Secretary, will identify the principal risks that may threaten the achievement of the Trust's objectives; these risks will then be discussed and approved by the Board.

- Once agreed by the ELT the completed BAF will be presented to the Trust Board for scrutiny and approval at all regular meetings.

The Trust is embarking on a maturity journey of the BAF which relies on risk appetite statements being aligned to it to inform decisions about its strategic direction and objectives and will have due regard for the requirements of the Duty of Quality.

3.6. The Trust's Strategic Objectives

The Trust's six strategic objectives as described in the long-term strategy are detailed below:

3.7. Risk Management Procedure

The full risk management process is articulated in the Risk Management Guidance (aligned to ISO31000) which supports this Risk Management Policy by explaining in detail how to manage risk in particular:

- Types of Risk (Strategic, Principal and Directorate)
- Risk Assessment
- Risk Identification
- Articulation of Risk (Title, summary description, controls, assurances, gaps, actions)
- Risk Analysis and Assessment
- Risk Treatment
- Monitoring and Review
- Recording and Reporting (Datix, BAF)
- Escalation/De-escalation of Risks
- Review of Risks
- Risk Scoring
- Risk Training
- Definitions

4. STATUTORY AND REGULATORY REQUIREMENTS

The Trust's governing documents, the Standing Orders, require the Trust to have a Risk Management Framework in place. The Chief Executive Officer, as Accountable Officer, has overall responsibility for ensuring that the Trust has an effective risk management framework and system of internal control; however, Directors have a responsibility for the ownership and management of principal and operational risks within their own portfolios.

This Policy is the overarching document for implementing the Risk Management requirements and is intended to meet all legal and internal requirements.

5. RISK MANAGEMENT ORGANISATIONAL STRUCTURE

5.1. The Three Lines of Defence in Effective Risk Management and Control

Apart from internal and external audit, the Trust has the freedom to decide on where it receives its assurance from. The Board, Audit Committee and ELT will determine the source of assurance it needs and from a wide range of sources.

The three lines of defence model is a risk management framework that is designed to create a system of checks and balances, promote transparency, accountability, and ensure the Trust takes a structured and effective approach to risk management. By clearly setting responsibilities and oversight functions, this model will help the Trust to prevent and detect risks early.

Each line of defence has a distinct role in creating a positive environment for risk management and control across the Trust. The three lines are described below:

First line: This is operational management assurance where day to day operations take place.

Second line: This is where the oversight of management activity takes place and is separate from those responsible for delivery. It provides guidance, monitoring, and independent assessment of risk management processes but it is not independent of the Trust's management chain.

Third line: This relates to independent and external bodies that are separate and detached from the Trust that operate autonomously which ensures transparency, credibility, and impartiality. These are mandated and commissioned. The principal aim of this type of assurance activity, such as internal audit, Audit Wales, and Health Inspectorate Wales (HIW) is not only to assure the Board, but also to provide assurance to the public and other stakeholders.

Whilst there is a wide range of assurance activities within the Trust, in determining its programme of assurance, the Board will need to ensure that they are making the best use of the information they have available to them.

The table below describes the types of assurance the Trust will receive in each of the three lines of defence.

First line of defence	Second line of defence	Third line of defence
• Evidence of delegation of responsibility through line management arrangements • Compliance with PADRs • Compliance with policies, procedures, strategies, and frameworks • Incident reporting and thematic reviews • Performance reports • Finance reports • Compliance with risk management processes and systems	• Quality, Performance Management Framework • Strategic Transformation Board • Local Delivery Plans • Key metrics • Audit Tracker • Clinical audit • Speaking Up Safely Guardians • Risk management • Local counter fraud • Quality standards self-assessment • Pulse surveys	• NHS Staff satisfaction survey • Patient feedback • Audit Wales Structured Assessment • Auditing of accounts Trust and Charity • WG monitoring status. • Commissioned/peer review reports. • HIW inspection report • WG reviews • Regulator visits • Accreditation schemes

	• NIS Toolkit • Annual report • Equality impact assessments • Welsh language standards compliance • Governance codes • PIRs • Systems of integrated governance	• Llais • Various Commissioners • Public service ombudsman • HSE

6. ROLES AND RESPONSIBILITIES

The section below describes the respective risk management duties for individual staff members.

6.1. Chief Executive

The Chief Executive is the Accountable Officer of WAST and has overall accountability and responsibility for ensuring it meets its statutory and legal requirements and adheres to guidance issued by the Welsh Government in respect of Governance. This responsibility encompasses risk management, health and safety, quality, financial and organisational controls, and governance.

The Chief Executive has overall accountability and responsibility for ensuring that the Trust maintains an up-to-date Risk Management and Board Assurance Framework that is endorsed by the Board.

In addition, the Chief Executive will:

- Ensure that there is a framework in place which provides assurance to the Board in relation to the management of risk and internal control.

- Ensure that risk issues are considered at each level of business planning from the corporate process to the setting of staff objectives.

- Have in place an effective system of risk management and internal control.

- Set out the Trust's commitment to the risk management principles, which is a legal requirement under the Health and Safety at Work Act 1974 and the National Health Service (Wales) Act 2006.

6.2. Board Secretary

The Board Secretary is responsible for the effective management of, and compliance with, this Policy. This includes:

- Work closely with the Chair, Chief Executive, Chair of the Audit Committee and Executive Directors to implement and maintain the Risk Management Policy and BAF and related processes, ensuring that effective governance systems are in place.
- Work with the Board to develop a shared understanding of the risks to the Trust's strategic objectives.
- Develop and communicate the Board's risk awareness, appetite, and tolerance.
- Lead and participate in risk management oversight at the highest level, covering all risks across the organisation, on a Trust basis.
- Work closely with the Chief Executive and Directors to support the development and maintenance of Corporate and Directorate level risk registers.
- Develop and oversee the effective execution of the BAF and ensure effective processes are embedded to rigorously manage the risks therein.
- Monitor the action plans and the processes for risk reporting to the Board and relevant Committees.
- Develop and implement the Trust's Risk Management Policy and BAF.
- Ensure the Policy is approved as part of the Governance framework by the Trust Board.
- Ensure that the document is accessible to all relevant staff, cascaded appropriately across the Trust and is reviewed in a timely manner.

6.3. Directors

The Directors are responsible for the effective management of and compliance with this policy within their Directorate.

Each Director is accountable for the delivery of their area of responsibility and will therefore ensure that the systems, policies, and people are in place to manage, eliminate or transfer the key risks related to the Trust's strategic objectives.

Specifically, they will:

- Communicate to their directorate the Board's strategic objectives and ensure that directorate, service and individual objectives and risk reporting are aligned to these.
- Ensure that a forum for discussing risk and risk management is maintained within their area which will encourage integration of risk management.
- Co-ordinate risk management processes to encompass risk assessments, incident reporting, the investigation of incidents/near misses and the management of the risk register.
- Ensure there is a system for monitoring the application of risk management within their area and that risks are treated in accordance with the risk grading guidance contained in this document.
- Provide reports to the appropriate committee of the Board that will contribute to the monitoring and auditing of risk.
- Assess and communicate the risk related training needs of their staff and ensure staff attend relevant mandatory and local training programmes.
- Ensure a system is maintained to facilitate feedback to staff on risk management issues and the outcome of incident reporting.
- Ensure the specific responsibilities of managers and staff in relation to risk management are identified within the job description for the post and those key objectives are reflected in the individual performance review/staff appraisal process.

Executive Directors are also responsible for ensuring that the BAF and the risk management reporting timetable are delivered to the Board.

6.4. Head of Risk/Deputy Board Secretary and Risk Team

The Head of Risk/Deputy Board Secretary will act as the Trust's operational gatekeeper with the responsibility for providing guidance, advice, and support for the process of risk management on behalf of the Trust.

The Risk Team are responsible for co-ordinating the Trust's operational and strategic risks, including the Corporate Risk Register and the BAF. The team has a remit to work with Executives and Managers to co-ordinate, integrate, oversee, and support the risk management agenda, ensuring that risk management principles are embedded across the Trust.

The team will also coordinate the Risk Management Internal Audit process.

On a quarterly basis they will receive from the ADLT risks for potential inclusion on the Corporate Risk Register, as well as updates on those risks already being managed on the Corporate Risk Register. The team also provides training and support for WASTs individuals and teams engaged in Risk Management.

6.5. Head of Service/ Service Managers/ Locality Managers/ Duty Operations Managers

Each Directorate operates within the First Line of Defence. They are responsible for risks within their areas of operation and providing assurance to the Executive Leadership Team on the operational management and any support required in relation to the management of risk.

The identification and management of risk requires the active engagement and involvement of staff at all levels. This First Line of Defence recognises that staff are best placed to understand the risks relevant to their areas of responsibility and that the identification and management of risk requires the active engagement and involvement of operational teams.

Therefore, staff must be supported and enabled to manage these risks, within a structured risk management framework, and Managers are expected to take an active lead to ensure that risk management is embedded into the way their service or team operates.

They will update existing risks, consider new risks for inclusion, and escalate any extreme risks, utilising, where required, specialist input from individuals/teams within the first line of defence. These are presented to the ADLT and ELT for review and decision respectively.

6.6. Line Managers

Managers must ensure that their staff understand and implement this Policy and supporting processes, ensuring that staff are provided with the education and training to enable them to do so, thus reducing the risk of misinterpretation.

In addition, ensuring that new members of staff that join the Trust are made aware of the policy process and associated documents at local induction, and how to access the Policy.

Managers must be fully conversant with the Trust's approach to risk management and governance. They will support the application of this Policy and its related processes and participate in the monitoring and auditing process.

6.7. All Staff

All members of staff are accountable for maintaining risk awareness, identifying, and reporting risks as appropriate to their line manager. More specifically they will:

- Accept personal responsibility for maintaining a safe environment, which includes being aware of their duty under legislation to take reasonable care of their own safety and all others that may be affected by the Trust's business.
- Report all incidents/accidents and near misses and comply with the Trust's incident and near miss reporting procedures.
- Be responsible for attending mandatory and relevant education and training events.
- Participate in the risk management system, including the risk assessments within their area of work and the notification to their line manager of any perceived risk which may not have been assessed.
- Be aware of and comply with the Trust's Risk Management Policy, processes, and associated procedures.

6.8. Central Corporate Functions

Central Corporate Functions such as Corporate Governance, Patient Safety and Putting Things Right, Health and Safety, Capital Estates and Facilities, Finance Directorate, People Services Directorate, Occupational Health etc all operate within the First Line of

Defence. They will assist clinicians and managers by providing risk related advice and support specific to their area of responsibility.

6.9. Local Counter Fraud Services.

The Trust's Local Counter Fraud Specialist (LCFS) provides assurance to the Audit Committee regarding risks relating to fraud and/or corruption. The Trust's Annual Counter Fraud Work Plan, as agreed by the Audit Committee, identifies the arrangements for managing and mitigating risks because of fraud and/or corruption. Where such issues are identified they are investigated by the LCFS and then reported to the Audit Committee as appropriate. The LCFS works with the Head of Risk/Deputy Board Secretary to review any fraud or corruption risks. Such risks are referred to the relevant risk register for the Finance Directorate and are then escalated through the Trust's escalation process**.**

6.10. Health and Safety Team

The Health and Safety Team will be responsible for providing advice where a risk is related to Health and Safety. These types of issues are closely linked with risk management and specialist Health & Safety advisers can assist with the conduct of specific and/or specialist assessments.

7. RISK MANAGEMENT REPORTING STRUCTURE

7.1. The Board

Executive Directors and Non-Executive Directors share responsibility for the success of WAST, including the effective management of risk, and compliance with relevant legislation. In relation to risk management, the Board is responsible for:

- Articulating the Strategic Objectives for the organisation.
- Protecting the reputation of the organisation.
- Providing leadership on the management of risk.
- Approving the risk appetite for the organisation.
- Ensuring the approach to risk management is consistently applied.
- Ensuring that assurances demonstrate that risk has been identified, assessed and all reasonable steps taken to manage it effectively and appropriately.
- Reviewing the BAF (strategic risks) and the high scored corporate risks (scored 15 and above) at each meeting.
- Endorsing risk related disclosure documents.
- Approving the Risk Management Policy on an annual basis.

7.2. Audit Committee

The Audit Committee has a specific role in relation to reviewing the effectiveness of the Risk Management Policy and the Board Assurance Framework by reviewing the adequacy and effectiveness of:

- A system of internal control and risk management.
- All risk and control related disclosure statements (particularly the Annual Governance Statement), prior to endorsement by the Board.
- The structures, processes, and responsibilities for identifying and managing clinical and non-clinical risks facing the organisation.
- The Trust's Corporate Risk Register and the adequacy of the scrutiny of risks by assigned Committees.
- The underlying assurance processes that indicate the degree of achievement of strategic objectives
- the systems and processes for the identification, management, escalation, and monitoring of risks.
- BAF and the appropriateness of disclosure documents.

7.3. Board Committees

The Committees of the Board all have a role to play in ensuring effective risk management. They will, through the scrutiny inherent in their committee activity, provide onwards assurance to the Board in relation to their elements of the BAF.

They will:

- Receive and scrutinise corporate risks and provide onward assurance to the Board in relation to risks assigned to them for oversight and scrutiny.
- Receive updates on actions taken to mitigate the risks and provide feedback and challenge to risk owners on these and any further actions required.

7.4. Executive Leadership Team

The Executive Leadership Team undertake the following duties:

- Promote a culture within the Trust which encourages open and honest reporting of risk with local responsibility and accountability.
- Provide a forum for the discussion of key risk management issues within the Trust.
- Ensure appropriate actions are applied to both clinical and non-clinical risks Trust wide.

- Enable risks which cannot be dealt with locally to be escalated, discussed, and prioritised.
- Ensure Directorate Risk Registers are appropriately rated and agreeing action plans to control them.
- Review the risks on the CRR to determine whether any of them will impact on the Trust's Strategic Objectives, and if so, adding the risk to the BAF.
- Review the BAF before presenting it to the Board.
- Advise the Board of exceptional risks to the Trust and any financial implications of these risks.
- Review and monitor the implementation of the Risk Management Policy.
- Ensure that all appropriate and relevant requirements are met to enable the Chief Executive to sign the Annual Governance Statement.
- Approve documentation relevant to the implementation of the Risk Management Policy.

These duties have the aim of providing assurance to the Board that there is an effective system of risk management across the organisation.

7.5. Assistant Directors Leadership Team

The Assistant Directors Leadership Team (ADLT) are responsible for risks within their areas of operation and providing assurance to the ELT on the operational management and any support required in relation to the management of risk.

The ADLT will review updates to existing risks, consider new risks for inclusion and escalate any extreme risks to the relevant Executive Director with responsibility for that risk and the ELT, utilising, where required, specialist input from the Risk Owner and individuals/teams. This framework is managed by the Risk Team for presentation by Directors throughout the governance structure.

7.6. Internal Auditors

Internal Auditors operate as the 3rd Line of Defence. Internal Audit Services, provided by NHS Wales Shared Services Partnership, through a risk-based programme of work, will provide the Trust with independent assurance in respect of the adequacy of the systems of internal control across a range of financial and business areas in accordance with the standards of good practice contained within the NHS Internal Audit Manual. They will also review the effectiveness of risk management arrangements as part of their programme of audits and reviews, reporting findings to the Audit Committee as appropriate.

8. EQUALITY IMPACT ASSESSMENT

An Equality Impact Assessment (EqIA) was carried out to ensure this policy maintained the Trust's equality standards. The Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on the grounds of any protected characteristic (Equality Act 2010), Human Rights and the Welsh Language. Evidence gathered by undertaking an initial screening has indicated that a full EqIA is not required.

9. TRAINING

The effectiveness of managing risk within the Trust relies upon the knowledge of staff, patients and public regarding risk identification and reporting.

It is important that all staff are aware of their responsibilities regarding risk management and the identification and management of risk must be a core competency of the personal appraisal and development review.

A range of training and education relating to risk management will be available aimed at the specific needs of staff members and will follow a tiered approach to enable personnel to meet their Risk Management responsibilities outlined in this policy.

Level One – Risk Management Awareness. This will be provided to all staff on induction, as part of Core Mandatory Training, and will be repeated on ESR every 2 years. The intended learning outcomes are to understand what risk is, what risk management is, how a risk is reported and how the organisation's risk culture operates.

Level Two – Practical Risk Management. This level of training is targeted for any employee undertaking risk management as part of their primary or secondary roles, and for Team Leaders/Managers/Departmental Heads. Line Managers and Directors have a specific role to play in identifying candidates for this training, ideally in prelude to assuming a risk facing role, but if not then as soon as practicable after taking up a role. Level Two training does not require repetition, though this does not mean that additional risk related training and education should not be identified through PADRs. This training will be in two parts:

- Part 1. To understand the risk management framework including the risk management policy, the associated procedures, the BAF, the corporate risk register, risk appetite, risk culture, and roles and responsibilities.

- Part 2. To understand the risk management process including context, risk versus issue and incidents. Risk assessment, risk tolerance, risk scoring, risk treatments, escalation, communication, monitoring, and review.

Level Three – Board Level Risk Management Awareness. This level of training is designed for Board Members. It will be provided on induction and, to meet governance requirements, it must be repeated every two years thereafter. Level Three training will be sourced by the Board Secretary and scheduled within the rhythm of board meetings. The training aim is to provide Members with an understanding of the risk management framework, with specific emphasis on the operational risk management approach; the risk management policy; 'setting the tone' and risk culture; risk appetite; the CRR and the BAF.

Non-Specific Training and Support. It is recognised that, in addition to these three levels of specified training, there may emerge a need for non-specific risk management training and support. Where this is applicable the Risk team can discuss the training need and either signpost to external sources of training/education or provide a bespoke training event for individuals, directorates, or small groups.

Where required the education and training programmes can also be extended to our independent contractor colleagues to support their responsibilities in the management of risk and safety.

Risk management training or awareness will be provided to all staff and further details are included in the associated Risk Management and Board Assurance Framework Procedure.

All Managers must ensure:

- That all members of staff receive sufficient training to fulfil their individual duties, to ensure compliance with this policy, and to understand the importance of identifying and controlling risks.
- That adequate risk assessment training is given to appropriate members of staff in their specific duties as defined within the Risk Management and BAF Procedure.
- It is essential that risk assessments are completed by competent members of staff, who have sufficient experience of the working procedures and have received the appropriate training.

10. AUDIT AND MONITORING

There is a requirement of all staff to comply with the provisions of this Policy and, where requested, to demonstrate such compliance.

Monitoring, compliance, and the effective implementation of this Policy will be considered through the ADLT, ELT and from feedback from the Risk Owners and Executive Directors which will ultimately support the risk maturity of the Trust.

All Risk Leads/Heads of Service will regularly monitor to ensure that measures to control risks are being fully implemented and remain effective. This includes the regular and continual review of risk assessments and risk registers, in accordance with the frequency set out in the Risk Assessment Procedure.

The regular review of the CRR and BAF will be undertaken and reported to each meeting of the Trust Board.

Internal Audit will undertake an annual review of the Risk Management within the Trust as part of its annual audit plan.

Audit Wales will consider the effectiveness of the Trust's Risk Management Framework within its annual Structured Assessment.

This Policy will be formally reviewed every year, or sooner should there be any service or legislative changes that require an earlier review to be undertaken.

11. HELP AND SUPPORT

Risk Management support and guidance is available from the Risk Team:

Head of Risk/Deputy Board Secretary
Risk Officer

AGENDA ITEM No	**10**
OPEN or CLOSED	**OPEN**
No of ANNEXES	**2**

AUDIT TRACKER 2.0 – DECEMBER 2023

MEETING	Audit Committee
DATE	01 March 2024
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Trish Mills, Board Secretary
CONTACT	trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. This paper provides the Audit Committee with the current position with respect to management actions for overall audits and within the purview of the Committee, noting that Internal Audit will present internal audit reviews finalised in quarter as a separate agenda item

2. The Audit Tracker has been updated in Quarter three following its complete revision in Quarter two and again there has been excellent engagement from Directorates. No internal audit recommendations assigned to the Committee for oversight were due in quarter.

3. With respect to the wider organisational recommendations 18.2% of the internal audit recommendations were closed in quarter and there are actions with a change in date proposed (which are marked in blue), many of which are due to be closed in Quarter four or Quarter one of 2024/25.

4. The current version of the tracker is now open for Directorate review for actions due in January, February, and March. These updates will then be reported to the Committee at its meeting in April 2024.

5. Due to the timing of reporting for Committee in January 2024 there are some actions which were due in December 2023 which may not have complete updates. These updates will be incorporated into the May 2024 Committee report.

RECOMMENDATION

6. The Committee is requested to:

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

KEY ISSUES/IMPLICATIONS
As set out above.
REPORT APPROVAL ROUTE
Tracker presented to ADLT via email in December 2023.

REPORT APPENDICIES
Annex 1 – Tracker 2.0 October - December 2023 for Committee Reporting - Audit Annex 2 – Tracker 2.0 October – December 2023 for Committee Reporting – Full Tracker

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

SITUATION

7. This paper provides the Committee with the current position with respect to management actions for audits within the purview of the Committee.

BACKGROUND

8. In September 2023 the Audit Committee approved the Audit Process and Reporting Handbook. In November the Committee received and approved version 2.0 of the Handbook and it was agreed that going forward non-material changes would be approved by the Executive Leadership Team.

9. Good progress has been made on the development of the SharePoint solution for Tracker 3.0 with colleagues in Digital Health and Care Wales Centre of Excellence. It is intended that this solution will be ready to implement / use early in the 2024/25 financial year.

ASSESSMENT

Audit Committee Audit Actions

10. The Handbook notes that it is the responsibility of a Board Committee to:

    - Receive audits in their remit;
    - Monitor management actions to address recommendations.

11. The audit recommendations within the purview of the Audit Committee relate to Risk Management and Standards of Business Conduct and are listed at **Annex 1.** No internal audit recommendations assigned to the Committee for oversight were due in quarter and therefore no actions have been proposed for closure.

Full Tracker Review

12. The Audit Tracker has been updated in Quarter three following its complete revision in Quarter two and again there has been excellent engagement from Directorates. Across the Tracker as a whole, 18.2% of the internal audit recommendations were closed in quarter and there are actions with a change in date proposed (which are marked in blue), many of which are due to be closed in Quarter four or Quarter one of 2024/25.

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

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

15. Discussions have also taken place on historical actions and those where management actions may need to be amended in view of the current operating context. There has been some traction with these, and discussions will continue into Q4 with a view to closing down or revising as many as possible.

16. The current version of the tracker is now open for Directorate review for actions due in January, February, and March. These updates will then be reported to the Committee at its meeting in April 2024.

17. Due to the timing of reporting for Committee in January 2024 there are some actions which were due in December 2023 which may not have complete updates. These updates will be incorporated into the April 2024 Committee report.

Impact of Closed Management Actions

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

Audit Committee Reporting

19. As noted in November, the development of Tracker 3.0 with Digital Health and Care Wales is ongoing with the reporting / functionality which the Audit Committee approved in September 2023. It is intended that this solution will be in use in Q1 of 2024/25.

RECOMMENDATION

20. The Committee is requested to:

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

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

Trust Ref. No.	Year/ Audit Plan	Committee assigned to	Report Title	Assurance Rating	Responsible Officer	Director	Priority Level	Rec. No in Audit	Recommendation	Response No in Audit	Management Response	Agreed Deadline in Report	Status - met or not met agreed deadline in report	1st revised date	2nd revised date	3rd revised date	Closure Status	Where a management action has not met the agreed or revised date, Director must inlcude here: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. **Please add most recent update first**
545	22/23	AC	Standards of Business Conduct: Declarations	Limited	Trish Mills	Trish Mills	Medium		4.1 Management should determine and implement a solution to ensure the completeness and accuracy of declarations of interest, including nil returns.		Initially 'decision makers' will be targeted for completing of declarations of interest and the register of those decision makers will be held centrally by the Board Secretary.	Jun-23	Not Met	Apr 24			Open	Last updated: 11/07/23 Declarations for the decision makers listed in the policy will commence from March 2024 so as not to duplicate efforts given declarations were sought from ADLT in March 2023 as part of the annual review.
547	22/23	AC	Standards of Business Conduct: Declarations	Limited	Trish Mills	Trish Mills	Medium		4.2 Consideration should also be given to introducing a tracking system and reporting the results, including declarations requested but outstanding, to an appropriate forum e.g., Audit Committee.		The 'decision makers' will be a finite known cohort and initially their declarations will be captured via Microsoft Forms to allow for tracking and escalation	Jun-23	Not Met	Apr 24			Open	Last updated: 11/07/23 There will be a known cohort to enable the tracking any outstanding declarations. The PADR form now has a prompt for the line manager to ensure staff have completed their declarations.
596	22/23	AC	Risk Management & Assurance	Reasonable	Julie Boalch	Trish Mills	Medium	1.1	Following the development of the risk appetite matrix, the Trust should develop and finalise its risk appetite statements	1.1	Accepted. Formal risk appetite statements will be developed in conjunction with the transformational BAF in 23/24; however, the risk consequence matrix is in place and includes risk appetite across a range of categories. The Trust sets out its risk appetite for patient harm in its annual report. This action forms part of the risk management transformation programme monitored at the Strategic Transformation Programme Board. Additionally, a Board Development Session is planned for February 2024.	Jun-24	Not Yet Due				Open	
598	22/23	AC	Risk Management & Assurance	Reasonable	Julie Boalch	Trish Mills	Medium	3.1	Management should continue the rollout of risk management training across the Trust and seek to obtain feedback from attendees, including to capture views on the impact the training has had on their understanding of risk management principles and practice and to identify areas of further training need and improvement.	3.1	Accepted. Risk Management training will continue; however, the level 1 and 2 training packages will not be fully established until late 2024. Bespoke and directorate training will continue to be delivered as requested and a feedback form will be put in place at the next session. Continuous 1:1 support is delivered to Risk Officers to manage their risks.	Sep-24	Not Yet Due				Open	
600	22/23	AC	Risk Management & Assurance	Reasonable	Julie Boalch	Trish Mills	Medium	4.1	The Trust should continue its work to strengthen the BAF, including to; a) ensure alignment to the broader long-term strategy. b) provide further assurances on	4.1	a) Accepted. This is one element of the Risk Management Transformation Programme included in the IMTP and monitored at the Strategic Transformation Board. b) Accepted. A review of mitigating actions and the impact these have had on current scores forms part of the quarter 2 reports for Trust Board and Committees. This is good practice risk management and is part of each risk review discussion. The impact and effectiveness of controls and mitigating actions will continue to be strengthened and drawn out in the risk reports over the coming year.	Mar-24	Not Yet Due				Open	

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

Trust Ref. No.	Year/ Audit Plan	Committee assigned to	Report Title	Assurance Rating	Responsible Officer	Director	Priority Level	Rec. No.in Audit	Recommendation	Response No in Audit	Management Response	Agreed Deadline in Report	Status - met or not met agreed deadline in report	1st revised date	2nd revised date	3rd revised date	Closure Status	Where a management action has not met the agreed or revised date, Director must inlcude here: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. **Please add most recent update first**
382	20/21	FPC	Clinical Contact Centres - Performance Management	Reasonable	Deborah Armstrong	Liam Williams	Medium		5. Review coaching and training arrangements within NHSDW/111 to ensure mechanisms are in place for all staff to receive regular feedback, coaching and training going forward.		5b. Following recruitment, a review of other aspects of training will be undertaken; It should be noted however that without outsourcing aspects of training and delivery for the new system, an overlap with Salus roll out may delay 'regular' coaching and training until at least Autumn.	Jan-22	Not Met	Nov-23			Closed in Quarter	11.12.23: There has been a vast improvement in the ratio of coaching sessions offered to staff across all operational sites. This can be evidenced through the data submitted and reviewed at the 111 Quality Meeting, which includes every coaching session booked and those which didn't go ahead/why they didn't go ahead i.e., high demand/sickness. It should be noted however that various pressures including accelerated recruitment and induction, and the upcoming updating of the CAS system, will impact on the ability of the team to do this with the regularity they would otherwise wish to. Proposed for closure on the basis that the team are achieving coaching/training and that there is a mechanism to review this at the 111 Quality Meetings. Board Secretary has reviewed the Education Professional and Clinical Practice Team Data Dashboard from Nov 23 with coaching and training elements. Last update 30/06/2023 SALUS is now planned for Go Live in November 2023. There has been an improvement in delivery of CPD to more staff but this remains a risk as will be put on hold when Salus needs to be trained to all. External Provider assistance may be required. A risk has been identified previously due to a number of unfunded posts in the training team that may not be made permanent however this risk has recently been reduced for someof the unfunded posts to be funded.
383	20/21	FPC	Clinical Contact Centres - Performance Management	Reasonable	Deborah Armstrong	Liam Williams	Medium		5. Review coaching and training arrangements within NHSDW/111 to ensure mechanisms are in place for all staff to receive regular feedback, coaching and training going forward.		5c. The risk relating to the lack of education, coaching and supervision is currently captured on the QSPE Directorate risk register. This risk will be reviewed and updated and if necessary escalated to the corporate risk register.	Apr-22	Not Met	May 23	Nov-23		Closed in Quarter	11.12.23: Risk 409 was not escalated to a Corporate Risk therefore it was reviewed at the Senior Quality Team Meeting on 15 November 2023. Given the evidence provided in Trust Ref 382, it was agreed by the Senior Quality Team that this risk would close and the Senior Quality Leadeship Team were advised on 28 November 2023 via the AAA. The risk may reoccur as the workload and workforce changes (but is currently no longer present). Propose for Closure (Board Secretary reviewed AAA) Last update 30/06/2023 CPD for 111 operational staff. New CPD year 2023/24 commenced April 2023 and is currently strong however important to note that indicative date for Salus training and implementation (Aug-Nov) will impact on ability to maintain other aspects of education and training.
420	21/22	FPC	Service Management	Reasonable	Aled Williams	Leanne Smith	Medium		WAST should develop their Service Management framework and once complete, the Service Catalogue should be published and communicated to all appropriate stakeholders.		Agreement has been reached to employ consultants to undertake a review of current position and to develop ITIL based procedures covering the whole service management disciplines. This work is expected to commence during September 2021. A deliverable of this work will be a refreshed service catalogue which can then be published and communicated.	Mar-22	Not Met	Dec22	Sep-23	Apr-24	Open	Last Updated: 10/10/23 - There is limited capability to support Service Catalogue in Service point and an attempt was made to develop one in Excel see attached draft. Whilst this could be completed and shared with stakeholders it would not be particularly user friendly. We are now close to procuring a replacement for Service Point where there will be a central service catalogue available to digital staff and the users within the system. Aim is to get new system operational by Mar-24.
462	21/22	QSPE	Role of Advanced Paramedic Practitioner	Reasonable	Kerry Robertshaw, Jonathan Chippendale	Andy Swinburn	Medium		Formal structures should be established to ensure APPs are appropriately supported to deliver a high standard of practice. This could include a peer review network, where feedback and themes are reported to the Care Closer to Home Group.		Development of proposed standardised clinical appraisal and supervision model to ensure APPs remain up-to-date and competent within their clinical practice.	Mar-22	Not Met	Dec 22	Mar-24		Open	Last updated: 03.07.2023 APP leadership/clinical supervision rollout not supported at formal SOT in the current financial climate due to concerns around releasing APP leadership (8a) workforce from clinical duties to engage in leadership portfolio work streams. Decision to be revised in Q3. AHP funding bid against installing APP leadership infrastructure within the workforce appears unlikely to be successful. ePortfolio and curriculum development underpinned by clinical supervision framework, unable to progress until review in Q3
463	21/22	QSPE	Role of Advanced Paramedic Practitioner	Reasonable	Kerry Robertshaw, Jonathan Chippendale	Andy Swinburn	Medium		The Trust should, through an effective appraisal process, appropriately monitor APPs development in order to achieve all four pillars of advanced practice.		The creation of a 'Principles of Advanced Practice' guidance document to be created which will detail the methodology, application and monitoring of how the four pillars of advanced practice are being addressed within APP practice. Following approval, reporting against this will take place on a 6-monthly basis.	Mar-22	Not Met	Dec 22	Mar-24		Open	Last updated: 03.07.2023 Principles of advanced practice document to be written over Q2 and steered through the Advanced practice Working group (new group created within LDP) and underpinned by the All Wales national advanced and enhanced advanced practice framework.
470	21/22	FPC	Asset Management - RAM System	Reasonable	Jill Gill	Chris Turley	Medium		The Trust should consider the requirement to use the proposed RFID system to validate assets not included in its current processes (e.g. stretchers, defibrillators, suction units, emergency lifting cushions and oxygen delivery systems) against the RAM Asset Management system and review and update its procedures as appropriate.		The Trust has considered the potential of linking RAM and an RFID system, however this would not be practical as RAM is updated on a quarterly basis and the RFID system is a live system with constant streaming updates. These two products would not align in a manner that would deliver a safe and valued output. The proposed solution will be a quarterly download from the RFID system that will be reconciled into RAM and variances investigated. RFID is currently in development, however due to operational pressures the rollout is unlikely to be completed before December 2022.	Mar-23	Not Met	Mar-24			Open	Last updated 25.09.23 This work cannot be taken any further forward until the RFID system is fully implemented and quarterly reports become available to reconcile to RAM, this is as per the management response. The RFID system needs to be implemented at pace by the Trust, work is progressing with Fleet in the North and SE to tag items however currently a separate ICT resource is required in C&W to complete, following the previous update the ICT lead has now left the Trust, in addition ICT currently has circa 10 vacancies and is experiencing difficulties in recruiting to these posts, this is resulting in other schemes having to be prioritised over this scheme to ensure core systems function. The previous completion date of Mar 2023 shows as it is unclear due to the recruitment issues faced by ICT exactly when this action will be completed, Mar 2024 put as estimate by ICT dept.
480	21/22	QSPE	Information Management - Hear and Treat	Reasonable	Paula Jeffery	Liam Williams / Andy Swinburn	Medium		1.1 We recommend that greater use is made of referral data in the incident records to inform further developments of current and future referral pathways, including; production of reports showing more detailed analysis by stop code.		1.1.1 A new report is available with data back to January 2021 which shows the referral pathway presented to the patient once the consultation with CSD is complete. This will be able to be broken down by health board area given the nature of the patient's location information. The Ops team is also reviewing in more detail the calls into CSD and their outcome. A review of this is likely late Q4 2022.	Mar-22	Not Met	Mar-24			Open	Last Updated: 061023: Capacity building in the CSD team will enable this action to be progressed. Currently in IMTP actions for this area for delivery Q3-4 pending team expansion. Detailed analysis by stop code can be reported from a CSD perspective. Can be evidenced through Power BI dashboards and this information can be shared with the National SDEC Pathway Group on a monthly basis. All 7 HBs are cited from a community and hospital background at this group. The information is not currently provided in a report as it is live data but a functionality request for referral data to be shown by Health Board on a Power BI dashboard will be raised with Health Informatics and should be achievable by end of Q4. Update 19/10/22 Q4 2022 Update (Q3 2022-23) - Data is now available in a report in Powr BI which shows the volume of telephone triaged calls which were referred to other services and can be broken down by Health Board area. Next steps this quarter is to work with Clinical Services to review the reports and analyse.
480	21/22	QSPE	Information Management - Hear and Treat	Reasonable	Paula Jeffery	Liam Williams / Andy Swinburn	Medium		1.2 Coordinated analysis, review and scrutiny of these internally to inform quality improvement.		1.1.2. The review can be shared to inform quality improvement.	Jun-22	Not Met	Sep-24			Open	Last Updated 061023: Further investigation to be undertaken on whether this data would benefit HB partners e.g. could report into SDEC meetings as it is currently unconfirmed whether there is a forum to enable this data to be shared. Management action relevent in 2018 before work undertaken to build on pathways. Info broken down for reporting currently not done by HB level in the usual process by CSD team (see 480 1.1 above). Team to look at possibility of incorporating this filter for reporting if it will be useful to the HBs or whether this is already reported on by Operations. Development of project work (480 1.2 above) may provide more information to accompany the data which HBs may find useful. Updated: 19/10/22 See above, subsequent action.
480	21/22	QSPE	Information Management - Hear and Treat	Reasonable	Paula Jeffery	Liam Williams / Andy Swinburn	Medium		1.3 Reporting referral volumes at health board level to assist with their service provision planning		1.1.3. The detail in the new stop codes will allow for the reporting referral volumes through Consult and Close in CSD.	Jun-22	Not Met	Nov 22	Mar-24		Open	Last Updated 061023: Further investigation to be undertaken on whether this data would benefit HB partners e.g. could report into SDEC meetings as it is currently unconfirmed whether there is a forum to enable this data to be shared. Management action relevent in 2018 before work undertaken to build on pathways. Info broken down for reporting currently not done by HB level in the usual process by CSD team (see 480 1.1 above). Team to look at possibility of incorporating this filter for reporting if it will be useful to the HBs or whether this is already reported on by Operations. Development of project work (480 1.2 above) may provide more information to accompany the data which HBs may find useful. Updated: 19/10/22 See above, subsequent action.

