Bundle Audit Committee (Open) 14 September 2023

Agenda attachments

ITEM 0 Agenda Audit Committee Open 14 September 2023

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: - 25 July 2023
ITEM 2 Audit Committee OPEN Minutes 25 July 2023 - V3

4 Action Log and Matters Arising
ITEM 4 PUBLIC AUDIT COMMITTEE Action and Decisions Log

4.1 ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION

5 09:40 - Internal Audit Items
ITEM 5.1 WAST_2324_Internal Audit Progress Report_September 23
ITEM 5.2 WAST2223_02 Health and Safety Final Internal Audit Report_for Trust issue
ITEM 5.3 WAST_2223-021_Follow Up_Final Internal Audit Report_for issue

6 10:10 - Audit Wales Reports
ITEM 6 WAST Audit Committee update 050923

7 10:30 - Amendments to the Standing Orders and Standing Financial Instructions – Welsh Government Review
ITEM 7 AC SBAR Standing Orders Review July 2023
ITEM 7.1 Annex 1 - Standing Orders Main Document v.6 draft for approval
ITEM 7.2 Annex 2 - Standing Orders - Schedule 2.1 Standing Financial Instructions v.6 for approval 280923
ITEM 7.3 Annex 3 - Standing Orders Schedule 1 Scheme of Reservation & D'gation v.6 for approval 280923

7.1 10:40 - COMFORT BREAK [10 Mins]

8 10:50 - Revised Audit Process
ITEM 8 SBAR to AC re Audit Handbook and Tracker
ITEM 8.1 Audit Handbook v.02 - August 2023

9 11:00 - Risk Management and Board Assurance Framework
ITEM 9 Executive Summary Risk Management Report AC 140923

10 11:15 - Losses and Special Payments
ITEM 10 Executive Summary SBAR Losses and Special Payments M05 2023-24
ITEM 10.1 Annex 1 - Losses Special and Payments 2023-24 M5 v2

11 11:25 - Speaking Up Safely Update

12 11:35 - Board/Committee Induction Programme
ITEM 12 Audit Committee Board and Committee Induction Programme Update
ITEM 12.1 WAST Board Induction Programme Template
ITEM 12.2 Annex 2 - NED Set Up Form

13 11:40 - Committee Cycle of Business Monitoring Report and Committee Priorities Report
ITEM 13 Audit Committee Priorities, Cycle Monitoring Report and Membership Update
ITEM 13.1 Cycle of Business Monitoring Report - September 2023

14 11:45 - Trust Policy Report
ITEM 14 Executive Summary Policy Report AC Sept 2023
ITEM 14.1 Policy Tracker 010923

14.1 11:55 - CONSENT ITEMS

15.1 11:55 - CLOSING ITEMS

16 Reflections & Summary of Decisions and Actions

17 Key Messages for Board

18 Any Other Business

19 Date and time of next meeting: 30 November 2023 – 09:30

Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru Welsh Ambulance Services NHS Trust

AGENDA

MEETING OF THE OPEN AUDIT COMMITTEE

Held in public on **14 September 2023 from 09:30 to 12:00**

Meeting held virtually via Microsoft Teams

No.	Agenda Item	Purpose	Lead	Format	Time
OPENING ITEMS					
1.	Chair's welcome; apologies and confirmation of quorum	Information	Martin Turner	Verbal	10 Mins
2.	Declarations of Interest	To State Conflicts	Martin Turner	Verbal	
3.	Minutes of last meeting: – 3.1 25 July 2023	Approval	Martin Turner	Paper	
4.	Action Log and Matters Arising 4.1 Open Actions	Discussion	Martin Turner	Paper	
ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION					
5.	Internal Audit Items 5.1 Head of Internal Audit Progress Report 5.2 Health and Safety 5.3 Follow up Audit	Assurance	Osian Lloyd Liam Williams Trish Mills	Paper	30 Mins
6.	Audit Wales Update Report	Assurance	Fflur Jones	Paper	20 Mins
7.	Amendments to the Standing Orders and Standing Financial Instructions – Welsh Government Review	Endorsement	Trish Mills	Paper	10 Mins
COMFORT BREAK [10 Mins]					
8.	Revised Audit Process	Approval	Trish Mills	Paper	10 Mins
9.	Risk Management and Board Assurance Framework	Assurance	Julie Boalch	Paper	15 Mins
10.	Losses and Special Payments	Approval	Chris Turley	Paper	10 Mins
11.	Speaking Up Safely Update (Whistleblowers)	Assurance	Paul Hollard	Verbal	10 Mins

No.	Agenda Item	Purpose	Lead	Format	Time
12.	Board/Committee Induction Programme	Assurance	Trish Mills	Paper	5 Mins
13.	Committee Cycle of Business Monitoring Report, Priorities Report and Membership Update	Approval	Trish Mills	Paper	5 Mins
14.	Trust Policy Report	Approval	Julie Boalch	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.**					
15.	No consent items.				
CLOSING ITEMS					
16.	Reflections & Summary of Decisions and Actions	Information	Martin Turner	Verbal	5 Mins
17.	Key Messages for Board	Information	Martin Turner	Verbal	
18.	Any Other Business	Discussion	Martin Turner	Verbal	
19.	Date and time of next meeting: 30 November 2023 – 09:30	Information	Martin Turner	Verbal	

Lead Presenters

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

WELSH AMBULANCE SERVICES NHS TRUST

UNCONFIRMED MINUTES OF THE OPEN MEETING OF THE AUDIT COMMITTEE OF THE WELSH AMBULANCE SERVICES NHS TRUST HELD ON THURSDAY 25 JULY 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
Judith Bryce	Assistant Director of Operations
Andrew Doughton	Performance Audit Manager Audit Wales
Jillian Gill	Head of Financial Accounting
Navin Kalia	Deputy Director of Finance and Corporate Resources
Angela Lewis	Director of People and Culture
Olaide Kazeem	Project Accountant Financial Services
Jason Killens	Chief Executive Officer (Left during Item 27/23)
Osian Lloyd	Head of Internal Audit
Gareth Lucey	Audit Wales
Rachel Marsh	Executive Director of Strategy, Planning and Performance
Trish Mills	Board Secretary
Steve Owen	Corporate Governance Officer
Alex Payne	Corporate Governance Manager
Erin Pollard	Audit Wales
Felicity Quance	Deputy Head of Internal Audit
Paul Seppman	Trade Union Partner
Marienela Stoicheri	Risk Officer
Andy Swinburn	Director of Paramedicine (Item 27/23 only)
Lisa Trounce	Business Manager, Corporate Services
Chris Turley	Executive Director of Finance and Corporate Resources
Damon Turner	Trade Union Partner

Liam Williams	Executive Director of Quality and Nursing
Carl Window	Counter Fraud Manager

APOLOGIES:

Lee Brooks	Executive Director of Operations
Fflur Jones	Audit Wales
Joga Singh	Non-Executive Director
Leanne Smith	Interim Director of Digital Services

25/23 PROCEDURAL MATTERS

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

Declarations of Interest, other than those listed in the Declarations of Interest register, there were no further declarations. The Committee noted that Kevin Davies was no longer a Trustee of St John, the register would be updated to reflect this. The apologies as described were noted.

Minutes: The Minutes of 2 March 2023 and 20 April 2023 were approved subject to reflecting that Paul Seppman had sent apologies for the meeting on 20 April 2023. He was unable to attend due to attending a meeting on industrial action with the Director of Paramedicine and the Executive Director of Quality and Nursing.

RESOLVED: The apologies as described were noted and the Minutes of 2 March 2023 and 20 April 2023 were approved.

26/23 2022-23 ANNUAL ACCOUNTS AND ANNUAL REPORT AND RECOMMENDATION TO TRUST BOARD

The Chief Executive was in attendance for this item.

The Committee gave detailed consideration to the Trust's accounts for the year ended 31 March 2023 which had been prepared by the Trust to comply with International Financial Reporting Standards adopted by the European Union, in accordance with HM Treasury's Financial Reporting Manual by the Welsh Ambulance Services NHS Trust under schedule 9 section 178 Para 3 (1) of the National Health Service (Wales) Act 2006 (c.42) in the form in which the Welsh Ministers, with the approval of the Treasury, directed.

Navin Kalia presented to the Committee with an overview of the 2022/23 Annual Accounts. The main points for the Committee's attention included:

(a) The draft accounts had been formally submitted to Audit Wales on 5 May 2023 with all statutory financial duties being met.

(b) A retained surplus for the year of £0.062m had been achieved; effectively a break-even position with total income of £296.092m and Net expenditure of £296.030m.

(c) The breakdown of income from patient care activities was £283.2m consisting of: Emergency Ambulance Services Committee, £230m, Local Health Boards, £17m, Welsh Government, £34m and income from other Trusts, £2m. The total increase from the previous year was £21.6m.

(d) The main reasons for the increase from last year included the demand and capacity phase two and phase three funding, growth and inflation and the recurrent impact of the 2021/22 pay award.

(e) In terms of expenditure, pay costs were £204m and Non pay and other costs came to £92m. The main differences for the previous year were an increase of £14.6m in pay and a net increase of £5.4m in Non-pay expenditure.

(f) With respect to the Balance Sheet, the Net Book Value as at 31 March 2023 was £99m. Debtors had increased by £1.4m with borrowings increasing by £10m as a result of recognition of finance leases re implementation of IFRS16 during the year.

(g) Presentational points on the draft Accounts had been raised by Audit Wales in which a comprehensive update was provided to the Committee.

(h) The Accounts, following today's meeting were due to be formally approved at Trust Board on 27 July 2023 for onward submission to Welsh Government by 31 July 2023.

Wales Audit of Accounts Report

Gareth Lucey presented the report and provided a summary on the following key details for the Committee's attention:

(a) It was proposed that an unqualified audit opinion would be submitted with the audit work now complete.

(b) Reference was made to some minor corrections but there were none of any significance. There were no corrections identified that impacted on the Trust's retained surplus position for the year.

(c) There were no uncorrected misstatements arising from the audit work; anything that required presentational correction had been carried out.

(d) The Committee were advised of the position concerning a Ministerial Direction regarding pension tax liabilities for certain senior clinical staff; it was no longer material and therefore did not affect the audit opinion.

(e) There were two items of expenditure recorded in the 2022/23 accounts which technically should have been recorded in the following year's accounts; however, the amount was below the recognised threshold for materiality hence required no adjustment.

Comments:

In respect of property, plant and equipment, clarity was sought on the comments with regards to valuation. Gareth Lucey explained the comments related to the 2022/23 accounts, and as a legacy of the pandemic, a number of asset valuers issued guidance on the material value uncertainty with evaluation reports at the time. No such uncertainty had been reported by the valuer for 2022/23, therefore this narrative had been removed from the final accounts.

Annual Report 2022/23

The report was presented by Trish Mills who indicated the report consisted of two parts, the Performance Report and the Accountability Report. The Performance Report contained details of how the Trust had performed during the last year. The Accountability Report detailed the key accountability requirements and Governance Statement. The Committee noted that the Board would receive one unified document when the report was presented for approval.

Trish Mills explained there were some minor non-material date changes to two of the graphs within the report; these have since been corrected for the version going to Trust Board.

In terms of translation to Welsh, the Committee were advised that the Annual Report will be translated in time for the Annual General Meeting (AGM) scheduled on 27 September 2023. Members noted that only the front page of the Accounts will be translated.

The Committee acknowledged the work by all involved in the production of these reports and recorded a note of thanks.

RESOLVED: **The Committee proposed and agreed that the Annual Accounts and Annual Report 2022/23 be recommended for approval by the Trust Board.**

27/23 INTERNAL AUDIT ITEMS

The Head of Internal Audit (HoIA), Osian Lloyd presented the reports which consisted of his opinion for the 2022/23 financial year – which was of reasonable assurance - and several Internal Audit (IA) Reports as listed below.

The HoIA report set out details of the IA work performed throughout the last financial year. It also contained a summary of audit performance and an assessment of conformity against the public sector internal audit standards.

It was noted that during the year 2022/23 19 Audit Reviews were reported on; 15 were rated as reasonable assurance, three as limited and one was just an advisory review with no rating applied.