Trust Ref. No.	Year/ Audit Plan	Committee assigned to	Report Title	Assurance Rating	Responsible Officer	Director	Priority Level	Rec. No.in Audit	Recommendation	Respons e No.in Audit	Management Response	Agreed deadline in Report	Status - met or not met agreed deadline in report	1st revised date	2nd revised date	3rd revised date	Closure Status	Where a management action has not met the agreed or revised date, Director must inlcude here: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. **Please add most recent update first**
483	21/22	QSPE	Information Management - Hear and Treat	Reasonable	Paula Jeffery	Liam Williams / Brendan Lloyd	Medium		We recommend that current analysis and sample examination of the 'Can't Send' call responses is extended to include other 'See and Treat' and 'Consult and Close' incident responses. This could be coordinated by theme and pathway type, to inform patient safety and quality improvement and should be routinely analysed and reported into the agenda of an appropriate group in the Trust's governance structure.		With the introduction of a dedicated training and audit team within the CSD more opportunity to analyse and sample Consult and close outcome will be possible. We will ensure it is part of normal audit of the activity in the CSD. Findings can be shared with other groups to ensure quality and enhanced clinical review similar to Can't Send outcomes.	Sep-22	Not Met	Dec 23			Closed in Quarter	Update 06122023: Monthy compliance audit reports are being produced where See & Treat and Consult & Close events are being reviewed. This will be covered off with individuals as part of the wider IMTP actions for CSD and from Q4 will become BAU. The team don't report on Can't Send outcomes but the findings can be shared if requested. Reports form part of the Monthly Integrated Quality Performance Reports and November report submitted as evidence for closure. Last Updated 061023: Achieved IAED/ACE accreditation in Sept 2023 and a prescribed percentage of audits for every clinician are undertaken every month and reported on compliance by PPeD. Management of staff who are not compliant with audits is stepped out within the quality assurance framework for ECNS. Consult and Close activity is reported on live in Power BI and includes several areas contribution to Consult and Close (CSD, APP NAV, PTAS, and 111 C&C) and is monitored through Operational performance meetings. The monthly audit reports are available and are reported to SLT. Updated: 19/10/22 Now that triage has moved to ECNS and reports and analysis of outcomes and audits are available this activity is more possible. The audit team are working on audit reviews and work closely with the Clinical Services team to produce this analysis. Exepcted Q3 2022-23)
496	21/22	PCC	Recruitment Practices – Equality, Diversity and Inclusion	Reasonable	Kat Cobley	Angela Lewis	Medium		4.1 a. The Terms of Reference for the EDI Steering Group should be updated to reflect the correct reporting structure.		4.1 a. The Trust accepts this finding and will update the Terms of Reference with support from the Deputy Board Secretary.	Jun-22	Not Met	Jan-23	Dec-23		Closed in Quarter	271023: Revised ToR reviewed by Board Secretary 051023: New date proposed and discussions with Head of EDI planned. 210823 Board Secretary re-opened as TOR not yet approved. Last Updated 11/01/23 COMPLETED - The Terms of reference discussions have been reviewed. Board Secretary to present at next meeting . 250923 Revised ToR shared with Board Secretary 061123 Requested amendments made to ToR (re: reporting lines) and returned to Board Sec
501	21/22	FPC	Waste Management	Limited	Richard Davies / Nicci Stephens	Chris Turley	High		1. The Waste Process document review should be concluded as scheduled, with consideration given to the Policy guidance set out in WHTM 07-01, and with enhanced detail regarding governance structure and training arrangements. The Trust should ensure the Waste Process document, following review and update, is approved at the relevant Board-level Committee as a formal policy, in accordance with WHTM 07-01 requirements.		1. Agreed as the key priority, recommendation and action for immediate further improvement from this review. From which the response and resolution for many of the other actions will naturally follow. To progress many of these, it has been jointly agreed at Exec level that a task and finish group (TFG) will be immediately created with representatives from the following departments: • Estates and Facilities • IPC • Health and Safety • Operations • ICT • Fleet • Corporate Services • Training • Finance • Medical directorate (for drug management issues) • Clinical equipment and logistics • TU rep The TFG will develop a National Waste policy to cover both domestic waste and clinical waste. The policy will identify the management structure for both sections of waste (which will be different) and therefore a reporting structure, including through to Board Committees (likely to be by exception) and therefore Trust Board itself. It will also identify training needs and all compliance and audit obligations.	Sep-22	Not Met	Sep-23	Nov-23	Mar-24	Open	Target date moved in Quarter 3 Update 201223. Discussions have now been held at Exec level, including with CEO on any required realignment of Exec level responsibilities, part of which links to changing Exec portfolios from 01/01/24. Following this, all remaining items to conclude the new waste management policy will be progressed at pace in January 2024, with a view for ensuring formal sign off before 31/03/24. Updatd 180923: Waste management policy is drafted however discussions regarding Director level responsibility for clinical waste are being held. The SOPs that form part of the master list of waste in the policy have been implemented however it is the overarching policy that brings them together with roles, responsibilities and governance structures that is out for consultation. Given the clinical waste ownership discussions, it is proposed that this action be moved to November 2023 for the policy to be presented back to the Policy Group to enable those discussions to be held. The policy will thereafter be approved by the FPC. Last updated 13/07/23 Waste Management Policy out to consulation and due to be approved by FPC in September 2023
505	21/22	FPC	Waste Management	Limited	Nicci Stephens	Chris Turley	High		5.1 The Trust should review the arrangements in place for the transfer of clinical waste and seek to gain assurance that the current arrangements as detailed are in keeping with the requirements of WHTM-07-01.		5.1 – The WHTM 07-01 was amended from HTM 07-01 in 2013, this predates the separation of HCS from WAST. Under its current form WAST is not able to comply with this particular section of the document as WAST does not have a direct contract with the current clinical waste contractor. NWSSP FS, the documents authors, have been contacted regarding this point. The WHTM is due for review. However, those confirmed under the TFG as clinical waste lead will produce an annual hazardous waste transfer note for Denbigh Stores and Pontypool Ambulance Station for completion by HCS, therefore compliant with current hazardous waste legislation.	Jun-22	Not Met	Sep-23	Jan-24	Mar-24	Open	Target date moved in Quarter 3 to align to update in 501 i.e. these will come to FPC with the Waste Mangement Policy in March 2024. Update 180923: WAST does not have a contract with HCS regarding clinical waste. A hazardous waste transfer note was sent to HCS but they have not signed it, stating it was not required. Natural Resources Wales have also confirmed that we have an exemption for transferring clinical waste to HCS and that the only agreements that need to be in place are between HCS and Stericycle (which they are). The only body to whom WAST could have a contract that satisfied WHTM 07-01 is NWSSP (the authors of that WHTM) and they have declined to do so. Propose that this item is closed when a paper is taken to the Finance and Performance Committee setting out the ways in which the risk regarding the absence of a contract for clinical waste for WAST is mitigated. It is proposed that the timing for this is when the Waste Management Policy is taken to FPC (January 2024) so that director responsibilities for clinical risk are clear. Last Updated: 13/07/23 A paper to be prepared and shared at an appropriate forum detailing the current status and the proposals to manage the risk.
505(a)	21/22	FPC	Waste Management	Limited	Nicci Stephens	Chris Turley	High		6. WAST should contact the respective Health Boards on an annual basis to obtain a duty of care transfer note covering handover of clinical waste from Ambulances at Health Board sites, in keeping with the requirements as stipulated in WHTM 07-01.		6. The WHTM 07-01 was amended from HTM 07-01 in 2013. HTM 07-01 is the English management of waste in healthcare technical note. On amending the HTM to the WHTM this section should have been replaced. As a commissioned service to the health boards clinical waste sits with the patient and therefore the health board. NWSSP FS, the documents authors, have been contacted regarding this point. However, to further add to the assurance of this, it is also now requested that the TFG will propose the production of an annual hazardous waste transfer note for each Health board, therefore compliant with current hazardous waste legislation. This will be included in the national waste management policy.	Sep-22	Not Met	Jan-24	Mar-24		Open	Target date moved in Quarter 3 to align to update in 501 i.e. these will come to FPC with the Waste Mangement Policy in March 2024 Reopened September 23 followng 22/23 Follow Up Audit. Update: Only two HBs have not returned the duty of care transfer. CVUHB are awaiting the appointment of their waste manager to sign the document. BCUHB did not sign it based on improvements being required on WAST segregation methods. WAST has held fortnightly meetings with local mangers in the HB region, as well as BCUHB management and conducted waste management audits in the area. WAST has identified issues and put in place mitigations and have written to BCUHB indicating as much and seeking their agreement to the duty of care transfer note. It is proposed that this action is closed when the paper which encompasses matter arising 5 and the Waste Management Policy are presented to the FPC in January 2024 Update 02/09/22. WTN have been written and sent.
512	21/22	FPC	Service Reconfiguration	Reasonable	Mark Harris / Deborah Kingsbury	Rachel Marsh	Medium		1.1 We recommend that the service specification is finalised and reissued for the period beginning June 2022, reflecting any amendments to the model that post-implementation service reviews have indicated. This is particularly significant because of the contribution this project may make to an upcoming all-Wales model to cover similar service reconfigurations. Future service change SLAs must be signed before the renew date.		1.1 The timescale is dependent on commissioners agreeing the longer term commissioning agreement. Meetings with commissioners (ABUHB and NCCU leading) have commenced to take forward the recommendations of the GUH Evaluation and this should include the agreement on the next commissioning agreement. However this may need to be backdated.	Sep-22	Not Met	Apr-24			Open	4.12.23:Requirement is related to an operational issue around the service specification at The Grange - Planning is assisting with the work and it should be finalised before the review date of April 2024. Update 101023: After initial exchange as noted on 030523 update, Pending receipt of something formally. Informal conversations indicate that based on activity review and remodelling work ABUHB will be looking to reduce peak capacity Currently 10 crews at 1400 hrs daily to 6 Crews. ABUHB will also be redefining the service purpose in the SLA refresh to take out what is believed to be mission creep example Step Across and Discharge activity. WAST will be undertaking its own modelling to corroborate Health Borad modelling and also to ensure there are no unintended consequences or at least the stakeholders are appraised of the risks if any. ABUHB has also indicated that they will be disinvesting from the Paramedic resource it commissioned under this contract and will be looking to increase the Transfer Practitioner resource (TP) instead. The single system project that is looking to move all ACA2 activity under the GUH inter site transfer service on to Cleric CAD system is being progressed with this assumption in agreement with ABUHB 03.05.23 Initial exchange on SLA undertaken, response from WAST considered by ABUHB who are preparing a report to their Execs, advised by NCCU that they will facilitate a further meeting to discuss, likely to be in June. Acknowledged that SLA will not be able to progress until requirements clear from ABUHB. 25.01.23 NCCU proposing a new SLA for April 23. Regular meetings led by the NCCU continue with supporting work to enable the new specification and SLA following the evaluation of the service. The remaining supporting actions are now being prioritised to enable. One key element is the work being undertaken by the health board to review its future clinical needs for transfers as part of the health boards model. Last updated: 02/11/22 Enabling pieces of work are scheduled to be completed for discussion with NCCU and AB in December, NCCU proposing a new SLA for April 23. Regular meetings led by the NCCU continue with supporting work to enable the new specification and SLA following the evaluation no the service. The remaining supporting actions are now being prioritised to enable. One key element is the work being undertaken by the health board to review its future clinical needs for transfers as part of the health boards model.

Trust Ref. No.	Year/ Audit Plan	Committee assigned to	Report Title	Assurance Rating	Responsible Officer	Director	Priority Level	Rec. No.in Audit	Recommendation	Respons e No.in Audit	Management Response	Agreed Deadline in Report	Status - met or not met agreed deadline in report	1st revised date	2nd revised date	3rd revised date	Closure Status	Where a management action has not met the agreed or revised date, Director must inlcude here: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. **Please add most recent update first**
524	21/22	QSPE	Respiratory Protective Equipment	Reasonable	Louise Colson	Liam Williams	Medium		4.1 We recommend the Trust refreshes the above paper in light of the challenges in meeting the requirement to quality assure all Fit testers under its current model. [the paper referred to her was a paper that went to SPT in 2021 estimating the time in hours over a 3 year period that fit testing would be required to comply with HSE legislation]		4.1 A report will be provided to the Clinical & Quality Governance Group on the output of the Quality Assurance programme recently undertaken. Furthermore, it will outline proposal for the emerging risk of sustainable fit testing across the Trust. A crossdirectorate position on a sustainable Fit Testing model will be developed.	Sep-22	Not Met	Jun-23	Dec-23		Closed in Quarter	21.11.23: Respiratory Protection Equipment Options Appraisal to be submitted to Senior Leadership Team 22.11.23 then Executive Leadership Team 29.11.23. This was seen by Board Secretary and next steps noted. Update 28.9.23 : An updated Respiratory Protection paper was presented to SOT on 28.04.23 with a recommendation that a multi-disciplinary task and finish group was established to explore a sustainable option of providing respiratory protection for staff. The first meeting took place on 22.06.23 and an options appraisal paper has been submitted to CQGG and SOT on 25.09.23. Further update will be provided once both meetings have taken place. Update 30.06.23 Issue has been discussed in IPC Strategic Group, and escalted issue to CQGG. The matter has also being rasied within Operations Senior Leadership Team, with the management of Fit Testers and associated challenges to be managed through the Senior Operations Team; a T&F group has commence led by IPC to determine a sustainable approach which includes review of PPE/RPE provision. The action related to report generation is complete, and IPC Strategic Group will monitor ongoing performance.
502	22/23	FPC	Immediate Release Directions	Reasonable	Caroline Miftari	Liam Williams	High		3.1 Datix incidents should be reviewed and closed in a timely manner and any lessons learned should be shared with the relevant parties.		It remains challenging for the Trust to investigate and subsequently close Datix as refusal to comply with an Immediate Release Direction is a Health Board Decision and so any harm that subsequently occurs, requires the Health Board to lead on a joint investigation, with the same principle being expected by the Trust where harm has not explicitly been identified. A new Joint Investigation Process is being piloted under the leadership of the NHS Wales Delivery Unit, which commenced in November and that will run until March 2023. IRD requests that have been declined and where harm has been identified or is considered to have occurred, will form a part of this Pilot and a decision to recommend changes to the process will follow this pilot.Of note the Duty of Candour, that comes into place on 1 April 2023, further regulates the need for openness and transparency with families across the NHS.	Mar-23	Not Met	Apr-23	Dec-23	Jan-24	Open	Target date changed in quarter. 14.12.23 The SOP for the management of all incidents reported over Datix Cymru is currently in final draft on the new Directorate template, feedback from patient safety to be incorporated. The Quality Management Group have received and considered a presentation on open incidents within the incident module on Datix Cymru. As part of the presentation, Immediate Release Declines reported via Datix was also reviewed. A draft SBAR for Immediate Release Decline has been discussed at QMG with a view to looking at an alternative process for the management of immediate release declines that are not considered, adverse incidents, near misses and/or hazzards as per the Adverse Incidident Policy 2023. Further discussions are planned in December 2023. As the SBAR for an alternative process for reporting Immediate Release Declines has not yet been shared with or approved by SOT, we request a revised date of January 2024 for completion 121023: The SOP developed is a QSPE SOP which relates to the management of records through datix as opposed to the SOP in 504 which is the guidance from EMS Coordination in relation to live management of incidents. The review undertaken by the delivery unit in relation to the joint investigation process did not specifically pick up any additional learning regarding immediate release declines however there is now a 'standing agenda' item in the quarterly PTR report regarding serious incidents linked to declines so that we have a method to capture incidents and identify thematic activity. TBC at next review if this now closes this item. Update: 26.09.23 - Standard Operating Procedure for Datix drafted to step out expectations for managers. Review currently ongoing for how datix is used with proposals to be drafted to more easily identify those IRD records where harm has occurred. Proposed revised date of 31.12.23 to allow datix team to provide analysis and proposols for change. Reason for proposed revised date is due to capacity within team. Senior QUality Governance lead now in place, OCP completed for department but 1 vacancy still remains. Last update: 14.04.23 Delayed due to management capacity and impacts of industrial request for extensiont to end of April 23 - coaching bulletin drafted
503	22/23	FPC	Immediate Release Directions	Reasonable	Caroline Miftari	Liam Williams	High		3.2 Noting the capacity issues above, the Trust should review the requirement to investigate all Amber 1 declined directions and consider introducing a streamlined mechanism of reporting. The Trust's SOP should then be updated accordingly to reflect the outcome of this review.		The Trust will agree a process to record all Amber 1 declined IRDs and report occurrence thematically based on UHB and clinical code sets. Where thematic analysis identifies additional areas of concern, these will be taken forward on a 'task and finish' basis by the Trust with the appropriate UHB and clinical representation.	Feb-23	Not Met	Apr-23	Dec-23	Jan-24	Open	Target date moved in quarter. 14.12.23 A draft SBAR for Immediate Release Decline has been discussed at Quality Management Group with a view to looking at an alternative process for the management of immediate release declines that are not considered, adverse incidents, near misses and/or hazzards as per the Adverse Incident Policy 2023. Further discussions planned in December 2023 therefore we request a revised date of January 2024 for completion Update 121023: Given that the action is to include the process to record all Amber 1 declined IRDs and report thematically, with TFGs being estabisherd where areas of concern identified, we will close this when the SOP (the SOP is different to that in item 504) has been approved as that will close off the action. The action was not to embed processes. Propose extending to Dec 23 on that basis. All Amber 1 declined IRDs are now recorded through datix. There may be further tweaks to the process as we continue to develop our quality management system. Update 26.09.23: Linked to Ref 502 review now ongoing for how datix is used which will include recommendations on how themeatic anaysis can be provided. Quality Management Group now commencing which will allow for review of thematic analysis to support quality improvement planning and subsequent T&F tasking. Proposed revised date of 31.03.24 to allow recommendations to be approved and QMG to embed processes, pre-requisite for Ref 502 to be completed before this action can be recommended for closure. Reason for delay is due to capacity within team. Senior Quality Governance lead now in place, OCP completed for department but 1 vacancy still remains. Last update: 14.04.23 Delayed due to management capacity and impacts of industrial request for extensiont to end of April 23 - coaching bulletin drafted
506	22/23	QSPE	Infection Prevention and Control	Reasonable	Louise Colson	Liam Williams	Medium		1.1 Once the overarching IPC policy is formally approved, the supporting policies/procedures/guidance documents should be reviewed and approved in a timely manner.		1.1-1.3 The recommendations are accepted. A project of work 'IPC 3P' will be undertaken to assess policies, procedures, and other 'powers' (including guidance documents, protocols, and activity-based risk assessments). The aim of the project is to 'map' current provision, monitoring arrangements, undertake a gap analysis, and embed a RACI framework to ensure organisational 'buy-in' and accountability. This work will lead to systematic review of departmental and relevant organisational documents.	Mar-23	Not Met	Sep-23	Dec-23		Open	201223: IPC Policy will go for approval by Chair's Action in December. Propose closing this action once policy is approved. Linked actions 507 and 508 relate to the wider IPC 3P programme actions also. 21.11.23: Ongoing discussions with TU Partners on IPC Policy which will be discussed at Executive Leadership Team 22.11.23 Update 27.09.23: Both the IPC and Premise and Vehicle cleaning policies are in the policy group process still. Several meetings have been cancelled due to competing priorities involving the public enquiry. Two policies are awating final approval, the next meeting is now the 10th October. I anticiapte approval at this meeting with final approval at QUEST at the December meeting. The 3P project initial outlay is complete and incorporated into annual plan of work and was presented at the IPC strategic meeting on the 26th September. 30.06.23 (as per previous) The IPC policy has now been to the Policy group 24.04.23, a longer delay than anticipated but this was due to circumstances outside of the control of the IPC team. This will now be available for consultation. This will be a new policy which combines the AACE national policy. In the meantime work has been undertaken within the 'IPC 3P' to map out other forms of Standard Operating Procedures and Guidance and where they are aligned to. The RACI framework is being used to aid with identifyng responsibilites, risks and monitoring responsibilities. This along with the audit tracker will be presented at the next IPC strategic meeting in Q2.
507	22/23	QSPE	Infection Prevention and Control	Reasonable	Louise Colson	Liam Williams	Medium		1.2 The Trust should clarify arrangements within the Premise and Vehicle Cleaning policy to ensure cleaning instructions, responsibilities and monitoring are comprehensive and align with other related documents.		1.1-1.3 The recommendations are accepted. A project of work 'IPC 3P' will be undertaken to assess policies, procedures, and other 'powers' (including guidance documents, protocols, and activity-based risk assessments). The aim of the project is to 'map' current provision, monitoring arrangements, undertake a gap analysis, and embed a RACI framework to ensure organisational 'buy-in' and accountability. This work will lead to systematic review of departmental and relevant organisational documents.	Mar-23	Not Met	Sep-23	Feb-24		Open	21.12.23: Estates have confirmed that the section regarding the Buildings Group and Buildings Manager are to remian in the Premises and Vehicle Cleaning Policy therefore this can now progress to Policy Group Update 121023: this action will be closed once the IPC and the Premises and Vehicles Polices are approved at Committee . These Policies have been deferred to February Committee due to cancellation of Policy Group Meetings.Update 27.09.23 The Premise and Vehicle cleaning policy is awating approval vai the Policy Group pathway. There is a delay in its progress due to cancelled meetings. The nxt meeting is the 10th October and i anticiapate fianl approval at QUEST December 2023 The trust has a clear vehicle decontamination SOP. The vehilce audit tool has been redesigned, piloted and is good to go.
508	22/23	QSPE	Infection Prevention and Control	Reasonable	Louise Colson	Liam Williams	Medium		1.3 The Trust should map IPC and related policies, responsibilities, ownership, monitoring and governance arrangements to support future review and development of policies and guidance		1.1-1.3 The recommendations are accepted. A project of work 'IPC 3P' will be undertaken to assess policies, procedures, and other 'powers' (including guidance documents, protocols, and activity-based risk assessments). The aim of the project is to 'map' current provision, monitoring arrangements, undertake a gap analysis, and embed a RACI framework to ensure organisational 'buy-in' and accountability. This work will lead to systematic review of departmental and relevant organisational documents.	Mar-23	Not Met	Mar 24			Open	21.11.23: Meeting arranged with Julie Boalch for 3 January 2024 on taking the 3 Ps Project forward Update 27.09.23: The 3 P project continues, the content of which is now incorporated into the IPC annual plan. This was discussed and shared with the IPC Strategic meeting and is now at a stage for cross directorate working. All IPC related policies within the trust have been identified as the parent document, along with associated guidance, standards, SOPs, audit tools, risk assessments and training. Included is the RACI for each area of responsibility.This document has now started to identify the gaps and the work is at the stage to be shared as there are cross directorate responnsibilites. The progress has also been reported in the IPC Q1 highlight report Update 30.06.23 IPC 3P project to be reported to CQGG in Q2
517	22/23	QSPE	Infection Prevention and Control	Reasonable	Louise Colson	Liam Williams	Low		The Trust should ensure online resources contain up to date links and guidance		We accept the recommendation, future workplans will detail requirements.	Jan-23	Not Met	Sep-23	Apr-24		Open	Update 27.09.23: Proposed revised date 31.03.24. The prehospital Care ESR training resources has been updated. The ANTT Training package is in the process of being updated along with the All Wales ANTT policy. We have a plan with training school for ANTT training on the MIST training for 2024/25. This will commence April 2024. A discussion with the training school at the last IPC strategic meeting to transer some of the onclick training to the Learning Launchpad. The priority modules will be PPE, RED Level PPE training, Vehicle Cleaning and Waste management. The other modules via onlick can be incorporated into these modules as they are largely pandemic related training.. Updated 30.6.23 (as per previous 26.04.2023)

Trust Ref. No.	Year/ Audit Plan	Committee assigned to	Report Title	Assurance Rating	Responsible Officer	Director	Priority Level	Rec. No.in Audit	Recommendation	Response No.in Audit	Management Response	Agreed deadline in Report	Status - met or not met agreed deadline in report	1st revised date	2nd revised date	3rd revised date	Closure Status	Where a management action has not met the agreed or revised date, Director must inlcude here: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. **Please add most recent update first**
519	22/23	QSPE	Infection Prevention and Control	Reasonable	Louise Colson	Liam Williams	High		6.2 The Trust should consider longer term mechanisms for compliance which incorporate and map responsibilities of the wider IPC Strategic membership and include outline of compliance monitoring and reporting.		We accept the recommendation to standardise documentation formats. This action will be addressed through the IPC 3P Project (management response 1.1)	Jun-23	Not Met	Mar-24			Open	Update 27.09.23:The 3P project documentation was presented to the IPC strategic group in the September meeting, this will be reflected in the AAA report to CQGG and then in Q2 IPC Highlight report. Update 30.6.23: 3P project outputs to be presented to IPC Strategic Group and CQGG in Q2.
522	22/23	FPC	Data Analysis	Reasonable	Jon Hopkins	Leanne Smith	Medium		1.1 A report (template) catalogue should be created and maintained. It should list all reports available, their purpose, the data fields they contain, and the parameters that can control the actual report production e.g. period, location etc. This can be supported by the MI on report production; if it has not been produced for over 12 months is it still needed, should it be archived?		A report catalogue is already in development. We will also set up a small selection of report templates to help speed up development, make self-serve easier for consumers, and streamline this report cataloguing effort.	Apr-23	Not Met	Dec-23	Feb-24		Open	Last updated 22/11/23: A specialist 'Reporting Analyst' secondment position was created and successfully recruited into to support this work. Progress has been made since this appointment in Oct-23, with a goal of finalising and publishing Jan-24. Update 28/06/23: Capacity in the analytics team means although progress has been made against this action, it is not yet complete. The report catalogue now exists, but cycles of review for the reports contained within it have not yet commenced.
523	22/23	FPC	Data Analysis	Reasonable	Jon Hopkins	Leanne Smith	Medium		1.2 The process of requesting a new or modified report should be formalised. It should include reference to the catalogue at 1.1 so that specialised analyst time is not wasted reproducing existing reports		The recommendation is welcomed, and we will look to expand on the existing request process with a formalised (potentially guided self-serve) check of existing functionality, and an ability to decline requests if the content already exists in other places, or if not aligned with organisational priorities.	May-23	Not Met	Dec-23	Feb-24		Open	Target date moved in quarter. Last updated 22/11/23: This work is on-track, and the proposed process is waiting review by the data and analytics leadership team. Changed date requested. Update 28/06/23: The new report catalogue has been embedded within HI processes: when new requests for intelligence are received a check is made whether a report already exists which could allow the requestor to self-serve the information before the task is actioned. Due to capacity constraints within the team, the request mechanism is still to be amended to ensure alignement with WAST strategic priorities in 2023-24.
524	22/23	FPC	Data Analysis	Reasonable	Leanne Smith	Leanne Smith	Medium		1.3 Data on report production and usage should be maintained, and feedback from the requestor obtained. This should be used to maintain and limit the reports available to a manageable number of reports with their usage and priority recorded.		We do already obtain some feedback on service and products, but will look to formalise the collection of this and the embedding of findings within the development cycle process, as well as create management KPIs around these metrics to take through Digital governance routes. However, a dependency here is the management of the HI HelpDesk inbox, and work to converge this with the ICT ServiceDesk inbox.	Jun-23	Not Met	Dec-23	Feb-24		Open	Target date moved during quarter. Last updated 22/11/23: This action is linked to the catalogue work of action 522. We have gathered intel on all available data products and are now grading reports. Expected to be able to complete early 2024 - propose date change to Feb-24. Update 02/10/23: Report usage data is routinely collected and used on an ad-hoc basis, but we don't currently obtain much feedback from requester/users. We are beginning to implement a report review cycle for all reports. Linked to 522.
525	22/23	FPC	Data Analysis	Reasonable	Jon Hopkins	Leanne Smith	Low		2.1 There should be a series of Entity Relationship Models available covering all of the tables in the data warehouse.		We will develop an ERD library, including meta-data, starting with **EMS CAD.** We will plan out a roadmap for this exercise to expand into the other systems supporting EMS, Ambulance Care, 111 and Corporate teams around the organisation, to build up a full WAST ERD library and meta-data source.	Mar-23	Not Met	Mar-24			Open	191223: Update from LS: Role being interviewed for this week.The ability to meet the March date will therefore depend on the notice period and start date of the appointed candidate. Leave as Mar-24 for now and review if required in January. Last updated 22/11/23: Recruitment is in progress to bring in a principal data engineer to bolster capacity in the team, but also support oversight on this project from March-24. Update 28/06/23: The EMS CAD Data diagram is now complete. Deadline for full ERD library is unrealistic, suggest this is reviewed against other priorities. This work will ultimately be used within Digital and not wider Trust stakeholders. There has been a Principal Data Engineer vacancy since Jun-23 and as part of the savings plan, there is no intention to backfil for this post in the short-term.
526	22/23	FPC	Data Analysis	Reasonable	Jon Hopkins	Leanne Smith	Low		2.2 All tables should have a completed meta-data table describing their contents		We will develop an ERD library, including meta-data, starting with EMS CAD. We will plan out a **roadmap** for this exercise to expand into the other systems supporting EMS, Ambulance Care, 111 and Corporate teams around the organisation, to build up a full WAST ERD library and meta-data source.	Jul-23	Not Met	Dec 23	Mar-24		Open	Target date moved in quarter 3. 191223: Update from LS: Update from LS: Role being interviewed for this week. The ability to meet the March date will therefore depend on the notice period and start date of the appointed candidate. Move to Mar-24 for now and review if required in January. Target date moved during quarter 2. Last updated 22/11/23: Recruitment is in progress to bring in a principal data engineer to bolster capacity in the team, but also support oversight on this project from March-24. Update 02/10/23: As per update of item 525. A sequence of design for the ERD library has been agreed within Digital, but timelines for completion are not yet available due vacancies in the team (recruitment is underway). The EMS CAD item is complete, with goal of achieving ePCR diagram by December 2023 (followed by CAS then NEPTS in Spring 2024).
527	22/23	FPC	Data Analysis	Reasonable	Aled Williams	Leanne Smith	High		3.1 A programme to replace all of the Qlik reports with Power BI equivalents should be scoped and completed. Qlik should then be decommissioned and removed.		**A risk-assessment** will be conducted to understand the exposure to WAST of Qlik Sense being out of vendor support. This platform is not internet facing (i.e. for internal users only, not on a publicly accessible web url), and not believed to present an information security risk, but pending ICT assessment, we will devise a mitigation plan, or an options appraisal for maturity - **due March 23**. In the meantime, there is already a programme of work to migrate reports and dashboards to **PowerBI.** However, this is a lengthy and high-capacity activity, and is not prioritised highly at this current time - due March 24.	Mar 24	Not Yet Due				Open	Last Updated 02/10/23: Risk assessment completed and in Datix. A 12-month secondment has been created for a PowerBI specialist to start the work of migration from Qlik before decommissioning. March-24 is likely unrealistic, but a roadmap will be developed once the secondment begins (November-23). Previous update 27/06/23: Qlik is considered a low IS risk. Work is already ongoing to move reports into powerBI but due to capacity constraints within the team will take most of 2023-24 to complete
531	22/23	FPC	Data Analysis	Reasonable	Leanne Smith	Leanne Smith	Low		5.1 A defined quality (accuracy) level should be established for all data fields, so that particular focus can be made on those determined as being key, e.g., patient identifiers have to be 100% accurate.		It should be noted that we have only 0.4 WTE capacity in this specialist function and so any activities around data quality management improvements will not be able to be completed quickly. However, we will commit to review our Data Quality Policy, adding in detail regarding the minimum level of acceptable accuracy and error rates for key fields where appropriate.	Aug-23	Not Met	Dec 23	Jun-24		Open	Target date moved during quarter 3. Last updated 22/11/23: propose that the target date be moved out 12 months to enable review of the policy in 2024-25 and a data quality assurance plan to be created with appropriate resource secured to support the work. **The approval of the policy will close this action.** Update 02/10/23: Data Quality Policy review not yet started - this is agreed to be part of the 2024-25 policy workplan. (Digital are reviewing 3 other higher priority policies in 2023-24.). Date for approval of the Data Quality Policy aimed at November 2024 QUEST.
532	22/23	FPC	Data Analysis	Reasonable	Leanne Smith	Leanne Smith	Low		5.2 Acceptable error rate(s) should be agreed and processes put in place or improved, so that Trust data reaches the agreed accuracy levels.		It should be noted that we have only 0.4 WTE capacity in this specialist function and so any activities around data quality management improvements will not be able to be completed quickly. However, we will commit to review our Data Quality Policy, adding in detail regarding the minimum level of acceptable accuracy and error rates for key fields where appropriate.	Aug-23	Not Met	Dec 23	Jun-24		Open	Target date moved during quarter 3. Last updated 22/11/23: propose that the target date be moved out 12 months to enable review of the policy in 2024-25 and a data quality assurance plan to be developed with appropriate resource secured to support the work. **The approval of the policy will close this action.** Update 02/10/23: Data Quality Policy review not yet started - this is agreed to be part of the 2024-25 policy workplan. (Digital are reviewing 3 other higher priority policies in 2023-24.) Date for approval of the Data Quality Policy aimed at November 2024 QUEST
533	22/23	FPC	Major Incidents	Reasonable	Clare Langshaw	Lee Brooks	High		2.1 The Trust should consider options to support more frequent testing of incident plans, this should also consider the location of exercises to ensure equal opportunity for Commanders across the territories.		2.1 The Trust accepts this recommendation. As the pandemic period closes, the Trust has resumed ongoing work with partner agencies to increase the frequency of plan testing on a multi agency basis. The EPRR team will also develop an internal programme of plan testing, which will be on a Pan Wales basis. Monitoring and reporting will be made through the Senior Operations Team (SOT) and for assurance through to Senior Leadership Team (SLT). Any exercising will be subject to available funding.	Mar-23	Not Met	Mar-24			Closed in Quarter	BS noted evidence of SOT report indicating EPRR team developed a record sheet that will record the details of each exercise commanders within the Trust take part in and will identify the plans that are tested during the exercise. Also reporting to FPC on MAI. Update 27.09.2023 Developed tracker, annual EPRR report to Welsh Government has been predominantly favourable in the number of excersises we have undertaken, this action has also be superseaded by the Manchester Arena recommendations therefore this action is recommended for closure. Last updated: 26.06.23 - The EPRR team has developed a tracker to record commanders who have undertaking exercising. An exercise plan has been put in place but is limited by available budget and capacity within the EPRR Team so this is currently only available via Teams. Further development is required to enable hybrid table top and live exercises across the Trust to deliver this the EPRR Team requries a dedicated exercise budget and increased capacity within the team.
545	22/23	AC	Standards of Business Conduct: Declarations	Limited	Trish Mills	Trish Mills	Medium		4.1 Management should determine and implement a solution to ensure the completeness and accuracy of declarations of interest, including nil returns.		Initially 'decision makers' will be targeted for completing of declarations of interest and the register of those decision makers will be held centrally by the Board Secretary.	Jun-23	Not Met	Apr 24			Open	Last updated: 11/07/23 Declarations for the decision makers listed in the policy will commence from March 2024 so as not to duplicate efforts given declarations were sought from ADLT in March 2023 as part of the annual review.

Trust Ref. No.	Year/ Audit Plan	Committee assigned to	Report Title	Assurance Rating	Responsible Officer	Director	Priority Level	Rec. No.in Audit	Recommendation	Respons e No.in Audit	Management Response	Agreed deadline in Report	Status - met or not met agreed deadline in report	1st revised date	2nd revised date	3rd revised date	Closure Status	Where a management action has not met the agreed or revised date, Director must inlcude here: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. **Please add most recent update first**
547	22/23	AC	Standards of Business Conduct: Declarations	Limited	Trish Mills	Trish Mills	Medium		4.2 Consideration should also be given to introducing a tracking system and reporting the results, including declarations requested but outstanding, to an appropriate forum e.g., Audit Committee.		The 'decision makers' will be a finite known cohort and initially their declarations will be captured via Microsoft Forms to allow for tracking and escalation	Jun-23	Not Met	Apr 24			Open	Last updated: 11/07/23 There will be a known cohort to enable the tracking any outstanding declarations. The PADR form now has a prompt for the line manager to ensure staff have completed their declarations.
554	22/23	FPC	Fleet Maintenance	Reasonable	Dave Holmes	Chris Turley	High		3.1 The Trust should review fleet maintenance expenditure and ensure that the procurement rules have been adhered to.		3.1 Agreed. The Fleet Management Team will review all suppliers against fleet maintenance expenditure in partnership with our procurement colleagues in NWSSP. Action arising for the review will be implemented at the earliest opportunity. All expenditure with suppliers exceeding the financial threshold will be tendered for and/or framework agreements / contracts awarded.	Nov-22	Not Met	April 23	Jun-23	Aug-23	Closed in Quarter	Last updated 27/09/23 Work has been undertaken with our partners in NWSSP. Suppliers/services identified as requiring a procurement exercise have now been completed as follows. MOT services-Tender awarded. Gearbox specialist services -awarded. Windscreen services-completed. Service maintenance repair North Wales is to re added to the next Pan Wales SMR tender as advised by IA at NWSSP. This action is now complete - Board Secretary has reviewed trail of emails with NWSSP.
558	22/23	FPC	IMTP Delivery	Reasonable	Heather Holden	Rachel Marsh	Medium		1.1 The PDDs of the sample programmes should be enhanced to include a Quality Management element to assure the quality of the programme and its deliverables.		This recommendation is accepted. We will define the quality standards to be implemented across all projects and programmes as part of the development of the project and programme management framework and will consider how we define quality measures for project deliverables for the delivery of the next iteration of the IMTP. This will commence with a framework workshop by the end of April to determine the actions required to put this in place.	Apr-23	Not Met	Jun-23	Nov-23	Feb-24	Open	Target date moved in quarter 3. 4.12.23: It was stated that this would come through the Project Path Framework document which will be updated and brought back to STB on 15th January 2024. **This item will be closed when the pathway framework document is approved by the Strategic Transformation Board.** Target date moved in quarter 20.09.2023 - Since the audit a review of the approach to IMTP delivery has been undertaken and a more agile approach to IMTP and transformation delivery is being developed recognising the complexity and interrelatedness of the programme structures that are currently running. A Project Path Framework is in development (due October/November 2023) to replace the current outdated Project and Programme Management framework along with a standard suite of templates. A first draft of the framework will be presented internally to the SPP team by the end of September and will then be presented to ISPG for feedback and approval. This will include a revised Programme Definition Document that includes a Quality Management section. Following approval, the current programmes will be transitioned to the new templates and the QM sections will be populated. Last Updated: 17.04.23 Workshop with transformation team on 3rd April, outcomes to be written up and next steps agreed.
560	22/23	FPC	IMTP Delivery	Reasonable	Kelsey Rees-Dykes	Rachel Marsh	Medium		2.1 The G2C programme board should implement a programme level deliverables plan to assure the management of dependencies in the event of individual project / workstream slippage or other development; and that this is universally implemented across the transformation programmes of the Trust.		Currently programme level plans are included within the overarching reporting via STB. With specific plans developed at project level. We will therefore develop a detailed G2C Programme Action Plan (Milestone timeline aligned to IMTP deliverables) with project Gantt charts feeding into this timeline.	Mar-23	Not Met	Jun-23	Nov-23	Feb-24	Open	Target date moved in quarter 3. 4.12.23 - Key milestones under each of the projects that sit in G2C to be updated - revised date of February 2024 required. Confirmed that all Project Managers need to ensure there is an overarching deliverable plan for all projects so dates can be seen by SRO in one place. 20.09.2023 - Since the audit a review of the approach to IMTP delivery has been undertaken and a more agile approach to IMTP and transformation delivery is being developed recognising the complexity and interrelatedness of the programme structures that are currently running. **This item will be closed when the pathway framework document is approved by the Strategic Transformation Board.** A Project Path Framework is in development (due October/November 2023) to replace the current outdated Project and Programme Management framework along with a standard suite of templates. A first draft of the framework will be presented internally to the SPP team by the end of September and will then be presented to ISPG for feedback and approval. RAID (Risk, Action, Issues, Decision) logs are part of the standard suite of documentation. Last updated: 17.04.23 Focus of March planning and transformation was landing the IMTP which required additional attention from the team to meet the challenging outlook for 2023/24. Following a review of the governance and reporting into STB we are now re-setting the programme plans in line with the 2023-26 IMTP so this will form part of that work.
562	22/23	FPC	IMTP Delivery	Reasonable	Heather Holden	Rachel Marsh	Medium		3.1 Programme documentation should incorporate a standard benefit realisation plan that includes the methods to assess the identified benefits, the timing of the benefit realisation work and the criteria that will be applied to measure success.		We would consider there to be a benefits plan in place for EMS Operational Transformation. For other programmes, this has been something that we have intended to do for some time, as we awaited the appointment of a new Head of Transformation. We recognise the need to clearly articulate and plan programme benefits and will review all programmes to determine whether current benefits plans meet the requirement of a benefits realisation plan and will identify dates to hold benefits planning workshops to finalise benefits realisation plans for each programme where this is required.	Apr-23	Not Met	Jun-23	Oct-23	Feb-24	Open	Target date moved in quarter 3. 4.12.23: Project Path Framework includes Benefits Realisation Plan headings for use across the Trust. To be signed off on 15th January 2024 at STB. REQUEST REVISED DATE OF Feb-24 20.09.23 - A Benefits Realisation Plan template has been developed and will be rolled out across the existing programmes. Due October 2023. Will propose closure once action complete Last Update: 17.04.23 Workshop with transformation team on 3rd April, outcomes to be written up and next steps agreed.
566	22/23	FPC	Hazardous Area Response Team (HART)	Reasonable	Clare Langshaw/Judith Bryce	Lee Brooks	Medium		1.1 The Trust should engage with Welsh Government to update the content within the SLA to recognise that HART capabilities and include reference, where appropriate to National Standards		The Trust accepts this recommendation, recognising that the SLA is proivded to WAST by Welsh Government who procure the services from WAST. We will therefore seek to agree the content of the SLA	Mar-22	Not Met	Mar 23	Sep-23	Mar-24	Open	Update 22.11.2023 Confirmed March 2024 is a reasonable date for SLA Target. Update 27.09.2023 new SLA in draft and agreement with Welsh Governmanet that the new SLA will come into 2024/2025 financial year. Last Updated: 26.06.2023 - Agreement obtained that Welsh Government will review the SLA and the process has commenced. EPRR Team has commenced the review of SLA. Proposed completion date changed from Sep23 to Mar24 as an extensives amount of work needs to be undertaken.
567	22/23	FPC	Hazardous Area Response Team (HART)	Reasonable	Clare Langshaw/Judith Bryce	Lee Brooks	Medium		2.1 The Trust should undertake a self-assessment agains the NARU key lines of enquiry review document. This could support any future "critical friend" review undertaken		The Trust accepts this recommendation and is committed to undertaking a self-assessment aginst the NARU review document	May-23	Not Met	Mar-23	Mar-24		Open	Update 22.11.2023 We are looking to undertake an internal review carried out by the Specialist Operations Locality Manager against the same criteria that the English Trusts are reviewed against to ensure interoperability is maintained. Update 27.09.2023 NARU still unable to support due to capacity limitations. HART uplift currently rolled out in england which is NARU's current focus. To ensure this action is undertaken an internal review will now take place in line with this action. Last Updated: 26.06.2023 NARU has been approached, but they are not able to support this at the moment due to staff shortages. Although they are supportive of the Trust in this. Proposed completion date changed from Mar23 to Mar24.
568	22/23	FPC	Hazardous Area Response Team (HART)	Reasonable	Clare Langshaw/Judith Bryce	Lee Brooks	Medium		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		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.	Apr-22	Not Met	Sep-23			Closed in Quarter	Update 22.11.2023 Single Tender Waiver completed, Suggest action to CLOSE as the asset register on Proclus for HART is being updated and maintained. Number of items on register currently stands at 1,942. Specialist Ops LM will be providing assurance in monthly 1:1 meetings to assure that proclus compliance is maintained going forward. Board Secretary reviewed screen grab of Proclus including the detail of one of the assets (there are over 1000). POTENTIAL REVISED DATE REQUIRED Update 27.09.2023 process in place to put the asset onto proclus however a waiver needs to be implemented to pay for the licence. Procurement to agree on the single tender waiver. Last Updated: 26.06.2023 - Meeting held with Proclus on 30.03.23 to discuss and agree a plan to progress this matter. This is a significant piece of work but on track for completion by end of Sept23.
570	22/23	FPC	Hazardous Area Response Team (HART)	Reasonable	Clare Langshaw/Judith Bryce	Lee Brooks	Medium		5.1 The Trust should consider undertaking a periodic review of the CAD codes assigned to prompt specialist response, or establishing a link between the group and HART for its input into ongoing reviews.		The Trust accepts this recommendation and will undertake a review of CAD codes to ensure they are applicable to HART capabilities and also maximise the use of HART deployments. Any changes will be subject to CPAS approval and we will engage with CPAS to reflect this work on their work programme.	Jun-23	Not Met	May-23	Oct-23	Apr-24	Open	Target date moved in Quarter 3 Update 22.11.2023 Suggest revised date to change to April 24 to account for the expected winter pressures in the coming months and EMSC capacity to support. Update 27.09.2023 - Specialist ops LM has approached EMSC for support, EMSC unable to support at this time due to thier capacity, unable to move this action forward without EMSC support. Last Updated: 26.06.2023 - EPRR Team linking with EMSC colleagues to progress this audit recommendation.