The Committee noted that the latest external quality assessment had been conducted by the Chartered Institute of Public Finance and Accountancy; this had confirmed that the IA work fully conformed to the requirements of the Public Sector Internal Audit Standards.

The following Internal Audit reports were received:

(a) Risk Management & Assurance: – Opinion was reasonable. Felicity Quance explained that the purpose was to review the framework of organisational assurances in place for the reporting of risk management. Four medium priority recommendations had been raised. The review had clearly demonstrated improvement in risk reporting and strengthening of the Board Assurance Framework (BAF). It was noted that the timely review of risk mitigations had been impacted by the challenges faced as a result of winter pressures and industrial action. Furthermore, it was recognised the recent appointment of a Risk Officer will benefit the risk management arrangements going forward.

Trish Mills reminded the Committee that a transitional BAF had been introduced last year and continued to mature to a much more strategic one. She further noted that work was continuing to ensure that the mitigation actions achieved the intended impact.

The Committee were pleased to see the progress being made in particular acknowledging where management challenged the recommendations made to agree a more appropriate or realistic management action.

Members queried whether and how lessons were being learned in this area. Felicity Quance commented that the Trust were kept informed of any relevant information for improvement.

(b) Savings and efficiencies: – Opinion was reasonable. Felicity Quance explained that the purpose to the report was to ensure that savings plans were specific, realistic, and measurable and that monitoring arrangements were effective. Four medium priority recommendations had been raised. It was noted in the report that achieving financial balance for the forthcoming year would be a challenge for the Trust. It was pointed out that a review of the Financial Sustainability Programme was not

undertaken as this will be part of the 2024/25 Internal Audit plan. Several areas which required management attention included; the requirement to develop guidance to assist staff in assessing and approving savings plans, provide financial training and to develop a template to ensure savings information was robustly recorded and reported. It was further noted that whilst some of the individual savings schemes had been achieved, management and processes of those that were underachieved required enhancement.

It was queried whether sufficient scrutiny had been applied in the report in terms of the impact on the Trust's ability to support patients as a result of the savings efficiencies. Felicity Quance assured the Committee that going forward this level of scrutiny would be applied to ensure that the wider impact for the delivery of savings was achieved. Liam Williams added that as part of the quality impact assessment process, the Trust would only action savings plans where they did not have detrimental impacts on patients. Trish Mills added that work was underway to identify when impact assessments required implementation.

Navin Kalia assured the Committee that the points raised in the review were being addressed as part of the Financial Sustainability Programme management going forward.

The Committee were keen to understand if the Trust could adopt areas of best practice around savings from other health boards. Osian Lloyd advised the Committee that a data base was held by Internal Audit to capture best practice across Wales and that the savings and efficiencies element would be added going forward. The database was shared with the Board Secretaries Network.

Members noted and as described by Martin Turner, that at a recent Finance and Performance Committee meeting concern had been expressed that the Trust was in part relying on non-recurring savings to balance throughout 2023/24.

(c) Trade Union Release Time: – Opinion was limited. Felicity Quance explained that the purpose of the report was to provide assurance on the deployment of the refreshed Trade Union facilities agreement and to include a review of progress made to implement recommendations raised in the 2018/19 report which was of limited assurance. It was acknowledged that whilst some progress had been made, several of the significant matters raised replicated the recommendations picked up in the 2018/19 report. Of the recommendations made, three were high priority and one was medium. As part of the review, sample testing had revealed a lack of an audit trail to demonstrate appropriate and timely request when facility time was made. The recording of detail of the facility time was currently only available using the GRS system; access to this system was not available during the review. As there was no system in place to record the system release time, it had not been possible to evidence accurate management information.

Paul Seppman explained that a great deal of TU time was not within their control and was taken up in attending various meetings. He assured the Committee that when TU staff were on shift there was an auditable trail in terms of how release was applied. He added there were challenges in managing the time effectively; however, the impact on operational shifts was kept to a minimum. He stressed the importance of dedicating time to partnership working and the need for clinical skills to be maintained.

Carl Window assured the Committee that his team produce reports that echoed some the findings contained within the review.

Members recognised that the management response to the review had clearly demonstrated the continued good relationship with TU partners. The Committee further noted that progress on the recommendations would be monitored through the People and Culture Committee.

(d) Pain Management: – Opinion was limited. Felicity Quance explained that the purpose of the review was to consider the application of pain relief methods and the effect on patient outcomes in terms of pain relief and patient satisfaction. It was noted that this was the first time a review of this kind had been conducted. Three recommendations had been raised, two high and one medium. It should be borne in mind that clinical outcomes of the drugs administered and the cost effectiveness of drugs currently in use at the Trust were not part of the assessment. Key points raised from the review which required management attention included; poor compliance rates in Patient Group Direction (PGD, legal mechanisms that permit Paramedics to administer drugs that were not currently included in schedule 17 of the Human Medicines regulations (2012)), completion for Advance Paramedic Practitioners (APC), PGD's were not reviewed on a regular basis, a lack of oversight into pain scores, and administration of analgesia and the administration of analgesia by appropriately qualified clinicians.

(e) Information Management and Technology (IM&T) Infrastructure: - Opinion was reasonable. Osian Lloyd explained that the objective of the review was to provide assurance over the management and operation of the Trust's IM&T infrastructure. The review demonstrated that the Trust maintains a record of infrastructure assets and that the equipment is kept up to date. The key management actions included; ensuring accuracy of the asset register, formalising the alert management process, ensuring all switches which were used to connect devises on the network were recorded on the register and ensuring that the services to be provided within the back-up site were prioritised appropriately. Three medium priority findings and one high were raised.

RESOLVED: The Internal Audit reports as presented were received.

28/23 AUDIT WALES REPORTS

The Committee received the Audit Wales update report from Andrew Doughton who presented it as read and highlighted the following:

(a) The workforce review was in progress and should be available at the next Committee meeting.

(b) In terms of good practice events, the Committee were advised of upcoming events which would focusing on digital, particularly around leadership and strategy. The events were due to take place in Cardiff and North Wales on 21 and 27 September, respectively. Further details can be obtained from the Audit Wales Team.

Comments:

It was queried whether the good practice events would include how the digital strategy work linked to the impact of the duty of quality. Andrew Doughton explained they will have a citizen focussed approach and was certain that the quality aspect would be taken into consideration.

Members queried the timeline for publication in respect of the Unscheduled Care Review. Andrew Doughton explained that part one was due out soon and once available will be published on the Audit Wales website.

Detailed Audit Plan 2023

Gareth Lucey presented the plan which had recently been forwarded to Members for comment.

Work programme for 2023-2026

Andrew Doughton presented the report for the Committee's information.

RESOLVED: The Committee received and noted the Audit Wales detailed audit plan for 2023 and the work programme for 2023-2026.

29/23 RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK

The update was provided by Julie Boalch and the Committee were asked to note the following:

(a) All of the risks except for 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 283 (Failure to implement the EMS Operational Transformation Programme) had been reviewed during July. This was in line with the reviewing schedule.

(b) Two risks had increased in score, risk 424 (Prioritisation or availability of resources to deliver the Trust's IMTP) from 12 to 16 and risk 163 (Maintaining effective and strong Trade Union Partnerships) from 12 to 16.

(c) Two risks have been closed, risk 245 (Failure to have sufficient capacity at an alternative site for EMS Clinical Contact |Centres which could cause a breach of Statutory Business Continuity regulations) and risk 557 (Potential impact on services as a result of Industrial Action).

(d) 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 been included on the register with a score of 15.

(e) The Committee noted the update on the Risk Management Transformation Programme.

RESOLVED: The Committee:

(1) Noted the review of each high rated principal risk including ratings and mitigating actions.

(2) Noted the inclusion of the Civil Contingencies Risk on the Corporate Risk Register at a score of 15 as presented to Trust Board in May 2023.

(3) Noted the increase in score of Risk 424 from 12 to 16.

(4) Noted the increase in score of Risk 163 from 12 to 16.

(5) Noted the closure of Risk 245 from the Corporate Risk Register.

(6) Noted the closure of Risk 557 from the Corporate Risk Register;

(7) Noted the update on the Risk Management Transformation Programme.; and

(8) Received the Guidance on Interpreting the Board Assurance Framework.

30/23 AUDIT TRACKER REPORT

Julie Boalch presented the report advising the Committee there were 143 internal audit recommendations with 52 being overdue from their agreed completion dates.

The Committee were advised there were several historical recommendations overdue from the 2019/20 and 2022/21 financial years. Following advice from Internal Audit a number of these have since been closed. Members also noted that further consideration will be given to the longest overdue recommendations with a view to closing these in due course.

Work with the tracker was continuing, particularly looking at refreshing the overall process of mapping recommendations.

Comments:

A note of thanks was recorded for Internal Audit for their assistance in closing some of the more historical audits.

Trish Mills explained that at the next meeting the Committee would receive a revised Audit Tracker which will include a revised process for tracking recommendations and a new tracking format; it will also include a new guidance document.

Osian Lloyd added that several recommendations had been captured prior to the pandemic. He further added that the follow up review report, which tested a sample of recommendations that had been closed on the tracker, was near completion and would receive a reasonable assurance report at the next meeting.

RESOLVED: The Committee noted the update and:

(1) Considered the audit activity since the last Audit Committee; and

(2) Considered the proposals to address each recommendation particularly arrangements for the closure of historic recommendations.

31/23 POLICY REPORT

Julie Boalch explained that the purpose of the report was to provide an update on the status of the Trust's policies.

Several 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 has resulted in most policies being past their review date; however, it is important to note that these remain extant policies, they are in use and have not expired. The majority of policies will only require minor changes during the review process as they have already been through robust governance.

The Committee were advised that of the Trust's 93 policies, only 13 were within their review date. A prioritisation exercise was underway to address this and also the governance process was underway which will include a review of the policy on policies. The work will also look at whether any non-critical policies could be considered as a Standing Operating Procedure as opposed to a policy.

Julie Boalch assured the Committee that the majority of policies had already been subject to a robust governance process; with experts within the Trust keeping a close eye on any legislative changes that could impact on the policies.

Comments:

Trish Mills assured the Committee that the Board was aware of the current situation in respect of the status of policies.

Following a query in respect of the number of NHS Wales policies, Julie Boalch explained there were 19 NHS Wales policies relevant to the Trust and the next iteration of the report would include timelines of these policies.

RESOLVED: The Committee;

(1) Considered the contents of the report and the programme of work in development to mitigate risk and bring policies in line with appropriate review dates; and

(2) Provide a view on any of the policies within Committee's remit that should be included on the priority work plan.

32/23 STANDARDS OF BUSINESS CONDUCT POLICY

Trish Mills presented the revised Standards of Business Conduct Policy to the Committee to endorse for onward submission to Trust Board, for approval.

The Committee were reminded that a limited assurance opinion was given on the Standards of Business Conduct review which was conducted last year; one of the recommendations was to develop a revised Policy.

The Policy has undergone a wholesale revision and details of the material changes were set out in the covering report. An All-Wales approach to standards of business conduct was being developed, however the policy has been drafted on best practice principles and has been reviewed and endorsed by the Policy Group and the Executive Management Team. A focused campaign of stakeholder consultation has assisted in the presentation of a well-rounded policy to the Committee.

RESOLVED: The Committee;

(1) Noted the update on the Standards of Business Conduct Policy;

(2) Noted the next steps for the Corporate Governance Team; and

(3) Endorsed the revised Standards of Business Conduct Policy for approval by Trust Board.

33/23 LOSSES AND SPECIAL PAYMENTS FOR THE PERIOD 1 APRIL 2022 TO 31 MARCH 2023 AND 1 APRIL 2023 TO 31 MAY 2023

Navin Kalia gave an update on the losses and special payments for the following periods: Total net losses and special payments during 1 April 2022 to 31 March 2023 amounted to £380k and for 1 April 2023 to 31 May 2023 amounted to net reimbursements of £41k.

RESOLVED: The Committee received the report.