Trust Ref. No.	Year/ Audit Plan	Committee assigned to	Report Title	Assurance Rating	Responsible Officer	Director	Priority Level	Rec. No.in Audit	Recommendation	Respons e No.in Audit	Management Response	Agreed deadline in Report	Status - met or not met agreed deadline in report	1st revised date	2nd revised date	3rd revised date	Closure Status	Where a management action has not met the agreed or revised date, Director must inlcude here: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. **Please add most recent update first**
573	22/23	FPC	Hazardous Area Response Team (HART)	Reasonable	Clare Langshaw/Judith Bryce	Lee Brooks	Medium		8.1 The Trust should make arrangements to update and finalise the MOU with Fire and Rescue services		The Trust accepts this recommendation and will ensure that the MOU with Fire and Rescue Services is updated appropriately	May-23	Not Met	May-23	Dec-23		Closed in Quarter	28.11.23 - WAST have provided input to the JESG MOU which supercedes this action. The MOU incorporates how the emergency services work together and FRS have agreed that a seperate MOU for HART is not required. Currently the Police have refused to sign this JESG MOU. There is therefore no further action for WAST to take here as any resolution is beyond the scope of this recommendation. CLOSURE PROPOSED 29.09.2023 - following discussion at SLT, and in line with the update on the 1st August 2023, this recommendation is recommended for closure. The JESG document is in development with JESG and is unconnected with this action. CLOSURE PROPOSED. 27.09.2023 - The action will not be closed untill JESG doc approved 2nd revised date for December 2023. Update: 01.08.23 - SWFRS are unable to locate this document. A review of the need for this document, taking into account the content of the document now being outdated, as it was orginally intended to aid the start up of HART and the length of time this document has been pending with no serious untoward incidents. I recommend this action is closed as it is no longer relevant. On 8/8/23 the SLT approved document 'Requests for Assistance and/or Support MoU between WAST, Police Forces and Fire & Rescue Services'. This document is due to be approved by JESG and establishes support arrangements between services. Update: 11.04.2023 - SWFRS who own the MOU have confirmed that they have the document and are in the process of reviewing it. Response from SWFRS will be progressed during Apr23 in order to aim for completion of this recommendation by end of May23 as planned.
583	22/23	PCC	Attendance Management	Reasonable	Liz Rogers	Angie Lewis	Medium		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		Accepted – we will investigation options for evaluation of quality and effectiveness	Dec-23	Met				Closed in Quarter	Dec 23 - closure proposed on basis that we have reviewed the information which is recieved from internal and external providers. As the information and data provided is reporting on different things, with different parameters and external providers delivering different services, then standardisation of management information is not possible.
595	22/23	FPC	Hazardous Area Response Team (HART)	Reasonable	Clare Langshaw/Judith Bryce	Lee Brooks	Medium		6.1 HART management should undertake periodic comparison of data extracted from the CAD system to compare against activity reported on PROCLUS to support ongoing efforts to improve data recording on that system		The Trust accepts this recommendation and will undertake a comparison of CAD data to Proclus, with a view to improving the accuracy and system of reporting on Proclus in the future.	May-23	Not Met	May-23	Oct-23	Apr-24	Open	Target date moved in Quarter 3 Update 22.11.2023 Suggest revised date to change to April 24 to account for the expected winter pressures in the coming months and EMSC capacity to support. Update 27.09.2023 - Specialist ops LM has approached EMSC for support, EMSC unable to support at this time due to thier capacity, unable to move this action forward without EMSC support. Last Updated: 26.06.2023 - EPRR Team linking with EMSC colleagues to progress this audit recommendation.
596	22/23	AC	Risk Management & Assurance	Reasonable	Julie Boalch	Trish Mills	Medium	1.1	Following the development of the risk appetite matrix, the Trust should develop and finalise its risk appetite statements	1.1	Accepted. Formal risk appetite statements will be developed in conjunction with the transformational BAF in 23/24; however, the risk consequence matrix is in place and includes risk appetite across a range of categories. The Trust sets out its risk appetite for patient harm in its annual report. This action forms part of the risk management transformation programme monitored at the Strategic Transformation Programme Board. Additionally, a Board Development Session is planned for February 2024.	Jun-24	Not Yet Due				Open	
598	22/23	AC	Risk Management & Assurance	Reasonable	Julie Boalch	Trish Mills	Medium	3.1	Management should continue the rollout of risk management training across the Trust and seek to obtain feedback from attendees, including to capture views on the impact the training has had on their understanding of risk management principles and practice and to identify areas of further training need and improvement.	3.1	Accepted. Risk Management training will continue; however, the level 1 and 2 training packages will not be fully established until late 2024. Bespoke and directorate training will continue to be delivered as requested and a feedback form will be put in place at the next session. Continuous 1:1 support is delivered to Risk Officers to manage their risks.	Sep-24	Not Yet Due				Open	
600	22/23	AC	Risk Management & Assurance	Reasonable	Julie Boalch	Trish Mills	Medium	4.1	The Trust should continue its work to strengthen the BAF, including to; a) ensure alignment to the broader long-term strategy. b) provide further assurances on	4.1	a) Accepted. This is one element of the Risk Management Transformation Programme included in the IMTP and monitored at the Strategic Transformation Board. b) Accepted. A review of mitigating actions and the impact these have had on current scores forms part of the quarter 2 reports for Trust Board and Committees. This is good practice risk management and is part of each risk review discussion. The impact and effectiveness of controls and mitigating actions will continue to be strengthened and drawn out in the risk reports over the coming year.	Mar-24	Not Yet Due				Open	
604	22/23	Quest	Pain Management	Limited	Duncan Robertson	Andy Swinburn	High	1.2(c)	The Trust should ensure all PGDs follow the Medicines Management policy, with a review undertaken every three years as a minimum.	1.2 (c)	The PGD development and review process is resource intensive, and pharmacist input is an essential requirement. Pharmacist Advisor availability is currently limited to 4-hours per month and does not currently meet the needs of the organisation, particularly given the uplift in advanced practitioners and extended skills (enhanced analgesia) of the paramedic workforce. We will develop an options appraisal to determine a costed and effective way forward to provide additional Pharmacist Advisor capacity	Mar-24	Not Yet Due				Open	
605	22/23	Quest	Pain Management	Limited	Duncan Robertson	Andy Swinburn	High	2.1	To gain assurances on the completeness of pain management recorded for patients, additional pathways within the ePCR system, should be established to extract the required data; and reported to an appropriate forum with any themes or trends highlighted within the report.	2.1	We propose to set up a task and finish group, to develop/design a pain management framework to support analysis and presentation of pain/analgesia related data. We anticipate this will enable a fuller picture of pain management, across a range of conditions, in addition to STEMI and Fractured Neck of Femur. The framework will be presented to the Clinical Intelligence and Assurance Group by the end of Q3 2023/24 and then through to CQGG and QUEST. There will be a co-dependency on some of the actions on the outcome of Matter Arising 3.	Dec-23	Not Met	Jan-24			Open	Dec 23: Update 221223 from Clinical Directorate: Agreed for implementation by CIAG (done in December) and will be passed to CQGG for approval in January. T&F group is set up, they have had 3 meetings and AAA received to November CIAG. Framework and supporting documents will be presented to the December CIAG for approval and onward communication to CQGG and upwards. AAA to be submitted for evidence. (On track for December completion).
607	22/23	PCC	Trade Union Release Time	Limited	Liz Rogers	Angela Lewis	High	1.1	In partnership with the trade unions the Trust should revisit the agreement and associated documentation and ensure that there is a consistent, mandated, approach throughout the Trust.	1.1 (a)	Internal conversation on whether full time representatives are appointed in WAST [see context narrative that prefaced this action in the report - too large to include]	Mar-24	Not Yet Due				Open	This recommendation should be read in the context of the audit report. The recommendation was noted but not accepted per se based on the relationship with TUPs at the current time. The management response column notes the actions committed. Discussion paper to ELT in January 2024.

Trust Ref. No.	Year/ Audit Plan	Committee assigned to	Report Title	Assurance Rating	Responsible Officer	Director	Priority Level	Rec. No.in Audit	Recommendation	Response No.in Audit	Management Response	Agreed deadline in Report	Status - met or not met agreed deadline in report	1st revised date	2nd revised date	3rd revised date	Closure Status	Where a management action has not met the agreed or revised date, Director must inlcude here: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. **Please add most recent update first**
608	22/23	PCC	Trade Union Release Time	Limited	Liz Rogers	Angela Lewis	High	1.1	In partnership with the trade unions the Trust should revisit the agreement and associated documentation and ensure that there is a consistent, mandated, approach throughout the Trust.	1.1 (b)	Broader discussion with TU reps regarding maintenance and development of clinical skills whilst undertaking TU duties with the aim of reaching a shared understanding [see context narrativethat prefaced this action in the report - too large to include]	Mar-24	Not Yet Due				Open	
609	22/23	PCC	Trade Union Release Time	Limited	Liz Rogers	Angela Lewis	High	1.1	In partnership with the trade unions the Trust should revisit the agreement and associated documentation and ensure that there is a consistent, mandated, approach throughout the Trust.	1.1 (c)	Regular discussions with senior TU reps in WAST re time for TU duties, trends and peaks in activity [see context narrativethat prefaced this action in the report - too large to include]	Mar-24	Not Yet Due				Open	Amended the date of 'ongoing' in the original deadline to March 24 and will review the conversations that have taken place at that time.
611	22/23	PCC	Trade Union Release Time	Limited	Liz Rogers	Angela Lewis	High	2.1	A standardised process to formally request trade union time should be agreed and appropriate monitoring mechanisms put in place to ensure practices are applied and managed consistently. The process should also incorporate the method of approval and payment / TOIL as well as the management of refusals.	2.1 (b)	The comments of audit colleagues are noted and accepted. Whilst there was a template provided, reps were advised that they needed to maintain a personal record but flexibility was given on how this was to be done. The audit feedback will be shared with TU partners for information and clarification. The current spreadsheet can not be completed on an iPad. Also managers are often not able to respond to a request as soon as it is submitted due to shift patterns and operational pressure **Action:** Revisit manager's responsibilities in signing off TU time with managers across WAST. [see context narrativethat prefaced this action in the report - too large to include]	Dec-23	Met				Closed in Quarter	040124: Board Secretary reviewed evidence of notices to staff and proposed closure. This action refers to the action in the audit report to revisit manager's responsibilities in signing off TU time with managers across WAST. Managers are being reminded of their responsibilities under the Facilities Agreement in terms of checking timesheets.
612	22/23	PCC	Trade Union Release Time	Limited	Liz Rogers	Angela Lewis	High	2.1	A standardised process to formally request trade union time should be agreed and appropriate monitoring mechanisms put in place to ensure practices are applied and managed consistently. The process should also incorporate the method of approval and payment / TOIL as well as the management of refusals.	2.1 (c)	The comments of audit colleagues are noted and accepted. Whilst there was a template provided, reps were advised that they needed to maintain a personal record but flexibility was given on how this was to be done. The audit feedback will be shared with TU partners for information and clarification. The current spreadsheet can not be completed on an iPad. Also managers are often not able to respond to a request as soon as it is submitted due to shift patterns and operational pressure **Action:** Engagement with the senior TU partners will be undertaken with the aim of reaching agreement on implementing a standardised simplified approach (in the context of IA within WAST).	Sep-24	Not Yet Due				Open	
613	22/23	PCC	Trade Union Release Time	Limited	Liz Rogers	Angela Lewis	High	3.1	A standardised process to formally record facility time, and in sufficient detail, should be agreed and implemented.	3.1 (a)	WAST do not currently have the systems to record this information centrally and to do this manually will take more administrative support which is not good value for money. Most TU reps are based in Operations and are recorded in GRS. Only a handful are working outside of the GRS system. **Action:** We will review whether the information could be held in ESR effectively and what the maintenance of this would be and the ease of collecting it. It needs to be in one place for ease of reporting and management. If this is not a realistic option (in terms of cost), we will explore options for alternative methods of recording total time.	Nov-23	Not Met	Mar-24			Open	Target date moved in quater 3 Dec 23 - The management response to this item was:- 'We will review whether the information could be held in ESR effectively and what the maintenance of this would be and how easily could be be accessed and collected. It needs to be in one place for ease of reporting and managment. It this is not a realistic option (in terms of cost) , we will explore options for alternative methods of recording total time.' This is wrapped up in the wider challenges in terms of TU relationships and therefore we want to treat with sensitivity. Facility Time is recorded in GRS and Shift Track. We don't have any reps who are not using one or other of those systems. 111 and other areas are likely transferring to GRS so all will be captured in one system. Also the potential work around electronic timesheets will also impact on record keeping. There is a potential option to record TU time in ESR but we are in the early stages of exploring this but we will give it due consideration. Our ESR lead is currently away from work. **Propose an extension to March 24 when we will likely have more clarity on electronic timesheets and moving all colleagues on shifts into GRS.**
614	22/23	PCC	Trade Union Release Time	Limited	Liz Rogers	Angela Lewis	High	3.1	A standardised process to formally record facility time, and in sufficient detail, should be agreed and implemented.	3.1 (b)	WAST do not currently have the systems to record this information centrally and to do this manually will take more administrative support which is not good value for money. Most TU reps are based in Operations and are recorded in GRS. Only a handful are working outside of the GRS system. **Action:** We will review the recording of time in shift track for 111/ CSD colleagues	Nov-23	Not Met	Mar-24			Open	The management response to this item was:- 'We will review the recording of time in shift track for 111/CSD colleagues' **Please see comments above and proposed extension to March 24**
615	22/23	PCC	Trade Union Release Time	Limited	Liz Rogers	Angela Lewis	Medium	4.1	Accurate and timely management information detailing the time spent and cost of facility time, both on an individual basis and in total for the Trust should be generated. This information should be reviewed on a regular basis and action taken where necessary.	4.1	This is acknowledged. Our aim is to be able to provide this level of detail. However it is dependant on agreeing a standardised method of recording the time spent that is adopted by all TU's, and identifying a corporate system that will collate this information and produce accurate reports, alongside costs in a meaningful way.	Mar-24	Not Yet Due				Open	
616	22/23	FPC	Cyber Security	Reasonable	James Rowland	Leanne Smith	Medium	1.1	The cyber plan should be approved, with appropriate timescales defined for the actions.	1.1	Cyber improvement plan under development and the Trust has undergone a review of readiness by NHS Wales CRU and any recommendation will also be included in the action plan. Once the plan is approved progress monitored will be monitored and reported via IG Steering Group	Dec-23	Not Met	Feb-24			Open	Target date moved in Q3. 201223 - documentation to move formally to IGSG in Q4. Last updated 22/11/23: an improvement plan has been created and submitted for sign-off. This includes the CRU recommendations and is reported on in the now monthly Cyber Security Management Report (which passes from ICT to DLG and to IGSG and QUEST).
617	22/23	FPC	Cyber Security	Reasonable	James Rowland	Leanne Smith	Medium	1.2	The cyber related policies and procedures should be reviewed, updated and any missing items developed and issued.	1.2	Will be included in the plan above [Refers to action 1.1 - *Cyber improvement plan under development and the Trust has undergone a review of readiness by NHS Wales CRU and any recommendation will also be included in the action plan. Once the plan is approved progress monitored will be monitored and reported via IG Steering Group]*	Dec-23	Not Met	Feb-24			Open	Target dated moved in Q3 201223 - documentation to move formally to IGSG in Q4 re actioin plan for SOPs. Last updated 22/11/23: the InfoSec policy was approved at QUEST in November 2023 following Trust-wide consultation. A number of SOPs are in developement (including 3rd Party Assurance, Privilege Access Management and New Software Assurance) and planned to pass through governance cycles for approval from December 2023.
619	22/23	FPC	Cyber Security	Reasonable	James Rowland	Leanne Smith	High	2.1	A formal reporting structure for cyber security should be established. This should include regular monitoring of progress against cyber improvement plans, and reporting on key KPIs that show the security posture of the organisation.	2.1 (b)	In due course progress against the agreed Cyber action plan will also be included in the KPI [refers to cyber KPI report (action 2.1(a)]	Dec-23	Met				Closed in Quarter	Last updated 22/11/23: a number of Information Security metrics are now reported to IGSG and QUEST on a regular basis. Other Cyber Security and Resilience metrics report bi-monthly to Finance & Performance committee. This passage of reporting was approved at the August-23 QUEST and September-23 FPC committees respectively and so have now completed two cycles.
620	22/23	FPC	Cyber Security	Reasonable	James Rowland	Leanne Smith	High	3.1	Backups should be encrypted.	3.1	The Trust server, storage and backup infrastructure is being refreshed during 2023-2024 and we will look to consider these improvements where practicable and affordable	Mar-24	Not Yet Due				Open	
621	22/23	FPC	Cyber Security	Reasonable	James Rowland	Leanne Smith	High	3.2	Consideration should be given to providing immutable storage for backups.	2.3	The Trust server, storage and backup infrastructure is being refreshed during 2023-2024 and we will look to consider these improvements where practicable and affordable	Mar-24	Not Yet Due				Open	

Trust Ref. No.	Year/ Audit Plan	Committee assigned to	Report Title	Assurance Rating	Responsible Officer	Director	Priority Level	Rec. No.in Audit	Recommendation	Response No.in Audit	Management Response	Agreed deadline in Report	Status - met or not met agreed deadline in report	1st revised date	2nd revised date	3rd revised date	Closure Status	Where a management action has not met the agreed or revised date, Director must inlcude here: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. **Please add most recent update first**
622	22/23	FPC	IM&T Infrastructure	Reasonable	Aled Williams	Leanne Smith	Medium	1.1	WAST should schedule a physical stocktake to ensure the asset register is 100% accurate.	1.1	With the majority of corporate staff remote working since Covid it has been difficult to conduct a physical audit. Also given the range of equipment provided to staff for home working (laptop, dock and monitors) we will have to develop a new way of undertaking a physical audit.	Apr-24	Not Yet Due				Open	
623	22/23	FPC	IM&T Infrastructure	Reasonable	Robert Walker	Leanne Smith	Low	2.1	The contract management SOP should be appropriately reviewed and authorised and communicated to relevant staff.	2.1	The Contract Management SOP has been approved at ICT SMT and will now be presented to Digital Leadership Group for approval, following which it will be communicated to staff across the Trust	Sep-23	Not Met	Dec-23			Closure Proposed (pending evidence)	Last updated 06/12/23: approved by DLG comms to go out Trust-wide on Siren in Dec-23. Board Secretary reviewed DLG action/decisions log. **Awaiting Siren notice for full closure.**
624	22/23	FPC	IM&T Infrastructure	Reasonable	Wyn Morris	Leanne Smith	Medium	3.1	The process for clearing all PRTG/system alerts should be formalised and documented. It would typically include •A shared mailbox, all alerts go to one place •Prioritisation guidelines for all calls. •Scheduled review times for technicians and managers. •Process for storing cleared alerts for periodic analysis to	3.1	Agreed, will look to formalise the process and provide some ownership to the defined process	Dec-23	Not Met	Jun-24			Open	Target date moved in quarter 3 Last Updated 06/12/23: Technical solution still to be designed but likely solution superceded by implementation of new Service Desk platform which will address this need in core requirements. Timeline June 2024. 18/12/23: Contract for new service desk software signed 15/12/23, Draft implementation plan produced with full implementation expected to take 6 months, individual modules are yet to be priortiesed
625	22/23	FPC	IM&T Infrastructure	Reasonable	Tony Raine	Leanne Smith	High	4.1	Switches should be identified within the asset register.	4.1	This work was underway prior to the audit but the member of staff is on long term sick. As our switches are configured not to respond to general network sweeps it is a manual task to collate and add this information to the CMDB.	Mar-24	Not Yet Due				Open	
626	22/23	FPC	IM&T Infrastructure	Reasonable	Tony Raine	Leanne Smith	High	4.2	A process for patching of unpatched switches or other network components should be established.	4.2	We will look to develop a risk based patching procedure for network switches and devices	Mar-24	Not Yet Due				Open	
627	22/23	FPC	IM&T Infrastructure	Reasonable	Tony Raine	Leanne Smith	High	4.3	A mechanism to deal with/isolate equipment that cannot be brought up to the required security specification should be defined.	4.3	This will be included in the above patching procedure	Mar-24	Not Yet Due				Open	
628	22/23	FPC	IM&T Infrastructure	Reasonable	Aled Williams	Leanne Smith	Low	5.1	Consideration should be given to how long the switch to the disaster recovery site will take and if automation is a practical option.	5.1	There are differing requirements for fail over of Trust systems in DR terms with some also only supporting a manual failover process to the DR site. The Trust infrastructure is being refreshed during 2023-2024 and we will look to areas where it can improve failover where practicable or required	Dec-23	Not Met	Jun-24			Open	Target date moved in quarter 3. 22/11/23: CAD will always have aspects that need manual intervention with MIS. Trust infrastructure refresh in the process of migrating (Dec-23) which will improve capability for failover. Next to agree failover requirements, during annual review Business Impact Analysis (BIA). CONSIDER REVISED DATE TO JUN-24 DEP ON 111 project solution.
629	22/23	FPC	IM&T Infrastructure	Reasonable	Aled Williams	Leanne Smith	Medium	6.1	A review should be undertaken to ensure that the assessment of the criticality of the services is still valid. The backup site capacity should then be reviewed to ensure all the required services can be hosted and what systems have priority and their restoration order.	6.1	The Trust server, storage and backup infrastructure is being refreshed during 2023-2024 and we will look to align capacity and to improve failover where practicable and affordable	Mar-24	Not Yet Due				Open	
630	22/23	PCC	Health & Safety	Reasonable	Nicola White	Liam Williams	Medium	1.1	Management should ensure that all policies and procedures that relate to health and safety arrangements, are updated as soon as possible.	1.1 (a)	The Trust's Health and Safety Policy is currently undergoing the substantial consultation process. Upon ratification the Health & Policy to be sent for approval from Executive Management Team (EMT) and People & Culture Committee (PCC).	Dec-23	Met				Closed in Quarter	23.11.23 Health & Safety Policy approved at People & Culture Committee on 16.11.23 and ratified at Trust Board on 23.11.23. Proposed for Closure
631	22/23	PCC	Health & Safety	Reasonable	Nicola White	Liam Williams	Medium	1.1	Management should ensure that all policies and procedures that relate to health and safety arrangements, are updated as soon as possible.	1.1 (b)	Policies and Procedures will be updated in line with the Health and Safety Management System (HSMS). The HSMS will be reviewed to articulate the timeframe for the review of arrangements.	Sep-23	Not Met	Feb-24			Open	Target date moved in quarter 3 11.12.23: Revised target date of February 2024 (previously indicated December 2023) as Health & Safety Management System is not scheduled to be submitted to Senior Leadership Team Meeting until January/February 2024 (no date set as yet). SLT paperwork will be shared as evidence once tabled. Target date moved into quarter 28.11.23 Health & Safety Management System reviewed. To be submitted to Quality, Safety & Patient Experience Directorate Meeting, Senior Operations Team Meeting and Senior Leadership Team Meeting once approved by the Assistant Director of Quality Governance. The majority of policies are in date so will be Business as Usual. Possible extension request for December 2023. 28.09.2023: Proposed revised date Nov-23. HSMS review highlighted approval route changes that have to be agreed before other procedures can be reviewed and approved. HSMS reviewed and propsed edits being considered. The Health & Safety Policy is expected to be presented at People and Culture Committeeon on 16 November 2023 for ratification. The HSMS review is underway. Expectation of seeking approval at ADLT in November 23. The HSMS requries approval before other procedures can be developed/reviewed and approved.
632	22/23	PCC	Health & Safety	Reasonable	Graham Stockford	Liam Williams	Medium	1.2	Once approved, policies and procedures should be circulated to all staff.	1.2	Policies and Procedures will be issued via corporate communication platforms.	Mar-24	Not Yet Due				Open	11.12.23: On track for completion by March 2024 28.11.23 Action to be completed once Trust Ref 631 is completed.
633	22/23	PCC	Health & Safety	Reasonable	Graham Stockford	Liam Williams	Medium	2.1 (a)	All programme documentation should be stored in a centralised location to efficiently measure outcomes and capture ongoing learning	1.2 (a)	Review of documentation sources and centralise on MS 365 platform.	Dec-23	Met				Closed in Quarter	28.11.23 All complete. 'Propose for closure'. Link to MS 365 to be shared with Corporate Team. Board Secretary provided with link to the Working Safely Programme Teams Channel and reviewed a number of folders and documents on the site.
635	22/23	PCC	Health & Safety	Reasonable	Graham Stockford	Liam Williams	Medium	2.1 (c)	The Programme Closure report should be appropriately approved and circulated to assist with the sharing of best practice and lessons learnt.	2.1 (c)	Programme Closure to be rediscussed at Strategic Transformation Board and closure noted in meeting minutes	Sep-23	Not Met	Nov-23			Closed in Quarter	27.11.23 Working Safely Closure Report presented to Strategic Transformation Board on 27 November 2023. Propose for closure. 28.9.2023: Working Safely Programme closure report to be presented to Strategic Transformaiton Board to close item. 15.08.23 and cirulated virtually to STB members for approval. Revised plan and timescales now incorporated in IMTP and safety annual plan
636	22/23	PCC	Health & Safety	Reasonable	Graham Stockford	Liam Williams	High	3.1	Monitoring of compliance against health and safety legislation and that corrective action is taken promptly, where applicable, should be undertaken. Areas to consider should include: •Ensuring that risk assessments of the required standard are in place across all Trust sites, are periodically reviewed, and appropriately stored; •Wider circulation of inspection reports and a completed action plan to be shared with all action owners; •Determine the follow up process to ensure that corrective action has been taken; •Provide a clear audit trail of where non-compliance has been identified, recording the action that is proposed along with action owners and target dates; and confirmation when the corrective action has been taken; and •Issue of clear, documented guidance clarifying the roles and responsibilities of those involved.	3.1 (a)	Develop performance indicators around sharing inspections outcomes within 10 working days.	Dec-23	Not Met	Jan-24			Open	Target date moved in quarter 3 28.11.23 A centraised document library (excel spreadsheet) identifies review periods required for major legislative Policies and Procedures. It also identifies Trust wide Risk Assessments and review dates. Inspection Reports are sent out to respective Duty Operational Managers, with a meeting scheduled for 28.11.23 to ascertain how to manage actions going forward. The proposal is a Teams channel to notify responsible individuals of the actions from the Audits, which will include action owners and target dates. SOP currently in development. Extension request for January 2024.

Trust Ref. No.	Year/ Audit Plan	Committee assigned to	Report Title	Assurance Rating	Responsible Officer	Director	Priority Level	Rec. No.in Audit	Recommendation	Response No.in Audit	Management Response	Agreed Deadline in Report	Status - met or not met agreed deadline in report	1st revised date	2nd revised date	3rd revised date	Closure Status	Where a management action has not met the agreed or revised date, Director must inlcude here: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. **Please add most recent update first**
637	22/23	PCC	Health & Safety	Reasonable	Graham Stockford	Liam Williams	High	3.1	Monitoring of compliance against health and safety legislation and that corrective action is taken promptly, where applicable, should be undertaken. Areas to consider should include: •Ensuring that risk assessments of the required standard are in place across all Trust sites, are periodically reviewed, and appropriately stored; •Wider circulation of inspection reports and a completed action plan to be shared with all action owners; •Determine the follow up process to ensure that corrective action has been taken; •Provide a clear audit trail of where non-compliance has been identified, recording the action that is proposed along with action owners and target dates; and confirmation when the corrective action has been taken; and •Issue of clear, documented guidance clarifying the roles and responsibilities of those involved.	3.1 (b)	Update the Health and Safety Management System to reflect new design.	Dec-23	Not Met	Feb-24			Open	Target date moved in quarter 3 11.12.23: Process for updating audits needs to be placed into a procedure - Not started. Propose new target date of February 2024
638	22/23	PCC	Health & Safety	Reasonable	Leanne Smith	Liam Williams	High	3.1	Monitoring of compliance against health and safety legislation and that corrective action is taken promptly, where applicable, should be undertaken. Areas to consider should include: •Ensuring that risk assessments of the required standard are in place across all Trust sites, are periodically reviewed, and appropriately stored; •Wider circulation of inspection reports and a completed action plan to be shared with all action owners; •Determine the follow up process to ensure that corrective action has been taken; •Provide a clear audit trail of where non-compliance has been identified, recording the action that is proposed along with action owners and target dates; and confirmation when the corrective action has been taken; and •Issue of clear, documented guidance clarifying the roles and responsibilities of those involved.	3.1 (c)	Explore a digital solution to advise relevant managers of their compliance and actions.	Mar-24	Not Yet Due				Open	
639	22/23	PCC	Health & Safety	Reasonable	Nicola White	Liam Williams	Medium	4.1	The Trust should revisit its training needs analysis to consider training frequency, monitoring arrangements and reporting tools to confirm that staff have attended the necessary training.	4.1	Trust's training needs analysis to be amended to include frequencies and mechanism for reporting compliance.	Sep-23	Not Met	Dec-23			Closed in Quarter	16.11.23 Health & Safety Policy approved at People & Culture Committee on 16.11.23 and ratified at Trust Board on 23.11.23 which includes Training Needs Analysis as Appendix 17.1. Proposed for Closure. Board Secretary reviewed policy and TNA. 19.9.23 TNA within H&S Policy revised to include training frequencies. Action to be closed following ratification of H&S Policy by PCC.
641	22/23	PCC	Health & Safety	Reasonable	Nicola White	Liam Williams	Medium	4.3	The corporate health and safety team's training matrix should be updated in line with job descriptions and management should ensure that succession planning arrangements have been appropriately considered.	4.3	The training matrix for the Health and Safety functions is a best practice model and exceeds the requirements within each respective job description. This allows the team to able to support other departments (e.g. Estates) by providing advice and undertaking activities that contribute to providing a safe working environment (i.e. lighting assessments). This also contributes to cost savings negating the requirement for external provider in some instances. It also provides a route for succession planning. The function's training matrix will be revised to include; Essential; Desirable and Beneficial to make clear where the minimum standard is being attained.	Dec-23	Met				Closed in Quarter	221223: Training matrix received; action proposed for closure. 11.12.23: Graham Stockford to complete Training Matrix by end of w/c 15.12.23 and provide excel spreadhset as evidence 28.11.23 A Training Matrix for the Health & Safety function is currently being developed and will include Essential; Desirable and Beneficial to make clear where the minimum standard is being attained.
643	22/23	FPC	Savings & Efficiencies	Reasonable	Navin Kalia	Chris Turley	Medium	1.1	Guidance should be developed to clearly outline: - Roles and Responsibilities (including assessments, approvals, monitoring and reporting arrangements). - Documentation to be used within the savings process to ensure that key elements are included, e.g. impact, risks, success measures, timescales, etc. - Escalation process to be followed (when, to whom and actions to be taken) where savings are not	1.1	Guidance on roles and responsibilities, documentation and escalation to be developed and shared by Financial Sustainability Programme.	Jul-23	Not Met	Dec-23	Feb-24		Open	Target date moved in quarter. Update 12.12.23 - Draft Financial Sustainability Programme Delivery Strategy document developed which covers off guidance on roles and responsibilities, documentation and escalation - to be shared with relevant stakeholders over the coming months. Action to be closed off when document presented to STB on 15.1.24
645	22/23	FPC	Savings & Efficiencies	Reasonable	Jason Collins	Chris Turley	Medium	2.1	A formal programme of financial training should be provided to budget holders to allow them to effectively carry out their role.	2.1	Key objective for WAST FM Team (and wider Finance teams) for 23/24 will be to undertake a series of Finance Training to Board Members, Budget Holders and other non-financial staff. This will be delivered by several methods such as face to face training, TEAMS sessions and induction.	Dec-23	Not Met	24-Mar			Open	Target date moved in quarter. Update 12.12.23 - this has commenced with formal training to board members / TU partners taken place in April 23 and training sessions held with Operational Managers in November 23. Training to budget managers will now be captured in Quarter 4 to include any potential updates to finance system rollouts being undertaken by NHS Wales. In the interim all budget managers have assigned Senior Finance Business Partners who support and informally train on all finance related matters.
646	22/23	FPC	Savings & Efficiencies	Reasonable	Jason Collins	Chris Turley	Medium	2.2	Training records should be maintained to confirm attendance, which should be monitored to identify non-attendance so this can be followed up.	2.1	Schedule of Training and who has attended to be recorded.	Dec-23	Not Met	24-Mar			Open	Target date moved in quarter. Update 12.12.23 - As per audit ref 645, formal training has commenced and a log of attendees has commenced and this will be further updated during quarter 4 roll out of formal training to budget managers
647	22/23	FPC	Savings & Efficiencies	Reasonable	Navin Kalia	Chris Turley	Medium	3.1 (a)	Savings and efficiency plans should be enhanced using SMART criteria to define success and provide realistic timescales.	3.1 (a)	Will be evidenced by project management principles being applied to every individual savings schemes as it is identified and its ongoing monitoring.	Mar-24	Not Yet Due				Open	
648	22/23	FPC	Savings & Efficiencies	Reasonable	Navin Kalia	Chris Turley	Medium	3.1 (b)	Noting the expected future financial challenges, there should be prioritisation and recording of recurring funding against one-off savings to assist with financial sustainability.	3.1 (b)	Impact of Non-recurring schemes in 23/24 will be addressed by FSP and as part of WAST Financial Plan for future financial years.	Mar-24	Not Yet Due				Open	
649	22/23	FPC	Savings & Efficiencies	Reasonable	Navin Kalia	Chris Turley	Medium	3.1 (c)	A log should be implemented to enhance the current process recording changes to the savings programme, during the financial year, from that originally approved.	3.1 (c)	Schedule of 23/24 agreed plans and any additions will be controlled through FSP.	Mar-24	Not Yet Due				Open	