34/23 QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE REPORT – CLINICAL AUDIT PLAN 2022/23 APPROVAL

Trish Mills explained that the Quality, Patient Experience and Safety Committee (Quest) were required, in line with its terms of reference, to assure the Audit Committee of its approval of the Clinical Audit Plan annually.

RESOLVED: The Committee noted the approval of the clinical audit plan for 2022/23 by the Quest Committee.

35/23 AUDIT COMMITTEE CYCLE OF BUSINESS

Trish Mills presented the report and drew the Committee's attention to the following points which were in the Committee's terms of reference but not clearly evident in the cycle of business:

(a) Whistleblowing processes and arrangements; regular verbal updates in respect of the investigation progress will be provided by the Chair of the People and Culture Committee (PCC) as an interim measure until the speaking up safely framework was fully developed. Overall oversight will remain with PCC.

(b) Near miss reports; the National Audit Office recommends that Audit Committees review information on near misses to assist in determining whether the systems in place were sufficiently robust to mitigate future risk events. It was proposed that reports of this nature be monitored at the Quest Committee.

Comments:

Paul Hollard considered that it would be prudent for near misses to be captured at each Committee and should there be a consistent issue or trend then Audit Committee would be alerted to those by the Chair of that Committee.

The Committee were made aware by Trish Mills that near miss reports would not only cover patients but would have a much wider context, for example cyber security near misses and that would be overseen at the Finance and Performance Committee.

Trish Mills further explained that as the near miss report was being developed, that Committees deal with near misses under their remit, and the Chair of each Committee update the Audit Committee accordingly.

It was agreed that Trish Mills would provide further clarity on recommendation (b)(Approve the approach to the whistleblowing and near misses elements of the terms of reference such that the whistleblowing process and arrangements for special investigations will come to Audit Committee with regular verbal updates from the Chair of the People and Culture Committee on progress in the interim, and that QUEST will monitor near miss reporting), specifically to indicate the reporting process involved for each Committee and that the mechanism by which near misses – with respect to the criteria for escalation to Audit Committee where there are concerns regarding governance, internal controls, and management of risk - will be further considered and brought back to the Committee for endorsement.

Liam Williams provided the Committee with an overview of near misses were currently reported from a quality and patient safety point of view. Based on the level of severity the near miss incurs or not, it is recorded on Datix and reviewed either by the Health and Safety or quality Safety team; this would then determine whether an intervention was required as a result of the near miss. Thematic analysis would also be carried out, and if required would be escalated to the relevant assurance Committee. Of note he added that the volume of incidents was significant, and achieving the right response was a real challenge.

RESOLVED: The Committee

(1) Reviewed and approved the 2023-24 cycle of business at Annex 1; and

(2) Further clarity on recommendation be provided (b)(Approve the approach to the whistleblowing and near misses elements of the terms of reference such that the whistleblowing process and arrangements for special investigations will come to Audit Committee with regular verbal updates from the Chair of the People and Culture Committee on progress in the interim, and that QUEST will monitor near miss reporting), specifically to indicate the reporting process involved for each Committee and that the mechanism by which near misses – with respect to the criteria for escalation to Audit Committee where there are

concerns regarding governance, internal controls, and management of risk - will be further considered and brought back to the Committee for endorsement was agreed.

36/23 COMMITTEE PRIORITIES REPORT

The report updated the Committee on progress against the priorities it set for 2023/24 and was noted.

RESOLVED; The Committee noted the update.

37/23 20 APRIL 2023 AAA REPORT

The report was presented for information.

RESOLVED: The Committee noted the report.

38/23 REFLECTIONS & SUMMARY OF DECISIONS AND ACTIONS

Trish Mills asked, and it was agreed that a verbal update be provided at the Board meeting.

RESOLVED: The Board will receive a verbal update.

Meeting concluded at: 11:44

Date of Next Meeting: 14 September 2023

ACTION LOG

WELSH AMBULANCE SERVICES NHS TRUST - AUDIT COMMITTEE - December 2021

35/23	25 July 2023	Audit Committee Cycle of Business	To provide further clarity on recommendation (*b)(Approve the approach to the whistleblowing and near misses elements of the terms of reference such that the whistleblowing process and arrangements for special investigations will come to Audit Committee with regular verbal updates from the Chair of the People and Culture Committee on progress in the interim, and that QUEST will monitor near miss reporting).*specifically to indicate the reporting process involved for each Committee and that the mechanism by which near misses – with respect to the criteria for escalation to Audit Committee where there are concerns regarding governance, internal controls, and management of risk - will be further considered and brought back to the Committee for endorsement.	Trish Mills	14 September 2023	Update for 14 September 2023 Verbal Update	Open

Internal Audit Progress Report

Audit Committee

September 2023

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

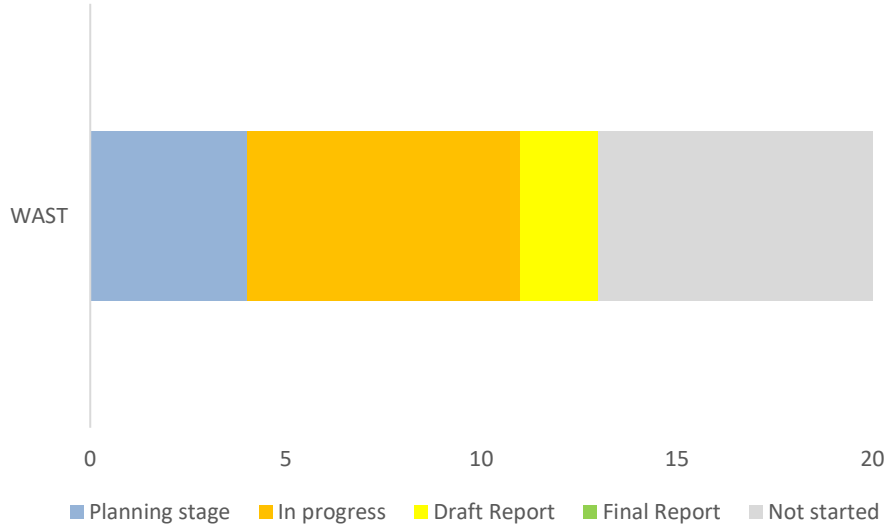
1. Introduction

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 20 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

No further changes are proposed in respect of the 2023/24 Internal Audit Plan.

4. Engagement

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

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

5. Key Performance Indicators

Correct on 31 August 2023

Indicator	Status	Actual	Target
Operational Audit Plan agreed for 2023/24		March	By 30 June
Audits reported over planned		2	3
Work in progress		7	
Report turnaround: time from fieldwork completion to draft reporting [10 days]		2 out of 2	80%
Report turnaround: time taken for management response to draft report [15 days]		0 out of 0	80%
Report turnaround: time from management response to issue of final report [10 days]		0 out of 0	80%

Key:

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

6. Recommendation

The Audit Committee is invited to note the above.

Appendix A: Progress against 2023/24 Internal Audit Plan

Review	Status	Rating	Key matters arising	Anticipated Audit Committee[1]
Risk management and assurance	Not started			June 2024
Decarbonisation	In progress			November 2023
Delivery of Major Change Programmes	Not started			March / June 2024
111 Service Commissioning Arrangements (Advisory)	In progress			November 2023
Integrated Quality Performance and Management Framework	Not started			March / June 2024
Strategy Development	In progress			March 2024
Serious Adverse Incidents Joint Investigation Framework	In progress			November 2023
Clinical Handover	Planning			March 2024
Senior Paramedic Role	In progress			November 2023
Clinical Audit	Not started			June 2024
Volunteers Governance	Not started			June 2024
Seatbelt Action Plan	Planning			March 2024
Records Management	Draft report			November 2023
Technical Resilience	In progress			November 2023 / March 2024
ICT Contract Management	Planning			March 2024
Retention of Staff	Planning			March 2024
Disciplinary Case Management – Compassionate	Not started			March 2024

[1] May be subject to change

Review	Status	Rating	Key matters arising	Anticipated Audit Committee[1]
Leadership				
Recommendations tracker	Not started			June 2024
Capital & Estates				
Estates Assurance: Estate Condition	Draft report			November 2023
Capital Assurance: Vehicle Replacement Programme	In progress			June 2024

[1] May be subject to change

Health & Safety
Final Internal Audit Report
July 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-2223-02
Report status:	Final
Fieldwork commencement:	24 May 2023
Fieldwork completion:	7 July 2023
Draft report issued:	13 July 2023
Draft report meeting:	13 July 2023
Management response received:	27 July 2023
Final report issued:	28 July 2023
Auditors:	Osian Lloyd, Head of Internal Audit Felicity Quance, Deputy Head of Internal Audit Lisa Harte, Internal Audit Manager
Executive sign-off:	Liam Williams, Executive Director of Quality & Nursing
Distribution:	Jonathan Turnbull-Ross, Assistant Director of Quality Governance Nicola White, Head of Health & Safety Graham Stockford, Deputy Head of Health & Safety Leanne Smith, Assistant Director for Data & Analytics
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 Trust's structures and arrangements for complying with the Health & Safety legislation.

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- Policies / Procedures within Health and Safety require updating;
- Strengthening key project management documentation;
- Enhancing the systems for monitoring compliance and clarifying roles and responsibilities;
- Providing a robust mechanism for assessing demand for training; and
- Finalising the governance framework to effectively monitor health and safety arrangements.

Report Opinion

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

Assurance summary[1]

Objectives		Assurance
1	Health and safety policy	Reasonable
2	Health and safety structure	Reasonable
3	Working Safely Programme	Reasonable
4	Compliance mechanisms	Reasonable
5	Training requirements and needs	Reasonable
6	Monitoring of risks and issues	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	Out-of-date policies and procedures	1, 2	Operation	Medium
2	Working Safely Programme Learning	3	Operation	Medium
3	Managing Compliance	4	Operation	High
4	Training Compliance	2, 5	Design	Medium
5	Governance Arrangements	2, 3, 6	Operation	Medium

1. Introduction

1.1 All organisations have a legal duty to put in place suitable arrangements to manage health and safety as outlined within the Health and Safety at Work Act (1974) and reinforced by the Management of Health & Safety at Work Regulations (1999). It is for the management, employees and stakeholders of the Welsh Ambulance Services NHS Trust ('the Trust') to work together to fulfil current legislation, and essential that the organisation can demonstrate compliance with the Act through robust governance arrangements.

1.2 The Trust recognises the importance of ensuring work environments and job designs enable good employee health, ensure safe working practices, and do not have a detrimental impact wellbeing. '*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'* continues to be escalated as an item on the Corporate Risk Register.

1.3 Organisational learning from the Covid-19 pandemic required additional intervention to improve health and safety performance and deliver sustainable improvements. The Trust, as part of the Integrated Medium-Term Plan (IMTP), launched a five-year Working Safely Programme which formally commenced on 1 October 2021 with £293,722 funding approved to resource a 'pump-prime' phase of twelve months. The aim of the programme is to embed a mature safety culture based upon safe systems of work, reducing accidents, injury rates, and poor health.

1.4 Additionally, whilst undertaking this audit, we have considered the content of Audit Wales, '*Structured Assessment 2022 – Welsh Ambulance Services NHS Trust*' (January 2023), which included reviewing the Trust's governance arrangements (see para 2.4).

1.3 The key risks considered in this review were:

- The Trust does not comply with its statutory responsibilities resulting in harm to patients and staff; and
- Financial and reputational implications associated with the failure to effectively manage health and safety requirements.

2 Detailed Audit Findings

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

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	-	1	-	1
Operating Effectiveness	1	3	-	4
Total	1	4	-	5

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

Objective 1: The Trust has a health and safety policy that sets a clear direction and which outlines statutory requirements and key responsibilities.

2.3 The Trust's health and safety policy (the 'Policy') is available to staff via the intranet but details a review date of November 2020 (see **Matter Arising 1**). The policy has been revised following a rigorous review by the membership of the Policy Review Group. There is now a two-week consultation period (effective from 10 July 2023) with the workforce before it can be finalised and presented to the Executive Management Team (EMT) and the People & Culture Committee (PCC) for approval.

2.4 We note that Audit Wales (see paragraph 1.4) 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. They noted that the "*Trust's policy tracker shows that many policies are overdue for review, including the Trust's policy on policies. Given the thorough process utilised by the Trust to review its policies, it will likely take some time to bring all policies up-to-date. The Office of the Board Secretary is aiming to address the backlog of overdue policies, and is also seeking to encourage greater local ownership over policies within directorates which could potentially reduce future delays.*"

2.5 The draft Policy (version 10) has been updated to ensure it complies with legislation, details health and safety accountabilities for key posts, and reflects the Trust's responsibilities for the Duty of Candour and Duty of Quality in line with the Health and Social Care (Quality and Engagement) (Wales) Act 2020.

2.6 The executive lead for health and safety is the Executive Director of Quality & Nursing, but the Policy also refers to a Health and Safety Champion. Discussions are ongoing as to the individual who will be appointed.

2.7 The Head of Health & Safety explained that when the Policy is finalised, it will be used as a pilot, which will ensure that all Trust employees are alerted of the Policy via email when published as well as it being updated on the intranet. Other health and safety procedures that require updating (see para 2.11) are planned to be circulated in the same way once finalised.

Conclusion:

2.8 The version of the health and safety policy available on the Trust's intranet is out-of-date. However, the Trust is taking the necessary steps to revise the policy, which is currently being consulted on. Therefore, we provide **reasonable** assurance for this objective.

Objective 2: The Trust has an established structure to manage health and safety responsibilities.

Health and Safety Team

2.9 A detailed Workforce Transformation business case was taken to the Executive Management Team (EMT) for approval in March 2022, outlining options to restructure the health and safety team to assist with sustainable improvement and assuring legislative compliance. The current team has been resourced in line with the agreed option.

2.10 We note that current postholders have not attained some of the essential qualifications required for each role within the team as documented within the training matrix. The Head of Health & Safety explained that the document requires updating in line with job descriptions, and that the majority of staff have the essential qualifications required for their post or are working towards them (see **Matter Arising 4**).

Health and Safety Management System

2.11 The Trust's health and safety management system (HSMS) provides a structured framework for ensuring a safe and healthy workplace and has been designed based on ISO 45001 (an international standard for health and safety at work). This framework includes having policies and procedures to provide practical guidance to comply with health and safety legislation. Our review of both the Trust's intranet content and the Working Safely Programme Plan has highlighted some gaps where policies and procedures were overdue for review (see **Matter Arising 1**).

2.12 The Datix system is used, by operational staff across the Trust to record health and safety incidents. There have previously been challenges in terms of data coding and the timeliness of reporting RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) indicators. To address this, data is monitored weekly in consultation with operational staff where required. The feasibility of using Power BI is also being pursued to extract data from Datix and enable 'live' reporting at the Trust's sites. Currently, the timeliness of RIDDOR reporting compliance is at 83%.

Operational Reporting

2.13 There is regular operational oversight of health and safety arrangements within the Trust through reporting to the Senior Leadership Team, Senior Operations Team, and Assistant Director Leadership Team (ADLT). Health and Safety managers attend regional meetings (South-East, Central and North). However, we were unable to ascertain the level of engagement with the North region as meeting

minutes have not been taken due to staff capacity (see **Matter Arising 5**). Local partnership forums have recently been agreed, which will replace the regional meetings, and provide an opportunity to further strengthen operational reporting and engagement. Forums will report into the National Health, Safety and Welfare Committee (refer to Objective 6 for reporting of the wider governance arrangements).

Conclusion:

2.14 The Trust has established a clear structure for the management of health and safety arrangements and taking appropriate action where gaps have been identified, e.g. Datix recording and regional reporting. The main area for improvement is ensuring that policies are procedures are reviewed to ensure that the information is still valid and up to date, and to establish and embed the groups recently agreed to provide operational oversight. We provide **reasonable** assurance for this objective.

Objective 3: The Working Safely Programme has been implemented effectively within the local operational settings.

2.15 The Working Safely Strategic Programme Board has a clearly defined role in monitoring the programme through its terms of reference (TOR). The Board is supported by a Working Safely Programme Dynamic Delivery Group. The terms of reference were approved in September 2021, and details that they will be reviewed as required by the Programme Board. Good practice is that terms of reference are reviewed at each juncture of the project to reflect required practices, but we note that terms of reference for both the Programme Board and the Delivery Group have been revised, but not finalised, recognising that governance arrangements are currently being reviewed (see **Matter Arising 5**).

2.16 There is good oversight over the Programme with regular reporting to the Programme Board and to the People and Culture Committee (PCC) but could be enhanced by noting progress against the programme's deliverables (see para 2.37). There is also a STB highlight report that prompts for recording escalations from the Programme Board.

2.17 Beyond the Programme Board, we were unable to evidence the documentation of wider roles and responsibilities and outcomes of the Working Safely Programme. Usually, this is contained in a Programme Definition Document (PDD). A draft PDD was provided at the conclusion of our review, but this was not complete, e.g. arrangements for roles and responsibilities, financial management, progress monitoring, etc. were not detailed (see **Matter Arising 2**).

2.18 The Working Safely Programme Plan identified 82 actions to be implemented during the five-year period. 23 of these actions were prioritised during the 'Pump, Prime' phase to ensure greater compliance with the regulatory framework. 12 of these have been completed, but it is acknowledged that the plan has been implemented during a period of significant challenge with progress also impacted by industrial action. The Programme Plan provides an overview of the delivery of

these actions, action owners, RAG status, progress to date, but could be further enhanced to detail timescales for achievement of actions (see **Matter Arising 2**).

2.19 The Working Safely 'Pump, Prime' phase concluded in September 2022 and moved into the 'Business as Usual' phase. We verified that the programme closure report for the former was discussed at the Programme Board meeting in January 2023; and presented to the National Health, Safety and Welfare Committee in April 2023. Aside from the Programme Manager, it is unclear who has also approved the programme closure report and how the recommendations made in the report will be taken forward (see **Matter Arising 2**).

2.20 To assess how well the measures introduced as part of the Working Safely Programme are embedding, discussions were held with four operational leads across different regions. Feedback was overall very positive with those that had been in post for some time highlighting the significant improvements that had been made, including being clear who their designated contact was within the health and safety team, who they found to be responsive to queries and supportive.

Conclusion:

2.21 Overall, the Working Safely Programme delivery is effectively embedding, and the corporate health and safety team are involved appropriately. However, there remain opportunities to strengthen key project management documentation and governance arrangements. Therefore, we provide **reasonable** assurance for this objective.

Objective 4: Mechanisms are in place to ensure compliance with health and safety legislation, including workplace risk assessments and a programme of routine inspections.

2.22 There are several mechanisms that have been recently implemented to monitor the Trust's compliance with health and safety legislation, including inspections, hazard and compliance registers, and the utilisation of a HSMS baseline audit tool is planned.

2.23 Compliance is regularly reported to senior management, PCC and the National Health & Safety Committee. However, there is currently no system to monitor and confirm that corrective action has been taken to address where non-compliance has been identified (see **Matter Arising 3**).

Risk Assessments

2.24 The health and safety team has undertaken a review of its risk assessment processes in conjunction with trade union partners and operational staff. This has resulted in a revised process with a recently updated risk assessment template, which was rolled out to sites during the latter part of 2022. The rolling programme clarifies who should be involved in the process but has been impacted by industrial action. The Head of Health & Safety explained that the central team are only responsible for corporate-level risk assessments, and operational staff should manage the local risk assessments. Compliance with the appropriate completion of operational risk assessments is monitored centrally, however recent reporting to

ADLT highlighted that whilst risk assessments had been undertaken at c72% of the Trust's estate, the required standard was not being met. Issues cited included that assessments were out-of-date, insufficient, or unsuitable, e.g. not utilising the correct version of the revised template. The current level of compliance is detailed below:

Up-to-date risk assessments	Risk assessments requiring review	No risk assessment in place
8%	66%	26%

2.25 Compliance will be monitored by the Senior Operations Team (SOT) going forward. The intranet content will need updating when risk assessments meet the required standard, and clarification of roles and responsibilities for carrying out, documenting and reviewing risk assessments should be reinforced (see **Matter Arising 3**). Documented risk assessment guidance has been provided to staff and risk assessment training is planned as part of the wider health and safety training programme (see para 2.31).

Inspections

2.26 A two-year schedule for health and safety inspections commenced in September 2022 covering 119 of the Trust's premises. The inspection schedule has been developed to prioritise those sites with higher risks attached, e.g. size of site, footfall, known health and safety issues, etc. Despite the impact of industrial action, good progress is being made against the inspection schedule with 93 premises being visited (at 21/07/23) with 77 of these rated green in terms of compliance.

2.27 A template has been designed to ensure a consistent approach is undertaken when carrying out the audits, but no follow up process has been designed to confirm that corrective action had been undertaken. Discussions with a sample of operational leads also highlighted that the majority did not receive written feedback of the outcome of the inspections (see **Matter Arising 3**).

2.28 The Head of Health & Safety advised that there have been discussions with the Estates team to provide a more integrated process as some of the actions arising from inspections relate to building issues. They also plan to develop a RASCI (Responsible, Accountable, Supportive, Consulted, Informed) chart so responsibilities are clearer between Health and Safety, Estates, and operational managers.

Conclusion:

2.29 The Trust has recently put in place several measures to monitor compliance against legislation, but these have not yet embedded. The mechanisms have been well-designed but there is a low level of compliance with operational risk assessments in particular not being of the desired standard. There also needs to be an effective mechanism to monitor corrective action is taken promptly where non-compliance is identified. This should take into consideration the capacity of the team to effectively monitor arrangements. However, there is mitigation through the

positive progress in the undertaking of health and safety inspections providing assurance over 78% of the Trust's sites. We provide **reasonable** assurance for this objective.

Objective 5: Training requirements and needs have been identified for those with executive and operational health and safety responsibilities.

2.30 The Trust has undertaken a training needs analysis for all levels of staff and non-executive directors related to health and safety requirements. This is contained within the draft Health and Safety Policy. We have considered the training requirements of the health and safety team as part of paragraph 2.10.

2.31 A health and safety training programme is currently being designed around this analysis, which includes the delivery of both the Institution of Occupational Safety and Health (IOSH) courses (Managing Safely for Managers and Leading Safely for Directors and Senior Managers).

2.32 Attendance at statutory and mandatory training courses is reported to ADLT, the National Health, Safety and Welfare Committee and the People and Culture Committee (PCC). At the date of audit fieldwork, the report to PCC (9 May 2023) detailed that, "*Statutory Health and Safety, Fire Safety and Manual Handling training compliance are below Trust's and Welsh Government standards."* Noting the national target is 85%, current compliance at Quarter 1 (2023/24) is as follows (see **Matter Arising 4**):

Course/Subject area	Required	Achieved	Compliance
Health and Safety	4,347	3,157	72.62%
Moving and Handling	7,057	5,526	78.31%
Fire Safety	4,347	3,292	75.73%
Violence & Aggression	4,347	4,247	97.70%

2.33 While some attendance trackers are maintained showing whether the staff that have booked onto health and safety courses have attended, there is no robust mechanism in place to determine the planned uptake for training. This would clearly identify that all staff have received the training required in line with the analysis (see **Matter Arising 4**).

Conclusion:

2.34 The Trust has also analysed its health and safety training requirements and is designing a training programme to encompass both senior and operational levels. Efforts have been made to identify demand for courses and encourage staff to attend, while current training compliance is below target, we note that there has been improvement since Q4 (2022/23) reporting where health and safety training compliance was 66.8%. The majority of staff within the health and safety team have the essential qualifications required for their post or are working towards them. We provide **reasonable** assurance for this objective.

Objective 6: Health and safety risks are monitored at committee level and key issues escalated and reported to the Board.

2.35 From May 2022, the reporting of health and safety arrangements within the Trust changed from the Quality, Patient Experience and Safety Committee (QuEST) to the People and Culture Committee (PCC). Terms of reference have been updated for both committees to reflect the change.

2.36 The annual Health and Safety Performance Annual Report 2021/2022, which included an AAA (Alert, Advise, and Assure) highlight report, was presented to the PCC in September 2022. This detailed that there had been no enforcement action from the Health & Safety Executive (HSE) or local authority, but improvements were needed with attending statutory health and safety training, and with the reporting of RIDDOR incidents.