Trust Ref. No.	Year/ Audit Plan	Committee assigned to	Report Title	Assurance Rating	Responsible Officer	Director	Priority Level	Rec. No.in Audit	Recommendation	Response No.in Audit	Management Response	Agreed deadline in Report	Status - met or not met agreed deadline in report	1st revised date	2nd revised date	3rd revised date	Closure Status	Where a management action has not met the agreed or revised date, Director must inlcude here: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. **Please add most recent update first**
650	22/23	Quest	Records Management	Reasonable	Jonny Sammut	Jonny Sammut	High	1.1	Management should ensure that a full review of current resources, how resource is used and time required to complete all legislative duties is undertaken, to identify gaps and risk areas upon which capacity and resilience can be measured.	1.1	Previous time & motion study showed significant variance in the tasks undertaken, and similar pressure is felt across records service community in NHS Wales with increasing complexity. A risk will be captured around legislative duties. Exploration of digital tooling to support better tracking of activity in the RM team is already being taken forward, and the ways of working of the team is under continuous review for improvement.	Dec-23	Not Met	Jan-24			Open	Taget date moved in Quarter 4 Update 18/12/23: Risk register training conducted for team in Dec, to enable creation of this risk. Digital tooling has been explored and is progressing through procurement process. A demo is to be arranged for the team in January-24. Expected risk action to be completed in January-24 (after passing through relevant governance routes within Digital).
651	22/23	Quest	Records Management	Reasonable	Judith Birkett	Jonny Sammut	High	1.2(a)	The IG reports should include a measure of the complexity of requests.	1.2(a)	Coroner requests have been identified as a process possibly suitable for automation. This process will be mapped to see if automation would create additional capacity within the team.	Jan-24	Met				Closed in Quarter	Update 18/12/23: after further discussion, the coroner request process has been determined to *not* be appropriate for automation at this stage as secure file transfer would still need to be done manually given exisiting techologies. However, as per recommendation 650, the introduction of digital tooling for tracking activity may make this feasible in future. Proposal that this Management Response action be closed - this was one of multiple ideas to address the problem. 201223 - Board Secretary noted the above comments and agreed closure on the basis that compexity will be drawn out in action 652.
652	22/23	Quest	Records Management	Reasonable	Leanne Smith	Jonny Sammut	High	1.2(b)	The IG reports should include a measure of the complexity of requests.	1.2(b)	Additional metrics will be included in the IG & InfoSec KPI report, representing complexity of and utilisation in legislative duties.	Jan-24	Not Yet Due				Open	Update 18/12/23: to help identify and define complex cases, employee requests are now being tracked to understand effort / length of time typically required for such responses. This will inform a metric that can be built into the reporting for Information Governance Steering Group from January-24. Additional work required still to understand how a case which *becomes* complex is logged, e.g. fire & police requests.
653	22/23	Quest	Records Management	Reasonable	Leanne Smith	Jonny Sammut	Medium	2.1(a)	A record management improvement plan should be developed, based on a formal assessment of records throughout the Trust.	2.1(a)	Additional fixed-term support will be sought to conduct the assessment and craft an improvement plan. The risk of not developing an improvement plan in 2023-24 will be included in the risk being developed as per action 1.1.	Sep-24	Not Yet Due				Open	
654	22/23	Quest	Records Management	Reasonable	Judith Birkett	Jonny Sammut	Medium	2.1(b)	A record management improvement plan should be developed, based on a formal assessment of records throughout the Trust.	2.1(b)	A Digital Notice re records management will be published on the intranet to increase awareness of individual staff responsibility.	Dec-23	Not Met	Jan-24			Open	Target date moved in Quarter 3 to January-24. Update 18/12/23: materials have been developed to help raise awareness of records management. These are being finalised, with a plan to share and put on the Records Siren page with a living FAQ sheet. Plan to release this in January-24.
655	22/23	Quest	Records Management	Reasonable	Judith Birkett	Jonny Sammut	High	3.1(a)	A formal agreement for storage of records should be developed. This should set out the responsibilities and requirements for management of health records.	3.1(a)	Additional temporary resource to be sought (from Jan-24) to conduct review of DCC stored boxes and retention schedules. A forecast of storage requirements at DCC will be created to inform a decision on if/when it will be possible to move these records into WAST-managed storage (e.g. at VPH).	Apr-24	Not Yet Due				Open	
656	22/23	Quest	Records Management	Reasonable	Judith Birkett	Jonny Sammut	High	3.1(b)	A formal agreement for storage of records should be developed. This should set out the responsibilities and requirements for management of health records.	3.1(b)	Should [following the review at 3.1a being evaluated] we still need space at Denbigh County Council then we will pursue an agreement with them for those storage, retention and disposal. In the meantime, we will ask for the policies and procedures the Council have in place for their receipt, retention and destruction of records and confirm that this is the way they treat our records. That should provide some assurance on the issues in the matter arising.	Sep-24	Not Yet Due				Open	
657	22/23	Quest	Records Management	Reasonable	Leanne Smith	Jonny Sammut	Medium	4.1	Records should be moved into the new storage area.	4.1	RSAM to review suitability of the VPH storage facility and access management arrangements. If appropriate, secure transfer of the records from Pontypool to VPH will require budget approval beyond the funds available for Records Services (to be discussed with Corporate Governance & Finance).	Jan-24	Not Yet Due				Open	
658	22/23	Quest	Records Management	Reasonable	Judith Birkett	Jonny Sammut	Medium	5.1	The records management improvement plan noted in MA2 should include a programme of identification and assessment of all records storage areas within the Trust.	5.1	The risk of not fully assessing storage areas in 2023-24 will be acknowledged in the risk being developed as per action 1.1. A Trust-wide request will be made to gather intel on what paper records are being stored across the organisation and where. This will inform the improvement plan of how to assure these storage areas.	Sep-24	Not Yet Due				Open	
659	22/23	Quest	Records Management	Reasonable	Judith Birkett	Jonny Sammut	High	6.1	The records management improvement plan noted in MA2 should include an assessment of the disposal of records (both physical and digital) and ensure that records are removed as appropriate.	6.1	Agreement that this is needed, but dependency on the assessments of MA2 and MA5, for which additional fixed-term expert support would be required. There is however an individual staff responsibility and asset owner responsibility to ensure records are disposed of correctly, which will be included in the Digital Notice of action 2.1.	Dec-23	Not Met	Feb-24			Open	Target date moved in Quarter 3 to February-24. Update 18/12/23: materials have been developed to help raise awareness of records management. These are being finalised, with a plan to share and out on the Records Management intranet page. Plan to release this in January-24. An Information Asset Owners forum is also planned to be established from February-24.
606	22/23	PCC	Senior Paramedic Role	Reasonable	Greg Lloyd	Andy Swinburn	Medium	1.1	Periodic analysis of GRS data should be undertaken to ensure all SPs are adhering to the recommended split of their shifts.	1.1	A GRS report will be generated using a randomised sample of the SP group; and this report will be submitted to the SP Steering Group.	Jan-24	Not Yet Due				Open	
607	22/23	PCC	Senior Paramedic Role	Reasonable	Greg Lloyd	Andy Swinburn	Medium	2.1(a)	A review of allocation of Ps and Ts is undertaken to ensure consistency across Wales.	2.1(a)	The SP shown with the highest ratio was due to a vacancy in the operational area. This post has now been recruited into, so the team size has reduced to 35 each for the two SPs in the area and further SPs have been recruited with induction starting on 13 November (up to the 45 FTE).	Complete	Met				Closed in Quarter	Marked as complete when the audit was submitted to Internal Audit
608	22/23	PCC	Senior Paramedic Role	Reasonable	Greg Lloyd	Andy Swinburn	Medium	2.1(b)	A review of allocation of Ps and Ts is undertaken to ensure consistency across Wales.	2.1(b)	A review of options for reducing variances in the size of SP teams will be presented to the quarterly SP Steering Group.	Jan-24	Not Yet Due				Open	
609	22/23	PCC	Senior Paramedic Role	Reasonable	Greg Lloyd	Andy Swinburn	Medium	2.2	Arrangements should be put in place for the appropriate escalation of issues with ratios and ensure regular monitoring through an appropriate forum.	2.2	Team sizes and ratios will form part of a report into the quarterly SP Steering Group.	Jan-24	Not Yet Due				Open	
610	22/23	PCC	Senior Paramedic Role	Reasonable	Greg Lloyd	Andy Swinburn	Medium	2.3	An assessment should be undertaken to establish and highlight the wider impact of not achieving the full growth of the SP role.	2.3	An analysis on the impact of not achieving the full growth of SPs has been completed and reviewed at internal clinical/operational and financial groups in light of the current financial savings plan.	Complete	Met				Closed in Quarter	Marked as complete when the audit was submitted to Internal Audit 201223 - Board Secretary has seen QIA
611	22/23	PCC	Senior Paramedic Role	Reasonable	Greg Lloyd	Andy Swinburn	Medium	3.1	Training status for all SPs should be collated and captured with regular reporting within an appropriate forum to monitor progress.	3.1	Updated reports on education progress of the SP cohorts to be brought together into a single progress report. This will be presented through the Clinical Directorate Business meeting and the Senior Operations Team.	Jan-24	Not Yet Due				Open	

Trust Ref. No.	Year/ Audit Plan	Committee assigned to	Report Title	Assurance Rating	Responsible Officer	Director	Priority Level	Rec. No.in Audit	Recommendation	Response No.in Audit	Management Response	Agreed deadline in Report	Status - met or not met agreed deadline in report	1st revised date	2nd revised date	3rd revised date	Closure Status	Where a management action has not met the agreed or revised date, Director must inlcude here: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. **Please add most recent update first**
612	22/23	PCC	Senior Paramedic Role	Reasonable	Darren Panniers	Andy Swinburn	Medium	3.2	A training plan, and expected timeline for the required clinical skill enhancements should be established.	3.2	An Extended Skills Working Group has been established to deliver four new areas for skill development during 2024. The first meeting is in November 2023 with two priorities already agreed (sedation for post ROSC patients and the management of ABD). The workplan and draft terms of reference have been shared with Audit for information. These skills will initially be for the SP group only until an assessment and audit is completed for further consideration on safety and efficacy.	Dec-23	Not Met				Open	201223 - update received however further queries raised on training plan by Board Secretary
613	22/23	PCC	Senior Paramedic Role	Reasonable	Darren Panniers	Andy Swinburn	Low	4.1	The terms of reference should be reviewed to: •Include a defined pathway for escalation of issues; •Update membership to ensure representation from each locality; andNov •Define quoracy.	4.1	The SP steering group has changed to a quarterly meeting and the terms of reference are being updated to reflect the audit findings. An Alert/Assure/Advise report will be completed and submitted to the Senior Operations Team	Nov-23	Not Met	Feb-24			Open	Target date moved in quarter 3. 201223 - Meetings to finalise TOR in January
614	22/23	PCC	Senior Paramedic Role	Reasonable	Greg Lloyd	Andy Swinburn	Medium	5.1	The Trust should undertake a lessons learned exercise on the development and evolution of the SP role.	5.1	A review on the evolution of the role will be completed to highlight any lessons that can be learned for future role development.	Feb-24	Not Yet Due				Open	
615	22/23	PCC	Senior Paramedic Role	Reasonable	Greg Lloyd	Andy Swinburn	Medium	5.2	The Trust should report regularly on the impact and effectiveness of the SP role, including analysis of their utilisation across Wales and the achievement of the wider IMTP objective.	5.2	A report including number of rideouts undertaken and the outcomes (action plans/issues resolved during the shift/documentation/CPD/NQP portfolio reviews) will be developed into a regular report into the SP Steering Group on a quarterly basis.	Jan-24	Not Yet Due				Open	
616	22/23	PCC	Senior Paramedic Role	Reasonable	Greg Lloyd	Andy Swinburn	Medium	5.3	Feedback from Paramedics and Technicians should be included as a standing agenda item on the SP Steering Group for consideration / action as appropriate.	5.3	Feedback through the Power BI reporting process will be included on the SP Steering Group quarterly meeting.	Jan-24	Not Yet Due				Open	
617	22/23	FPC	Technical Resilience	Reasonable	Aled Williams	Jonny Sammut	Medium	1.1	A record of the contents of the VPH datacentre should be maintained. This should track power and cooling requirements, with any changes communicated to Estates and Facilities. From the record, an assessment of power and cooling provision and redundancy should be undertaken to ensure this is appropriate.	1.1	The Trust will utilise the NGD template to document the equipment racks at VPH along with other satellite sites at Llanfairfechan, Matrix, Ty Elwy, and Thanet too with other engineers.	Mar-24	Not Yet Due				Open	
618	22/23	FPC	Technical Resilience	Reasonable	Aled Williams	Jonny Sammut	Medium	2.1	The programme of testing should be expanded to include all systems.	2.1	The Trust Digital department will review the requirement for testing of resilience and DR for non-critical systems in partnership with system owners as part of the annual review of BIA.	Mar-24	Not Yet Due				Open	
619	22/23	FPC	Technical Resilience	Reasonable	Aled Williams	Jonny Sammut	Medium	3.1(a)	DR plans should be in place for all systems, and all DR plans should note the RTO / RPO position.	3.1(a)	Once the new Nutanix environment is fully operational a revised SOP will be developed to cover the DR of the infrastructure. As many non-critical systems are hosted on this infrastructure, they will benefit from this improved capability to aid resilience and recovery.	Jun-24	Not Yet Due				Open	
620	22/23	FPC	Technical Resilience	Reasonable	Aled Williams	Jonny Sammut	Medium	3.1(b)	DR plans should be in place for all systems, and all DR plans should note the RTO / RPO position.	3.1(b)	The Digital Directorate will work with system owners to define appropriate RTO/RPO for individual system	Mar-24	Not Yet Due				Open	
621	22/23	FPC	Technical Resilience	Reasonable	Aled Williams	Jonny Sammut	Medium	4.1	Work on the service catalogue should be completed. The service catalogue should include an assessment of resilience position and clearly state the RTO / RPO provided.	4.1	The current provision for service catalogues within ServicePoint is insufficient to support this recommendation and the Trust future ITSM requirements. The Trust has made the commitment to purchase a new ITSM tool with implementation due to commence in January 2024. The full development of the service catalogue will be a key element of the implementation of the new software.	Sep-24	Not Yet Due				Open	
622	22/23	FPC	Estates Condition	Limited	N/A	Chris Turley	Medium	1.1	Management should consider the advantages and disadvantages of specialist capital expertise provided by a Non-Executive Director to oversee the capital programme.	1.1	Noted. The capital programme is overseen by the Capital Management Board and reported to the Finance and Performance Committee where both non execs and executive directors attend. Further consideration may be undertaken in relation to a NED champion role on the Board if such an opportunity arises but, noting that this is not a mandatory requirement, and the alternative assurances provided as to the scrutiny and oversight of such matters undertaken at committee and board level, it is not deemed required or indeed feasible at this stage.	Complete	Met				Closed in Quarter	Marked as complete when the audit was submitted to Internal Audit
623	22/23	FPC	Estates Condition	Limited	Richard Davies	Chris Turley	Medium	1.2	The Trust should advise NWSSP:SES that the "designated person" will be re-allocated to an appropriate Board member in accordance with WHEN 07-02.	1.2	Designated named persons will be updated to appropriate board members.	Dec-23	Not Yet Due				Open	Update 181223: Designated person will be updated by end of December.
624	22/23	FPC	Estates Condition	Limited	N/A	Chris Turley	Medium	2.1	The adequacy of the existing Capital Development & Estates workforce will be affirmed (in terms of capacity and associated skill sets required) based on the current configuration of the estate, and to inform a financial model for required revenue support.	2.1	Agreed. And due to the completion of a recent OCP, this has already been undertaken	Complete	Met				Closed in Quarter	Marked as complete when the audit was submitted to Internal Audit
625	22/23	FPC	Estates Condition	Limited	Richard Davies	Chris Turley	Medium	2.2	Future estate workforce reviews should acknowledge the refreshed Estates Strategy ensuring that it adequately reflects any delays in the associated investment programmes informing the capacity, skill set and future requirements of the service.	2.2	Agreed	N/A	Met				Closed in Quarter	Marked as closed as it relates to action 2.1 which was marked as complete when the audit was submitted to Internal Audit
626	22/23	FPC	Estates Condition	Limited	Richard Davies	Chris Turley	Medium	3.1	Management should review and confirm the accuracy of published backlog maintenance data with consultation with NWSSP: Specialist Estates Services.	3.1	Agreed, however guidance will need to be sought from NWSSP to ensure accuracy of backlog maintenance for the unique ambulance service estate within NHS Wales. Action will be closed once such guidance is sought.	Mar-24	Not Yet Due				Open	
627	22/23	FPC	Estates Condition	Limited	Richard Davies	Chris Turley	Medium	4.1	The Trust should review the risk categorisation within the EFPMS and engage with NWSSP: SES to ensure consistency in approach when applying risk categories to the estate backlog maintenance figures.	4.1	Agreed, however again guidance will need to be sought from NWSSP to ensure risk categorisation within EFPMS is appropriate for the unique ambulance service estate within NHS Wales. Action will be closed once guidance is sought.	Mar-24	Not Yet Due				Open	

Trust Ref. No.	Year/ Audit Plan	Committee assigned to	Report Title	Assurance Rating	Responsible Officer	Director	Priority Level	Rec. No.in Audit	Recommendation	Response No.in Audit	Management Response	Agreed deadline in Report	Status - met or not met agreed deadline in report	1st revised date	2nd revised date	3rd revised date	Closure Status	Where a management action has not met the agreed or revised date, Director must inlcude here: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. **Please add most recent update first**
628	22/23	FPC	Estates Condition	Limited	Richard Davies	Chris Turley	Medium	5.1	The Trust should engage with NWSSP: SES to ensure that the survey approach is appropriate noting the need for a consistent all-Wales assessment of the estate.	5.1	Agreed, noting that the service followed the six-facet approach to ascertain the condition of the estate, engagement is therefore required with NWSSP to further highlight the unique ambulance estate within NHS Wales. Action will be closed once this is done.	Mar-24	Not Yet Due				Open	
629	22/23	FPC	Estates Condition	Limited	N/A	Chris Turley	Medium	5.2	Planned disposals should be removed from backlog maintenance data in accordance with guidance.	5.2	Agreed	Complete	Met				Closed in Quarter	Marked as complete when the audit was submitted to Internal Audit
630	22/23	FPC	Estates Condition	Limited	Richard Davies	Chris Turley	Medium	6.1	Management should report progress e.g., annually, against backlog maintenance and estate investment targets to an appropriate forum (e.g., Finance and Performance Committee), including funding variances and forecast variances to targets.	6.1	Agreed, backlog maintenance will be reported through the Finance & Performance Committee annually in line with the EFPMS submission.	Jun-24	Not Yet Due				Open	
631	22/23	FPC	Estates Condition	Limited	Richard Davies Joanne Williams Edward Roberts	Chris Turley	High	7.1	The Estates Strategy should be updated to provide a funded target solution separately to eliminate "high and significant" and overall backlog maintenance profiled by year.	7.1	Agreed, a refreshed Strategic Outline Programme is required upon receiving guidance from NWSSP as detailed within recommendation 4.	Sep-24	Not Yet Due				Open	
632	22/23	FPC	Estates Condition	Limited	Richard Davies Susan Woodham Edward Roberts	Chris Turley	Medium	7.2	Revisions to the Estates Strategy should include performance indicators linked to reducing High/Significant backlog maintenance, opportunities linked to space utilisation etc.	7.2	Agreed, noting that this would form part of managing facilities and through pre planned maintenance contracts to ultimately reduce high and significant backlog maintenance.	Sep-24	Not Yet Due				Open	
634	22/23	FPC	Estates Condition	Limited	Richard Davies	Chris Turley	Medium	8.1	Statutory, "high", and "significant" risk backlog maintenance items that remain unaddressed by investment proposals should be appropriately profiled at the corporate risk register and reported to management for acceptance and approval / implementation of mitigating actions.	8.1	As noted at MA 4, additional advice will be taken in respect of "high" and "significant" risk classifications, which may largely remove this issue. Further consideration of any residual reporting through the Corporate Risk Register will then be considered.	Mar-24	Not Yet Due				Open	
634	22/23	FPC	Estates Condition	Limited	N/A	Chris Turley	Medium	9.1	Management should confirm to Welsh Government, via appropriate surveys, the absence or extent of Reinforced Autoclaved Aerated Concrete.	9.1	Actioned since audit fieldwork and ahead of the audit being completed A structural surveyor has now affirmed that appropriate surveys has been undertaken & Welsh Government have been advised that RAAC is not present within WAST buildings.	N/A	Met				Closed in Quarter	Marked as complete when the audit was submitted to Internal Audit
635	22/23	FPC	111 Commissioning Final Advisory Report	Not Rated	N/A	Rachel Marsh	N/A	1.1	Noting that roles and responsibilities will have changed since the national NHS 111 Wales service has been implemented, roles and responsibilities should be clearly detailed within the National Collaboration Agreement and signed by both parties (Commissioner and Trust). Opportunities should be provided for partners to reflect on their roles and functions regularly so that the Agreement can be amended to reflect any changes.	1.1	A new Joint Commissioning Committee will come into effect from 01/04/24. The Trust wants to wait and see what develops in this space rather than commit time to a document that could cease on the 31/03/24.	Apr-24	Not Yet Due				Open	
636	22/23	FPC	111 Commissioning Final Advisory Report	Not Rated	N/A	Rachel Marsh	N/A	1.2	A copy of the previous signed version of the National Collaboration Agreement should be retained in a central location and monitored to ensure roles and responsibilities are fulfilled.	1.2	The previously signed version will apply until the new version is agreed, so the Trust will seek to obtain and retain a copy until recommendation 1.1 is enacted.	Dec-23	Not Yet Due				Open	
637	22/23	FPC	111 Commissioning Final Advisory Report	Not Rated	N/A	Rachel Marsh	N/A	1.3	The Trust should ensure that it has finalised versions of the terms of reference for forums and groups where it participates within the NHS 111 Wales governance structure.	1.3	The responsibility for up-to-date terms of references rests with 111 commissioners, but the Trust will collaborate with commissioners and seek to ensure all relevant terms of reference are updated. The Trust will feedback to commissioners on the National Urgent Primary Care (Out of Hours) Forum and the Joint Operational & Performance Group) but considers these outside of the formal commissioning arrangements.	Jan-24	Not Yet Due				Open	
638	22/23	FPC	111 Commissioning Final Advisory Report	Not Rated	N/A	Hugh Bennett	N/A	2.1	Management should ensure that all operational policies and procedures that relate to NHS 111 Wales service delivery, are updated as soon as possible.	2.1	The Clinical Safety Plan and the Fire Evacuation Procedure are currently being reviewed and the other documents are old versions. The reviews will be completed and the old versions of policies removed and replaced.	Feb-24	Not Yet Due				Open	
639	22/23	FPC	111 Commissioning Final Advisory Report	Not Rated	N/A	Hugh Bennett	N/A	2.2	Once approved, policies and procedures should be circulated to all staff.	2.2	Updated policies to be placed on Siren and accompanied by Siren communications and more direct staff briefings, where appropriate e.g. fire evacuation procedure.	Feb-24	Not Yet Due				Open	
640	22/23	FPC	111 Commissioning Final Advisory Report	Not Rated	N/A	Rachel Marsh	N/A	3.1	Develop a mechanism to enable post-implementation learning of benefits, lessons learnt and impact to service delivery to be completely captured.	3.1	Proceed with the planned "time out" for Executives who interface with the commissioning arrangements, 111 Senior Leadership Team and other Assistant Directors/Heads of Service who support the commissioning arrangements.	Feb-24	Not Yet Due				Open	
641	22/23	FPC	111 Commissioning Final Advisory Report	Not Rated	N/A	Chris Turley	N/A	4.1	Key outcomes from meetings that Trust employees attend on commissioning arrangements should be appropriately recorded and reported to ensure that there is appropriate oversight of key discussions held.	4.1	Action notes/minutes for the Finance Group are the responsibility of 111 commissioners. The Trust will discuss with 111 commissioners and seek a formal record of each meeting.		Not Yet Due				Open	
642	22/23	FPC	111 Commissioning Final Advisory Report	Not Rated	N/A	Rachel Marsh	N/A	4.2	Progress with delivering the commissioning framework should be reported within the Trust.	4.2	The Trust does report progress on the commissioning framework i.e. commissioning intentions, but recognises that internal reporting is more intermittent. Re-establish regular reporting of the commissioning intentions (every quarter) to the Trust's Strategic Transformation Programme Board.	Feb-24	Not Yet Due				Open	
643	22/23	FPC	111 Commissioning Final Advisory Report	Not Rated	N/A	Rachel Marsh	N/A	4.3	The Trust should obtain written confirmation of the escalation process to be followed within the current governance structure.	4.3	A letter will be collaboratively drafted and agreed between the 111 Board Chair and Trust CEO to formalise the informal escalation arrangements that do currently exist.	Jan-24	Not Yet Due				Open	
644	22/23	FPC	111 Commissioning Final Advisory Report	Not Rated	N/A	Rachel Marsh	N/A	5.1	The Trust's Corporate Risk Register should be amended to capture risks relating to the NHS 111 Wales commissioned arrangement or service delivery.	5.1	The Trust's Corporate Risk Register commissioning risks to be updated to reflect that 111 is now also a commissioned service.	Jan-24	Not Yet Due				Open	

Trust Ref. No.	Year/ Audit Plan	Committee assigned to	Report Title	Assurance Rating	Responsible Officer	Director	Priority Level	Rec. No.in Audit	Recommendation	Response No.in Audit	Management Response	Agreed Deadline in Report	Status - met or not met agreed deadline in report	1st revised date	2nd revised date	3rd revised date	Closure Status	Where a management action has not met the agreed or revised date, Director must inlcude here: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. **Please add most recent update first**
645	22/23	FPC	111 Commissioning Final Advisory Report	Not Rated	N/A	Rachel Marsh	N/A	5.2	The Gateway to Care Programme Board's risk register should be reviewed and updated to ensure that the risks documented remain current and there are appropriate mitigating controls in place.	5.2	Gateway to Care Programme Board's risk register to be reviewed and updated.	Jan-24	Not Yet Due				Open	

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

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

Trust Ref No	Audit Wales or HIW Report	Year	Committee Assigned to	Report Title	Responsible Officer	Director	Priority Level	Rec No in Audit	Recommendation	Response Ltrs. in Audit	Management Response	Agreed Deadline in Report	Status	1st revised date	2nd revised date	3rd revised date	Where a management action has not met the agreed or revised date, Director must inlcude here: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. **Please add most recent update first**	Closure Status
106	Audit Wales	22/23	QUEST	Review of Quality Governance Arrangments	Jonathan Turnbull-Ross/ Wendy Herbert/ Hugh Bennett	Liam Williams			R8 We found that the QuESt Committee is well served with quality information, but there are opportunities for improvement. The Trust should: develop a system to triangulate learning themes across its quality assurance reports. This should ensure clarity about what improvement actions have been taken as a result and how learning has been disseminated across the organisation. enhance Covid-19 reporting in the integrated quality and performance report by including information about the harm caused to patients by ongoing service pressures caused by the virus. (d) work with health bodies so that there are systems to determine the outcomes for patients who have received emergency ambulance services. This should particularly seek to understand the consequence and harm resulting from service failures such as long ambulance waits. develop patient outcome measures to support its existing quality measures.		d) The Trust will continue to share information and intelligence with partners that detail the consequences of system failures. Whilst particularly evident where experience or outcome is poor and results in complaint or adverse incident. The Trust will pursue patient outcome data through development of the ePCR over 2022/23.	Mar-23	Not Met	Dec-23	Mar-24		201223: Given the comment below Board Secretary suggests a 'check in' date of 31 March 2024. Audit Wales will be doing a further review at that time and may wish to reframe this recommendation. 11.12.23 Update from Duncan Robertson: The WAST and DHCW data-sharing agreement is with the ICO and Welsh Government as part of a consultation. This will provide the legal basis to share data. No completion date has been provided, therefore the December target date will not be met. It is completely outside of WAST's gift to propose a completion date The Putting Things Right Team are strengthening the Putting Things Right Quarterly Reports to include themes, patterns and trends. **REVISED DATE OF DECEMBER 2023** 21.11.23: Update 121023: Work Ongoing and will take a period to complete. Conversations continue with DHCW and the Ambulance Data Set (ADS) lead in England to define the ePCR definitions. Work is also continuing with DHCW to establish data sharing to enable joining up of patient records to report on outcome data. no timeline as yet and meeting with DHCW continue to clarify some of the definitions following discussions with the lead for the ADS in England. Trust Information Governance colleagues are working with DHCW for this. 26.09.23: Duty of Quality Implementation plan includes the four quadrants of quality management system as set out in the 'road map'. Quality & Performance Management Steering Group continue to monitor and review the development of 'always on' reporting in line with the requirements of the act. Additional metrics have been approved by Trust Board for inclusion in the MIQPR including PREMS/PROMS, Duty of Candour metrics. New HI post now appointed to support MIQPR move to Power BI dashboard. Proposed Revised date 31.12.23 rationale for extension is to allow BI Dashboard work to commence to allow analysts to identify how best to report 'Patient Reported Experience' measures that add value to decision making. Historic Update: We continue to work with Welsh Government colleagues and NHS Executive in the development of the 'all-Wales' Quality Management System, including how the QMS will 'join up' and detail the impact of ambulance performance on HBs/patient care. The Trust PECI Team have also continued to develop the Civiva patient experience software, alongside HBs, to enable analysis of patient experiences of services.	Open
106	Audit Wales	22/23	QUEST	Review of Quality Governance Arrangments	Jonathan Turnbull-Ross/ Wendy Herbert/ Hugh Bennett	Liam Williams			R8 We found that the QuESt Committee is well served with quality information, but there are opportunities for improvement. The Trust should: develop a system to triangulate learning themes across its quality assurance reports. This should ensure clarity about what improvement actions have been taken as a result and how learning has been disseminated across the organisation. enhance Covid-19 reporting in the integrated quality and performance report by including information about the harm caused to patients by ongoing service pressures caused by the virus. work with health bodies so that there are systems to determine the outcomes for patients who have received emergency ambulance services. This should particularly seek to understand the consequence and harm resulting from service failures such as long ambulance waits. develop patient outcome measures to support its existing quality measures.		e) The Trust is often limited by data accessibility where the patient journey extends beyond the organisational boundary. The Trust will pursue patient outcome data through development of the ePCR over 2022/23, which will enable 'joining up' of patient records. Furthermore, the Trust will further consider accessibility and governance matters for wider adoption of Patient Reported Outcome Measures, and Patient Reported Experience Measures.	Mar-23	Not Met	Mar-24			201223: Given the comment below Board Secretary suggests a 'check in' date of 31 March 2024. Audit Wales will be doing a further review at that time and may wish to reframe this recommendation. Update: 11.12.23 DEVELOPMENT OF EPCR: Update will be provided by Duncan Robertson via update of item d) PATIENT REPORTED OUTCOME MEASURES: The Trust has defined standardised data to measure. Minimum dataset of approximately 600 definitions to agree with DHCW. Currently linking with England to assess available datasets and definitions. Data sharing agreements currently sit with DHCW and Welsh Government for approval. Instruction letters shared and awaiting response. (Leanne Hawker liaising with Alex Crawford on completion date) PATIENT REPORTED EXPERIENCE MEASURES: Data survey and narrative for generalised PREMs has been standardised and feeds into the MIQPR. A bespoke PREM is being developed in relation to Pain Management and Learning Disability (should be completed by end January 2024) REVISED DATE OF MARCH 2024 Update 121023: PREMS live, but in development. PLICS is due to come on stream in Mar-24. PROMS is in development and dependent on DCHW. Business Care Process and Project Management Pathway are relevant considerations.	Open
119	Audit Wales	22/23	PCC	Structured Assessment 2022	Angela Lewis	Angela Lewis			R5 While the Trust has introduced a programme of services to support staff wellbeing, it is not currently undertaking sufficient evaluation and review to ensure these are meeting the needs of staff. The Trust should introduce a regular process to evaluate its staff wellbeing services, such as via pulse surveys or participant questionnaires. This evaluation should inform long-term investment decisions for such services.		• Follow up surveys will be carried out to identify utilisation of wellbeing services, gaps and impact on a twice-yearly basis.	Jun 23 Dec 23	Met				Noted on Structured Assessment 2023 that this is complete: The Trust worked with Swansea University to conduct a wellbeing survey and a report of the survey results was shared with the Trust's Executive Management Team in February 2023. The report contained insight into the wellbeing services offered by the Trust as well as suggested areas for further focus	Closed in Quarter
120	HIW	20/21	FPC	EMSCCC Patient Safety Review	Lee Brooks	Lee Brooks			21.1 Complete the North Wales EMS CCC estate strategy and identify opportunities for improvement		See note in column T		Not Met	Apr-24			**PROPOSED CHECK POINT OF APRIL 2024** Note - the entire EMSCCC review actions have not been transferred to the tracker, only the two identified in the 3/8/23 EMT paper. QUEST updated 10 August 2023 Update 030823: The Bryntirion site for EMSC in the North has been allocated some discretionary capital fundig for this financial year (23/24) to support some progress in this area. It should be noted that WAST have completed and rolled out the estate's strategy in VPH with a view to progress plans with DPP for Llangunnor now to progress with the redevelopment of the ground floor. This is at design stage currently but funding has been allocated from this year's discretionary capital budget to support this) The project will likely span two years. In terms of the North Wales Estate (Bryntirion) initial work has started across departments to ensure that all elements of the work are mapped out and options are considered. The existing site requires remedial work which is considered poor investment given the site is not WAST owned. There is a technological development (Airwave replacement) required that enables a full move out of Bryntirion; early indication from the Ambulance Radio Programme (ARP) is that the roll-out of this technology is likely to be Q1 2024. A capital budget (discretionary) has been identified and allocated.	Open
121	HIW	21/22	FPC	EMSCCC Patient Safety Review	Liam Williams	Lee Brooks			12.1 Continue with the work of the CAD Phase 3 project to realign workloads within the EMSCCC for more efficient operation		See note in column T		Not Met	Jan-24			**PROPOSED CHECK POINT OF JANUARY 2024** Note - the entire EMSCCC review actions have not been transferred to the tracker, only the two identified in the 3/8/23 EMT paper. QUEST updated 10 August 2023 Update 030823: The EMS Configuration Programme recommended in Q1 2023 following being paused due to Industrial Action and Operational Pressures. Roster Reviewv of call takers is complete. The realignment of boundaries aspects of this work, which provides the necessary re-alignment of workloads has commenced and engagement with staff had taken place prior to the pause. This work has re-commenced and is currently waiting on a refresh of the data to finalise discussions with staff and TU partners. The realignment of desks is currently being paused due to awaiting data. It is anticipated that this will be available in Q2 2023 and that this aspect of the project will be completed end of Q3, subject to management capacity.In addition, we continue to pursue the changes identified above that require a £750k investment however funding support for this is contingent on external investment which in the current economic climate is difficult to secure.	Open
122	Audit Wales	23/24	PCC	Review of Workforce Planning Arrangements	Hugh Bennett / Liz Rogers	Angela Lewis	Medium	1.1	Terms of Reference We found that the Terms of Reference for both the Integrated Technical Planning Group and the Forecasting and Modelling Group require review. The Trust should review these to ensure they are accurate and up-to-date, particularly to clarify what role they will play in supporting the new People and Culture Plan and developing strategic workforce plan (medium priority).	1.1	Chair and Vice Chair of the ITPG and Forecasting and Modelling Group will update the Terms of Reference within the context of the internal governance structures	Dec-23	Not Met	Feb-24			201223: The ToR for both the ITPG and F&M have been reviewed and are going through the governance approvals route. The ITPG will be revised by the group this week for endorsement and the F&M in January, so the due date has been revised to February 2024 to allow for these approvals to be received. ToR have been reviewed and agreed by the Intergrated Technical Planning Group	Open

Tracker Ref No	Audit Wales or HIW Report	Year	Committee Assigned to	Report Title	Responsible Officer	Director	Priority Level	Rec. No in Audit	Recommendation	Response no. in Audit	Management Response	Agreed Deadline in Report	Status	1st revised date	2nd revised date	3rd revised date	Where a management action has not met the agreed or revised date, Director must inlcude here: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. **Please add most recent update first**	Closure Status
123	Audit Wales	23/24	PCC	Review of Workforce Planning Arrangements	Linda Phillips	Angela Lewis	Medium	2.1	Workforce information systems We found that there is scope for the Trust to make better use of its workforce information by ensuring data is consistent, joined up and up to date. The Trust should work to ensure that (medium priority):	2.1	Use of Power BI reporting feeding into the Integrated Technical Planning Group is in development by the workforce planning team. This will be used for reporting and maintenance of the data.	Sep-24	Not Yet Due					Open
124	Audit Wals	23/24	PCC	Review of Workforce Planning Arrangements	Hugh Bennett	Angela Lewis		2.1(a)	Workforce information systems We found that there is scope for the Trust to make better use of its workforce information by ensuring data is consistent, joined up and up to date. The Trust should work to ensure that (medium priority): • Systems that hold workforce information including Electronic Staff Record (ESR), Global Rostering System (GRS) and finance systems interconnect, where possible.	2.1(a)	Alongside this we are working on Integrated Planning Nexus via the Planning and Strategy team which enables our understanding of the interconnection between workforce, fleet, estate etc. *Excel version*	Mar-24	Not Yet Due					Open
125	Audit Wales	23/24	PCC	Review of Workforce Planning Arrangements		Angela Lewis		2.1(b)	Workforce information systems We found that there is scope for the Trust to make better use of its workforce information by ensuring data is consistent, joined up and up to date. The Trust should work to ensure that (medium priority): • Explore ways to resource the management of a system to ensure an up-to-date establishment model.	2.1(b)	Alongside this we are working on Integrated Planning Nexus via the Planning and Strategy team which enables our understanding of the interconnection between workforce, fleet, estate etc. *Potential PowerB1 version*	Sep-24	Not Yet Due					Open
126	Audit Wales	23/24	PCC	Review of Workforce Planning Arrangements	Dee Udeze-Chibuzor / Liz Rogers	Angela Lewis	Medium	3.1	Evaluating workforce planning training We found that the Trust is strengthening workforce planning capability through training initiatives, but it will need to evaluate these to ensure they are having the desired impact. The Trust should develop an evaluation framework to measure the success of its training programme (medium priority).	3.1	We will implement an evaluation process to baseline where managers are pre and post training and post 3 months to measure improvement.	Jun-24	Not Yet Due					Open
127	Audit Wales	23/24	PCC	Review of Workforce Planning Arrangements	Dee Udeze-Chibuzor / Liz Rogers	Angela Lewis	Medium	4.1	Recruitment support We found that only the emergency ambulance services department has dedicated support from the central management team for recruitment activity, due to capacity issues. While the central team can provide support on a case-by-case basis, the Trust should review opportunities to increase the corporate support offered to other departments across the organisation (medium priority).	4.1	The recruitment team focus primarily on EMS but do offer support where needed to other services. This would need to be agreed by ELT and the Directorates as resource would need to be moved into the team from elsewhere. Report to be produced and shared with ELT.	May-24	Not Yet Due					Open
128	Audit Wales	23/24	PCC	Review of Workforce Planning Arrangements	Dee Udeze-Chibuzor / Liz Rogers	Angela Lewis	Medium	5.1	Metrics for People and Culture plan monitoring The Trust has recently approved the metrics to enable monitoring progress of the People and Culture Plan, however the metrics do not include targets or milestones. The Trust should work to develop targets and milestones to enable the Committee to understand the progress against the Plan (medium priority).	5.1	Recommendation Accepted. We will build in appropriate targets and milestones into the plan which will be frequently reviewed for delivery and effectiveness of both the plan and the measures	May-24	Not Yet Due					Open
129	Audit Wales	23/24	PCC	Review of Workforce Planning Arrangements	Liz Rogers / Hugh Bennett	Angela Lewis	Medium	6.1	Benchmarking The Trust does not routinely benchmark its workforce performance metrics with other health bodies in Wales. Its performance benchmarking with other ambulance trusts is infrequent. The Trust should introduce regular workforce benchmarking with similar organisations and use this to inform relevant groups and committees on its performance and efficiency and to identify and share good practice (medium priority	6.1	Recommendation accepted for high level measures and will be based on what other organisations share / make available. Benchmarks need to be with ambulance sector rather than Health Boards	Jun-24	Not Yet Due					Open
130	HIW	23/24	Quest	National Review of Patient Flow – a journey through the stroke pathway	Lee Brooks			4	Welsh Government, health boards and WAST must work collaboratively, to consider whether the Immediate Release Directions are effective or need improvements, given the high number of declined Immediate Release Directions occurring across Wales.	4	It is imperative to acknowledge that Immediate Release Directions are required when there is no ambulance to send to the patient. The inability to respond in a timely way is the lost capacity due to extended emergency department handover delays that in recent months absorbs between 20% to 33% of WAST conveying resource capacity. There is an argument that relying on immediate release to respond to patients is too late, as capacity is needed to respond in a timely way without relying on this mechanism. The All-Wales Immediate Release Protocol is approved by the NHS Wales Chief Executive group and used by WAST when directing immediate release. Its next review is due in January. The existing script used by WAST when entering the direction to health boards includes the age and chief complaint for the patient. In a recent meeting, led by EASC representatives with health board colleagues, it was suggested that the reason for the release direction should not have to be justified by WAST, and this helps to decrease the length of the script. This would be achieved by removing the age and chief complaint for the patient. It is posited this reduces moral injury for ED staff receiving the direction (sought by health board representatives) who may then be unable to accommodate. Considering this position and if required, it would not be possible for WAST to differentiate stroke patients from others when submitting the direction to health boards and arguably inhibits clinical prioritisation. WAST continues to validate immediate release directions, including providing health boards with data outputs following this process. WAST has been audited on its application of the protocol and recommendations appear in the WAST audit tracker. At this stage, there is nothing more that WAST can do to progress this recommendation. Accommodating immediate release directions is a matter for health board partners whilst WAST continues with its strategy to resolve more episodes of care closer to home (as per IMTP).	N/A						

Tracker Ref No	Audit Wales or NTFW Report	Year	Secondary Assigned to	Report Title	Responsible Officer	Director	Priority Level	Rec. No in Audit	Recommendation	Respon. e no. in Audit	Management Response	Agreed Deadline in Report	Status	1st revised date	2nd revised date	3rd revised date	Where a management action has not met the agreed or revised date, Director must inlcude here: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. **Please add most recent update first**	Closure Status
131	HIW	23/24	Quest	National Review of Patient Flow – a journey through the stroke pathway	Liam Williams			12	Health boards and WAST should engage with people to better understand the barriers to them accessing, or choosing, from the range of healthcare services available in Wales. Once the barriers are understood, this in turn, could be used to influence service design.	12	The Welsh Ambulance Service's Patient Experience & Community Involvement Team (PECI) operate a model of continuous engagement with patients, carers, service users, organisations, including the Stroke Association and Age Alliance Wales, stakeholders and the general public across Wales,. Meeting, listening to, capturing and acting on people's experiences of using the Welsh Ambulance Service, including Emergency Medical Services, Non-Emergency Patient Transport Services and NHS 111 Wales. WAST consistently aspire to work in partnership to develop services which are safe and appropriate, and to improve people's experiences and outcomes. In 2023, the PECI Team also established a People & Community Network for the Welsh Ambulance Service. Aligned to our Quality Strategy 2021-2024 and informed by the Health and Social Care (Quality & Engagement) (Wales) Act 2020; the People & Community Network is a group of people with a shared goal: to help develop and improve the services provided by Welsh Ambulance Services NHS Trust. The Network represents the voices and opinions of patients, service users, carers, staff and wider stakeholders from across Wales, in respect of services we provide. The Network will also work with Llais, the Welsh Government's new citizen voice body, to understand people's views and experiences of health and social care, and to make sure feedback is used by decision-makers to shape services and support the continuous improvement of person-centered services. WAST has a long-term aspiration to enhance its service offer managing more patients in the community. In delivering this, we aim to ensure greater emergency ambulance availability by supporting patients through the most appropriate part of the system in their times of crisis.	12 months						
132	HIW	23/24	Quest	National Review of Patient Flow – a journey through the stroke pathway	Andy Swinburn			13.1	WAST must ensure that all relevant staff are fully aware of the WAST stroke pathway to minimise risks to patient safety.	13.1	It is noted that within the report 85% of the 44 staff involved in the survey undertaken by Health Inspectorate Wales (HIW) stated that they have received training to support and manage stroke patients. 77% of staff understood the stroke pathway however, only 49% of WAST respondents said that they always allocate or take a stroke patient to a specialist stroke unit. Considering the relatively low numbers of staff involved in this survey WAST will undertake its own clinical audit to ascertain as to widespread any short fall in adherence to the stroke pathway there may be. Paramedic and Emergency Medical Technician (EMT) education is underpinned by the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) Clinical Guidelines, these are available to all EMTs and Paramedics via an app on their individually issued I-Pads. These guidelines provided comprehensive guidance to Paramedics and EMTs on the pathophysiology, signs and symptoms, assessment and management of both stroke and TIA. Included in these guidelines is recognition that acute stroke is a 'time critical' condition and that patients should be conveyed to an appropriate stroke unit. WAST has for many years had in place a pathway for patients suffering an acute stroke, this includes a pre-alert which informs the receiving unit, preparing them to receive a possible stroke patient enabling the relevant stroke teams to be ready for their arrival. It is worth noting that the only hospital with an accident and emergency department where there is not a stroke unit is the Royal Glamorgan hospital. Clearly the WAST pathway for stroke does not include this hospital.	6 months						
133	HIW	23/24	Quest	National Review of Patient Flow – a journey through the stroke pathway	Andy Swinburn			13.2	WAST must ensure that all relevant staff are fully aware of the WAST stroke pathway to minimise risks to patient safety.	13.2	WAST is currently working with the stroke networks in Wales in relation to the upcoming reconfiguration of stroke services and the development of Hyper Acute Stroke Units (HASU), this will potentially result in a change to the existing stroke pathways that are in place. However, to ensure that the current stroke pathway is clearly understood by WAST staff, a clinical bulletin will be circulated updating staff on the current pathways that are in place across Wales relating to stroke, this will then be updated the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) app that is available to all Paramedics and EMTs via their personal issue I-Pads.'	1 month						
134	HIW	23/24	Quest	National Review of Patient Flow – a journey through the stroke pathway				14	Welsh Government should consider how it can support WAST to develop and implement improvements with its service delivery model, such as increasing the number of advanced paramedic practitioners across Wales, to help reduce the pressure on EDs and improve flow through healthcare systems.	14	While WAST recognises that this is not a recommendation for WAST, we wholly endorse this recommendation and remain ready to play our part in growing the number of APPs.							