2.37 Quarterly AAA performance reports have also been prepared providing updates on the delivery of the ambitious Working Safely Programme (see objective 3), noting compliance with training, risk assessments, RIDDOR, and updates on policies, procedures, and inspections. However, there has been no reporting providing an overview of progress in implementing the Programme, noting that the Programme Closure report detailed that 12 of the 23 actions have been completed as part of the 'Pump, Prime' Phase (see **Matter Arising 5**). Required improvements recognised by the Trust include improving health and safety incident reporting, developing a risk assessment training package, and development of communication and performance management tools.

2.38 The Trust's Board also receives regular updates through highlight reporting from the PCC, and as part of reviews of the Corporate Risk Register so they are kept aware of key health and safety issues.

2.39 There has also been regular reporting of progress with the Working Safely Programme and legislative compliance to the National Health, Safety and Welfare Committee. While we appreciate that governance arrangements are currently being evaluated as part of a wider Trust review (see para 2.13), we note that the Committee has been reviewing the terms of reference and those of its sub-groups since August 2022 with no timescale set for conclusion (see **Matter Arising 5**).

Conclusion:

2.40 There is regular oversight over the health and safety framework to the PCC, which in turn regularly reports its key issues to Trust Board. The review of the governance arrangements for the National Health, Safety and Welfare Committee and its sub-groups have yet to be finalised. We provide **reasonable** assurance for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Out-of-date policies and procedures (Operation)	Impact
The Health & Safety Policy (version 8), which is available to all staff via the intranet, details a review date of November 2020. We note that the policy review will have been impacted by the Covid-19 pandemic and the redesign of health and safety arrangements as part of the Working Safely Programme. The Head of Health & Safety explained that the revised Policy has been discussed at both ADLT (Assistant Director Leadership Team) and Policy Review Group (20th June 2023) and is currently out for consultation. Depending on the outcome of the consultation, the plan is for the Policy to be approved by EMT and PCC during the summer period. The Policy also refers to Health and Safety Champion. We understand that when the Policy is approved, the champion will be appointed from the Trust's non-executive directors. The draft Policy (version 10) refers to several other policies and procedures in place to ensure the Trust complies with relevant health and safety legislation. Our review of the health and safety's intranet noted the following issues: • Risk Assessment Procedure – did not record the date of approval (which we were advised was July 2022) or a review date; and • Premises and Vehicle Cleanliness Policy – records a policy review date of July 2021 (we were advised that the Estates Department is the Policy owner). The Working Safely Programme Plan refers to new policies and procedures that should be put in place (some of which the Plan details were due for Quarter 4 2022/23) to ensure that they outline the current processes and comply with the relevant legislation including: • Provision and Use of Work Equipment Regulations/ Lifting Operations and Lifting Equipment Regulations policy/ procedure; • Personal Protective Equipment policy/procedure; • First Aid procedure; and • Young Persons policy/procedure.	Potential risk of: • Outdated health and safety arrangements which are not compliant with legislation.

Recommendations			Priority
1.1	Management should ensure that all policies and procedures that relate to health and safety arrangements, are updated as soon as possible.		**Medium**
1.2	Once approved, policies and procedures should be circulated to all staff.		
Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	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). 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.	December 2023 September 2023	Head of Health & Safety Deputy Head of Health & Safety
1.2	Policies and Procedures will be issued via corporate communication platforms.	March 2024	Deputy Head of Health & Safety

Matter Arising 2: Working Safely Programme Learning (Operation)	Impact
While the delivery of the overall Working Safely Programme is well managed, we identified some areas of learning: • Documentation: a draft version of the Programme Definition Document (PDD) was provided at the conclusion of audit fieldwork so we were able to evidence the documentation of wider roles and responsibilities and outcomes of the Working Safely Programme, but other elements of the document were not populated, e.g. financial management, progress monitoring, etc. We were advised that the PDD is saved on a staff member's local drive who was absent during our audit although the Planning team were trying to locate a final version; • Action Plan: Reporting on the Working Safely Programme Plan detailed that 11 of 23 actions have not been completed during the 'Pump Prime' phase – six had a red RAG status and five with amber status. Noting progress of the Plan will have been impacted by industrial action, it would benefit from a review to ensure that actions encapsulate SMART criteria, and have clear targets when actions will be completed; and • Closure Report: a closure report (Pump Prime Phase) has been prepared and discussed at Programme Board; however we were unable to confirm that it had been approved at the appropriate senior level (the only approval recorded was that of the Programme Manager). It is also unclear how recommendations made in the report will be taken forward.	Potential risk of: • programmes being managed inconsistently resulting in outcomes not being clear or achieved; and • failure to deliver key programmes and projects.

Recommendations		Priority
2.1a	All programme documentation should be stored in a centralised location to efficiently measure outcomes and capture ongoing learning.	**Medium**
2.1b	The Programme plan should be enhanced to provide realistic timescales.	
2.1c	The Programme Closure report should be appropriately approved and circulated to assist with the sharing of best practice and lessons learnt.	

Agreed Management Action		Target Date	Responsible Officer
2.1a	Review of documentation sources and centralise on MS 365 platform.	December 2023	Deputy Head of Health & Safety
2.1b	Review plan and adjust timescales, and present to the Working Safely Programme Board.	September 2023	Deputy Head of Health & Safety
2.1c	Programme Closure to be rediscussed at Strategic Transformation Board and closure noted in meeting minutes	September 2023	Deputy Head of Health & Safety

Matter Arising 3: Managing Compliance (Operation)	Impact
While we appreciate that measures to monitor compliance have only recently been implemented. The following enhancements were identified: • Roles and Responsibilities: Our discussions during the audit highlighted, at times, a lack of understanding where responsibilities lie between operational staff, the corporate health and safety team as well as clarifying the role of trade union partners. • Action Plans: There are several mechanisms for monitoring the Trust's compliance against health and safety legislation. Action plans are produced where improvements are identified, but there is no system in place to effectively manage the action plans to confirm that any non-compliance identified has been addressed promptly; • Risk Assessments: Our review of the health and safety's intranet noted that of a sample of 21 risk assessments reviewed, three did not record a review date (fumes risk assessments) and four were overdue for review (operational/workplace risk assessments). However, this has previously been identified as an area of non-compliance with workplace risk assessments either not being in place, out-of-date, or not of the required standard. The risk assessment template has only recently been amended, which has led to some sites not utilising the correct template and a Risk Assessment procedure has only been recently introduced. Our discussions with a sample of operational leads across regions highlighted the lack of a mechanism for prompting when risk assessments required reviewing; and • Inspections: Discussions held with Operational Leads identified that the majority did not receive written feedback of the outcome of the inspections. Further, no follow up process has been designed to confirm that corrective action has been taken by all action owners where areas for improvement have been identified.	Potential risk of: • lack of accountability and oversight; and • corrective action not being taken resulting in non-compliance with legislation, patient/staff harm and reputational damage for the Trust.

Recommendations		Priority
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.	**High**

Agreed Management Action		Target Date	Responsible Officer
3.1	Develop performance indicators around sharing inspections outcomes within 10 working days.	December 2023	Deputy Head of Health & Safety
	Update the Health and Safety Management System to reflect new design.	December 2023	Deputy Head of Health & Safety
	Explore a digital solution to advise relevant managers of their compliance and actions.	March 2024	Assistant Director for Data & Analytics / Head of Health & Safety

Matter Arising 4: Training Compliance (Design)		Impact
The Trust has undertaken a training needs analysis for all level of staff and non-executive directors, with a training programme currently being designed around it. This could be enhanced to reflect how frequently training is required. However, there is no robust reporting tool in place to determine the planned uptake for this training and confirm that all staff have had the required training. Attendance at statutory and mandatory training courses is monitored and reported to ADLT, the National Health, Safety and Welfare Committee and the PCC. Current compliance is below both the Trust and Welsh Government's standards with only 72.62% having attended health and safety training. A training matrix has been developed for the Health & Safety team in line with best practice comparing the essential qualifications for each post against that of the postholder. We note that some postholders are working towards the essential qualifications detailed in their job descriptions.		Potential risk of: • Without a clear assessment, or appropriate detail of requirements, there could be inconsistencies in the training of staff.
Recommendations		**Priority**
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.	**Medium**
4.2	The Trust should ensure that all staff complete the statutory health and safety training.	
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.	

Agreed Management Action		Target Date	Responsible Officer
4.1	Trust's training needs analysis to be amended to include frequencies and mechanism for reporting compliance.	September 2023	Head of Health & Safety
4.2	Statutory and mandatory training for Operational Staff to be communicated at Senior Operations Team. For all other directorates will be supported via an identified H&S Business Partner.	September 2023	Head of Health & Safety
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.	December 2023	Head of Health & Safety

Matter Arising 5: Governance Arrangements (Operation)	Impact
While we acknowledge that governance arrangements for health and safety are currently under review, linking with the Trust's integrated board assurance, the following gaps have been identified: • Working Safely Programme: The terms of reference for both the Programme Board and the Dynamic Delivery Group have been reviewed but not been finalised. Good practice is that terms of reference are reviewed at each juncture of the project to reflect required practices, yet the Group's terms of reference were last approved September 2021. Committee reporting could also be enhanced noting progress against the programme's deliverables. • National Health, Safety & Welfare Committee and sub-groups: the Committee has been reviewing their terms of reference and of its sub-groups since August 2022. The Executive Management Team last approved the Committee's terms of reference during quarter 3 (2021/22). Additionally, we were unable to ascertain the level of engagement with the North regional sub-group as the meeting minutes have not been taken due to staff capacity (this was being rectified at the conclusion of our audit).	Potential risk of: • Unclear governance and reporting arrangements leading to a lack of accountability and oversight.

Recommendations		Priority
5.1	Upon finalisation of the review of the governance structure, the terms of reference for the Working Safely Programme Board, Dynamic Delivery Group, the National Health, Safety & Welfare Committee and its sub-groups should be updated accordingly and appropriately approved.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
5.1	Terms of reference to be reviewed for Working Safely Programme Board and Dynamic Deliver Groups and reflect changes within HSMS	September 2023	Deputy Head of Health & Safety

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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Follow Up Review
Final Internal Audit Report

August 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

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Final report issued:	31 August 2023
Auditors:	Osian Lloyd, Head of Internal Audit Felicity Quance, Deputy Head of Internal Audit Ross Hughes, Principal Auditor
Executive sign-off:	Trish Mills, Board Secretary
Distribution:	Julie Boalch, Head of Risk / Deputy Board Secretary Richard Davies, Assistant Director of Capital and Estates Nicci Stephens, Environment and Sustainability Manager Mark Harris, Assistant Director of Operations NEPTS
Committee:	Audit Committee

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

Acknowledgement

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

Executive Summary

Purpose

We undertook a follow-up review of the following limited assurance reports to assess whether the Welsh Ambulance Services NHS Trust (the Trust) has implemented the related Internal Audit recommendations:

- Waste Management; and
- NEPTS Transfer of Operations – Benefits Realisation

Overview

The Trust has effective arrangements to track progress in relation to audit and review findings. However, there is scope to strengthen these to enable more robust scrutiny.

Our testing confirmed that seven of the eleven recommendations tested were appropriately classified as complete on the tracker.

However, evidence provided by management did not support the Trust's proposed closure on the tracker of three recommendations relating to Waste Management, and one recommendation from this review remains outstanding.

To maintain the integrity of the Trust's Audit Recommendations Tracker, it is imperative that recommendations remain open until fully complete.

Report Classification

		Trend
Reasonable 	**Follow Up:** Some high and medium recommendations implemented with other partially implemented. A high and medium recommendations still outstanding.	2021/22 Substantial

Assurance summary[1]

	High	Medium	Low	**Total**
Closed	5	2	-	**7**
Superseded	-	-	-	**-**
Partially closed	2	1	-	**3**
Outstanding	1	-	-	**1**
Total	**8**	**3**	**-**	**11**

Key matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
1	Recommendation tracker	-	O	Medium

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

1. Introduction

1.1 We undertook a follow-up review of limited assurance internal audit reports issued during 2021/22, to provide assurance that the Welsh Ambulance Services NHS Trust (the Trust) has implemented the related recommendations appropriately and in a timely manner. We also reviewed the systems and arrangements the Trust has in place to monitor progress with the implementation of actions.