Tracker Ref No	Audit Wales or IA/PM Report	Year	Committee Assigned to	Report Title	Responsible Officer	Director	Priority Level	Rec. No in Audit	Recommendation	Respon. e no. in Audit	Management Response	Agreed Deadline in Report	Status	1st revised date	2nd revised date	3rd revised date	Where a management action has not met the agreed or revised date, Director must inlcude here: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. **Please add most recent update first**	Closure Status
135	HIW	23/24	Quest	National Review of Patient Flow – a journey through the stroke pathway	Andy Swinburn			15	WAST should consider the benefits of training its paramedic staff in the use of the ROSIER stroke assessment tool, to enable staff to differentiate patients with stroke and stroke mimics, such as TIA.	15	WAST has previously considered the implementation of ROSIER, however the decision not to adopt was informed by a study undertaken by a large ambulance service in England that demonstrated that ROSIER was no better than the Face Arm Speech Test (FAST) in the prehospital setting. As stated above clinical practice is underpinned by JRCALC, these guidelines inform the attending EMT/Paramedic to the level of assessment that should be undertaken. JRCALC does not include ROSIER as part of the recommended assessment, it does however suggest that clinician may consider using the PASTA (Paramedic Acute Stroke Treatments Assessment) structured assessment and handover as per local agreement. To further inform the debate around prehospital stroke assessment, the HIW report will be presented to the WAST 'Ambulance Practice Steering Group' for consideration. As part of that consideration WAST will undertake an up-to-date literature review to ascertain to whether the previous study has been superseded. To further inform this point WAST will consult the Welsh Stroke Network for a expert view on the use of ROSSIER or indeed any other stroke tool for the pre hospital setting. In addition, within the above-mentioned clinical bulletin all EMTs and Paramedics will be reminded that if a patient remains FAST positive despite some evidence of improvement, stroke should be considered as the primary differential diagnosis, TIA should only be consider following a complete recovery, this latter point is highlighted within JRCALC Practice Guidelines. To support ongoing education to all future Paramedics, WAST will seek to work further in partnership with both universities in Wales who deliver pre-registration education in developing an up-to-date syllabus for stroke education, supported by senior stroke specialists from across Wales.	6 months						
136	HIW	23/24	Quest	National Review of Patient Flow – a journey through the stroke pathway	Liam Williams			17	WAST and all health boards must work collaboratively to identify a consistent approach to ensure handover of stroke patients is made within the Welsh Government 15-minute target. This is to ensure that time critical investigations and treatment are undertaken promptly.	17	WAST recognises that it has a responsibility to undertake an appropriate clinical assessment of patients presenting with stroke symptoms. Where stroke is considered a potential diagnosis a pre alert should be provided to the appropriate unit to inform stroke teams of the patients' imminent arrival enabling them to be prepared for a rapid handover of care for that patient. It is recognised that system pressures that exist has a direct impact on the 15-minute handover period. WAST continues to work with the health boards to minimise the impact upon service delivery to all its patients. It is worth noting that there does exist improvements across some health boards in Wales, while still accepting that there are further improvements required across all health board areas. WAST will seek to work with Executive Directors of Nursing in the development of a handover standardised pathway.	6 months						
137	HIW	23/24	Quest	National Review of Patient Flow – a journey through the stroke pathway	Andy Swinburn			27	Health boards and WAST must ensure that all staff associated with potential stroke patients are aware of the updated guidance for thrombolysis treatment window of between 4.5 and nine hours, as highlighted within the National Clinical Guideline for Stroke updated in April 2023.	27	WAST recognises that the 'National Clinical Guideline for Stroke (2023) recommends that patients suffering with an acute stroke may be treated with alteplase or tenecteplase if that treatment can be started within 9 hours of known onset, or within 9 hours of the midpoint of sleep when they have woken with symptoms. In recognising this WAST will work with stroke networks to coordinate the dissemination of this information to all staff involved in the management of patients suffering an acute stroke to ensure a consistent approach across the NHS in Wales. It should be recognised that extending the time window from a 4.5 to a 9-hour window has a potential resource implication for WAST. Following the clarity from the stroke network further engagement with our commissioners will take place if necessary.	6 months						
138	HIW	23/24	Quest	National Review of Patient Flow – a journey through the stroke pathway	Andy Swinburn			32(a)	WAST must consider its current response times for patients awaiting interhospital transfers for urgent thrombectomy treatment which are classified as 'Red'. This is to ensure a thrombectomy can be completed within the six-hour timescale from the onset of symptoms.	32(a)	WAST has been working with the stroke leads and the South Wales Major Trauma Network to implement a process that supports the interhospital process for patients referred for thrombectomy outside of Wales. Patients identified for thrombectomy have their transfer arranged through the trauma desk which is situated in a WAST contact centre. The trauma desk team are contacted directly to discuss the transfer requirements of the patient and ensure we have the correct level of clinical support during the transfer and that the transfer is correctly prioritised. Red prioritisation is the highest level of response in our clinical response model, other examples in this group are cardiac arrest, choking and catastrophic haemorrhage. Welsh Government has set ambulance response targets at 65% of all calls categorised as immediately life threatening (red) to receive an emergency response within eight minutes, these standards are reported monthly by Local Health Board.	Complete						
139	HIW	23/24	Quest	National Review of Patient Flow – a journey through the stroke pathway	Andy Swinburn			32(b)	WAST must consider its current response times for patients awaiting interhospital transfers for urgent thrombectomy treatment which are classified as 'Red'. This is to ensure a thrombectomy can be completed within the six-hour timescale from the onset of symptoms.	32(b)	WAST will review this process in due course and ascertain its success and determine if any further actions are required	6 months						
140	HIW	22/23	FPC	NHS Trust Charity Audit of Accounts Report			High	1	**Allocation of funds between restricted and unrestricted.** The Charity has not retained supporting documents and records in respect of the 2015-16 financial year. Consequently, we have been unable to obtain sufficient appropriate audit evidence that the Charity's income for that year was correctly allocated between restricted and unrestricted income funds. Consequently, we cannot conclude that the opening balances of the Charity's income funds in this year's financial statements are not materially misstated. The value of the income in 2015-16 over which we are unable to obtain assurance is £28,000.	1	(a) The Charity should seek to obtain the missing supporting documents and records for 2015-16; and (b) ensure supporting documentation and records are retained for future financial years in accordance with the Charity's data retention policy.	Mar-23						Open

Tiaa Ref No	Audit Wales or IA/PW Report	Year	Committee Assigned to	Report Title	Responsible Officer	Director	Priority Level	Rec. No in Audit	Recommendation	Report e.no. in Audit	Management Response	Agreed Deadline in Report	Status	1st revised date	2nd revised date	3rd revised date	Where a management action has not met the agreed or revised date, Director must inlcude here: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. **Please add most recent update first**	Closure Status
141	HIW	22/24	FPC	NHS Trust Charity Audit of Accounts Report			Medium	2	**Bursary Creditors.** The draft financial statements included £11,000 of Other Creditors, which was wholly in respect of the Bursary Scheme. Review of the balances identified that £8,000 related to periods up to and including the 2018-19 financial year. Testing of a sample of creditors identified balances totalling £2,750 that were no longer required. These have now been removed from the accounts, as detailed in Appendix 3. Discussions with the Charity confirmed there is currently no process to regularly review the balances to determine whether they are still required.	2	Review all bursary creditors on an annual basis to determine whether the creditors are still valid, and if not, remove these from the financial statements.	Mar-23						Open
142	HIW	22/25	FPC	NHS Trust Charity Audit of Accounts Report			Medium	3	**Harlequin system access controls** Review of the access controls for the Charity's Harlequin financial system identified that there is no minimum password complexity requirement for users.	3	Introduce password complexity requirements for users in line with industry best practice.	Mar-23						Open
143	HIW	22/26	FPC	NHS Trust Charity Audit of Accounts Report			Medium	4	**Harlequin system user accounts** Review of live users on the Harlequin financial system at the time of audit identified a member of staff who left the employment of the Trust a number of years ago. The former employees should have been removed from the system when they left the employment of the Trust.	4	Remove the user from the Harlequin financial system and introduce a regular documented review of system users and their rights of access to ensure they remain appropriate.	Mar-23						Open

QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE
HIGHLIGHT REPORT TO AUDIT COMMITTEE

This report provides the Audit Committee with key escalation and discussion point at the last Committee meeting.

Audit Committee Meeting Date	01 March 2024
Committee Meeting Date	08 February 2024
Chair	Bethan Evans

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of escalation)

1. No alerts for the Audit Committee.

ADVISE

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

2. No areas to advise for the Audit Committee.

ASSURE

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

3. This Committee's terms of reference at paragraph 3.16 provides that it will:
   *Approve the annual clinical audit plan that meets the standards set for the NHS in Wales; review the outcomes of **clinical audits** in line with the clinical audit plan and provide assurance to the Audit Committee in this respect.*
4. The Trust's annual **Clinical Audit Plan**, which allows the planning and prioritisation of clinical audits across the financial year, was **approved for 2024/25** at this meeting. Further audit topics will be considered for inclusion as new guidelines and medicines are introduced and changes to clinical practice are implemented. As such, it is not always possible to predict all the topics that require evaluation and therefore this is a dynamic document which will be updated quarterly. The Committee will monitor the plan and outcomes on a quarterly basis.

RISKS

N/A

AGENDA ITEM No	**12**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**1**

LOSSES AND SPECIAL PAYMENTS - PAYMENTS FOR THE PERIOD FROM 1ST APRIL 2023 TO 31st JANUARY 2024

MEETING	**Audit Committee**
DATE	**1st March 2024**
EXECUTIVE	**Executive Director of Finance and Corporate Resources**
AUTHOR	**Olaide Kazeem – Financial Services Project Accountant**
CONTACT	**Chris Turley Chris.Turley2@wales.nhs.uk**

EXECUTIVE SUMMARY

In accordance with SFI's this report presents to the Committee full details of Losses and Special Payments made between the months of April 2023 and January 2024 (**Annex 1**)

KEY ISSUES/IMPLICATIONS

Total net Losses and Special Payments made were as follows: -

- period 1st April 2023 to 31st January 2024 – £522.94k – Net payments

REPORT APPROVAL ROUTE

Audit Committee 1st March 2024 – no action required for information under SFI's only.

REPORT APPENDICES

Annex 1 – Summary and details of payments made for the ten months to 31st January 2024

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

WELSH AMBULANCE SERVICES NHS TRUST
AUDIT COMMITTEE
LOSSES AND SPECIAL PAYMENTS - PAYMENTS FOR THE PERIOD FROM 1st APRIL 2023 TO 31st JANUARY 2024

SITUATION

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

BACKGROUND

2. This report presents to the Committee a summary and full details of all Losses and Special Payments made during the ten months from 1st April 2023 to 31st January 2024 (**Annex 1**)

ASSESSMENT

3. Total net Losses and Special Payments made during the period 1st April 2023 to 31st January 2024 amounted to £ 522.94k of net payments.

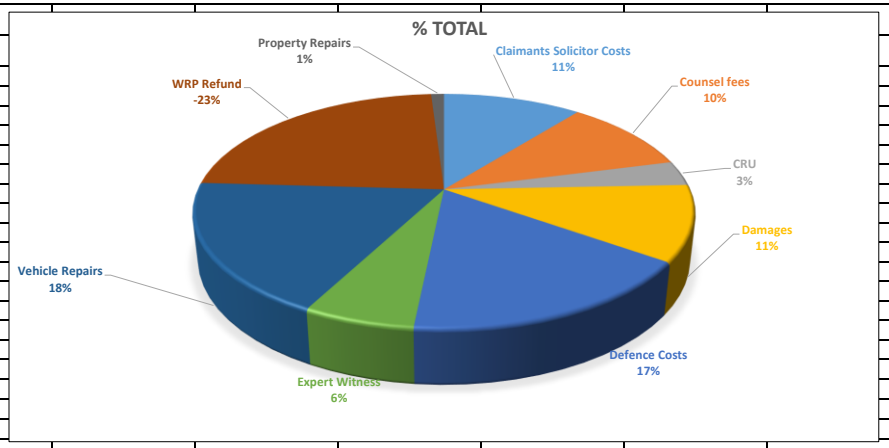
4. This relates to actual payments made less reimbursements received from the Welsh Risk Pool and does not relate to any adjustments made to the provision. During the ten months to 31st January 2024 payments made exceeded the reimbursements received by £522.94k.

RECOMMENDED: That the Losses and Special Payments Report for this period is noted.

Welsh Ambulance Services NHS Trust

Losses and Special Payments

Annex 1



Summary of payments for the 10 months to 31st January 2024:

	£
April 2023	- 69,261.75
May 2023	28,671.21
June 2023	1,571.34
July 2023	16,364.51
August 2023	89,145.51
September 2023	168,540.51
October 2023	- 5,493.69
November 2023	95,516.86
December 2023	101,123.75
January 2024	96,764.30
February 2024	-
March 2024	-
	£522,942.55

Losses and Special Payments Breakdown:

Payment Type	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
	£	£	£	£	£	£	£	£	£	£	£	£	£
Claimants Solicitor Costs	9,371.50	5,000.00	5,266.00	0.00	10,754.40	117,000.00	-48,212.72	9,861.00	-14,527.48	9,382.00	0.00	0.00	£103,894.70
Counsel fees	8,912.79	2,123.91	9,387.22	1,250.00	12,505.84	22,538.33	13,687.50	19,182.66		9,870.00	0.00	0.00	£99,458.25
CRU	0.00	0.00	688.00	0.00	0.00	744.00	688.00	5,702.00	24,705.00	743.00	0.00	0.00	£33,270.00
Damages	8,448.00	14,200.45	3,550.00	0.00	36,119.97	8,414.00	2,100.00	9,646.65	14,800.00	4,000.00	0.00	0.00	£101,279.07
Defence Costs	3,713.72	521.58	1,501.84	212.38	854.55	7,878.83	2,905.55	6,946.30	134,006.96	4,765.67	0.00	0.00	£163,307.38
Expert Witness	4,680.00	2,319.00	6,581.50	4,000.00	11,772.26	5,636.67	2,477.61	9,330.00	0.00	12,551.19	0.00	0.00	£59,348.23
Vehicle Repairs	3,520.77	4,506.27	16,058.18	10,848.43	5,256.61	6,012.68	22,561.37	33,165.45	21,105.97	53,802.44	0.00	0.00	£176,838.17
WRP Refund	-107,908.53	0.00	-41,461.40	0.00	9,066.88	0.00	-4,000.00	0.00	-79,815.20	0.00	0.00	0.00	-£224,118.25
Property Repairs	0.00	0.00	0.00	53.70	2,815.00	316.00	2,299.00	1,682.80	848.50	1,650.00	0.00	0.00	£9,665.00
Court Refund	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	£0.00
Total	**-£69,261.75**	**£28,671.21**	**£1,571.34**	**£16,364.51**	**£89,145.51**	**£168,540.51**	**-£5,493.69**	**£95,516.86**	**£101,123.75**	**£96,764.30**	**£0.00**	**£0.00**	**£522,942.55**

Welsh Ambulance Services NHS Trust	Key	
Losses and Special Payments	MN	Medical Negligence
	PI	Personal Injury
Summary of payments for the ten months to 31st January 2024:	DP	Damage To Property
	£	
PI cases < £1,000	4,607.72	11 CASES
DP cases < £1,000	18,844.87	54 CASES
23RT4MN0014	5.74	
24RT4MN0001	25.83	
20RT4MN0008	410.00	
22RT4MN0012	452.50	
24RT4MN0007	812.96	
21RT4MN0009	977.50	
23RT4GN0037	1,000.00	
24RT4GN0009	1,000.00	
24RT4EG0014	1,000.00	
LRS050	1,103.96	
24RT4DP0037	1,105.00	
24RT4DP0007	1,113.10	
18RT4MN0016	1,137.50	
22RT4GN0034	1,159.87	
23RT4MN0004	1,200.00	
21RT4PI0006	1,200.00	
24RT4DP0008	1,215.00	
24RT4EG0005	1,250.00	
24RT4EG0015	1,250.00	
24RT4EG0016	1,250.00	
316	1,250.00	
24RT4DP0032	1,275.00	
24RT4DP0020	1,285.00	
22RT4MN0018	1,300.00	
24RT4DP0019	1,310.00	
24RT4DP0006	1,320.00	
24RT4DP0001	1,322.35	
24RT4DP0041	1,332.62	
24RT4DP0035	1,404.00	
22RT4MN0013	1,430.00	
8269	1,500.00	
24RT4DP0016	1,530.00	
24RT4DP0009	1,573.39	
22RT4DP0013	1,579.05	
24RT4DP0023	1,592.90	
22RT4GN0031	1,600.00	
22RT4DP0085	1,632.84	
23RT4EG0019	1,650.00	
22RT4GN0040	1,650.00	
LRS023	1,650.00	
32	1,682.80	
24RT4DP0034	1,719.76	
91	1,733.02	
23RT4DP0069	1,768.50	
18RT4MN0012	1,775.00	
24RT4DP0003	1,784.17	
102	1,796.00	
24RT4EG0017	1,800.00	
016	1,859.79	
24RT4GN0008	1,900.00	
24RT4DP0015	1,919.29	
8971	1,992.32	
8701	1,998.20	
22RT4PI0026	2,000.00	
002	2,019.10	
8574	2,025.01	
075	2,062.14	
20RT4PI0037	2,125.00	
21RT4PI0023	2,213.20	
111	2,295.00	
22RT4MN0010	2,365.41	
23RT4DP0003	2,389.26	
23RT4PI0035	2,400.00	
21RT4GN0011	2,448.00	
22RT4MN0016	2,450.00	
24RT4EG0018	2,475.00	
24RT4DP0026	2,491.60	
24RT4EG0007	2,500.00	
24RT4DP0036	2,513.09	
24RT4DP0013	2,513.69	
24RT4DP0017	2,545.65	
24RT4DP0010	2,555.88	
24RT4PI0001	2,587.95	
23RT4MN0003	2,608.00	
8908	2,642.50	
21RT4DP0048	2,872.40	
24RT4DP0027	2,956.83	
24RT4DP0043	2,964.80	
0139-8699	2,970.20	
25RT4EG0009	3,000.00	
22RT4DP0094	3,013.14	
24RT4DP0044	3,107.33	
24RT4DP0028	3,109.05	
23RT4MN0011	3,180.00	
24RT4DP0012	3,234.28	
22RT4MN0011	3,234.40	
23RT4DP0079	3,369.46	
24RT4DP0029	3,383.48	
8075	3,409.99	
LRS103	3,500.00	
23RT4EG0017	3,575.00	
0350-8609	3,608.38	
24RT4DP0039	3,647.57	
8227	3,791.63	
LRS067	4,063.16	
23RT4EG0001	4,100.00	
23RT4PI0013	4,101.00	
LRS 057	4,221.48	
8302	4,346.60	
22RT4PI0017	4,766.00	
22RT4MN0002	4,808.44	
23RT4PI0022	5,000.00	
23RT4GN0036	5,000.00	
20RT4PI0025	5,155.50	
23RT4EG0018	5,175.29	
8803	5,346.00	
20RT4MN0018	5,470.00	
22RT4PI0019	6,098.00	
22RT4MN0003	6,175.00	
23RT4DP0057	6,204.45	
23RT4MN0012	6,422.75	
8512	6,450.42	
23RT4PI0004	6,610.00	
313	6,845.99	
23RT4DP0032	8,576.15	
23RT4PI0003	8,616.00	
22RT4PI0035	9,107.00	
24RT4GN0004	9,400.00	
23RT4PI0024	9,611.00	
19RT4PI0037	9,625.84	
22RT4PI0011	9,646.65	
22RT4PI0023	10,312.00	
8962	10,448.00	
20RT4MN0011	10,509.68	
19RT4MN0008	12,565.73	
23RT4DP0030	15,079.18	
20RT4MN0019	19,750.00	
21RT4GN0023	21,802.00	
21RT4PI0035	26,550.00	
16RT4MN0009	30,000.00	
20RT4PI0008	30,500.00	
22RT4PI0039	34,061.37	
21RT4MN0011	39,042.50	
22RT4MN0001	98,326.65	
20RT4PI0025	11,316.88	WRP Refund
23RT4GN0010	-200.00	WRP Refund
21RT4PI0034	-249.82	WRP refund
22RT4GN0021	-250.00	WRP Refund
22RT4GN0019	-300.00	WRP Refund
22RT4GN0027	-400.00	WRP Refund
22RT4GN0020	-500.00	WRP Refund
22RT4GN0015	-600.00	WRP Refund
23RT4GN0025	-1,000.00	WRP Refund
22RT4GN0033	-1,500.00	WRP Refund
23RT4GN0016	-1,500.00	WRP Refund
23RT4GN0032	-2,300.00	WRP Refund
19RT4PI0028	-5,955.00	WRP refund
21RT4PI0035	-23,868.20	WRP refund
21RT4PI0001	-32,956.58	WRP refund
21RT4PI0017	-47,967.00	WRP refund
19RT4PI0008	-107,908.53	WRP refund
Total	**522,942.55**	

Nov-23

Case Reference	Details	Amount (£)
21RT4PI0023	Counsel Fees	125.00
19RT4MN0008	Expert Witness	1,300.00
19RT4MN0008	Expert Witness	5,600.00
20RT4MN0011	Defence Costs	1,875.00
22RT4MN0001	Expert Report	1,500.00
22RT4MN0001	Counsel Fees	525.00
22RT4MN0001	Expert Report	180.00
22RT4MN0011	Defence Costs	250.00
23RT4MN0011	Counsel Fees	786.67
24RT4MN0007	Expert Witness	750.00
896	Vehicle Repairs	150.00
8890	Vehicle Repairs	256.05
042	Vehicle Repairs	288.00
382	Counsel Fees	300.00
5972	Vehicle Repairs	399.51
372	Counsel Fees	850.00
8302	Defence Costs	1,033.88
313	Counsel Fees	1,146.00
316	Counsel Fees	1,250.00
32	Property Repairs	1,682.80
91	Vehicle Repairs	1,733.02
23RT4DP0079	Vehicle Repairs	1,741.52
102	Vehicle Repairs	1,796.00
016	Vehicle Repairs	1,859.79
002	Vehicle Repairs	2,019.10
8574	Vehicle Repairs	2,025.01
075	Vehicle Repairs	2,062.14
313	Counsel Fees	2,083.33
111	Vehicle Repairs	2,295.00
21RT4DP0048	Vehicle Repairs	2,371.90
8302	Defence Costs	3,312.72
313	Counsel Fees	3,616.66
23RT4DP0057	Vehicle Repairs	6,204.45
24RT4GN0004	Counsel Fees	8,500.00
LRS050	Vehicle Repairs	1,103.96
24RT4DP0025	Vehicle Repairs	6,860.00
7961	Vehicle Repairs	- 2,456.63
7961	Vehicle Repairs	2,456.63
22RT4DP0013	Defence Costs	474.70
22RT4PI0011	Damages	9,646.65
23RT4PI0024	Claimants Solicitor Costs	9,611.00
23RT4MN0003	Claimants Solicitor Costs	250.00
21RT4GN0023	CRU	5,702.00
Totals		**95,516.86**

Dec-23

Case Reference	Details	Amount (£)
22RT4PI0026	Damages	2,000.00
22RT4PI0039	CRU	24,705.00
20RT4MN0019	Claimants Solicitor Costs	16,900.00
22RT4MN0001	Defence 1osts	134,006.96
8971	Vehicle Repairs	1,992.32
8075	Vehicle Repairs	1,453.10
8075	Vehicle Repairs	1,956.89
LRS 057	Vehicle Repairs	4,221.48
8908	Vehicle Repairs	2,642.50
23RT4PI0022	Claimants Solicitor Costs	5,000.00
21RT4GN0023	Damages	12,500.00
24RT4GN0008	Damages	300.00
24RT4GN0008	Claimants Solicitor Costs	1,600.00
8867	Property Repairs	848.50
21RT4PI0035	Wrp Refund	- 23,868.20
21RT4PI0017	Wrp Refund	- 55,947.00
8512	Vehicle Repairs	6,450.42
23RT4DP0003	Vehicle Repairs	2,389.26
8366	Vehicle Repairs	- 777.65
8366	Vehicle Repairs	777.65
16RT4MN0009	Claimants Solicitor Costs	30,000.00
22RT4MN0001	Claimants Solicitor Costs	- 68,027.48
Totals		**101,123.75**

Jan-24

Case Reference	Details	Amount (£)
19RT4PI0037	Counsel Fees	1,500.00
19RT4PI0037	Counsel Fees	250.00
20RT4PI0037	Court Fees	261.40
22RT4PI0019	Counsel Fees	350.00
22RT4PI0039	Expert Witness	100.00
23RT4PI0001	Defence Costs	170.50
18RT4MN0012	Counsel Fees	787.50
18RT4MN0012	Expert Witness	987.50
19RT4MN0008	Counsel Fees	200.00
19RT4MN0008	Counsel Fees	350.00
20RT4MN0018	Counsel Fees	1,375.00
20RT4MN0018	Expert Witness	1,500.00
20RT4MN0019	Defence 1osts	2,850.00
21RT4MN0009	Counsel Fees	787.50
22RT4MN0001	Expert Witness	231.23
22RT4MN0001	Expert Witness	330.05
22RT4MN0001	Expert Witness	368.92
22RT4MN0001	Expert Witness	990.00
22RT4MN0001	Expert Witness	450.00
22RT4MN0001	Expert Witness	2,222.66
22RT4MN0001	Expert Witness	1,233.33
22RT4MN0002	Expert Witness	1,687.50
22RT4MN0002	Counsel Fees	2,250.00
22RT4MN0016	Expert Witness	2,450.00
23RT4MN0011	Counsel Fees	520.00
LRS067	Vehicle Repairs	4,063.16
LRS063	Vehicle Repairs	450.00
23RT4DP0030	Vehicle Repairs	15,079.18
8596	Vehicle Repairs	801.00
8269	Counsel Fees	1,500.00
LRS023	Property Repairs	1,650.00
LRS103	Vehicle Repairs	3,500.00
8803	Vehicle Repairs	4,646.00
8227	Vehicle Repairs	3,791.63
191	Defence Costs	51.66
8701	Vehicle Repairs	613.20
8701	Vehicle Repairs	1,385.00
8962	Vehicle Repairs	3,807.18
8962	Vehicle Repairs	6,640.82
0350-8609	Vehicle Repairs	3,608.38
0139-8699	Vehicle Repairs	2,970.20
23RT4DP0069	Vehicle Repairs	1,724.69
8803	Vehicle Repairs	700.00
21RT4DP0048	Vehicle Repairs	22.00
22RT4DP0013	Defence costs	484.80
22RT4PI0019	Claimants Solicitor Costs	5,748.00
22RT4PI0035	CRU	743.00
23RT4PI0004	Damages	4,000.00
23RT4PI0004	Claimants Solicitor Costs	2,610.00
22RT4MN0001	Claimants Solicitor Costs	1,024.00
23RT4GN0027	Defence Costs	37.31
23RT4GN0028	defence costs	910.00
Totals		**96,764.30**

AGENDA ITEM No	**13.1**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**0**

TRUST POLICY REPORT

MEETING	Audit Committee
DATE	01 March 2024
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Julie Boalch, Head of Risk/Deputy Board Secretary
CONTACT	Julie.Boalch@wales.nhs.uk

EXECUTIVE SUMMARY

1. The purpose of the report is to provide an update to the Committee on the status of the Trust's policy work programme to bring key policies up to date.

2. As reported at the July 2023 meeting of the Audit Committee, the number of Policies within their review date fell below reasonable levels during the Covid-19 pandemic as the policy work plan was largely paused and efforts directed to support the response. This meant that most policies had passed their review date; however, it is important to note that these remain our extant policies, they are in use and have not expired. There will be several policies that will only require minor changes during the review process as they have already been through robust governance.

3. A priority work programme was established for 2023/24 and a further work plan agreed for 2024/25.

4. A detailed report on the progress of the work plans and the status of all policies was provided to Committee in September and November 2023 and regular updates provided to the Executive Leadership Team (ELT) following each Policy Group meeting via the Alert, Advice, Assure (AAA) reports.

5. At the last Committee meeting in November 2023, it was agreed that the Corporate Governance Team would report by exception only.

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

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

8. As a result of the work undertaken to date, 33% of Trust owned policies will be within their review date after the next round of approvals compared to 14% overall reported to Committee in July 2023. This figure does not include those policies developed by NHS Wales or the NHS Employers Unit which are adopted by the Trust.

9. The Trust's Policy for Policies is undergoing a 'light touch' review and will be presented to the ELT for endorsement in early 2024 and submitted to Audit Committee and Trust Board in April and May 2024 respectively for approval.

10. Further, the Trust's policy governance process is being refreshed in partnership with Trade Union colleagues which will include the process for other written control documents such as Standard Operating Procedures, Frameworks, Guidelines and Procedures to ensure good governance is maintained. Proposals will be drawn up as part of a Policy Improvement Programme which will begin in the latter half of 2024/25 and into 2025/26.

RECOMMENDATION: Members are asked to note the update and next steps.

KEY ISSUES/IMPLICATIONS
11. The key issues are set out in the Executive Summary above.
REPORT APPROVAL ROUTE
12. Progress against the work plans was reported to ELT via the monthly, Policy Group AAA following each Policy Group meeting.

REPORT ANNEXES
N/A

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

AGENDA ITEM No	**13.2**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**1**

COUNTER FRAUD, BRIBERY AND CORRUPTION POLICY

MEETING	Audit Committee
DATE	01 March 2024
EXECUTIVE	Finance & Corporate Resources
AUTHOR	Carl Window
CONTACT	Carl.window2@wales.nhs.uk 01792 562947

EXECUTIVE SUMMARY

1. The Local Counter Fraud Service is responsible within WAST for the delivery of all work areas connected to Fraud, Bribery and Corruption, with an overarching objective to secure a robust anti-fraud culture within the service. The service has a responsibility to educate and support all departments, alongside investigating and applying both criminal and civil sanctions for any aspects of Fraud, Bribery and Corruption identified within the service. The Local Counter Fraud Specialists (LCFS) employed within WAST work in compliance to Welsh Government directions, with reference to the Government Functional Standard GovS 013: Counter fraud.

2. As a requirement of these standards, and to ensure engagement and assurance around Counter Fraud activities, this overarching policy, in conjunction with the annual report and work plan, is produced to highlight the work completed in tacking Fraud, Bribery and Corruption within the Trust, and the controls and arrangements in place to manage such activities effectively.

3. This policy provides a framework for responding to suspicions of fraud, providing advice and information on various aspects of fraud and implications of an investigation. This policy has no significant changes since the last review, other than to replace old references and make use of the new WAST policy template. The aims of the policy continue to;

    - Improve the knowledge and understanding of all employees, irrespective of their position, about the risk of fraud, bribery and corruption within the organisation and its unacceptability.

- Assist in promoting an anti-fraud climate with a culture and environment of staff confidence to raise concerns sensibly and responsibly, with clear direction as to the progress of such raised concerns.

- Ensure the appropriate sanctions are considered following an investigation, which may include any or all of the following: criminal prosecution, civil prosecution, or internal/external disciplinary action, and where required, referral to professional bodies.

- Provide clear strategic control and assurance in the delivery of a robust counter fraud service, with easily identified links of contact for support and reporting within.

RECOMMENDED: That

(1) the policy is noted as having only minor changes that relate to references and use of a new policy template. There is no significant change to any processes or functions that need consideration in amendment of the policy; and

(2) the Committee approves the Counter Fraud, Bribery and Corruption Policy is for continual acceptance as the overarching policy for Counter Fraud Activities within WAST.

KEY ISSUES/IMPLICATIONS

4. The Policy has not undergone any significant strategic or process change, and the review process has simply resulted in the use of the WAST policy template, alongside removal of historical references to agencies which no longer exists, or where they have merged into another identity.

REPORT APPROVAL ROUTE		
Audit Committee	**1st March 2024**	**For Information and endorsement**
REPORT PURPOSE	**Continued approval of Counter Fraud, Bribery and Corruption policy – reviewed and updated template**	

REPORT APPENDICES
COUNTER FRAUD, BRIBERY AND CORRUPTION POLICY

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)	Y	Financial Implications	Y
Environmental/Sustainability	Y	Legal Implications	Y
Estate	Y	Patient Safety/Safeguarding	Y
Ethical Matters	Y	Risks (Inc. Reputational)	Y
Health Improvement	Y	Socio Economic Duty	Y
Health and Safety	Y	TU Partner Consultation	Y

Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services
NHS Trust

Counter Fraud, Bribery & Corruption Policy

Policy Number:	025	**Version No:**	V3	**Supersedes:**	V2
Date of Approval:	08/01/2024	**Review Date:**	08/01/2027	**Impact Assessments Completed:**	Yes
Classification of Document:	Corporate	**Type of Document:**	Policy	**Approved by:**	Policy Group
Brief Summary of Document:	WAST is committed to reducing the level of fraud and corruption within the NHS to an absolute minimum and keeping it at that level, freeing up resources for better patient care. This policy has been produced by the Local Counter Fraud Specialists (LCFS) as a guide for all employees on anti-fraud, bribery, and corruption work.				
Scope:	This policy provides a framework for responding to suspicions of fraud, providing advice and information on various aspects of fraud and implications of an investigation. It is intended that this policy is promoted throughout the Trust through programmed awareness events. Applicable to all staff, contractors and patients that engage with the service.				
To be read in conjunction with:	Disciplinary Policies – WAST Disciplinary Policy and Procedure Procedure for NHS staff to raise concerns. Standards of Business Conduct Policy Fraud Act 2006 Bribery Act 2010 NHSCFA strategy: NHS Fraud: Organisational Strategy 2020-23				
Owned By	Audit Committee				
Policy Lead: **Trade Union Lead:**	Carl Window Rudi Lewis	**Job Title:**	Local Counter Fraud Manager Trade Union Partner		
Director:	Chris Turley	**Job Title:**	Director of Finance and Corporate Resources		

Version Control Sheet

Version	Date	Author	Summary of Changes
1.0	Nov 2017	Carl Window	New Policy: Working Draft
2.0	10/01/2018	Carl Window	Incorporation of noted grammatical changes presented through consultation. Inclusion of records management paragraphs noted.
3.0	17/08/2023	Carl Window	Movement to new policy template. New Director Title listed. Insert of Definitions. Replacement of NHS Protect references to NHSCFA. Removal of references to HR / Workforce. Removal of referring to the FIRST case management system and to include “Clue” as the new system for fraud cases.