1.2 Our review incorporates recommendations raised in the following reports:

i. Waste Management - to assess the Trust's compliance with relevant waste management legislation and guidance, and progress towards agreed national and local waste reduction targets.; and

ii. NEPTS Transfer of Operations – Benefits Realisation – to provide assurance that benefits realised reflect those identified at the outset of the transfer project.

1.3 We reviewed all recommendations from these reports (all were rated either high or medium priority), noting that they have either been recorded as implemented or proposed to be closed in the Trust's Audit Recommendations Tracker (the Tracker).

1.4 The scope of this follow-up review will not provide assurance against the full scope and objectives of the original audits. The 'follow-up review opinion' provides assurance against the level of implementation of the recommendations as identified above.

1.5 The potential risks considered in this review are:

i. failure to implement agreed audit recommendations in a timely manner;

ii. increased financial, clinical, statutory and reputational risk for the Trust; and

iii. inaccurate reporting of the Tracker within the Trust.

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.

2.2 As previously reported, the Trust has effective arrangements to monitor progress in relation to the implementation of recommendations.

2.3 The audit tracker is maintained by the Corporate Governance Team. The Team receives all audit reports (both internal and external) for inclusion in Committee papers which ensures that the recommendations tracker captures all recommendations raised.

2.4 The tracker is reviewed by the Assistant Directors Leadership Team (ADLT), on a monthly basis, and the Executive Management Team prior to Audit Committee to ensure realistic timescales have been proposed and a rationale is included to

support any revisions to completion dates. We noted that a number of requests have been received from management to extend implementation dates, for those recommendations due in quarters 3 and 4 due to winter pressures and industrial action.

2.5 A recent Structured Assessment by Audit Wales stated *the Trust's tracker enables effective oversight of recommendations made by internal and external audit and other bodies, including Health Inspectorate Wales and the Welsh Language Commissioner. However, the tracker does not consistently make clear the reasons why some actions have become overdue, what/whether progress has been achieved and/or whether actions have a new proposed completion date*. (**See MA1).** We understand that the Trust is in the process of making further improvements to the Tracker.

2.6 The Audit Committee reviews the internal and external audit recommendation report and tracker at each meeting. The format of the tracker enables committee members to view updates on progress in relation to the implementation of each recommendation and it provides an opportunity to challenge and scrutinise. The Trust also submits extracts of the audit tracker to relevant Board Committees to support oversight and scrutiny of recommendations relating to their remit. However, it was noted that due to capacity and resource challenges within the Corporate Governance Team, the Trust was not able to review evidence of closure of actions undertaken. This was only applicable for the March and April reporting periods; with updates provided at May meetings. No recommendation has therefore been raised at this report.

2.7 This section captures a summary of our previous findings from our testing sample, along with the progress made to implement the associated recommendations:

Waste Management

2.8 The report had a total of seven Matters Arising (MA) with some MAs producing multiple recommendations, eight recommendations in total. All recommendations were marked as complete on the Trust tracker, this included six high priority and two medium priority recommendations.

Recommendation 1 – Policies & Procedures (Design) High Priority

2.9 Welsh Health Technical Memorandum (WHTM) 7.1: 'Safe Management of Healthcare Waste,' sets out the importance of a healthcare waste policy:

"To effectively manage healthcare waste, all those involved in the management of the waste stream should have access to an appropriate healthcare waste policy that identifies who is responsible for the waste and provides clearly written instructions on how it should be managed" (6.2).

At the time of the 2021/22 review the Trust did not have a formal policy on Waste Management in place, instead utilising a Guidance Note.

2.10 It was determined the Guidance Note had expired and was not compliant with WHTM 07-01 with the following not incorporated:

- Conformation of Board-Level Committee responsibility for waste management;
- Document Executive Lead Responsibility;
- Detail of contractual arrangements (including contingencies);
- The process of identifying improvement programmes;
- Detail regarding staff training arrangements.

2.11 Since the 2021/22 internal audit review, the Trust created the 'Waste Management Task and Finish Group (WMTFG) to look to achieve the recommendations set within the internal audit report. On review, the group only met on three occasions (June, July and August 2022) before it halted.

2.12 From the original recommendation, the management response outlined that attendance at the WMTFG would include representation from Estates and facilities; Infection, Prevention and Control; Health and Safety; Operations; ICT; Fleet; Corporate Services; Training; Finance; Medical Directorate (for drug management issues); Clinical Equipment and Logistics; and a Trade Union representative.

2.13 As part of the follow up we reviewed the attendance at the three meetings that took place. The first meeting (June 2022) was well attended, with all areas outlined within the management response in attendance (with the exception of Trade Union). However, the July and August meeting failed to have representation from Corporate Services; Medical Directorate; ICT; Operations; Finance (no representation in August only); and Trade Union.

2.14 The WMTFG was tasked with developing a National Waste policy to cover both domestic waste and clinical waste. During the review we were informed that the WMTFG had reviewed and updated the Waste Management Standard Operating Procedures (SOPs). We were supplied with the updated documents for:

- Fleet Workshop waste storage and disposal;
- HART specialist equipment waste disposal;
- Disposal of Healthcare waste;
- Non-clinical and clinical equipment disposal.

2.15 The Trust is currently in the process of approving a Waste Management Policy. A draft policy was approved at the April 2023 Policy Group and is currently out for consultation. A review of the draft policy identified that it covers areas expected, including: Training and implementation; Roles and responsibilities; Audit; and Reporting lines (within Audit section, not a standalone section).

2.16 Appendix A of the policy (Master List of Waste) outlines the type of waste, responsible manager, written SOPs and policies in place within the Trust and European Waste Codes the waste relates too. Appendix B of the policy also has links to all Standard Operating Procedures and associated documents for Waste Management. These include the four SOPs above as well as:

- High Consequence Infectious Diseases SOP
- Controlled Drugs destruction (under draft with no link)
- Sharps Policy

- Medicines Management Policy
- Management of Controlled Drugs Policy
- Medical Devices Management Policy

There are also links to guidance documents for general waste and recycling, disposal of Waste Electrical and Electronic Equipment and Asbestos.

2.17 This finding is considered **partially implemented**. Noting the Trust's proposal to close the recommendation on the tracker, we have concluded that it remain **open** until the Waste Management Policy is formally approved at the relevant Board-level Committee and is communicated and made available to all staff via the SharePoint site.

Recommendation 2 – Governance Structure (Operation) High Priority

2.18 During the 2021/22 review, it was noted that it was important an Executive lead is assigned with championing Waste related matters. The Waste Guidance Note did not include details of the nominated Executive.

2.19 The Trust's Waste Guidance Note document detailed that the National Estates Manager is the nominated General Waste and Recycling Manager, however operational responsibility for Clinical Waste across each site had not been formally assigned. Management advised that an Organisational Change Process was underway and that would address the issue.

2.20 On conclusion of the 2021/22 review, the Trust identified the Director of Finance as its Executive Lead for Waste Management. On discussion with the lead, it was noted that a process has been agreed to ensure Trust Board members are fully sighted on Waste Management matters. Noting that this can be at any point during the year, if required and by exception, through regular reporting of Environmental matters at the Finance and Performance Committee, with Waste Management also being subject to an annual report at the Committee. This has been formally built into the Committee's cycle of business.

2.21 In addition to appointing an Executive Lead for Waste Management, the Trust has also produced a Waste Register via the WMTFG. A review of the register identifies different types of waste within the Trust, with a responsible manager assigned to each. The register also highlights written procedures and/or policies in place connected to the type of waste, as well as the European Waste Codes assigned to each type of waste.

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

Recommendation 3 – Governance Structure (Operation) High Priority

2.23 The Waste Guidance Note document did not identify any Trust Committee with responsibility for waste management. Confirmation was sought as to the forum at which Waste Management is routinely discussed, it was advised that Waste Management has not historically been an agenda item at any Trust committees/meeting groups.

2.24 We recommended that both clinical and general waste compliance / issued should be formally reported periodically within the confines of a set Committee/Group.

2.25 As noted in para 2.16 the Trust have identified the Director of Finance as its new Executive Lead for Waste Management. The Lead has identified the Finance and Performance Committee as its designated Committee to escalate compliance and issues associated with Waste via regular Environmental reports. A Waste Management annual report has also been included within the Committees Work Programme. The report is due September.

2.26 This finding is considered **fully implemented** and is therefore **closed,** noting that management may wish to review the operational reporting arrangements after the first committee report in September.

Recommendation 4 – Training (Operation) Medium Priority

2.27 Waste management training is a module within Electronic Staff Records for all staff as well as being part of the standard induction process. During the 2021/22 review, training compliance data was not available, management cited issues with the IT system which were beyond their control but were however escalated at the time.

2.28 Furthermore, a formal training needs assessment had not been undertaken to determine more specific training needs and responsibilities for key roles. At the time of the 2021/22 review, there were no arrangements in place to deliver wider training to clinical and general staff, in respect of e.g. handling of clinical waste / recycling etc.

2.29 As noted in the 2021/22 review, the Trust utilises ESR to provide on-line training, with an Environmental training module that incorporates both Environmental and Waste Training. A compliance report was created for us during the review which only highlighted the compliance levels for the Administrative and Clerical staff to the end of February 2023 which was at 83.73%, compliance levels for other staff groups was not evidenced. However, no evidence was supplied to support that the training compliance rate have been reported to any groups or forums within the Trust. This was further confirmed on discussion with the Estates Environment and Sustainability manager.

2.30 The Trust have also produced training videos for Waste Disposal and Sharps Management. The videos have been uploaded to the Health & Safety section of the Siren SharePoint site, for all staff within the Trust to access.

2.31 This finding is considered **partially implemented**. Noting the Trust's proposal to close the recommendation on the tracker, we have concluded that it remain **open** as there is currently no formal reporting route for waste management training compliance within the Trust, with only compliance levels for Administrative and Clerical currently being undertaken. Responsibility for this action should also transfer to the Director of People and Culture.

Recommendations 5.1 & 5.2 – Clinical Waste Transfer Arrangements (Operation) High and Medium Priority

2.32 Our previous audit identified that clinical waste was collected from Trust sites by Health Courier Services (HCS) and transferred to two locations, Mamhilad in Pontypool and NWSSP Denbigh Stores. From there it was collected by the waste contractor for incineration. Management advised that the Trust did not have a direct contractual relationship with the contractor, but it accessed the contract via HCS. The SLA put in place following the disaggregation of HCS in 2017 did not reference waste management arrangements. It was recommended that the Trust look at the revised arrangements to ensure that it continues to meet its full obligations, noting that it is unlikely to be able to rely on HCS as being part of WAST (recommendation 5.1).

2.33 Management confirmed that a meeting has been held with NWSSP to discuss updates to the SLA noting that whilst HCS has been disaggregated from the Trust, the legacy remains the same i.e. waste management arrangements and maintenance of HCS vehicles, IT systems and estate. However, nothing further has progressed. It is recognised that this requires further escalation to address therefore, whilst noting the Trust's proposal to close the recommendation on the tracker, we have concluded that it remain **open** until a confirmed status on the content of the SLA has been reached or the Trust is able to demonstrate how the associated risk is being monitored and actively managed.

2.34 Our prior year audit also found that in 2015, Natural Resources Wales agreed that HCS transfer notes were not required for collecting clinical waste from WAST sites. However, this refers back to a time when HCS was a part of WAST and the waste was being transferred from WAST Ambulance Stations to WAST premises. In the North, the waste was taken to Denbigh Stores, a facility operated by NWSSP. It was concluded that Natural Resources Wales (NRW) should be approached to reaffirm that the revised arrangements continue to comply (recommendation 5.2). Management has provided confirmation from NRW that whilst the location has changed, the service provision has not; therefore concluding that the original exemption remains valid i.e. no consignment note required for the transfer of ambulance waste from ambulance station to central hub. This recommendation is considered to be **fully implemented** and is therefore **closed**.