Keywords	Counter Fraud, Fraud, Bribery, Corruption

Impact Assessment Reviews

Area	Date of Review	Name of Reviewer
Training	No Change since last review 25/11/23	Carl Window (Policy Lead) Rudi Lewis (TU Partner)
Counter Fraud	No Change since last review 25/11/23	Carl Window (Policy Lead) Rudi Lewis (TU Partner)
Information Governance	No Change since last review 25/11/23	Carl Window (Policy Lead) Rudi Lewis (TU Partner)
Records Management	No Change since last review 25/11/23	Carl Window (Policy Lead) Rudi Lewis (TU Partner)
EqIA / Welsh Language	No Change since last review 25/11/23	Carl Window (Policy Lead) Rudi Lewis (TU Partner)
Estates	No Change since last review 25/11/23	Carl Window (Policy Lead) Rudi Lewis (TU Partner)
Environment	No Change since last review 25/11/23	Carl Window (Policy Lead) Rudi Lewis (TU Partner)
ESMCP	No Change since last review 25/11/23	Carl Window (Policy Lead) Rudi Lewis (TU Partner)

Task and Finish Group Members

Name	Job Title
Carl Window	Local Counter Fraud Manager
Rudi Lewis	Trade Union Representative
Lynne Haddow	Local Counter Fraud Specialist
Chris Turley	Director of Finance and Corporate resources

Policy Approval Route

Meeting Title	Meeting Date	Purpose/Outcome
Policy Group Meeting	07/12/2017	Review initial draft
Policy Group Meeting	06/02/2018	Review final draft post consultation
Trade Union Partners Team Meeting	09/03/2018	For WASPT Agenda
WASPT	26/03/2018	Recommend for approval / Approved
EMT	11/04/2018	Recommend for approval / Approved
Audit Committee	24/05/2018	Adoption and approval / Approved
Policy Group Meeting	19/12/2023	Review and approval / Approved
Audit Committee	01/03/2024	For Noting

Disclaimer
If the review date of this document has passed, please ensure that the version you are using is the most up to date either by contacting the document author or by emailing AMB_Policies@wales.nhs.uk

CONTENTS

1. INTRODUCTION

Welsh Ambulance Services NHS Trust (WAST) is committed to ensure that the Counter Fraud work within the Trust compliments the overall fraud strategy for the NHS in Wales. WAST is committed to reducing the level of fraud and corruption within the NHS to an absolute minimum and keeping it at that level, freeing up resources for better patient care. This policy has been produced by the Local Counter Fraud Specialists (LCFS) as a guide for all employees on anti-fraud, bribery, and corruption work. All genuine suspicions of fraud, bribery or corruption should be reported directly to the nominated LCFS, through the NHS Fraud and Corruption Reporting Line (FCRL) on Free phone 0800 028 40 60, or via the online reporting portal at www.reportnhsfraud.nhs.uk

WAST is committed to maintaining an honest, open working environment, with a strong adoption of an anti-fraud culture. It is also committed to the elimination of any fraud within the Trust, and to the rigorous investigation of such reported cases. The Trust, through the collaborative actions of the LCFS, senior management, and the Trust board committees, will seek the appropriate disciplinary, regulatory, civil and criminal sanctions against fraudsters. Additionally, where possible, the Trust will attempt to recover losses through both criminal and civil recovery sanctions. Outcomes of Counter Fraud enquiries and investigations will be fed back through to the relevant parties, alongside lessons learnt reports being shared where system weaknesses or fraud risk is identified.

2. POLICY STATEMENT

This policy is required to demonstrate compliance with the Welsh Government Directions in Countering Fraud in the NHS and seeks to promote and encourage a robust anti-fraud culture within the Trust.

WAST is committed to ensuring its resources are appropriately protected from fraud, bribery, and corruption (collectively referred to as economic crime). Activities to tackle such crime will be carried out within the key principles for action, as set out in NHS Counter Fraud Authority's strategy that include work areas within the following categories of delivery.

- Inform and involve
- Prevent and deter
- Hold to account

This policy is applicable to all staff and stakeholders regardless of level and position, and the requirements within this policy for reporting any suspicions of Fraud, Bribery and

Corruption, should be followed to ensure concerns are investigated properly by suitably trained accredited investigators.

3. SCOPE

This policy provides a framework for responding to suspicions of fraud, providing advice and information on various aspects of fraud and implications of an investigation. It is intended that this policy is promoted throughout the Trust through programmed awareness events.

The overall aims of this policy are to:

- Improve the knowledge and understanding of all employees, irrespective of their position, about the risk of fraud, bribery and corruption within the organisation and its unacceptability.

- Assist in promoting an anti-fraud climate with a culture and environment of staff confidence to raise concerns sensibly and responsibly, with clear direction as to the progress of such raised concerns.

- Ensure the appropriate sanctions are considered following an investigation, which may include any or all the following: criminal prosecution, civil prosecution or internal/external disciplinary action, and where required, referral to professional bodies.

- Provide clear strategic control and assurance in the delivery of a robust counter fraud service, with easily identified links of contact for support and reporting within.

Definitions

NHS Counter Fraud Authority (NHSCFA)

The NHSCFA's vision and purpose is to lead and proactively support the NHS to understand, find, prevent, and respond to fraud.

The NHSCFA strategy: NHS Fraud: Organisational Strategy 2020-23. Available at: Corporate publications | NHSCFA

Government Functional Standard GovS013

Under the NHS Standard Contract, the Trust must take the necessary action to meet

NHSCFA Requirements, including in respect of reporting via the NHS fraud case management system.

NHS funded services are required to provide NHSCFA details of their performance against the Government Functional Standard GovS013 annually. To this end, NHSCFA have launched a suite of requirements tailored to enable NHS organisations to meet the Government Functional Standard.

This includes the requirement that the organisation has a counter fraud, bribery and corruption policy and response plan that follows NHSCFA's strategic guidance and has been approved by the executive body or senior management team.

Fraud

Fraud involves dishonestly making a false representation, fraud by failing to disclose information, or fraud by abusing a position held with the intention of making a financial gain or causing a financial loss.

It may be useful to refer to the definitions in the Fraud Act 2006,

Bribery and Corruption

Bribery and corruption involve offering, promising, or giving a payment of benefit-in-kind to influence others to use their position in an improper way to gain an advantage.

It may be useful to refer to the definitions in the Bribery Act 2010.

What service area is covered by the document? Who does it affect? What patient groups? What professional groups or individuals does it affect? What actions are impacted by the policy?

4. AIM

One of the basic principles of public sector organisations is the proper use of public funds. Most people who work in the NHS are honest and professional; however, a small minority will seek to exploit and take advantage of resource that is intended for patient care and linked support services. Such behaviour is totally unacceptable, and the Trust is committed to a zero-tolerance approach in its aim to eliminate Fraud, Bribery and Corruption within the service. Awareness of and involvement in counter fraud work

should be a general responsibility of all professionals with an increased anti-fraud culture being supported at all levels.

WAST already has procedures in place that reduce the likelihood of Fraud, Bribery and Corruption. Such may include supporting policies through People services, payroll, audit, and procurement, to include standing orders, standing financial instructions, documented procedures and systems of internal control and risk assessments.

This document is intended to provide direction and support to employees of all levels in understanding fraud, and to present guidance to senior management members who may often first identify or be presented with suspected cases. This policy and response plan should be adhered to in consideration of tackling reported concerns, alongside providing a summary of how subsequent actions and investigations may be undertaken.

5. OBJECTIVES

This Policy should be read in conjunction with applicable linked policies and documents in support of applying appropriate sanctions and processes to prevent Fraud, Bribery and Corruption. Such may include:

- Disciplinary Policies
- Respect and Resolution
- Guidance around raising concerns at work
- Applicable WAST employee codes of conduct / standards of business conduct, (to include documents around registers of gifts, hospitality & sponsorship, and declarations of interests).

The Trust supports and acknowledges the adoption of NHSCFA's key principles designed to minimise the incidence of crime, and to deal effectively with those who commit crimes against the NHS. To meet its objectives, the Trust has adopted the operational framework developed by NHSCFA which encompasses these following principles, forming the structure of service delivery for Counter Fraud.

- **Strategic Governance** - that supports a zero-tolerance approach to wrongdoing; makes this clear to all staff; and monitors, at the very top of the organisation, the effectiveness of the arrangements in place. The Trust ensures the continued appointment of a qualified Local Counter Fraud Specialist (LCFS) to support this commitment. This ensures that anti-crime measures are embedded at all levels across the organisation.

- **Inform and Involve** - through setting clear policies and a code of conduct for all staff; raising awareness of the risks; and liaising with other organisations to develop

a shared resistance to wrongdoing This section sets out the requirements in relation to raising awareness of crime risks against the NHS and working with NHS staff, stakeholders, and the public to highlight the risks and consequences of crime against the NHS.

- **Prevent and Deter** - through focused assessment of risks in existing systems and processes; audit and review of records; proactive checks of new employees and new service suppliers, alongside addressing system process weaknesses. This section sets out the requirements in relation to discouraging individuals who may be tempted to commit crimes against the NHS and ensuring that opportunities for crime to occur are minimized.

- **Hold to Account** - through audit and assessment of key risk areas; investigating allegations and indications of wrongdoing; and seeking maximum punishment and recovery where wrongdoing is proven. This section focuses on the requirements for detecting and investigating economic crime, using applying suitable sanctions and seeking redress.

6. COUNTER FRAUD, BRIBERY AND CORRUPTION RESPONSE PLAN

The organisation routinely undertakes risk assessments to assess how bribery and corruption may affect the organisation. Outcomes of such assessments and audit review, support the creation and development of proportionate procedures being put in place to mitigate identified risks.

The Trust holds service wide policies and procedures that complement the Counter Fraud Strategy in tackling Fraud, Bribery and Corruption. The Trust's Standards of Business Conduct Policies are key documents to support the Trust in ensuring opportunity for bribery and corruptive practices is minimised. All employees have a responsibility to adhere to the content of these requirements. A recommended practice would be to have an inclusion of such within the annual appraisal process, and return to work processes following sickness, which provides a reminder to staff regarding their responsibilities to record such interests.

The Trust's intranet site holds records of the mentioned linked policies and should form part of an employee's professional practice to adhere to the recommendations within.

6.1 Reporting Fraud, Bribery or Corruption

The organisation's reporting process should start with a referral being made to the LCFS, or seeking advice with the LCFS, although reports can also be considered to the Director of Finance and corporate resources who in turn will notify the LCFS.

In cases where the subject of concern involves the LCFS or the Director of Finance, then the NHS Fraud reporting line should be considered for guidance and referral, where it would then be most likely investigated by NHS (Wales) Counter Fraud Service, who operates on an All-Wales level.

NHS Fraud Reporting line / Online service

Reports of concerns about fraud or corruption in the NHS, can be completed using a secure and confidential system: **Freephone - 0800 028 4060, or via the online form www.reportnhsfraud.nhs.uk**

Whichever method is used to make a report, it is helpful to have all the relevant information to hand. This may include, for example:

- What sort of fraud is taking place?
- How is the NHS affected by this activity?
- Who is doing it?
- Where is it happening?
- When is it happening?
- How long has it been going on?
- Are any other people or organisations involved?
- Outline any specific incidents that demonstrate what is happening?
- Any key dates?

When using the online form, supporting documents can be added to a report which can be completed anonymously if preferred. NHSCFA is a "Prescribed Person" under the Public Interest Disclosure Act 1998 (PIDA) and exists to tackle fraud (including bribery, corruption or wider economic crime) anywhere it is found in the NHS in England and Wales. Reporting parties can be assured that they are supported in the protection of their identity, in line with the relevant legal provisions.

Alternatively, should a reporting party wish to be identified and provide a supporting witness statement, then the LCFS and appropriate legal services will be on hand to support throughout the investigation, and any subsequent legal proceedings.

Anonymous letters, telephone calls, etc. are occasionally received from individuals who wish to raise matters of concern, but not through official channels. While the suspicions may be erroneous or unsubstantiated, they may also reflect a genuine cause for concern and will always be taken seriously. The LCFS will make sufficient enquiries to establish whether or not there is any foundation to the suspicion that has

been raised. If the allegations are found to be malicious, they will also be considered for further investigation to establish their source.

Staff should always be encouraged to report reasonably held suspicions directly to the LCFS, and should not attempt to undertake their own investigations, or approach the offending party directly around their concerns. The Trust seeks to ensure that persons feel confident and supported, that they can expose any wrongdoing without any risk to themselves. In accordance with the provisions of the Public Interest Disclosure Act 1999, the Trust also adheres to procedures for staff to raise concerns. These procedures are intended to complement the Trust's counter fraud, bribery and corruption policy and standards of business conduct, ensuring there is full provision for staff to raise any concerns with others.

6.2 Disciplinary action

The disciplinary procedures of the Trust must be followed if an employee is suspected of being involved in a fraudulent or otherwise illegal act. It should be noted, however, that the duty to follow disciplinary procedures will not override the need for legal action to be taken. In the event of doubt, legal statute will prevail, although such processes may, and often will result in parallel investigations being undertaking both by the LCFS and the People Services team.

6.3 Police involvement

In accordance with the NHSCFA Counter Fraud and Corruption Manual, the Director of Finance, and corporate resources, in conjunction with the LCFS, will decide whether a case should be referred to the Police. Any referral to the police will not prohibit action being taken under the local disciplinary procedures of the Trust.

The LCFS will maintain a close liaison with the Director of Finance and corporate resources, in cases where the subject of concern is likely to face Police arrest to assist in questioning of an alleged offender, connected to Counter Fraud enquiries.

6.4 Managing the investigation

The LCFS, in consultation with the Trust's Director of Finance and corporate resources, will investigate an allegation in accordance with procedures documented in the NHSCFA Fraud and Corruption Manual.

The LCFS must be aware that staff under an investigation that could lead to disciplinary action have the right to be represented at all stages. In certain circumstances, evidence

may best be protected by the LCFS recommending to the Trust that the staff member is suspended from duty. The Trust will decide based on People Services Team advice on the disciplinary options, which include suspension.

6.5 Gathering Evidence

The LCFS will take control of any physical evidence, and record this in accordance with the procedures outlined in the NHS Counter Fraud and Corruption Manual. If evidence consists of several items, such as many documents, LCFS's should record each one with a separate reference number corresponding to the written record. Note that in criminal actions, evidence on or obtained from electronic media needs a document confirming its accuracy.

Interviews under caution or to gather evidence will only be carried out by the accredited LCFS, or the investigating police officer in accordance with the Police and Criminal Evidence Act 1984 (PACE). The LCFS will take written statements where necessary.

All employees have a right to be represented at internal disciplinary interviews by a trade union representative or accompanied by a friend, colleague, or any other person of their choice, not acting in a legal capacity in connection with the case. For interviews conducted in connection with criminal investigations, this right to a representative only extends to a legal representative suitably qualified to advise on criminal legal proceedings. A union representative does not fulfil these criteria and would not be permitted to attend a formal interview held in compliance with the Police and Criminal Evidence Act 1984.

6.6 Sanctions and redress

The Trust is committed to the rigorous investigation of all reported cases of potential fraud, bribery or corruption impacting the organisation, and to seeking appropriate sanctions and redress wherever possible. There is a wide range of possible sanctions available throughout the process, and the application of parallel sanctions is always considered. The outcome and potential sanctions cannot be prescribed, as the decisions and applicable sanctions will be considered on a case-by-case basis, following the appropriate legal, and internal processes guidance available.

The key most frequently used sanctions available to the Trust are here outlined, all of which may also include a parallel use of financial recovery, and internal disciplinary sanctions. Where such offences are considered by the LCFS, the outcomes may be as follows:

- **Civil** – sanctions can be taken against those who commit fraud, bribery, and corruption to recover money and/or assets which have been fraudulently obtained, including interest and costs. Such sanctions can be taken with the cooperation of offender or can be enforced upon the subject through civil proceedings / civil recovery processes, where the financial detriment may be recovered with or without the assistance of the alleged.

- **Criminal**– The LCFS will work in partnership with NHSCFA, the police and/or the Crown Prosecution Service to bring a case to court against an alleged offender. Outcomes can range from a criminal conviction, fines and / or imprisonment, alongside a Police Caution if appropriate.

- **Disciplinary** - procedures will be initiated where an employee is suspected of being involved in a fraudulent or illegal act. The People Services Team will undertake this element of the investigation under their own policies, although LCFS may support in any shared intelligence concern around the alleged conduct.

  Consultation should be made with the applicable Trust's disciplinary policies, which can be found upon the Trust's intranet pages, or Management team members should be able to provide a copy to anyone who requests sight of the policy. As prescribed by the policy, additional sanctions from this process may include, verbal and written warnings, through to suspension or dismissal for more serious cases.

- **Professional body disciplinary** – If warranted, staff may be reported to their professional body because of a successful investigation/prosecution and supporting statements may be provided to such agencies if requested surrounding the alleged conduct.

6.7 Redress

Recovery of the loss caused should always be sought; however, it is important to stress that recovery decisions will be made on a case-by-case basis and may be undertaken through voluntary agreement / mediation with the subject, or through more enforcement-based measures under civil proceedings.

Following consultation with Counter Fraud Wales, the Director of Finance and Corporate Resources, and legal services, additional mechanisms available may be considered such as court injunctions, asset recovery, and using the Proceeds of Crime Act 2002 (POCA) for applicable cases under criminal investigation. Such processes may

involve the freezing or recovery of assets, and resulting in further fines, or extended prison sentences should the legal orders not be complied with.

The Proceeds of Crime Act 2002 ("POCA") sets out the legislative scheme for the recovery of criminal assets with criminal confiscation being the most used power. Confiscation occurs after a conviction has taken place. Other means of recovering the proceeds of crime which do not require a conviction are provided for in the Act, namely civil recovery, cash seizure and taxation powers. The aim of the asset recovery schemes in POCA is to deny criminals the use of their assets, recover the proceeds of crime and disrupt and deter criminality.

The Act also provides for several investigative powers, such as search and seizure powers, and powers to apply for production orders and disclosure orders and allows for the "restraint" or "freezing" of assets to prevent dissipation of assets prior to a confiscation order being made.

7. TRAINING AND IMPLEMENTATION

Training and support around the application and interpretation of this policy can be obtained from the Local Counter Fraud Manager, or the Local Counter Fraud Specialist.

The Counter Fraud Service offers scheduled training and bespoke training presentations to a variety of service areas, with a reference to the existence of this policy and how elements of Counter Fraud matters should be addressed.

Additionally, departmental briefings and regular awareness messages continue as part of the Counter Fraud Service's education and awareness commitments to ensure the policy is referred to and followed within the Trust.

8. IMPACT ASSESSMENTS

Policies will not be approved without an Equality Impact Assessment (EqIA) or a Welsh Language Impact Assessment being undertaken as this process has been developed to help promote fair and equal treatment in the delivery of services. It is the responsibility of the Policy Lead to ensure that impact assessments are undertaken during development or review of a policy.

8.1 Equality Impact Assessment

In accordance with the Equality Act 2010, this policy has been subject to an Equalities Impact Assessment EqIA, and full consideration has been given throughout. This consideration enables resources to be targeted effectively and can help to reduce

inequalities. The EqIA is a process to find out whether a policy will affect people differently based on their 'protected characteristics': age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion, sex or sexual orientation and if it will affect their human rights.

As part of this policy, an initial screening assessment has been completed, alongside an outcome report and action plan to support this policy. Based upon the outcomes of the screening assessment, many outcomes provided a neutral impact based upon the specifics of the policy, so a full screening assessment was not completed.

8.2 Welsh Language Impact Assessment

Under the The Welsh Language (Wales) Measure 2011 the Trust's Welsh Language Scheme will be replaced by standards. This means that the Trust, when formulating new policies or reviewing or revising existing policies, will be required to assess what effect a policy decision would have on opportunities for persons to use the Welsh language and on treating the Welsh language no less favourably than the English language. Further guidance can be obtained from the Welsh Language Officer.

In order to comply with the Welsh Language Standards and the Trust's Compliance Notice, the Trust is required to publish several policies in Welsh; particularly those that relate to:

- behaviour in the workplace;
- health and well-being at work;
- salaries or workplace benefits;
- performance management;
- absence from work;
- working conditions;
- work patterns

8.3 Environmental Standards and Impact Assessment

All policies must be considered as to whether they have any environmental impact during the review/development process. For those policies that are deemed to have no environmental impact it will be sufficient to include the following paragraph:

This policy will put the relevant requirements in place (such as waste management plan, reduction of CO_2 emissions & reduction of carbon footprint) in order to ensure that the Welsh Ambulance Services NHS Trust ongoing commitment to reduce its

impact on the environment is maintained and to become a more sustainable organisation in line with Trust policy and Environmental Governance System.

However, the Policy Group or Employment Policy Subgroup will ensure that the Estates Team have had an opportunity to consider all policies within the process in order to establish whether an impact assessment, waste management plan, or CO_2 Reduction Plan is required.

8.4 Counter Fraud

All policies shall be reviewed by the Trust's Counter Fraud team during the development/review process to ensure that the policy contains the correct counter fraud advice to deter fraud. For most policies, it will be acceptable to include the following paragraph; however, the Policy Group or Employment Policy Subgroup will ensure that the Counter Fraud Team have had an opportunity to consider all policies within the process.

8.5 Anti-Fraud and Corruption Concerns

The Welsh Ambulance Services NHS Trust is committed to taking all necessary steps to counter fraud, bribery, and corruption within the Trust. Staff should report suspected incidents of fraud and corruption to the Trust Local Counter Fraud Specialist, who will be happy to discuss any issues or concerns. Alternatively staff may contact the confidential NHS Counter Fraud Authority, Fraud and Corruption Reporting line on 0800 028 40 60; or the on-line reporting facility https://cfa.nhs.uk/reportfraud Fraud investigations may lead to disciplinary action and / or prosecution and civil recovery procedures.

8.6 Records Management

Policy Leads are asked to consider whether the policy being developed or reviewed requires the inclusion of the standard statement described below or a more in-depth statement as to how the records relating to the policy will be managed. Please refer to the Trust's Records Management Policy 2017 as a guide.

The Welsh Ambulance NHS Services Trust (WAST) recognises the importance of sound records management arrangements for both clinical and corporate records. The Trusts' records are its corporate memory, providing evidence of actions and decisions and representing a vital asset to support daily functions and operations. Records support policy formation and managerial decision-making, protect the interests of the Trust and the rights of patients, staff and members of the public.

8.7 Information Governance

Policy Leads shall consider information governance when developing or reviewing policies and establish whether inclusion of the paragraph below will suffice or whether a more in-depth statement is required as to how this will be addressed by the policy. Please refer to the Trust's Information Governance Policy 2018 as a guide.

Information Governance (IG) is an overarching term used to describe all aspects of information management. The Trust and its staff shall ensure that they provide satisfactory assurance to stakeholders as to how the organisation fulfils its statutory and organisational responsibilities in relation to the management of information. It will enable management and staff to make correct decisions, work effectively and comply with relevant legislation and the organisations aims and objectives.

The IG framework ensures that it sets out the high-level principles for confidentiality, integrity, and availability of information to promote and build a level of consistency across the Trust.

8.8 Training

All policies must be considered as to whether they have any education or training requirements during the review/development process. For those policies that are deemed to have no education or training impact it will be sufficient to include the following paragraph:

WAST is committed to providing high quality evidence-based education to an engaged and skilled workforce operating within an organisational culture and framework that enables colleagues to work to the top of their skill set to deliver high quality care and services with competence and confidence.

Any policy specific training would need to be devised by the Policy Lead and subject matter expert.

9. ROLES AND RESPONSIBILITIES

9.1 Chief Executive

The Chief Executive, as Accountable Officer, has overall responsibility for ensuring the Trust has appropriate policies in place to ensure the organisation works to best practice and complies with all relevant legislation. This overall responsibility ensures

that appropriate procedures are in place to protect the Trust and the public funds it receives.

The Chief Executive has overall responsibility for ensuring compliance with Directions on fraud, bribery and corruption notified by the Welsh Government. The Chief Executive shall further ensure that action to counter fraud and corruption is taken in accordance with the NHS Counter Fraud and Corruption Manual and in accordance with the Government Directions which set out the respective operational and liaison responsibilities of Trusts, Counter Fraud Services, and NHS CFS (Wales).

The Chief Executive shall liaise and reach agreement with LCFS and/or NHS CFS (Wales) where the appropriate sanction is felt to be prosecution action before any further action is taken by either the Trust or NHS CFS (Wales).

9.2 Director of Finance and Corporate Resources

The Executive Directors are responsible for the effective management of and compliance with this policy. They are responsible for ensuring that all policies within their remit are maintained and updated by liaising with the appropriate policy leads. They are responsible for ensuring that the appropriate advice and assistance is provided to authors and that consideration is given to any training and resources implications that are defined.

The Director of Finance and Corporate Resources has responsibility for monitoring and ensuring compliance with Welsh Government Directions on Counter Fraud, and also ensuring that action to counter fraud and corruption is taken in accordance with the NHSCFA Counter Fraud and Corruption Manual.

The Director of Finance and Corporate Resources, and the Deputy Director of Finance will also support and steer the financial processes in any civil or financial recoveries and will seek financial redress in respect of any loss.

The Director of Finance and Corporate Resources / Deputy Director of Finance shall inform and consult the Chief Executive at the first opportunity in all cases where losses resulting from Fraud, Bribery or Corruption may hold a significant financial value, or where the incident may lead to adverse publicity. Notifications will also be considered for the Welsh Government, the Head of Internal Audit (NWSSP), and also People Services leads where significant cases have been processed and outcomes are required to be shared to improve system weaknesses or service risk areas.

9.3 Internal and External Audit

The Head of Internal Audit will ensure that any detected systems weaknesses are reported to the Local Counter Fraud Specialist so that they can be examined proactively to detect possible fraud.

Any incident or suspicion that comes to Internal Audit's attention will be passed immediately to the Lead LCFS. The outcome of the investigation may necessitate further work by internal or external audit to review systems. LCFS and Internal Audit will maintain a close working relationship and share relevant details surrounding risk concern in support of both Counter Fraud and Audit functions.

Regular review of audit report recommendations, and Counter Fraud investigation outcomes will ensure effective assurance in the reduction of fraud and financial risk to the Trust.

9.4 People Services Team

The People Services Team will liaise closely with managers and the LCFS from the outset if an employee is suspected of being involved in fraud and/or bribery. The People Services Team are responsible for ensuring the appropriate use of the Trust's disciplinary procedure and will advise those involved in the investigation on matters of employment law and other procedural matters, such as disciplinary and complaints procedures, as requested. Close liaison between the LCFS and People Services Team will be essential to ensure that any parallel sanctions (i.e., criminal, civil and disciplinary sanctions) are applied effectively and in a coordinated manner.

The People Services Team will take steps at the recruitment stage to establish, as far as possible, the previous record of potential employees, as well as the veracity of required qualifications and memberships of professional bodies, in terms of their propriety and integrity. In this regard, temporary and fixed-term contract employees are treated in the same manner as permanent employees.

9.6 Local Counter Fraud Specialist

The Directions to NHS Bodies (Wales) on Counter Fraud Measures (2005) require the NHS organisation to appoint and nominate an LCFS. The LCFS's role is to ensure that all cases of actual or suspected fraud, bribery and corruption are notified to the Director of Finance and Corporate Resources and reported accordingly. Adhering to NHSCFA standards is important in ensuring that the organisation has appropriate anti-fraud, bribery, and corruption arrangements in place and that the LCFS will look to achieve the highest standards possible in their work, working with key colleagues

and stakeholders to promote anti-fraud work, applying effective preventative measures and investigating allegations of fraud and corruption.

The LCFS will adopt and deliver a structured work plan of both proactive and reactive work areas, alongside conducting risk assessments in relation to their work to prevent fraud, bribery, and corruption.

It is a requirement of the NHS Standard Contract that each Health Body has a nominated and accredited LCFS. NHSCFA provides the NHS Counter Fraud Manual to both LCFS' and Directors of Finance and Corporate Resources. This details how counter fraud work should be delivered to comply with the requirements of the NHS Standard Contract. Specifically, the LCFS is required to.

- Regularly report on the progress of the investigation and when/if referral to the police is required. Ensure that the Chief Executive/Executive Director of Finance and Corporate Resources is informed about all significant referrals/cases.

- Be responsible for the day-to-day implementation of the NHSCFA operational framework, in particular, the investigation of all suspicions of fraud.

- Report any case and the outcome of the investigation through NHSCFA's national case management system, "CLUE".

- Ensure that other relevant parties are informed where necessary, e.g. People Services will be informed if an employee is the subject of a referral, and of any linked system weaknesses.

- The LCFS will not conduct a disciplinary investigation, but the employee may be the subject of a separate investigation by the People Services Team and be supported by the LCFS.

- The Local Counter Fraud Specialist(s) (LCFS) are appointed by the Director of Finance and Corporate Resources and will be responsible for the day-to-day implementation of action under the 4 Key Principles of economic crime activity:

    - Strategic Governance
    - Inform & Involve
    - Prevent & Deter
    - Hold to Account

- The LCFS will treat enquiries confidentially and anonymously, if so requested by the employee contacting him/her, and additionally will ensure compliance with the Data Protection Act in respect of all information received.

- The LCFS will ensure that the Audit Committee is informed of all cases under investigation, and will have access to attend Audit Committee meetings, with supported access to the relevant members and Chief Executive.

- The LCFS will provide a written report, at least annually, to the Trust on counter fraud work, alongside taking responsibility to complete an annual Quality Assurance Self review process.

9.8 NHS Counter Fraud Services (CFS) Wales

The CFS Wales team provides specialist criminal investigation, surveillance capability and financial investigation services to all health bodies in Wales. The CFS Wales team consists of experienced investigators who deal with large scale, complex frauds and corruption issues in NHS Wales in collaboration with LCFS provision. The team work closely with other investigative bodies including the Police and also provide support and guidance to the network of LCFS.

The CFS Wales team supports the LCFS in higher level, resource intensive cases, often where there is a cross border or national concern to be investigated. Additionally, CFS Wales undertakes key policy and strategic work to support the LCFS, in conjunction with NHSCFA and Welsh Government.

9.9 Managers

All managers are responsible for ensuring that policies, procedures, and processes within their local area are adhered to and kept under constant review.

Managers have a responsibility to ensure staff are aware of fraud, bribery and corruption and understand the importance of protecting the organisation. Managers will also be responsible for the enforcement of disciplinary action for staff who do not comply with policies and procedures and be required to support LCFS in their investigations and proactive work.

Reports of any instances of actual or suspected fraud, bribery or corruption should be brought to the attention of the LCFS immediately. It is essential that managers do not investigate any suspected financial crimes themselves, as this may impede

the ability to proceed via the appropriate mechanisms through the criminal or civil process.

Managers are also expected to ensure that risk of fraud within departments is reduced to its absolute minimum, and where weaknesses or increased risks are identified, then advice should be sought to address, or effective corrective actions should be introduced the mitigate the risk identified.

Managers at all levels have a responsibility to ensure that an adequate system of internal control exists within their areas of responsibility and that controls operate effectively. The responsibility for the prevention and detection of fraud, bribery and corruption therefore primarily rests with Managers but requires the co-operation of all employees. As part of their responsibility, Managers should work:

- Ensuring that procedures to guard against fraud and corruption are followed. They should be alert to the possibility that unusual events or transactions could be symptoms of fraud, bribery, and corruption. If they have any doubts, they must seek advice from the nominated LCFS.

- Managers must instil and encourage an anti-fraud, anti-bribery and anti-corruption culture within their team and ensure that information on procedures is made available to all employees. The LCFS will proactively assist the encouragement of an anti-fraud culture by undertaking work that will raise fraud awareness.

- All instances of actual or suspected fraud or corruption which come to the attention of a manager must be reported immediately. It is appreciated that some employees will initially raise concerns with their manager, however, in such cases, managers must not attempt to investigate the allegation themselves.

- Support and inform staff of the Trust's Standards of Business Conduct and Counter Fraud, Bribery and Corruption policy as part of their induction process, paying particular attention to the need for accurate completion of personal records and forms.

- Ensure that adequate control measures are put in place to minimise the risks. This must include clear roles and responsibilities, supervisory checks, staff rotation (particularly in key posts), separation of duties wherever possible so that control of a key function is not invested in one individual, and regular reviews, and test checks to ensure that control measures continue to operate effectively.

Failures by managers to apply effective internal controls and appropriate financial governance and verification could result in disciplinary action. As part of that responsibility, line managers should be working closely in association with the Board Secretary, to adopt a clear promotion and adherence to internal policies that support the overarching counter fraud strategy (such as compliance to Standards of Business Conduct and professional standards).

9.10 All employees

All employees are required to comply with the organisation's policies and procedures and apply best practice to prevent fraud, bribery, and corruption. Staff should be made aware of their own responsibilities in protecting the organisation from these crimes and understand that serious sanctions can be imposed for those identified as being involved with elements of criminal activity.

If an employee suspects that fraud, bribery, or corruption has taken place, they should ensure it is reported to the LCFS and/or to NHSCFA immediately, as outlined within this policy.

As part of any annual review or employee appraisal process, consideration should be made towards this policy. Additionally, those with any connected interests, or secondary employment, should bring this to the attention of their line manager, and ensure it is suitably declared using the appropriate register of interests, or declaration registers held within the Trust. Non-compliance with such standards of conduct may result in parallel sanctions being undertaken through internal disciplinary in addition to the sanctions imposed through the LCFS.

All staff should feel confident in making direct referrals of concern to their LCFS. Alternatively, any suspicions of Fraud Bribery or Corruption can be reported in the following ways, in confidence if so preferred. All reports are treated in strictest confidence and taken by trained professionals.

- NHS Fraud and Corruption Reporting Line on 0800 028 40 60

- On-line at www.reportnhsfraud.nhs.uk

10. AUDIT AND MONITORING

Effective monitoring and audit is essential to ensure that controls are appropriate and robust enough to prevent or reduce fraud, bribery and corruption. Arrangements exist within the Trust to review system controls on an ongoing basis, supporting the identification of weaknesses in process. Where such is identified, the LCFS will work with

service area leads, and report through to Audit Committee the developments of any recommendations.

The Director of Finance and Corporate Resources and the LCFS will agree annual and specific measures of the effectiveness of this policy. As a minimum, the LCFS will report annually on the number and nature of instances of suspected wrongdoing reported to the service. This report will include details of outcomes and consequences to the individuals involved, along with assurance as to how report outcomes are being implemented and developed.

Additionally, supplementary details of wider work to educate and raise awareness of Counter Fraud will also be documented and reported on to demonstrate the proactive approach to creating and maintaining a robust anti-fraud culture. As part of effective evaluation and review, and in line with NHSCFA Standards, the LCFS will aim to carry out an annual review, of the levels of awareness of this policy and its contents amongst staff. In support of this review, The LCFS will also consider risks and policy effectiveness through the annual programme of work (Work Plan) and implement proactive and reactive work streams to address any required areas of improvement.

The results of such monitoring will be reported in the LCFS annual report to the Audit Committee. Delivery of actions agreed to address weaknesses and lapses identified in the implementation of the policy will be monitored by the Audit Committee.

Additionally, in line with NHSCFA Quality Assurance reviews, the LCFS will annually complete a self-review assessment of compliance in conjunction with the NHSCFA Quality Assurance Team to present an overall rating for Counter Fraud compliance.

The Head of Internal Audit will ensure that any detected systems weaknesses are reported to the Local Counter Fraud Specialist so that they can be examined proactively to detect possible fraud.

Any incident or suspicion that comes to Internal Audit's attention will be passed immediately to the Lead LCFS. The outcome of the investigation may necessitate further work by internal or external audit to review systems. LCFS and Internal Audit will maintain a close working relationship and share relevant details surrounding risk concern in support of both Counter Fraud and Audit functions.

Regular review of audit report recommendations, and Counter Fraud investigation outcomes will ensure effective assurance in the reduction of fraud and financial risk to the Trust.

11. REFERENCES

This policy should be read in conjunction with the following linked polices, and supporting materials:

- Disciplinary Policies – WAST Disciplinary Policy and Procedure
- Procedure for NHS staff to raise concerns
- Standards of Business Conduct Policy (to include documents around registers of gifts, hospitality & sponsorship, and declarations of interests).
- Directions to NHS Bodies on Counter Fraud Measures (National Assembly Wales)
- NHS Anti-Fraud Manual (NHSCFA)
- NHS Counter Fraud Strategy (NHSCFA)
- Public Interest Disclosure Act 1998
- The Fraud Act 2006
- Bribery Act 2010
- Standards for NHS bodies (Wales) Fraud, Bribery and Corruption

12. APPENDICES

The appendices always come at the end of the document. Each appendix should start on a new page and be clearly titled, i.e., Appendix 1, 2 etc and include the name of the document.

AGENDA ITEM No	**14**
OPEN or CLOSED	**Open**
No of ANNEXES	**1**

Committee Priorities & Cycle Monitoring Report

MEETING	Audit Committee
DATE	01 March 2024
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 2023/24 and progress against the agreed cycle of business for the Committee. There are no matters to escalate with respect to the Priorities.

2. The Committee are reminded that the priority of oversight of the development of the Quality and Performance Management Framework – which has moved from the Finance and Performance Committee - is reflected in this update.

RECOMMENDATION: -

3. **The Committee is asked to NOTE the update.**

KEY ISSUES/IMPLICATIONS

No issues to raise.

REPORT APPROVAL ROUTE

Not applicable

REPORT APPENDICES

Annex 1 – Audit Committee Cycle of Business Monitoring Report

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

COMMITTEE PRIORITIES FOR 2023/24 AND CYCLE MONITORING REPORT

SITUATION

4. This report updates the Committee on progress against the priorities it set for 2023/24 and progress against the agreed cycles of business. There are no matters to escalate with respect to the Priorities. The report also seeks approval for a change to the prescribed attendance for the Committee.

BACKGROUND

5. During the course of the effectiveness reviews, it was agreed that it is good practice for Committees to set priorities for the forthcoming year. The Committee's priorities, which are set out below, were agreed by the Trust Board in May 2023 and will be tracked quarterly.

6. The Committee's cycle of business was approved by the Committee in July 2023. The agenda is set with reference to that cycle, together with the forward planner, action log and highest rated principal risks.

7. The monitoring report is at Annex 1. Items in green show they are cycled for a particular meeting. Items in beige indicate they are a prompt at agenda setting as they may be ad hoc items such as business cases or external reports. The blue indicates that the item is either on the agenda as scheduled or is an ad hoc item which was discussed in agenda setting.

ASSESSMENT

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

Priority	Progress
Review of the Board Member Induction Programme and Annex	• The induction programme and annex documents have been updated for the induction of the new Vice Chair. • An update on the induction programme has been programmed for the September 2023 meeting of the Committee, for assurance. • A scope for a session with Chairs and TU members on their role and mutual expectations has been developed and will be delivered in Q4 or Q1 subject to stakeholder availability.

Oversight of the development and effectiveness of the Quality & Performance Management Framework	• The Committee received a verbal update regarding the implementation of the Quality and Performance Management Framework at its meeting in November. • It was agreed that an update was not required for the March 2024 meeting however the reporting for this will be actively considered for early 2024/25.