Recommendation 6 – Clinical Waste Transfer-Hospital Sites (Operation) High Priority

2.35 As part of operational practice Ambulances routinely decant clinical waste when visiting Hospitals to transfer patients. This is because they are limited in the amount of clinical waste that can be physically stored on the vehicles. However, whilst noting that this is good practice WHTM 07-01 goes on to note that:

"Where the WAST drops its waste off at a hospital, this is classed as waste transfer. Therefore, duty of care applies and the WAST should ensure that the appropriate agreements are in place to enable it to transfer its waste to the hospital".

WHTM-0701 goes onto note that whilst waste transfer notes are not required:

"A duty of care transfer note is, however, required, although there are mechanisms to enable this to be done on an annual basis".

No evidence was provided to demonstrate that WAST have obtained the transfer notes from the respective Health Boards.

2.36 On conclusion of the 2021/22 internal audit review, the Trusts Environment and Sustainability Manager created a duty of care transfer note to cover the handover of clinical waste from ambulances at health board sites. The transfer note was issued to estate site leads at each NHS Wales health board. On discussion with the Environment and Sustainability Manager it was identified that only Swansea Bay UHB and Aneurin Bevan UHB has signed and returned the duty of care transfer note. It is also recognised that discussions are ongoing with representatives from the EMS service to establish how waste, from an ambulance, can be appropriately segregated into the six requisite waste-streams to ensure compliance with the IPC requirements.

2.37 This finding is considered **partially implemented**. Whilst the duty of care transfer notes have been issued, broader conversations are required between the Trust and the respective health boards as to how the risk of appropriate clinical waste segregation is managed. Noting the Trust's proposal to close the recommendation on the tracker, we have concluded that it remain **open** noting it would be helpful for a paper to be prepared and shared at an appropriate forum detailing the current status and the proposals to manage the risk.

Recommendation 7 – Independent Reviews (Operation) High Priority

2.38 The 2021/22 review identified that the Trust had not been undertaking Clinical Waste Duty of Care audits (reviewing contractors' practices) or Clinical Waste Pre-Acceptance audits (reviewing the segregation and handling of clinical waste on Trust premises).

2.39 It was also noted that compliance audits in respect to general waste and recycling and Infection Prevention and Control (IPC) audits had been suspended due to the Covid-19 pandemic.

2.40 The Trust has since produced a Systems Audit document which gives an annual environmental management system audit programme. To support the document we were provided with a number of completed audits for clinical waste and also general waste and recycling.

2.41 The original management response to the recommendation noted that the Trust were looking to incorporate the Clinical Waste audits into the Trusts Infection Prevention & Control (IPC) audits. On discussion with the Environment and Sustainability manager, it was noted that Health & Safety have agreed to incorporate the clinical waste into their site audits, with discussions ongoing on how to take this forward.

2.42 This finding is considered **fully implemented** and is therefore **closed**. Recognising clinical waste audits are being undertaken, with the intention to eventually incorporate them into the IPC site audits.

NEPTS Transfer of Operations – Benefits Realisation

2.43 The report had a total of two Matters Arising (MA) with one MA producing multiple recommendations, three recommendations in total. All recommendations were marked as complete on the Trust tracker, this included two high priority and one medium priority recommendations.

Recommendations 1.1 & 1.2 – Benefits Management Plan (Design) High Priority

2.44 Section 22.3 of the final business case for the transfer of works, approved in October 2015, outlined that *'a detailed benefits management plan will be developed for the duration of implementation. This will set out the required benefits and the rate at which they should be achieved'*. This has not been developed during the 2021/22 review and there was an absence of baseline information and detail on how and when benefits will be measured and any associated performance measures or targets.

2.45 We also noted during the 2021/22 review that a high-level update paper was provided to the Executive Management Team (EMT) in June 2018. This reported that 10 of the 16 expected benefits had been realised and six were partially realised, although we were not able to validate this. We recommended that the Trust complete a mapping exercise of the expected benefits in the business case to ensure they remained valid and to assess whether they had been realised or to set out when they would be realised.

2.46 During discussions with the Assistant Director of Operations NEPTS, it was explained that the Trust have added the recommendations from the 2021/22 review to a workstream as a standing item within the Ambulance Care Transformation Board, allowing for progress monitoring to be undertaken. The workstream is also being monitored via the NEPTS Delivery Assurance Group (DAG).

2.47 The Assistant Director informed us that a lead was identified on conclusion of the 2021/22 review to undertake a mapping exercise that identified the status and produce evidence to support the NEPTS Transfer of Operations benefits. A detailed spreadsheet was issued to us which outlines:

- Benefit Feature or Objective as per Business Case
- Area of impact
- Benefits Categorisation
- Measure of the benefit
- Is the benefit still valid
- Owner of the benefit
- Detail explanation of the benefit
- Evidence to support achievement of the benefit
- Date realised

The document contains a total of 17 benefits for the Trust, with all benefits closed as realised, last being in February 2023.

2.48 An SBAR has been developed by the Trust to support that benefits realisation has been achieved. This was discussed at the February 2023 NEPTS DAG, which is the lead commissioning meeting for NEPTS, agreeing that the information contained in the SBAR and the Benefits Mapping document is to be used at the next DAG meeting to close the business case and subsequently transfer the service to business as usual.

2.49 A Teams channel has been created in response to the 2021/22 review. The channel is being utilised as a document repository. It was explained during the review that the documents will eventually sit within the Ambulance Care Transformation Programme, which also has a Teams Channel, with the files section acting as the new repository. This was shown to us during a meeting and agreed that it is satisfactory with a number of key documents shown and explained to us, including the members of the channel with key NEPTS personnel included.

2.50 These findings are considered **fully implemented** and therefore **closed**.

Recommendation 2 – Reporting of Benefits Realised (Design) Medium Priority

2.51 The 2021/22 review highlighted that the Trust had not developed a detailed benefits management plan for the duration of implementation and a formal benefits realisation exercise had not been undertaken following the completion of the Transfer of Work (ToW). Therefore, there had been a lack of reporting on the benefits realised, both within the Trust and to EASC / health boards. It was recommended that the Trust ensured adequate reporting of benefits realised associated with the business case both within the Trust and to EASC / health boards

2.52 As per para 2.49, the Trust, via the NEPTS DAG, is proposing to close the business case and transfer the service to business as usual. Regular reporting will therefore transfer to the Ambulance Care Programme Board, which reports into the Strategic Transformation Board. The management response to MA2 during the 2021/22 review, stated that the Health Boards and commissioners are represented on the Strategic Transformation Board as core representatives of the board, therefore reporting to the Transport Service Performance and Monitoring Group and Transport Services Group is not deemed required.

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

Appendix A: Management Action Plan

Matter arising 1: Recommendation Tracker (Operation)	Impact
As stated in the Audit Wales Structured Assessment, t*he Trust's tracker enables effective oversight of recommendations made by internal and external audit and other bodies, including Health Inspectorate Wales and the Welsh Language Commissioner. However, the tracker does not consistently make clear the reasons why some actions have become overdue, what/whether progress has been achieved and/or whether actions have a new proposed completion date*. It is noted the same applies to other assurance providers, e.g. Counter Fraud, and the opportunity for the Trust to include their respective recommendations within the tracker.	Potential risk of: • Failure to implement agreed audit recommendations in a timely manner • Increased financial, clinical, statutory and reputational risk for the health board

	Recommendations	Priority
1.1	The Trust should look to enhance its tracker so it shows the reason why recommendations are overdue. It could further enhance the tracker to show if progress against the recommendation has been achieved and whether actions have a new proposed completion date.	Medium
1.2	The Trust should consider the inclusion of recommendations from other assurance provides within the tracker.	

	Management response	Target Date	Responsible Officer
1.1	The tracker has been enhanced to provide the following narrative next to proposed new dates: *Include here reasons why action is overdue and progress made if not yet complete*.	1 October 2023	Board Secretary
1.2	This is not accepted at this time. The Corporate Governance Team will endeavour to include HIW reports on the tracker but simply do not have capacity to widen the tracker further at this time.	N/A	N/A

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

 **Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure. **Follow up:** All recommendations implemented and operating as expected
 **Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved. **Follow up:** All high priority recommendations implemented and progress on the medium and low priority recommendations.
 **Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved. **Follow up:** No high priority recommendations implemented but progress on most of the medium and low priority recommendations.
 **No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved. **Follow up:** No action taken to implement recommendations

Prioritisation of Recommendations

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

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

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

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Audit Committee Update – Welsh Ambulance Service NHS Trust

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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.

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Contents

Audit Committee update:

Audit Committee Update

About this document

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

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

Accounts audit update

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

Exhibit 1 – Accounts audit work

Area of work	Current status
2021-22 Audit of the Charitable Funds' Financial Statements	The Charity's annual report and accounts were approved by the Board of Trustees on 16 February 2023 and were certified by the Auditor General for Wales on 17 February 2023.
Audit of the 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.

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: Drafting reports for each region Parts 2 and 3 to begin shortly.
Workforce planning	An assessment of workforce risks that NHS bodies are experiencing currently and are likely to experience in the future. The review will examine how local and national workforce planning activities are being taken forward to manage those risks and address short-, medium- and longer-term workforce needs	Report at draft stage. Anticipated to be presented to Audit Committee in November 2023.
Structured Assessment 2023 - core	This work will review the following core areas: • Board and committee cohesion and effectiveness;	Fieldwork completed. Anticipated to be presented to Audit

Topic	Focus of the work	Current status and Audit Committee consideration
	• Corporate systems of assurance; • Corporate planning arrangements; and • 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.	Committee in November 2023.

Exhibit 3 – Planned work not yet started or revised

Topic	Focus of the work	Current status
Structured Assessment – deep dive into digital	This work will examine digital arrangements, with a particular focus on how NHS bodies are investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency.	Early scoping. Fieldwork to commence during the autumn of 2023.
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 late 2023-24.

Good Practice events and products

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

5 There have been no Good Practice Exchange (GPX) events since we last reported to the Committee in July 2023. The next Good Practice Exchange events will be on the theme of 'Digital Strategy'. The events will be held in Llandudno on 27 September 2023 and in Cardiff on 5 October 2023. Further details of 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
Digital Inclusion in Wales Key questions for public bodies	March 2023
Orthopaedic Services in Wales – Tackling the Waiting List Backlog	March 2023
Poverty in Wales data tool	November 2022
Time for Change – Poverty in Wales	November 2022

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

AGENDA ITEM No	**7**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**3**

STANDING ORDERS, SCHEME OF RESERVATION & DELEGATION OF POWERS, AND STANDING FINANCIAL INSTRUCTIONS

MEETING	Audit Committee
DATE	14 September 2023
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Trish Mills, Board Secretary
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. The Trust's Standing Orders require an annual review to ensure they remain accurate and current. The Standing Orders (SOs) includes the Scheme of Reservation and Delegation of Powers (SoRD), and the Standing Financial Instructions (SFIs).

2. The Trust Board approved changes to Schedule 3 of the SOs in May 2023 following the updating of the terms of reference by all Board Committees. At that time non-material changes were also approved to the SoRD with respect to Directors' titles.

3. A review of the Model SOs and SFIs took place in July 2023 by Welsh Government. The amendments made are reflected in the SBAR.

RECOMMENDATION

4. The Audit Committee is requested to endorse the amendments to the Standing Orders, Scheme of Reservation and Delegation of Powers and Standing Financial Instructions and recommend their approval to the Trust Board.

KEY ISSUES/IMPLICATIONS

5. The Model SO have incorporated the change from Community Health Councils to the Citizen Voice Body (Llais) and reflect the requirements of the Health and Social Care (Quality and Engagement) (Wales) Act 2020.
6. The requirement for the Trust to publish Board papers has been changed from ten to seven days.
7. The SO now include the role of the Vice Chair and the additional voting Director introduced in 2022.