RECOMMENDATION: -

9. **The Committee is asked to NOTE the update.**

PAPER	PRE or POST C'EE FORUM	FREQUENCY	Q1a	Q1b	Q2	Q3	Q4	LEAD	PURPOSE	COMMENT
AUDIT COMMITTEE - CYCLE OF BUSINESS 2023/24										
For the rationale for this Committee's cycle see Note 8										
MAIN ELEMENTS										
Annual filings										
Annual accounts planning and emerging issues report	EMT	Annually						EDOF	Assurance	
Annual report timetable	EMT	Annually						BS	Assurance	
Audited accounts	EMT and Board	Annually						EDOF	Endorsement	
Annual report	EMT and Board	Annually						BS	Endorsement	
Head of internal audit report and opinion	EMT and Board	Annually						Internal Audit	Assurance	
Audit report on accounts	EMT and Board	Annually						Audit Wales	Assurance	
Internal Audit										
Audit Plan	EMT	Annually						Internal Audit	Approval	
Internal audit reports	EMT and C'ees	Quarterly						Internal Audit	Assurance	
Audit Wales										
Audit Plan	EMT and Board	Annually						Audit Wales	Review	Audit Plan not ready for Q4; will be taken to the April 2024 meeting of the Committee.
Update report	N/A	Quartlery						Audit Wales	Assurance	Programmed for all quarters.
Annual Audit Report	EMT and Board	Annually						Audit Wales	Assurance	Annual Audit Report not ready for Q4; will be taken to the April 2024 meetting of the Committee.
Structured Assessment	EMT and Board	Annually						Audit Wales	Assurance	Structured Assessment being taken in Q4 (rather than Q3) due to completion timelines.
Losses & Special Payments/Single Tender Waivers										
Quarterly lossess and special payments report	N/A	Quarterly						EDOF	Approval	
Tender update report and single tender waiver request	N/A	Quarterly						EDOF	Assurance	
Counter fraud										
Counter fraud update report	N/A	Quarterly						EDOF	Assurance	
Standing Orders & Standing Financial Instructions										
Standing Orders & Standing Financial Instructions	EMT and Board	Annually						BS	Endorsement	
Breach of Standing Orders & Standing Fin. Instructions	EMT	Ad Hoc						BS	Discussion/Assurance	Nothing to report for Q4.
Governance Practice Notes	EMT	Annually						BS	Approval	
Whistleblower, Declarations, Gifts & Hospitality										
Annual report on declarations of interest	EMT	Annually						BS	Assurance	
Report on gifts and hospitality	EMT	Annually						BS	Assurance	
Whistleblower report	TBC	TBC						BS	TBC	Agreed updates from Paul Hollard; nothing require for Q4 at agenda setting.
Other										
Near Miss Report	QUEST	Annually						TBC	Assurance	
Quality and Performance Management Framework	QUEST	TBC						EDSPP	Assurance	Included in Q3; reporting to continue to be developed. Agreed not required for Q4.
Policy										
Policy report	EMT	Quarterly						BS	Assurance	Policy Report added 28.06.2023
Policies	Policy Group	Ad Hoc						BS	Approval	
Financial procedures	TBC	Ad Hoc						EDOF	Approval	
Risk Management										
Review of risk related elements in IMTP	STB	Annually						BS	Assurance	Not programmed for Q4.
Board Assurance Framework	EMT	Each meeting						BS	Assurance	
Corporate Risk Register	EMT	Each meeting						BS	Assurance	
Audit Recommendation Tracker	EMT	Each meeting						BS	Assurance	
GOVERNANCE										
Escalations from Board Committees	Board Committee	Ad Hoc						Chairs	Various	
Committee effectiveness reviews and annual reports	All Committees	Annually						BS	Approval	
Audit Committee effectiveness review annual report	Audit/Board	Annually						BS	Approval	
Audit Committee Review of Terms of Reference	Audit/Board	Annually						BS	Approval	
Audit Committee Cycle of Business annual refresh	Audit/Board	Annually						BS	Approval	
Audit Committee Review of Annual Priorities	None	Quarterly						Chair	Review	Annual Review of Priorities scheduled for Q4 to take to April 2024 meeting.
Governance Practice Notes	EMT	Annually as due						BS	Review/Approve	
All Wales Audit Committee Chair's Meeting Report	AWACC	Bi-annually						Chair	Review	Added 19.09.23
PROMPTS										
External Reports	n/a	As required						TBC	TBC	

Two Q1 meetings. Q1b is a governance meeting to take the Committee annual reports and other items as noted
EDOF - Executive Director of Finance and Corporate Resources
BS - Board Secretary

Cycled for each meeting
Ad hoc item - prompt for agenda setting
Reporting developing
Presented as cycled/ad hoc item considered at agenda setting
Deferred

AUDIT COMMITTEE
HIGHLIGHT REPORT TO BOARD

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

Trust Board Meeting Date	25 January 2024
Committee Meeting Date	30 November 2023
Chair	Martin Turner

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

No alerts arose from this meeting

ADVISE

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

1. The Audit Committee chair held a **pre-meet** with Internal Audit and Audit Wales before the meeting in line with best practice.

2. A verbal update was received regarding the implementation of the **Quality and Performance Management Framework (QPMF)**, oversight of which transferred to this Committee from the Finance and Performance Committee in-year. Amendments are being made to the Framework to embed the Duty of Quality under the Health and Social Care (Quality and Engagement) Act 2022 and will come to this Committee and to the Board shortly. Revised terms of reference are in place for the QPMF Steering Group (which reports to Executive Leadership Team), and a work plan is in place.

3. Members **reflected** that the that papers were well prepared and presenters were clear. It was Martin Turner's last meeting and Chris Turley thanked him for support and expertise during his tenure as Chair of the Audit Committee, as did Paul Hollard, Non-Executive Director.

ASSURE

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

4. Paul Hollard, Chair of People and Culture Committee provided an update on the speaking up safely work underway as discussed at that Committee's meeting in November. The Audit Committee was assured that **arrangements for whistleblowing and speaking up safety** were developing well with the All Wales Speaking Up Safety Framework in place, guardians operating at WAST, and the Work in

Confidence platform operating for confidential reporting where it was felt our people could not go directly to their line manager.

5. The Board will recall previous AAA reports from this and other Committees noting that the number of **Policies** within their review date fell below reasonable levels during the Covid-19 pandemic as the policy work plan was largely paused and efforts directed to support the response. This meant that most policies have passed their review date; however, it is important to note that these remain our extant policies, they are in use and have not expired. The Committee has oversight of the work plan to review and update these policies and were assured that this was on track for the prioritised policies in 2023/24.

6. Progress against the **2023/24 Internal Audit Plan** was received, and the following four **Internal Audits** reviews were completed during the quarter and presented to the Committee:

    - **Senior Paramedic Role** – reasonable assurance. This was reviewed at the People and Culture Committee in November.

    - **Records Management** – reasonable assurance. This will be reviewed by the Quality, Patient Experience and Safety Committee in January.

    - **Technical Resilience** – reasonable assurance. This will be reviewed at the Finance and Performance Committee in January (closed session) and was also taken in closed session at this meeting.

    - **Estates Assurance: Estate Condition** – limited assurance. The Committee noted that this review is being conducted across all seven Health Boards, WAST and Velindre and that all have been given a limited assurance rated, therefore WAST is not an outlier. The rating is based on the lack of a funded strategy to address the backlog of maintenance and the inconsistency of reporting across Wales. Disappointment was expressed with the rating given the track record of WAST reducing backlog maintenance and investing in new facilities, and it was noted that many of the issues were outside of the trust's control. The Internal Audit team explained the rationale for the rating which included raising the profile of the issues at a national level, and the common challenges faced by all Health Boards and Trusts in Wales. They acknowledged the positive aspects of the trust's management approach and governance arrangements. This will be reviewed at the Finance and Performance Committee in January.

7. The **Audit Wales Update** was received as was the WAST Review of Workforce Planning Arrangements (at Annex 1) and the national NHS Workforce Data Briefing from the Auditor General for Wales. The WAST review sets out the workforce risks that NHS Bodies are experiencing currently and are likely to experience in the future. The report had been discussed in the People and Culture Committee in November with Audit Wales present, and the Committee noted that reference to increased agency costs in 2021/22 relates to cohorting outside of EDs during the pandemic, as opposed to other types of agency staffing. The report found overall that the Trust is taking effective steps to mitigate current workforce challenges and clarify its longer-term strategic vision, however medium to longer-term resourcing is a significant and ongoing barrier.

    The Audit Wales **Structured Assessment** work for 2023 has completed and the report is with the Trust in draft. It will be presented to the January Board and will be reviewed in more detail at the March

Audit committee. Planned work for 2024 includes a national deep dive into financial efficiencies and a follow up of the Review of Quality Governance Arrangements will begin in late 2023/24.

8. The **losses and special payments** made during the period 1st April to 31st October 2023 amounted to £229.4K net payments.

9. In private session the committee received the counter fraud update 1st September to 31st October 2023 as well as the report on **tenders and single tender waiver requests**. The **Local Counter Fraud Service** (LCFS) provided an update on its work including fraud awareness sessions delivered including during International Fraud Awareness Week in November, prevention and deterrence support and guidance. This quarter has seen the securing of the Counter Fraud Awareness E-Learning as a mandatory training course which has seen a significant increase in those undertaking the module. There are 20 recorded ongoing investigations by LCFS – which was the same number last quarter however there have been closures and new cases in that time - with a number of potential offences ranging from working whilst sick, to secondary employment.

10. The **2023/24 Committee Priority** (review of Board member induction programme and annex) was reviewed and is on track with that programme being presented at this meeting. A new priority was added as a transfer from the Finance and Performance Committee, that being the oversight of the development and effectiveness of the Quality and Performance Management Framework, a verbal update against which is noted above.

11. An update was received on the revised **Audit Tracker** with c.30% of all management actions closed in the quarter and a number of historical actions revisited to open up discussions on potential revisions of management actions due to the passage of time. There has been excellent engagement on the new process and Members welcomed the revised format, noting that 58% of the Audit Committee related recommendations had closed in quarter. **An updated version of the Audit Process Handbook was approved** following additions by Audit Wales. Good progress on a new digital solution was reported with specific reporting with escalations for this Committee and is due to be live in Q1 2024/25.

12. The **Committee's cycle of business** was reviewed and is on track.

RISK MANAGEMENT

The Committee is responsible for the review of the risk management framework and is not assigned individual risks for oversight.

The Committee reviewed progress against the risk management transformation programme. Areas of focus for the risk management improvement programme plan during 2023 are to deliver a risk management framework as a key enabler of our long-term strategy and decision making. This will be achieved by further developing the risk management framework, transitioning to a strategic BAF that reflects more closely the Trust's strategic objectives against its long-term strategy – Delivering Excellence: Vision 2030. Some accelerated work will be undertaken this financial year on establishing the strategic BAF and risk appetite statements.

The Committee noted that the Health and Safety Risk 199 has reached target and that this was discussed

in full at the People and Culture Committee.

COMMITTEE AGENDA FOR MEETING		
Policy report	Quality and Performance Management Framework Implementation Update	Internal Audit Report
Audit Wales Update	Risk Management and Board Assurance Framework	Q2 Audit Tracker Update
Losses and special payments	Whistleblowing (speaking up safely)	

COMMITTEE ATTENDANCE					
Name	**20 April 2023**	**25 July 2023**	**14 Sept 2023**	**30 Nov 2023**	**1 Mar 2024**
Martin Turner					
Paul Hollard					
Joga Singh					
Ceri Jackson					
Chris Turley					
Lee Brooks		Judith Bryce	Judith Bryce		
Judith Bryce					
Liam Williams	Duncan Robertson				
Angie Lewis					
Osian Lloyd (IA rep)					
Audit Wales rep		Andrew Doughton	Fflur Jones	Fflur Jones	
Paul Seppman					
Damon Turner					
Trish Mills					
Carl Window					

	Attended
	Deputy attended
	Apologies received
	No longer member

Archwilio Cymru
Audit Wales

Review of Workforce Planning Arrangements – Welsh Ambulance Services NHS Trust

Audit year: 2023

Date issued: November 2023

Document reference: 3819A2023

This document has been prepared as part of work performed in accordance with statutory functions.

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

We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

Mae'r ddogfen hon hefyd ar gael yn Gymraeg. This document is also available in Welsh.

Contents

Summary report

Introduction

1 An effectively planned workforce is fundamental to providing good quality care services. The NHS employs a range of clinical and non-clinical staff who deliver services across primary, secondary and community care, representing one of the largest NHS investments. Over the years there have been well documented concerns about the sustainability of the NHS workforce. And workforce challenges are routinely highlighted to us in our audit reviews and ongoing engagement with health bodies. Despite an overall increase in NHS workers, these concerns remain. The workforce gaps are particularly acute for certain professions such as GPs, nurses, radiologists, paediatricians and ophthalmologists (A Picture of Healthcare, 2021). In nursing alone, the Royal College of Nursing Wales reported 2,900 vacancies in their 2022 Nursing in Numbers analysis. In addition, the social care sector, is also facing its own workforce issues. These challenges have been exacerbated by the pandemic as the health sector looks to recover services.

2 Given the current challenges, robust and innovative workforce planning is more important than ever. Effective workforce planning ensures that both current and future services have the workforce needed to deliver anticipated levels of service effectively and safely. Planning is especially important given the length of time required to train some staff groups, particularly medical staff.

3 National and local workforce plans need to anticipate service demand and staffing levels over a short, medium, and long term. But there are a range of complex factors which impact on planning assumptions, these include:

- workforce age profile, retirement, and pension taxation issues;
- shifts in attitudes towards full and part-time working;
- developing home grown talent and the ability to attract talent from outside the country into Wales; and
- service transformation which can change roles and result in increasing specialisation of roles.

4 The Trust approved its 2023-26 People and Culture Plan in May 2023. The Trust is also developing a strategic workforce plan for the organisation to detail delivery which it is anticipating will be received by the Board in April 2024.

5 The key focus of our review has been on whether the Trust's approach to workforce planning is helping it to effectively address current and future NHS workforce challenges. Specifically, we looked at the Trust's strategic approach to workforce planning, operational action to manage current and future challenges, and monitoring and oversight arrangements. Operational workforce management arrangements, such as staff/nurse rostering, consultant job planning and operational deployment of agency staffing, fall outside the scope of this review.

6 The methods we used to deliver our work are summarised in **Appendix 1**.

Key findings

Overall, we found that **the Trust is taking effective steps to mitigate current workforce challenges and clarify its longer-term strategic vision, however medium to longer-term resourcing is a significant and ongoing barrier.**

Key workforce planning challenges

7 The Trust is facing significant workforce challenges. The workforce indicators presented in **Appendix 2** highlight that the Trust's workforce levels and costs have increased between 2017-18 and 2022-23. This included an increase in agency staffing, from £180,000 in 2018-19 to £1.7 million in 2021-22[1] which has since reduced and is significantly lower than Health Board agency spend. While vacancies are comparatively low, the Trust has seen higher than usual turnover and concerningly, for 67% of the staff who left the organisation in 2021-22, their reasons for leaving were stated as either unknown or other. A new process is due to be rolled out which aims to seek further clarity on the reasons for staff leaving. Noting that ambulance services tend to have higher sickness absence levels than other NHS organisations, the Trust has the highest percentage of sickness absence rates in Wales, which stood at 12.1% in January 2022, although this figure reduced to 8.2% in July 2023 levels increased in August 2023 to 9.2%.

Strategic approach to workforce planning

The Trust is strengthening its strategic workforce planning approach to address key risks and is effectively engaging with most stakeholders. However, it needs strengthen how it accesses and analyses workforce intelligence.

8 The Trust's strategic vision and plans focus on strengthening the workforce to overcome key current and future workforce risks. The Trust intends to strengthen its approach further by developing a strategic workforce plan for the organisation which it expects to complete by April 2024. The Trust has access to significant amounts of data which it uses to inform key decisions relating to its workforce. However, there is a need to better integrate IT systems to enable workforce data analysis and ensure its workforce establishment model is routinely updated. While the relationship between the Trust and its trade union partners is sometimes challenging, the Trust effectively engages with its staff, wider stakeholders and commissioners to provide assurance and develop workforce solutions.

[1] The Trust has indicated increased agency costs in 2021/22 to pandemic and system pressure-related factors, such as staffing to cohort patients outside of some Emergency Departments. This complicates spending comparisons with pre-pandemic levels. Agency use has subsequently decreased, with the Trust relying on alternative variable pay aspects, primarily overtime for employed staff, to support its capacity.

Operational action to manage workforce challenges

We found that The Trust is proactively addressing its workforce challenges, based on a strong understanding of risks. However broader workforce transformation is constrained by resource availability.

9 The Trust has invested in its workforce planning capacity and capabilities, such as by recruiting a head of workforce planning and transformation and developing workforce planning training for managers. The Trust will need to ensure that workforce planning training is realising the intended benefits. There is also a need to ensure consistent central support for recruitment activity across the Trust.

10 The Trust demonstrates a relatively strong understanding of the barriers and risks associated with implementing the strategic vision for its workforce. It is adopting a proactive approach to mitigate some longer-term and immediate challenges under its influence. For example, to overcome recruitment challenges. It is looking to introduce home working for nurses and raising the profile or paramedicine within universities.

11 While the Trust has costed its workforce plan through the development of its Integrated Medium-Term Plan (IMTP), it may require significant resource to fully achieve the significant transformation set out in its strategic vision. At the same time, the Trust currently holds substantial inefficiencies in its workforce due to handover delays caused by system pressures. It also finds securing ongoing additional investment from commissioners to build capacity challenging, and additional short term workforce funding can make recruitment and retention more difficult. To address these issues, the Trust will need to continue to work closely with its commissioners and Welsh Government.

Monitoring and oversight of workforce plan/strategy delivery

There is reasonable Board-level oversight of operational workforce challenges, but it is too early to judge the impact of delivering the People and Culture Plan.

12 The People and Culture Committee receive regular and comprehensive reports relating to the workforce. Information to the committee has been increasingly operational, however at the August 2023 committee, the Committee approved metrics and a data dashboard to help monitor the progress of strategic aims within the People and Culture Plan. The Trust will also need to ensure effective arrangements for monitoring progress of its strategic workforce plan, once approved.

13 External oversight by the Emergency Ambulance Services Committee (EASC)[2] ensures the commissioners understand the Trust's service workforce pressures. This helps to align commissioner's expectations, with available finance and workforce resource. The Trust has benchmarked its performance with other ambulance services however, this is not regular nor is it reported broadly within the organisation.

Recommendations

14 **Exhibit 1** details the recommendations arising from this audit. These include timescales and our assessment of priority. The Trust's response to our recommendations is summarised in **Appendix 3**.

Exhibit 1: recommendations

Recommendations
Terms of Reference R1 We found that the Terms of Reference for both the Integrated Technical Planning Group and the Forecasting and Modelling Group require review. The Trust should review these to ensure they are accurate and up-to-date, particularly to clarify what role they will play in supporting the new People and Culture Plan and developing strategic workforce plan. **(medium priority)**
Workforce information systems R2 We found that there is scope for the Trust to make better use of its workforce information by ensuring data is consistent, joined up and up to date. The Trust should work to ensure that: • Systems that hold workforce information including Electronic Staff Record (ESR), Global Rostering System (GRS) and finance systems interconnect, where possible; **(medium priority)** • Explore ways to resource the management of a system to ensure an up-to-date establishment model. **(medium priority)**

[2] The Emergency Ambulance Services Committee (EASC) is Joint Committee of the seven health boards in Wales with the responsibility for planning and securing sufficient ambulance services for the population.

Recommendations

Evaluating workforce planning training

R3 We found that the Trust is strengthening workforce planning capability through training initiatives, but it will need to evaluate these to ensure they are having the desired impact. The Trust should develop an evaluation framework to measure the success of its training programme. **(medium priority)**

Recruitment support

R4 We found that only the emergency ambulance services department has dedicated support from the central management team for recruitment activity, due to capacity issues. While the central team can provide support on a case-by-case basis, the Trust should review opportunities to increase the corporate support offered to other departments across the organisation. **(medium priority)**

Metrics for Strategic Workforce Plan monitoring

R5 Once the Trust has developed its strategic workforce plan it should also ensure there is appropriate reporting of targets and milestones to enable the People and Culture Committee to monitor its progress. **(medium priority)**

Benchmarking

R6 The Trust does not routinely benchmark its workforce performance metrics with other health bodies in Wales. Its performance benchmarking with other ambulance trusts is infrequent. The Trust should introduce regular workforce benchmarking with similar organisations and use this to inform relevant groups and committees on its performance and efficiency and to identify and share good practice. **(medium priority)**

Detailed report

Our findings

15 The following three tables set out the areas that we have reviewed and our findings. These focus on:

- the Trust's approach to strategic workforce planning (**Exhibit 2**);
- operational action to manage workforce challenges (**Exhibit 3**); and
- monitoring and oversight of workforce plan/strategy delivery (**Exhibit 4**).

Exhibit 2: strategic approach to workforce planning

This section focusses on the Trust's approach to strategic planning. Overall, we found that **the Trust is strengthening its strategic workforce planning approach to addressing key risks and is effectively engaging with most stakeholders. However, it needs strengthen how it accesses and analyses workforce intelligence.**

What we looked at	What we found
We considered whether the Trust's workforce strategy and plans are likely to address the current and future workforce risks. We expected to see a workforce strategy or plan which: • identifies current and future workforce challenges. • has a clear vision and objectives. • is aligned to the organisation's strategic objectives and wider organisational plans. • is aligned to relevant national plans, policies, and legislation. Including the	We found that **the Trust is strengthening its strategic approach for the workforce through recently approved and developing plans which align to its strategic vision** The Trust's strategic vision entitled 'Delivering Excellence: Our Vision for 2030', describes the Trust's aim to become a more clinically-focussed organisation that reduces the need to convey patients to hospital by increasingly providing care closer to home. This overall aim, along with other ambitions within the strategic vision, are based on identified current and future workforce challenges, including staff wellbeing and support, and delays in treating patients due to system pressures. 'Delivering Excellence' appropriately recognises the workforce as a key enabler of this vision and identifies relevant supporting ambitions including transforming the Trust's education and training provision and protecting staff wellbeing. There is clear alignment between this vision and the Trust's

What we looked at	What we found
national workforce strategy for health and social care. • is supported by a clear implementation plan.	recently approved People and Culture Plan 2023-26 (the Plan) and Integrated Medium-Term Plan (IMTP) 2022-23. The Plan also appropriately aligns to key national policies including the national Workforce Strategy for Health and Social Care. The IMTP and People and Culture Plan contain deliverables and measures against the ambitions of Delivering Excellence, with a focus on improving Culture, Capacity and Capability. The Trust intends to review its People and Culture Plan, in addition to its statutory review and refresh of the IMTP, each year. The People and Culture Plan has an initial one-year focus which contains an ambitiously high number of actions (49). Organisational capacity, service pressures and financial constraints are amongst its risks to its delivery of its actions, which it is actively managing. At a service level, the Trust has developed transactional service-specific workforce plans. For example, the plan for the Emergency Medical Service (EMS) details monthly national projections for the emergency medical workforce up to March 2027. The Trust is developing a corporate-level strategic workforce plan to fill the gap between annual iteration of the People and Culture Plan and the longer-term strategic vision of 'Delivering Excellence'. The strategic workforce plan, which is being developed using the HEIW's six step method for workforce planning, will have a medium to long term focus and will be reviewed annually. The Trust's intention is that it will provide a basis for workforce modelling to deliver its strategic ambitions and is aiming for Board-level approval in April 2024.
We considered whether the Trust has a good understanding of current and future service demands. We expected to see: • use of reliable workforce information to determine workforce need and risk in the short and longer term; and	We found that **the Trust understands its current and future service demands, however there is opportunity to better integrate systems to help ensure that capacity and demand information and workforce establishment can be regularly updated** The Trust demonstrates that it seeks to understand its workforce capacity and demand and performance information. Between 2018 and 2022, the Trust commissioned demand and capacity reviews: one for Emergency Medical Services and one Non-Emergency Patient Transport Services,

What we looked at	What we found
• action to improve workforce data quality and address any information gaps.	and an additional capacity review for 111 operations. These reviews focused on understanding the level of resource required to meet expected levels of performance, including which staff groups should be expanded or decreased. The Trust incorporated the findings into its ongoing workforce planning and informed discussions with its commissioners. The Trust has effective approaches for interpreting workforce data. These include a weekly 'Forecasting and Modelling Cell' and a weekly Integrated Technical Planning Group. The former analyses and interprets forecasts for the operations teams and the latter analyses key data relating to workforce, estate, vehicle fleet, rosters, and financial planning. We found these groups provide helpful ongoing information within reports. For example, reports that contain information provided by the Integrated Technical Planning Group demonstrated comprehensive and thorough analysis which helped inform key decisions relating to workforce. However, the Terms of Reference for both these groups require review and update as some arrangements appear to have evolved since they were established **(Recommendation 1).** A review of the terms of reference for these groups would also provide an opportunity to set out their roles in supporting delivery of the newly approved People and Culture Plan and developing strategic workforce plan. While the Trust has not undertaken a skills gap analysis, it has conducted service reviews as part of its financial sustainability programme. These reviews focused on ensuring consistency of job roles to achieve efficiencies where possible. We understand that the Trust intends to use this to inform its understanding of skill mix and need going forward and will be key to discussions on job planning and recruitment. There is also scope for the Trust to make better use of its workforce information by ensuring data is consistent, joined up and up to date. During interviews, we heard how managers within the organisation are not yet consistently providing data to the central team. We also understand that systems that hold workforce information including Electronic Staff Record (ESR), Global Rostering System (GRS) and finance systems are not effectively connected, therefore requiring resource intensive manual collation. In addition, while the Trust modelled its establishment for operational

What we looked at	What we found
	staff in 2022, the information was prepared at a single point in time and has not been kept up to date. Consequently, the Trust do not currently have up-to-date establishment information to support decisions relating to workforce **(Recommendation 2).**
We considered whether the Trust is working with partners to help resolve current and anticipated future workforce challenges. We expected to see: • effective and timely engagement and working with key internal and external stakeholders to tackle current and future workforce issues; and • shared solutions identified with key stakeholders to help address workforce challenges.	We found that **there are challenges with internal and external stakeholder engagement which the Trust is collaborating with partners to resolve** To inform its development of the People and Culture Plan, the Trust effectively engaged with staff, Trade Union partners, Non-Executive Directors and wider stakeholders, including peer Workforce and Organisational Development, and other UK ambulance services. Specifically in relation to training and qualifications, the Trust engages regularly with Health Education and Improvement Wales (HEIW) to explore opportunities to resolve key workforce challenges and support development. For example, the Trust worked with HEIW to develop apprenticeship schemes. The aim of this is to support career progression or those working in areas with high turnover within the Trust and to provide career opportunities and to develop skills and competencies. The Trust has dedicated forums to engage and inform its Trade Union partners, including through the Welsh Ambulance Services Partnership Team, and the Trade Union representatives that attend the People and Culture Committee and Board. At the time of fieldwork, those we spoke to recognised that relationships had come under strain due to recent industrial action. While we did not find any evidence that this was having adverse effects the time of our fieldwork, strained relationships could still present challenges. Nevertheless, senior leaders within the Trust and trade union representatives expressed eagerness to return to more meaningful engagement. As a commissioned organisation, the Trust engages with its commissioners to communicate key workforce challenges and needs and seeks to identify shared solutions. For example, Advanced Paramedic Practitioners receive the benefit of enhancing their skills through sharing their time between the ambulance service and primary care. Forums such as monthly meetings with the Chief

What we looked at	What we found
	Ambulance Services Commissioner and bi-monthly Emergency Ambulance Services Committee (EASC) meetings provide regular opportunities to engage. Meetings cover workforce issues and challenges including vacancies and sickness absence rates.

Exhibit 3: operational action to manage workforce challenges

This section focusses on the actions the Trust is taking to manage workforce challenges. Overall, **we found that the Trust is proactively addressing its workforce challenges, based on a strong understanding of risks. However broader workforce transformation is constrained by resource availability.**

What we looked at	What we found
We considered whether the Trust has identified sufficient resources to support workforce planning over the short, medium, and long term. We expected to see: • clear roles and responsibilities for workforce planning; • appropriately skilled staff to ensure robust workforce planning; • sufficient workforce capacity across the organisation to plan and deliver the workforce strategy or plan; and • sufficient financial resources to deliver the workforce strategy or plan.	We found that **the Trust is investing in its corporate workforce planning capacity and capability. However financial pressures and inefficiencies may inhibit the extent that the Trust can invest in delivering its strategic ambitions for example staffing community-based, prevention-focussed service models.** There appears to be sufficient capacity to support workforce planning. The People and Culture directorate, led by the People and Culture Director has a clear structure with teams covering education and development, workforce planning and organisational development and culture and wellbeing. In 2021, the Trust invested in corporate workforce planning by recruiting a Head of Workforce Transformation and Planning whose role includes developing the strategic workforce plan and managing the workforce planning team of nine staff and managers which includes the recruitment and Electronic Staff Record (ESR) teams. Service leads and operational management understand their role in workforce planning but that operational pressures do not allow them sufficient time to 'think strategically' to develop solutions. Service managers also felt there was a need to increase skills and confidence to undertake longer-term workforce planning. At the time of fieldwork, the Trust was developing workforce planning training to support managers to address these challenges. Once in place, the Trust should seek to evaluate the success of its training initiatives to ensure it is realising the intended benefits

What we looked at	What we found
	(**Recommendation 3**). Support for recruitment activities is not consistent across the organisation. Emergency Medical Services (EMS) recruitment is co-ordinated centrally through the workforce team, while other teams undertake their own recruitment activity. Recruitment support is available from the central team when requested for those services. Nevertheless, the devolved arrangement, places a strain on service manager capacity, and can lead to inconsistent practices **(Recommendation 4).** Achieving the vision outlined in 'Delivering Excellence' and linked plans may require significant ongoing investment to facilitate the additional staff, training and related costs. Those we spoke to were clear that frequent engagement takes place with commissioners to communicate the Trust's strategic direction which is well-received by partners. However, securing funding in the context of the current significant financial difficulties is a crucial challenge which is extremely difficult to mitigate. It is clear there are growing financial pressures. This will mean that the Trust will need to achieve efficiencies and/or secure additional investment to achieve its strategic ambitions. Delays in handing over patients at emergency departments cause significant inefficiencies for the Trust. For example, in August 2023, 27% of the Trust's ambulance response staff were unable to respond to further calls due to handover delays. In our 2022 Structured Assessment, we reported that handover delays accounted for around £50 million of inefficiencies for that year. That capacity, if released in part, could support the Trust's investment in community-based prevention-focussed service models. The Trust is engaged in ongoing work both independently and in partnership with commissioners to try and reduce the current levels of inefficiency. In terms of securing additional funding, the Trust is working in a challenging financial environment where additional funding is less likely. In the recent past, 'in-year' funding provided as part of winter pressures money in 2022 supported short-term recruitment of an additional 100 frontline staff.

What we looked at	What we found
	However, the short-term nature of such funding to be used for a specific purpose, restricts the extent that the Trust can invest in service transformation. Short-term funding can also make recruitment and retention difficult. The Trust also needs to make financial savings to achieve a breakeven position. It is addressing this in part through increasing its vacancy control target from £907,000 in 2022-23 to £2.6 million in 2023-24. However, vacancy control is a short-term solution, and it can create a strain on existing staff. The newly introduced vacancy control panel, which includes the Director of People and Culture and the Director of Finance, considers the impact of vacancies on the organisation as well as the potential financial savings. The Trust told us it intended to review the effectiveness of this process during Quarter 3 of 2023-24 to identify potential learning and improvement.

What we looked at	What we found
We considered whether the Trust has a good understanding of the short and longer-term risks that might prevent it from delivering its workforce strategy or plan. We expected to see: • a good understanding of the barriers that might prevent delivery of the workforce strategy or plan; • plans to mitigate risks which may prevent the organisation from achieving its workforce ambitions; and • clearly documented workforce risks that are managed at the appropriate level.	We found that **The Trust has a good understanding of the risks to delivery of its strategic workforce ambitions** The Trust demonstrates a good understanding of the shorter and longer-term risks to delivery of its workforce ambitions. These relate to buy-in from staff and stakeholders, financial pressures and staff morale and wellbeing. Corporately, the Trust appropriately manages and reports significant risks through the corporate risk register and Board Assurance Framework. The Trust's corporate risk register highlights high scoring risks related to the workforce, for example sickness absence, maintaining effective partnerships with the trade unions, and staff wellbeing. Each risk has a detailed list of controls, assurances, gaps in controls and actions which are clear and are likely to have a positive impact on mitigating the risk. For example, for reducing sickness absence the actions on the September 2023 risk register included long term sickness absence deep dives and review of top 100 cases by the people and culture team monthly. While sickness absence performance had significantly improved as of August 2023, the risk remains at 20 due to the likelihood of increased absence over the winter period. The People and Culture Committee is responsible for overseeing these risks which the Assistant Director Leadership Team regularly review.

We considered whether the Trust is effectively addressing its current workforce challenges. We expected to see:

- effective reporting and management of staff vacancies;
- action to improve staff retention;
- efficient recruitment practices;
- commissioning of health education and training which is based on true workforce need; and
- evidence that the organisation is modernising its workforce to help meet current and future needs.

We found that **the Trust is taking appropriate steps to address current workforce challenges through a range of recruitment, retention and training and development activities.**

The Trust has a successful track-record of recruiting paramedics, and the organisation had the lowest vacancy rate of NHS Wales bodies, at a rate of less than 1% during May 2023. The Trust is successful in recruiting newly qualified paramedics through recruitment events which focus on achieving a large intake. However, it is experiencing challenges in recruiting to other roles such as nurse advisors in its 111 service and staff in its digital team. The Trust is proactive in finding alternative solutions to some of these challenges. For example, the Trust found difficulties recruiting Ambulance Care Assistants, as some candidates do not have a C1 category driving license (necessary to drive an ambulance). To overcome this issue, the Trust now offers training in-house, provided candidates meet all other recruitment criteria. In response to difficulty recruiting nurses, the Trust is looking at allowing nurses in its call centres to work remotely. If this plan is successful, the Trust will seek to attract overseas nursing candidates who wish to work remotely from their own countries.

Beyond recruitment, the record for completing staff exit interviews has been inconsistent and in some cases poor. This means that it is difficult for the organisation understand the reasons for their departure and to introduce approaches to remove the ‘drivers’ that cause staff to leave. To address this, the Trust is trialling a new 'Moving on Interview' process in place of exit interviews. The new process includes newly designed questions, which staff can complete via MS Forms in their own time, rather than led by the manager. The Trust has designed the approach to provide more meaningful intelligence and support the Trust to develop more effective plans to retain staff. Nevertheless, in line with broader NHS Wales, since the pandemic, the Trust has been experiencing higher levels of turnover within its operations department. The increased turnover was particularly the case with within its 999 and 111 call-answering staff, due to the challenging working environment. The Trust has also seen a general increase in staff leaving within 6-12 months of recruitment. To resolve these challenges, the Trust has been trialling different working patterns and practices to retain staff. This includes shorter shifts and virtual working where possible, increased support for new staff and developing clear career progression routes.

What we looked at	What we found
	The Trust has had historic issues with managing its sickness rates. Pre-pandemic, rates were between 6% and 8% but increased during the pandemic with rates peaking at over 12% during winter 2022. The most recent project plan introduced in April 2022 has been effective in reducing rates from 10.6% in July 2022 to 8.2% in July 2023. The Trust has indicated that training for staff and investment in wellbeing services has been particularly successful. The People and Culture Committee receive regular reports containing analysis of specific pressures. There are higher rates of sickness within the operations department and reports also identify hotspots within local areas with helpful analysis and action plans identified, where appropriate. In relation to modernising its workforce, the Trust's long-term strategic framework details an ambition to significantly increase the number of Advanced Paramedic Practitioner positions. The roles which require eight years of training, necessitating longer-term planning. While there is a need for investment to achieve this vision, the Trust is taking steps, where possible, to make these changes, such as by substituting small numbers of vacant Emergency Medical Technician roles with increases in Advanced Paramedic Practitioner roles. The Trust successfully commissions health and education training of paramedics through HEIW and numbers of placements are based on the Trust's true workforce planning numbers. More recently this commissioning has expanded beyond a single University (Swansea) to also include Glyndwr University in Wrexham.

Exhibit 4: monitoring and oversight of workforce plan/strategy delivery

This section of the report focusses on the robustness of corporate oversight of workforce risks. We found that **there is reasonable Board level oversight of operational workforce challenges, but it is too early to judge the impact of delivering the People and Culture Plan.**

What we looked at	What we found
We considered whether delivery of the Trust's workforce strategy or plan is supported by robust monitoring, oversight, and review. We expected to see: • arrangements in place to monitor the progress of the workforce strategy or plan at management and committee levels; • effective action where progress on elements of the workforce strategy or plan are off-track; • performance reports showing the impact of delivering the workforce strategy or plan; and • the organisation benchmarking its workforce performance with similar organisations.	We found that **there is reasonable committee and management oversight of workforce performance information, and whilst the Trust has developed metrics to monitor its People and Culture Plan, it is too early to judge its effectiveness** The Trust has a clear and consistent focus on workforce performance indicators both operationally and at Board and committee level. A variety of different operational groups within the Trust as well as the People and Culture Committee and Emergency Ambulance Services Committee receive workforce metrics and information. Executive Management Team papers contain useful workforce information, such as analysis from the Integrated Technical Planning Group. This aligns to the Trust's strategic objectives, highlighting any financial and operational implications. It also helps the team effectively link workforce, finance, and operational issues for example, informing decisions on the recruitment of 100 additional frontline staff in the latter half of 2022-23. The Trust's People and Culture Committee receive significant information on workforce at each of its quarterly meetings. Where the committee has concerns about a particular workforce area or performance, it seeks further assurance by undertaking deep dives. Recent examples include deep dives on improving attendance, the Trust's volunteers, wellbeing, and turnover. Our review of papers in recent committee meetings found significant amounts of operational information provided to the committee, which may make it difficult for committee members to focus on strategic issues. However, the recent approval of the People and Culture Plan and work to develop a strategic workforce plan is likely to support the committee to maintain a medium to longer-term focus when considering the Trust's workforce.

What we looked at	What we found
	Following the People and Culture Plan's approval in May 2023, the People and Culture Committee approved metrics to monitor the Plan in August 2023. The metrics link to the themes and strategic objectives in the Plan and IMTP and will receive quarterly oversight. The metrics focus on short-term areas such as turnover and moving on interviews and employee engagement as well as some longer-term aspects including education and development. It will also include information from the Trust's newly purchased pulse survey tool, which should provide an insight into staff opinions, though it is currently too early to comment on the tool's effectiveness. Targets and milestones to deliver the People and Culture Plan are delivered via the Directorate Plan which is managed by the People and Culture leadership team and reported to the Strategic Transformation Board and PCC. The Trust is in the process of preparing a dashboard, which may help to provide this assurance on progress and impact. Once the Trust has developed its strategic workforce plan, it should also ensure there is appropriate reporting of targets and milestones to enable the People and Culture Committee to monitor its progress **(Recommendation 5).** The Committee also receives a comprehensive Monthly Integrated Quality and Performance Report (MIQPR). The Trust has recently revised the metrics covered in this report and now include additional, high-level people and culture indicators, including: • mental health-related sickness absence rates; and • data relating to applicants and shortlisted candidates from underrepresented groups. These additions should further strengthen the performance reports which provide helpful analysis across a multitude of relevant workforce indicators. While the Trust finds it difficult to benchmark performance with other NHS Wales, they benchmark performance with other ambulance services on an informal and irregular basis. The Trust should introduce regular workforce benchmarking with similar organisations and use this to inform relevant groups and committees on its performance and efficiency and to identify and share good practice **(Recommendation 6)**.

Appendix 1

Audit methods

Exhibit 5: audit methods

Exhibit 5: sets out the methods we used to deliver this work. Our evidence is limited to the information drawn from the methods below.

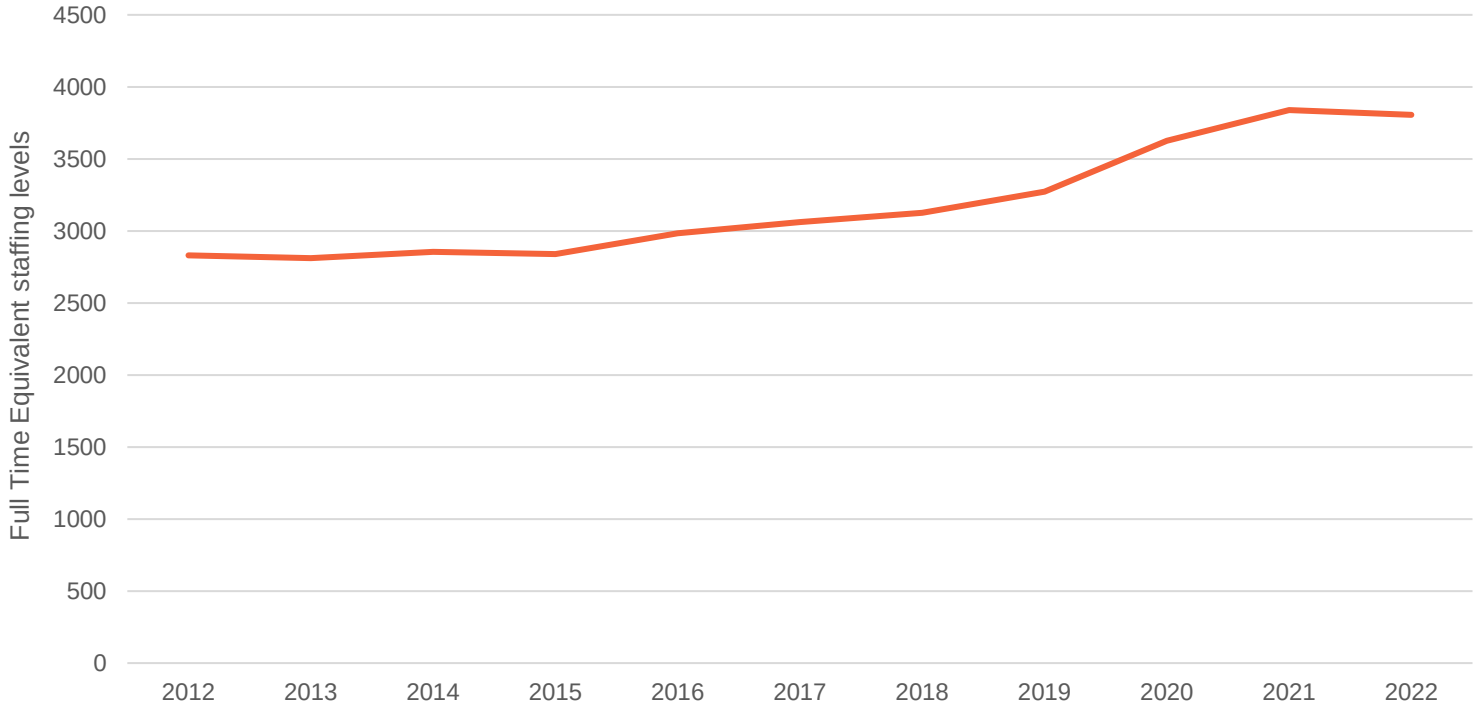
Element of audit approach	Description
Documents	We reviewed a range of documents, including: • Delivering Excellence strategy; • People and Culture Plan; • Integrated Medium Term Plan 2023-6; • Papers to inform workforce section of IMTP 2023-6; • Structure Charts for People and Culture and Programme Governance; • Demand and Capacity Reviews: Emergency Medical Services, Non-Emergency Patient Transport Services, and 111; • Terms of Reference for Forecasting and Modelling Cell and Integrated Technical Planning Group • Document relating to recruitment of addition 100 EMS staff; • EMS Workforce Plan 2023-8; • Evidence of evaluation of workforce strategy and/or associated initiatives; • Structure charts for workforce planning functions; • Corporate risk register; and • Corporate and operational level oversight and monitoring of workforce metric and strategy delivery
Interviews	We interviewed the following:

Element of audit approach	Description
	• Executive Director for Workforce and Organisational Development; • Deputy Director for Workforce and Organisational Development; • Director of Paramedicine; • Head of Workforce Transformation and Planning; • Strategic planning team officers; • Corporate and operational officers responsible for workforce data and intelligence; • Head of Finance; • Head of Workforce Education and Development; • Non-Executive Director with responsibility for Chairing People and Culture Committee; and • Trade Union representatives to the Board
Focus groups	We ran two focus groups with: • a selection of service leads involved in clinical workforce planning; and • a selection of service leads involved in the workforce planning of enabler services.

Appendix 2

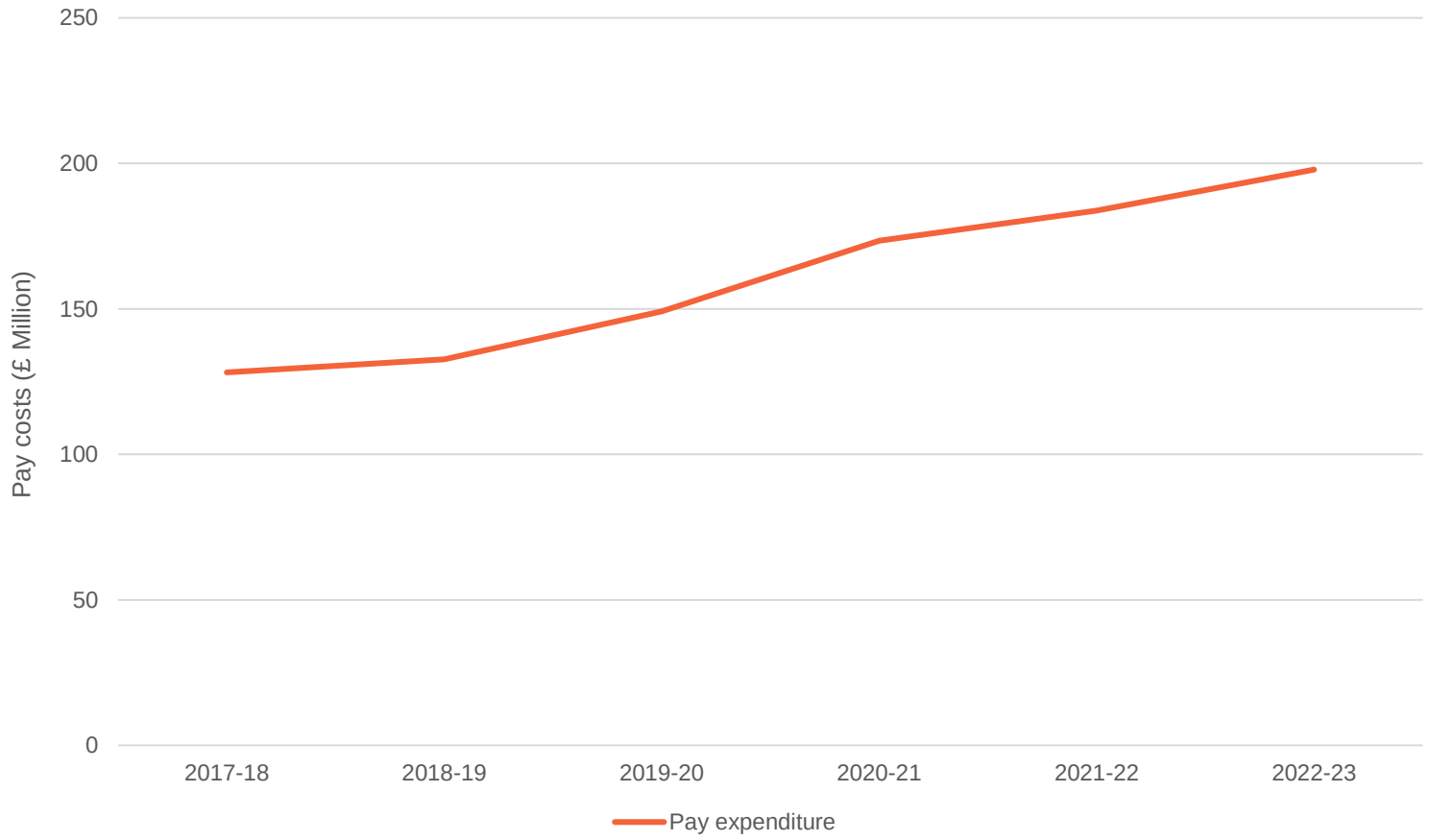
Selected workforce indicators

Exhibit 6: trend in workforce numbers (full time equivalent), Welsh Ambulance Services NHS Trust



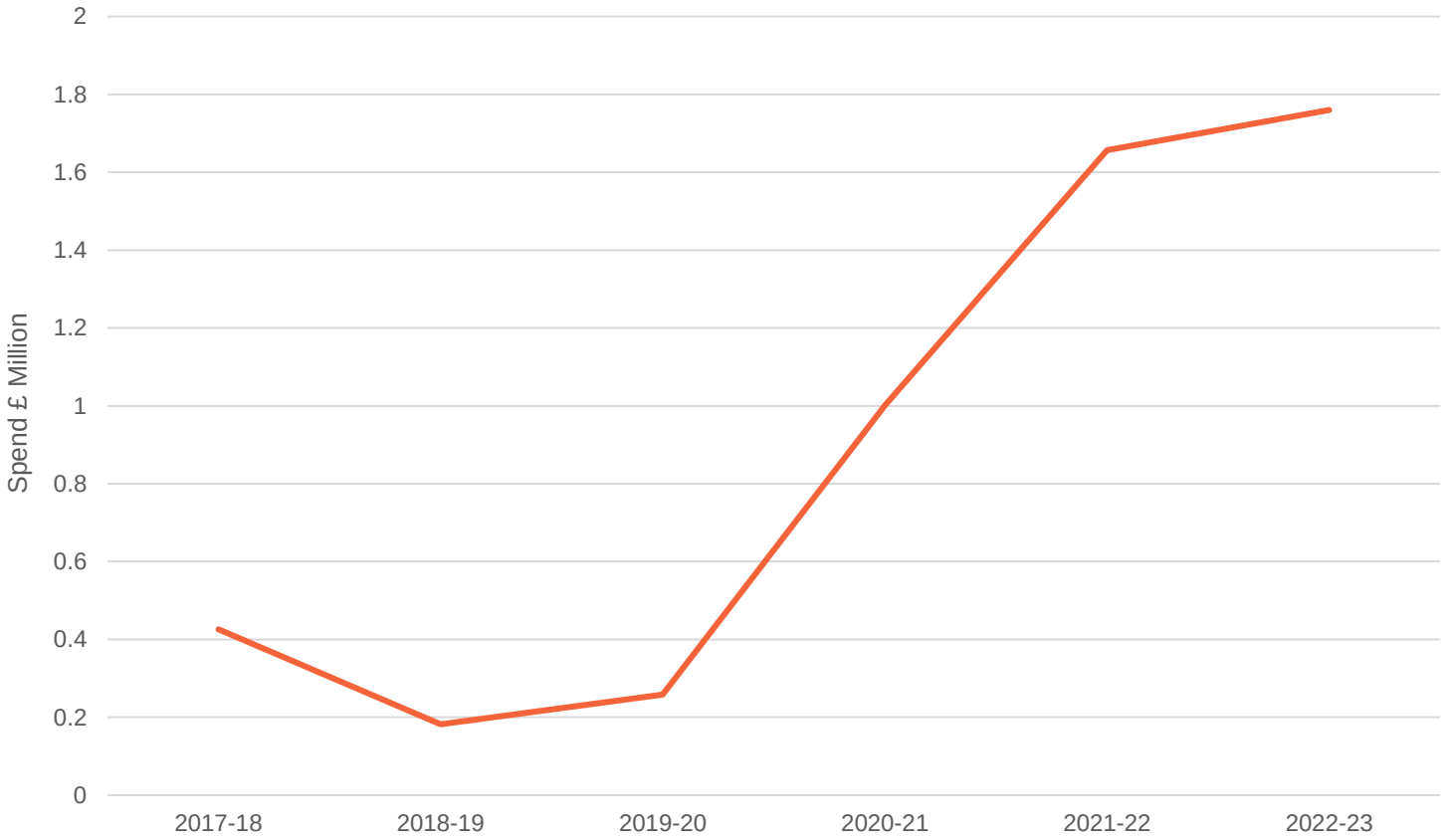
Source: Welsh Government, Stats Wales

Exhibit 7: trend in actual workforce costs, Welsh Ambulance Services NHS Trust



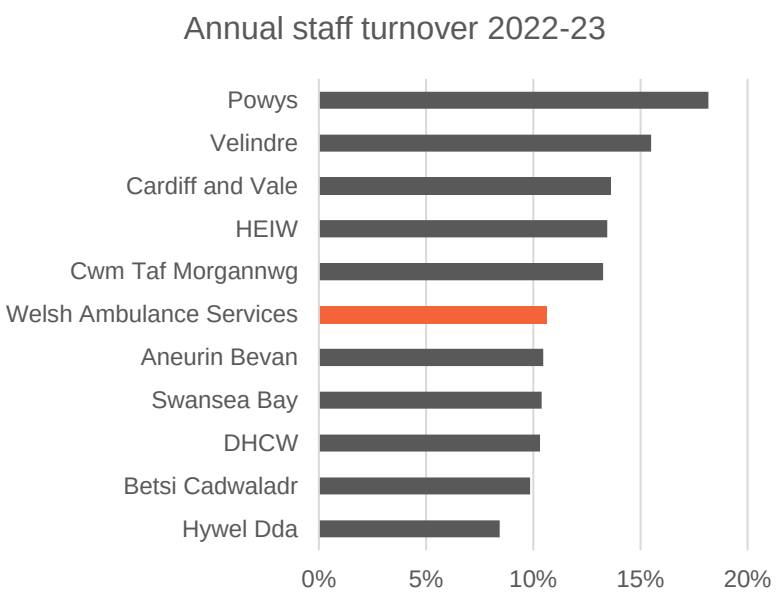
Source: Monthly Monitoring Returns reported to the Welsh Government

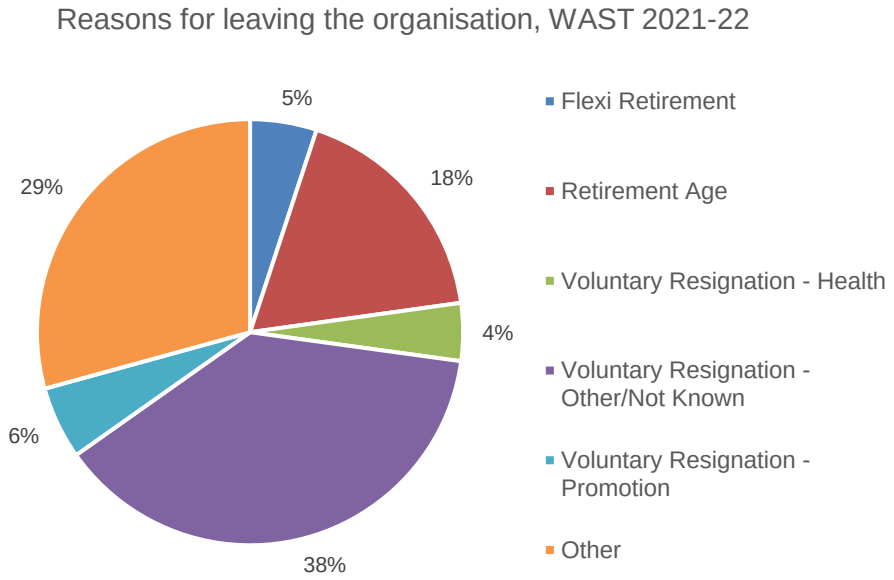
Exhibit 8: trend of expenditure on workforce agency £ million, Welsh Ambulance Services NHS Trust



Source: Monthly Monitoring Returns reported to the Welsh Government

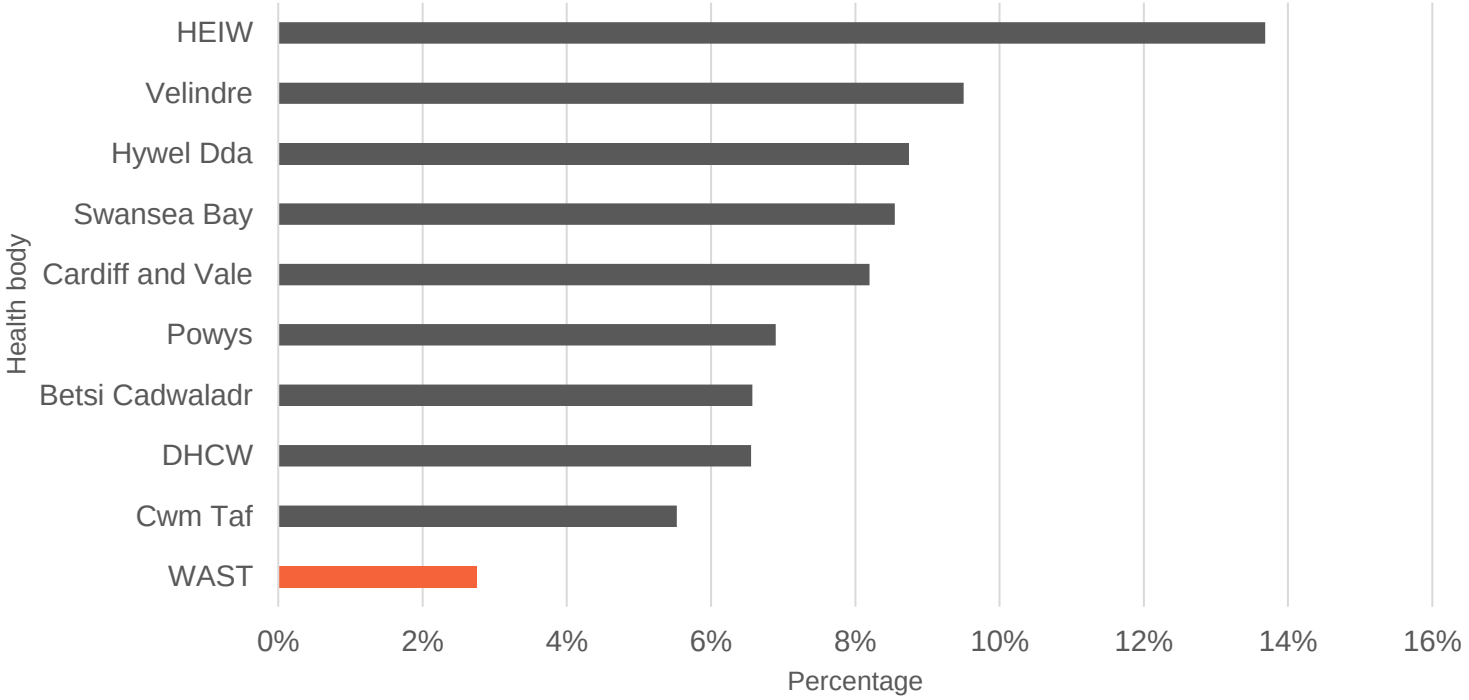
Exhibit 9: annual staff turnover and reason for leaving, 2021-22, Welsh Ambulance Services NHS Trust





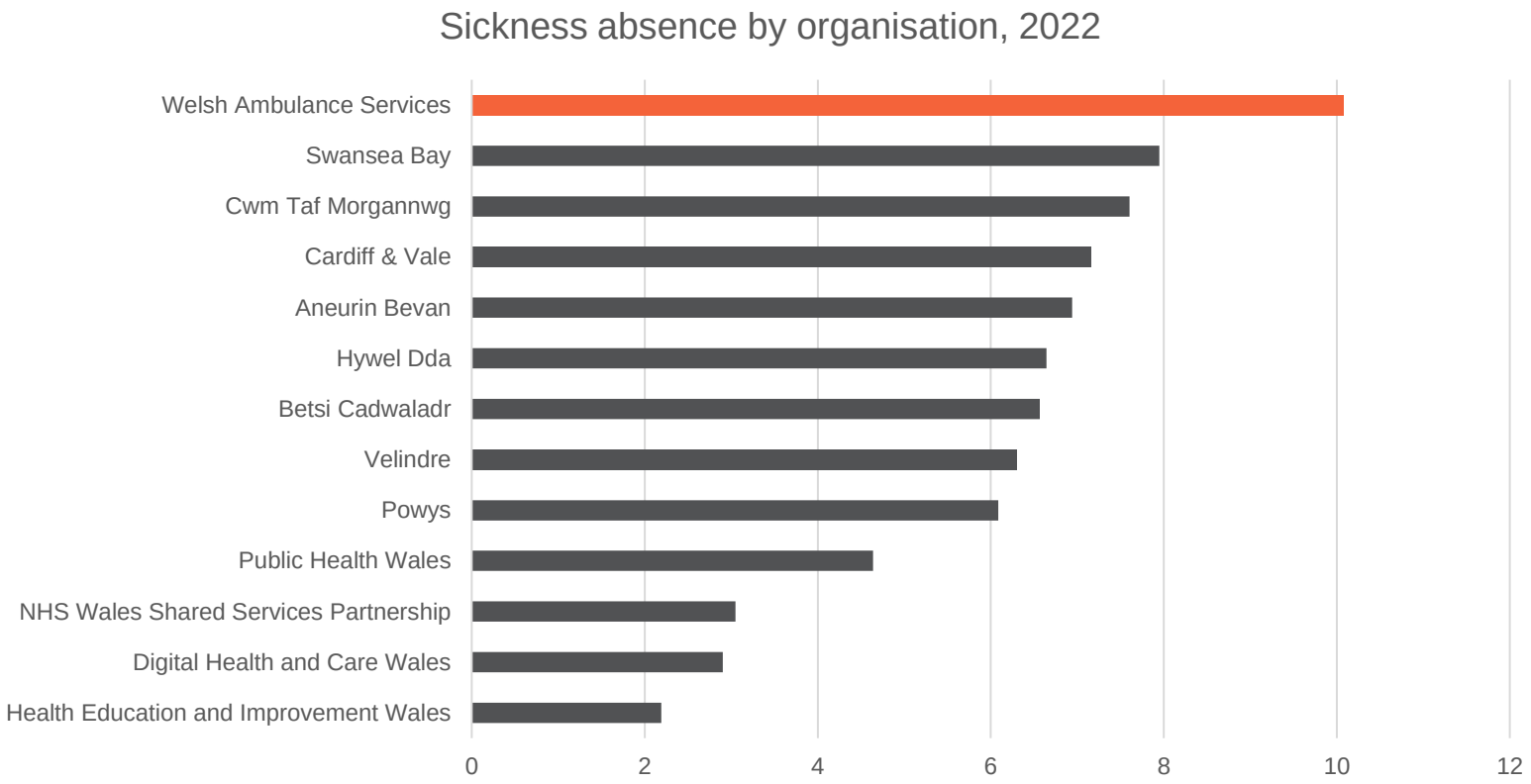
Source: staff turnover data sourced from Health Education and Improvement Wales. Reason for leaving data sourced from health body data request.

Exhibit 10: vacancies as a percentage of total establishment, as of March 2022 by organisation



Source: health body data request

Exhibit 11: sickness absence by organisation, 2022



Source: Welsh Government, Stats Wales

Appendix 3

Organisational response to audit recommendations

Exhibit 12: Trust response to our audit recommendations.

Ref	Recommendation	Organisational response	Completion date	Responsible officer (title)
R1	**Terms of Reference** We found that the Terms of Reference for both the Integrated Technical Planning Group and the Forecasting and Modelling Group require review. The Trust should review these to ensure they are accurate and up-to-date, particularly to clarify what role they will play in supporting the new People and Culture Plan and developing strategic workforce plan **(medium priority).**	Recommendation accepted Chair and Vice Chair of the ITPG and Forecasting and Modelling Group will update the Terms of Reference within the context of the internal governance structures.	End of December 2023	Assistant Director of Commissioning & Performance / Deputy Director, People and Culture

Ref	Recommendation	Organisational response	Completion date	Responsible officer (title)
R2	**Workforce information systems** We found that there is scope for the Trust to make better use of its workforce information by ensuring data is consistent, joined up and up to date. The Trust should work to ensure that **(medium priority)**: • Systems that hold workforce information including Electronic Staff Record (ESR), Global Rostering System (GRS) and finance systems interconnect, where possible. • Explore ways to resource the management of a system to ensure an up-to-date establishment model.	Use of Power BI reporting feeding into the Integrated Technical Planning Group is in development by the workforce planning team. This will be used for reporting and maintenance of the data. Alongside this we are working on Integrated Planning Nexus via the Planning and Strategy team which enables our understanding of the interconnection between workforce, fleet, estate etc.	Sept 2024 March 2024 (Excel version) Potential PowerBI version (Sept 2024)	Strategic Planning Officer (LP) / Deputy Director, People and Culture Assistant Director of Commissioning & Performance
R3	**Evaluating workforce planning training** We found that the Trust is strengthening workforce planning capability through training initiatives, but it will need to evaluate these to ensure they are having the desired impact. The Trust should develop an evaluation framework to measure the success of its training programme **(medium priority)**.	We will implement an evaluation process to baseline where managers are pre and post training and post 3 months to measure improvement.	June 2024	Head of Workforce Transformation and Planning / Deputy Director for Workforce and Organisational Development

Ref	Recommendation	Organisational response	Completion date	Responsible officer (title)
R4	**Recruitment support** We found that only the emergency ambulance services department has dedicated support from the central management team for recruitment activity, due to capacity issues. While the central team can provide support on a case-by-case basis, the Trust should review opportunities to increase the corporate support offered to other departments across the organisation **(medium priority).**	The recruitment team focus primarily on EMS but do offer support where needed to other services. This would need to be agreed by ELT and the Directorates as resource would need to be moved into the team from elsewhere. Report to be produced and shared with ELT.	May 2024	Head of Workforce Transformation and Planning; / Deputy Director, People and Culture
R5	**Metrics for People and Culture plan monitoring** The Trust has recently approved the metrics to enable monitoring progress of the People and Culture Plan, however the metrics do not include targets or milestones. The Trust should work to develop targets and milestones to enable the Committee to understand the progress against the Plan **(medium priority)**.	Recommendation Accepted. We will build in appropriate targets and milestones into the plan which will be frequently reviewed for delivery and effectiveness of both the plan and the measures.	May 2024	Head of Workforce Transformation and Planning; / Deputy Director, People and Culture

Ref	Recommendation	Organisational response	Completion date	Responsible officer (title)
R6	**Benchmarking** The Trust does not routinely benchmark its workforce performance metrics with other health bodies in Wales. Its performance benchmarking with other ambulance trusts is infrequent. The Trust should introduce regular workforce benchmarking with similar organisations and use this to inform relevant groups and committees on its performance and efficiency and to identify and share good practice **(medium priority)**.	Recommendation accepted for high level measures and will be based on what other organisations share / make available. Benchmarks need to be with ambulance sector rather than Health Boards	June 2024	Deputy Director, People and Culture / Assistant Director of Commissioning & Performance

Audit Wales

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

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

ALL WALES GROUP REPORT

ALL WALES AUDIT COMMITTEE CHAIRS (AWACC) MEETING

HIGHLIGHT REPORT

Date of Meeting	**20 November 2023, 10:15 – 12:15 [Virtual]**
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]
Nick Elliot	Public Health Wales
Rhodri Evans	Hywel Dda University Health Board
Marian Wyn Jones	Digital Health & Care Wales
Gill Lewis	Health Education & Improvement Wales
Nuria Zolle	Swansea Bay University Health Board
In Attendance:	
Trish Mills	Board Secretary, Welsh Ambulance Services NHS Trust
Alex Payne	Corporate Governance Manager
Simon Cookson	Internal Auditor, NWSSP [Left after item 3]
Chris Darling	Board Secretary, Digital Health & Care Wales [Item 4 only]
Anne Beegan	Audit Wales [Left after item 2]
Kate Havard	Audit Wales [Left after item 2]
Anthony Veale	Audit Wales [Left after item 2]
Apologies:	
Karen Balmer	Betsi Cadwaladr University Health Board
Iwan Jones	Aneurin Bevan University Health Board
Rhobert Lewis	Powys Teaching Health Board
Patsy Roseblade	Cwm Taf Morgannwg University Health Board
Martin Veale	Velindre NHS Trust
Rhian Thomas	Cardiff & Vale University Health Board

The following is a summary of the main issues discussed at the meeting

1. Introductions, Report from the 13 April 2023 and Actions Log

1.1. The report from the meeting held on the 13 April 2023 was received. The actions log was reviewed, and it was noted that all actions were completed and will be closed on the formal record;

1.2. With respect to the action regarding group members attending the Finance Directors Network it was proposed that respective Directors of Finance would feed back to their Audit Chairs separately, as required;

1.3. The group noted the sad passing of colleague Mark Taylor, Audit Committee Chair, and peer from Powys Teaching Health Board. The group sent their condolences to Mark's family.

2. Audit Wales Update

2.1. Colleagues from Audit Wales joined the group to provide updates regarding the NHS accounts audit reflections from 2022-23 and the NHS Performance Audit work including Value for Money;

NHS Wales Accounts Audit 2022-23 Reflections

2.2. All twelve bodies' accounts were delivered for 2022-23 to the statutory deadline. Anthony Veale noted the new audit approach taken in 2022-23 and thanked colleagues for their flexibility in supporting the delivery. It was a technically challenging year and more time was required by the audit teams with finance colleagues, with more adjustments required to accounts compared to previous years;

2.3. Of the seven Health Boards six organisations' accounts were qualified due to not achieving the breakeven. This will be the main regularity consideration for the 2023-24 accounting period. One issue that continued to surface was the issue of payments to Executive Officers being made at a higher rate than had been agreed by Welsh Government. The NHS finances data tool – an annual publication – was noted. This tool will be developed further;

NHS Wales Audit Planning 2023-24

2.4. The current timeline for certification of Annual Report & Accounts for 2023-24 is submission by the 30 June 2024; however, this is yet to be confirmed. Audit Wales has continued to experience recruitment and retention issues which could impact the audit delivery and submission schedule;

The following is a summary of the main issues discussed at the meeting

2.5. NHS bodies will receive communications from Audit Wales/Welsh Government (WG) before Christmas with an update on the position. Audit Wales reiterated that they are aware of the need to communicate the final schedule as soon as possible;

2.6. No significant technical issues are anticipated for 2023-24. It is possible that Reinforced Autoclaved Aerated Concrete (RAAC) may be an issue. The audit fees for 2022-23 exceeded the fee limits that were set prior to the audit process for some organisations. The fee limits for 2023-24 will be reviewed in the coming months;

2.7. The challenging financial position for the Welsh NHS bodies and the position that some find themselves in of continual qualification on the basis of failing to meet the break-even point, was noted. The group acknowledge the very challenging situation that the bodies are operating within;

2.8. The group asked whether there was any additional support that could be offered to ensure that bodies are complying with the WG requirements regarding executive pay. Kate Havard indicated that she would feed back specific issues and provide necessary guidance to the Technical Accounting Groups in addition to contacts in WG who prepare the Manual for Accounts;

2.9. Furthermore, the group wished to better understand why these issues were occurring. Anthony explained that responsibility for processing such pay requests is often with HR as opposed to finance, and there is often a disconnect between the two. Additionally, dialogue between bodies and WG regarding processes and retrospective approvals could be improved;

2.10. The group noted its disappointment that the schedule for the audit and submission of the Annual Report and Accounts was subject to adjustment, as was the case last year. This situation means that it is more difficult for audited bodies to plan and deliver the work. This view was acknowledged by Audit Wales, and it was accepted that the position should be communicated earlier than it was for 2022-23;

2.11. Audit Wales indicated that they work closely with Finance Directors across the NHS bodies in the planning process. There are mechanisms in place to inform the planning and to try to anticipate control issues. Kate Havard note that Audit Wales would test the market to anticipate issues which could impact the audit process. Additionally Audit Wales will share guidance sent to NHS bodies with regards to the preparation of the Annual Report and Accounts;

The following is a summary of the main issues discussed at the meeting

Value for Money Work Programme Update

2.12. The Annex prepared by Audit Wales with respect to the Value for Money (VfM) programme update was received. It was noted that the workforce planning work was ongoing and that all will have been received by respective Audit Committees by Spring 2024.

3. **Internal Audit & Assurance Update**

Programme Update

3.1. Simon Cookson provided an update on audit and assurance activity. As at the 31 October 2023 the position was as follows: - 319 anticipated audits/reviews will be completed for 2023/24. Of these 319 27% are complete, with 30% in progress (which is line with 2022/23);

3.2. Of the reviews to date 28% have been given the opinion of 'limited assurance'. The total of limited assurance reviews in 2022/23 by way of comparison was 16%. is intended that the audit work will be completed by the 31 May 2024 in line with the usual timeline, and additional work has begun in response to the limited opinions which will inform the annual opinions;

3.3. The audit position as at the 31 October 2023 is broadly as expected. Additionally further work has been completed on the audit database to identify risk themes. The Board Secretaries Network are engaged on this work. The NWSPP Internal Audit function has recently been appointed as the internal auditor for Llais;

3.4. With respect to the number of limited assurance reviews undertaken and the total figure of limited assurance compared to last year, Simon observed that this isn't unexpected as areas likely to have a limited opinion tend to be audited earlier in the financial year. A key theme regarding these reviews is that limited opinions tend to be given where a lack of funding is an issue;

Estates Condition Reviews

3.5. With respect to the Estates Condition audits, the estates condition across all Health Boards, WAST and Velindre has been set out. It has included a comprehensive review of the governance arrangements in place, in addition to respective estates strategies, funding strategies, monitoring/reporting and risk management;

3.6. To date, three of the Estates Condition reviews have been finalised, with five in draft. The fieldwork commenced in July 2023. The themes are consistent across all bodies, with all reports have been determined as 'limited assurance'. The adequacy, regularity and extent of survey information was variable, which impacted data quality;

The following is a summary of the main issues discussed at the meeting

3.7. There has been historical under-investment in estates which has resulted in significant gaps between required and approved levels of investment. Whilst capital bids were being submitted by many organisations and alternative funding streams were being provided, the identified backlog of risks cannot be managed within the available funding;

3.8. It is recommended that Boards focus efforts on business-critical areas within the backlog requirements to mitigate the highest risks. The WG have been updated on the status of their audit and NWSSP will prepare an All-Wales summary report detailing the key themes, areas of best practice, and wider issues for consideration;

IMTP Update 2023-24 and 2024-24

3.9. With respect to the objectives for 23-24 one has been completed (successful external quality assessment); four are on track (primary care focus, Partnerships approach, training and development plan, increased use of data analytics), and two are at risk (full implementation of new electronic working paper system and people requirements/recruitment and retention);

3.10. There are four new objectives proposed for 2024-25. These are to develop revised reporting methodology, focusing on outcomes and key messages; development of the staff pipeline programme, including new trainees and apprentices, to ensure the audit approach meets the NHS Wales future requirements and is aligned to the requirements of the updated Public Sector Internal Audit Standards, and to embed the training strategy within the division;

3.11. The group thanked Simon for his updates and acknowledged the messages given, specifically regarding the comments around lack of funding. Simon noted that his service meets with WG on a monthly basis to consider the limited or no assurance reviews. Simon was thanked for his update and congratulated on the service's appointment as internal auditor for Llais.

4. Programme Governance Changes for DHCW Hosted Programmes

4.1. Chris Darling, Board Secretary for Digital Health and Care Wales (DHCW) gave a presentation regarding the Programme governance changes for DHCW hosted programmes. The report recommendations and next steps were included in the presentation. The presentation can be viewed here:

DHCW Programme Governance Change

The following is a summary of the main issues discussed at the meeting

4.2. The Group thanked Chris for his attendance and providing this update on the Programme governance changes for DHCW hosted programmes. It was asked whether there were any insights into the national group. Chris advised that he would be happy to feed-back pertinent outcomes.

5. Scoping of future agenda items

5.1. Trish presented the following items for discussion by the group to scope out future agenda items: -

a) *<u>The independent review/learning from the LINC/RISP governance programmes</u> i.e., the way they were managed by the Collab and transferred to DHCW, lessons learnt etc. This work has been commissioned for an independent third party to undertake and is due to report back in November 2023.*

b) *<u>Local Counter Fraud:</u> Resource comparisons; common themes and fraud risk areas; All Wales approach to national proactive projects based on risk reviews; benchmarking reports of comparisons of key data within counter fraud such as case referrals, closure, and investigation progress updates.*

c) *<u>Welsh Language Standards:</u> Comparison of standards methodology; common themes/complaints from Commissioner; what are organisations doing around the More Than Just Words Action Plan.*

5.2. Trish stated that she hoped that the AWACC would consider these areas of business as interesting and appropriate for the work programme. The Chair suggested that this question could be posed to the members of the AWACC given the apologies received for the meeting. Gill Lewis noted that counter fraud matters is a significant issue and that this should return.

6. Update of key and relevant matters from the Board Secretaries Network

6.1. The following updates were received from Trish Mills:

- Commissioning Framework: - the Board Secretaries Network (BSN) have been involved in the governance workstream and informing the structures for the implementation board and the national commissioning oversight board.

- The BSN has recently reviewed its Terms of Reference and are considering how best they can support the Deputy Board Secretaries Network (DBSN). There will likely be changes to respective operating arrangements in the coming months.

The following is a summary of the main issues discussed at the meeting

- There are various programmes of work which the BSN are delivering, which include best practice in Board induction and development programmes, and the Independent Members' scrutiny toolkit updates. The BSN are also considering how Artificial Intelligence could help our organisations, particularly around note/minute-taking. Chris Darling in DHCW is piloting the use of Teams Intelligent Recap and MS Co-Pilot, as are WAST.

- The BSN receive regular updates from Internal Audit, Audit Wales, the NHS Confederation and Welsh Government on their work programmes and upcoming work. Recent updates from Welsh Government include changes to the Public Appointments Unit, the establishment of the NHS Wales Accountability Ministerial Task and Finish Group, and the recent changes to the model Standing Orders.

- The update received from the NHS Confederation include updates on legislation regarding the Social Partnership and Public Procurement (Wales) Act 2023 which has been enacted. Additionally, the BSN discussed the special purpose committee that has been established and the NHS Confederation has recently considered the Counter of Chester hospital case and regulation in the NHS.

7. Change of AWACC Chair

7.1. The Chair presented a request for the AWACC to consider the appointment of a new Chair as his tenure as a Non-Executive Director at the Welsh Ambulance Services NHS Trust was due to end in January 2024;

7.2. He noted that Nuria Zolle, Chair of the Swansea Bay University Health Board, had expressed her interest in the role. The members of the AWACC in attendance were overwhelmingly supportive of Nuria becoming the AWACC Chair and it was asked that this be re-confirmed upon distribution of the meeting report.

8. AOB

8.1. The Chair thanked colleagues for their contributions and their good wishes, and thanked Trish Mills and Alex Payne for their support in the facilitation of the AWACC over the last year and half.

9. Date of the Next Meeting

9.1. To be arranged once the Secretary/Secretariat for the group is re-confirmed. This will move to the body whose Audit Committee Chair is the Chair of the AWACC and is therefore expected to be the Board Secretary of Swansea Bay UHB.