REPORT APPROVAL ROUTE

6 September 2023 – Executive Leadership Team

REPORT APPENDICES
Annex 1 – Marked up Standing Orders Annex 2 – Scheme of Reservation and Delegation of Powers Annex 3 – Standing Financial Instructions

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

SITUATION

1. The Trust's Standing Orders must be kept under annual review to ensure they remain accurate and current. The Standing Orders (SOs) includes the Scheme of Reservation and Delegation of Powers (SoRD), and the Standing Financial Instructions (SFIs).

BACKGROUND

2. The Standing Orders underwent extensive review by the Audit Committee in December 2021 and the Trust Board in January 2022, including a wholesale review of the SFIs and Tables A and B of the SoRD.

3. The Trust Board approved changes to Schedule 3 of the SO in May 2023 following the updating of the terms of reference by all Board Committees. At that time non-material changes were also approved to the SoRD with respect to titles for Directors.

4. Welsh Government updated the Model SO and SFI in July 2023.

ASSESSMENT

<u>Standing Orders</u>

5. A marked up version of the changes to the SOs is attached at Annex 1. The changes primarily reflect the introduction of the Health and Social Care (Quality and Engagement) (Wales) Act 2020 including the introduction of the duty of quality and duty of candour, and the change from the Community Health Councils to the Citizens Voice Body (Llais). The Committee will note that there is regular engagement with Llais both from the executive team and the Patient Experience and Community Involvement Team. Llais also has a standing invitation to the QUEST and Board meetings.

6. Section 1.1.1 notes the formal introduction of the Vice Chair position and the additional voting director, reflecting the Board membership as 'the Chair, Vice Chair, six non-executive directors and six executive directors'.

7. Whilst the SOs note that WAST is not, at present, subject to the Wellbeing of Future Generations (Wales) Act 2015, it notes the commitment to achieving the wellbeing goals and sustainable development principles, which are reflected in our IMTP. It is anticipated that WAST will shortly come within the purview of the Act.

8. Paragraph 7.1.3 has been removed as it was not part of the model SOs and Board meetings are now live streamed and recordings maintained on the Trust website. A WAST policy is in development on meeting etiquette which will include a policy position and guidance on the recording and retention of meeting recordings.

9. Paragraph 7.4.3 has been amended to provide that Board members shall be sent an agenda and a complete set of supporting papers at least seven calendar days (was previously ten) before a formal Board meeting.

<u>Scheme of Reservation and Delegation of Powers</u>

10. The marked up changes to the SoRD appear at Annex 2 and the Committee will note the changes are non-material.

Standing Financial Instructions

11. The marked up amended SFIs appear at Annex 3. These have also had non-material changes given the extensive review they underwent in 2022.

12. The SOs require that the Trust undertakes an impact assessment on changes to the documents. We have received confirmation that a full Equality Impact Assessment (EqIA) is not necessary for these types of statutory requirements at a national government level, however a summary EqIA will be done for the Board to evidence this.

RECOMMENDATION: The Audit Committee is requested to endorse the amendments to the Standing Orders, Scheme of Reservation and Delegation of Powers and Standing Financial Instructions and recommend their approval to the Trust Board.

Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru

Welsh Ambulance Services
NHS Trust

Welsh Ambulance Services NHS Trust

STANDING ORDERS

For approval by Trust Board
28 September 2023

Adopted from the Model Standing Orders, Schedule of Reservation and Delegation of Powers, and Standing Financial Instructions issued by Welsh Government in July 2023

Date approved:	**28 September 2023**
Approved by:	**Trust Board**
Review date:	**Annual**
Version:	**6**

Foreword

These Model Standing Orders are issued by Welsh Ministers to NHS Trusts using powers of direction provided in section 19 (1) of the National Health Service (Wales) Act 2006. National Health Service Trusts ("NHS Trusts") in Wales must agree Standing Orders (SOs) for the regulation of their proceedings and business. When agreeing SOs Trusts must ensure they are made in accordance with directions as may be issued by Welsh Ministers.

They are designed to translate the statutory requirements set out in the National Health Service Trusts (Membership and Procedure) Regulations 1990 (S.I. 1990/2024) as amended into day to day operating practice, and, together with the adoption of a Schedule of decisions reserved to the Board of directors; a Scheme of decisions to officers and others; and Standing Financial Instructions (SFIs), they provide the regulatory framework for the business conduct of the Trust.

These documents form the basis upon which the Trust's governance and accountability framework is developed and, together with the adoption of the Trust's Values and Standards of Behaviour framework, is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

All Trust Board members and officers must be made aware of these Standing Orders and, where appropriate, should be familiar with their detailed content. The Trust's Board Secretary will be able to provide further advice and guidance on any aspect of the Standing Orders or the wider governance arrangements within the Trust.

Further information on governance in the NHS in Wales may be accessed at https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/.

Contents

SCHEDULES

The following Schedules which support the Standing Orders are held separately to this main Standing Orders Document. These are:

Schedule 1:	**Scheme of Reservation and Delegation of Powers**
Schedule 2:	**Key Guidance Instructions and Other Related Documents**
Schedule 2.1:	**Model Standing Financial Instructions**
Schedule 3:	**Board Committees Terms of Reference**
Schedule 4:	**Advisory Group Terms of Reference**

Section A – Introduction

Statutory framework

i) Welsh Ambulance Services National Health Service Trust ("the Trust") is a statutory body that came into existence on 1st April 1998 under the **Welsh Ambulance Services National Health Service Trust (Establishment) Order 1998 (S.I. 1998/678)**, "the Establishment Order".

ii) The principal place of business of the Trust is Beacon House, William Brown Close, Cwmbran NP44 3AB~~Vantage Point House, Ty Coch Way, Cwmbran, NP44 7HF~~.

iii) All business shall be conducted in the name of Welsh Ambulance Services National Health Service Trust, and all funds received in trust shall be held in the name of the Trust as a corporate Trustee.

iv) NHS Trusts are corporate bodies and their functions must be carried out in accordance with their statutory powers and duties. Their statutory powers and duties are mainly contained in the **NHS (Wales) Act 2006** which is the principal legislation relating to the NHS in Wales. Whilst the **NHS Act 2006** applies equivalent legislation to the NHS in England, it also contains some legislation that applies to both England and Wales. The NHS (Wales) Act 2006 and the NHS Act 2006 are a consolidation of the NHS Act 1977 and other health legislation which has now been repealed. The NHS (Wales) Act 2006 contains various powers of the Welsh Ministers to make subordinate legislation and details how NHS Trusts are governed and their functions.

v) **The National Health Service Trusts (Membership and Procedure) Regulations 1990 (S.I. 1990/2024)**, as amended ("the Membership Regulations") set out the membership and procedural arrangements of the Trust.

vi) Sections 18 and 19 of and Schedule 3 to the NHS (Wales) Act 2006 provide for Welsh Ministers to confer functions on NHS Trusts and to give directions about how they exercise those functions. NHS Trusts must act in accordance with those directions. The NHS Trust's main statutory functions

are set out in their Establishment Order but additional functions may also be contained in other legislation, such as the NHS (Wales) Act 2006.

vii) **The Health and Social Care (Quality and Engagement) (Wales) Act 2020 (2020 asc 1) (**the 2020 Act) makes provision for:

- Ensuring NHS bodies and ministers consider how their decisions will secure an improvement in the quality of health services (the Duty of Quality);
- Ensuring NHS bodies and primary care services are open and honest with patients, when something may have gone wrong in their care (the Duty of Candour);
- The creation of a new Citizens Voice Body for Health and Social Care, Wales (to be known as Llais) to represent the views of and advocate for people across health and social care in respect of complaints about services; and
- The appointment of statutory vice-chairs for NHS Trusts.

The act has been commenced at various stages with the final provision, relating to the preparation and publication of a code of practice regarding access to premises coming into effect in June 2023.

NHS Trusts will need ensure they comply with the provisions of the 2020 Act and the requirements of the statutory guidance.

The Duty of Quality statutory guidance 2023 can be found at https://www.gov.wales/duty-quality-healthcare

The NHS Duty of Candour statutory guidance 2023 can be found at https://www.gov.wales/duty-candour-statutory-guidance-2023

~~vii)~~viii) The Well-being of Future Generations (Wales) Act 2015 also places duties on LHBs and some Trusts in Wales. Sustainable development in the context of the Act means the process of improving economic, social, environmental and cultural well-being of Wales by taking action, in accordance with the sustainable development principle, aimed at achieving the well-being goals.

~~viii)~~ix) In exercising their powers NHS Trusts must be clear about the statutory basis for exercising such powers.

~~ix)~~x) In addition to directions the Welsh Ministers may from time to time issue guidance which NHS Trusts must take into account when exercising any function.

~~x)~~xi) NHS Trusts work closely with the seven Local Health Boards (LHBs) in Wales. The chief executive of the Trust is an associate member of the following joint-committees of the LHBs:

- The Welsh Health Specialised Services Committee, and
- The Emergency Ambulance Service Committee.

~~xi)~~xii) **The Welsh Health Specialised Services Committee (Wales) Directions 2009 (2009/35)** provide that the seven LHBs in Wales will work jointly to exercise functions relating to the planning and securing of specialised and tertiary services and for the purpose of jointly exercising those functions will establish the Welsh Health Specialised Services Committee ("WHSSC"). Under powers set out in paragraph 4 of Schedule 2 to the NHS (Wales) Act 2006, the Minister has made **The Welsh Health Specialised Services Committee (Wales) Regulations 2009 (S.I. 2009/3097)** which make provision for the constitution and membership of the WHSSC including its procedures and administrative arrangements.

~~xii)~~xiii) **The Emergency Ambulance Services Committee (Wales) Directions 2014 (2014/8 (W.08))** as amended by the **Emergency Ambulance Services (Wales) Amendment Directions 2016 (2016/8 (W.8))** provide that the seven LHBs in Wales will work jointly to exercise functions relating to the planning and securing of emergency ambulance services and for the purpose of jointly exercising those functions will establish the Emergency Ambulance Services Committee ("EASC"). Under powers set out in paragraph 4 of Schedule 2 to the NHS (Wales) Act 2006, the Minister has made **The Emergency Ambulance Services Committee (Wales) Regulations 2014 (2014/566)** which make provision for the constitution and membership of the EASC including its procedures and administrative arrangements.

~~xiii)~~xiv) **The Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012** (S.I. 2012) (as amended) require the Trust to establish a Shared Services Committee and prescribe the membership of the Shared Services Committee in order to ensure that all LHBs, Trusts and

Special Health Authorities in Wales have a member on the Shared Services Committee and that the views of all the NHS organisations in Wales are taken into account when making decisions in respect of Shared Services activities.

~~xiv)~~xv) **The National Health Service Bodies and Local Authorities Partnership Arrangements (Wales) Regulations 2000 (S.I. 2000/2993)** have effect as made under section 33 of the NHS (Wales) Act 2006 enable LHBs, NHS Trusts and Local Authorities to enter into any partnership arrangements to exercise certain NHS functions and health-related functions as specified in the Regulations. The arrangement can only be made if it is likely to lead to an improvement in the way in which NHS functions and health-related functions are exercised, and the partners have consulted jointly with all affected parties, and the arrangements fulfil the objectives set out in the Area Plan developed in accordance with the **Social Services and Well-being (Wales) Act 2014.**

~~xv)~~xvi) Section 72 of the NHS Act 2006 places a duty on NHS bodies to co-operate with each other in exercising their functions. NHS bodies includes NHS bodies in England such as the NHS Commissioning Board, NHS Trust and NHS Foundation Trust and, for the purposes of this duty, also includes bodies such as NICE, the Health and Social Care Information Centre and Health Education England.

~~xvi)~~xvii) Section 82 of the NHS Act 2006 places a duty on NHS bodies and local authorities to co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales.

~~xvii)~~xviii) The Welsh Language (Wales) Measure 2011 makes provision with regard to the development of standards of conduct relating to the Welsh Language. These standards replace the requirement for a Welsh Language Scheme previously provided for Section 5 of the Welsh Language Act 1993. The Welsh Language Standards (No.7) Regulations 2018 (2018/411) came into force on the 29 June 2018 and specifies standards in relation to the conduct of NHS Trusts. The Trust will ensure that it has arrangements in place to meet those standards which the Welsh Language Commissioner has required by way of a compliance notice under section 44 of the 2011 Measure.

~~xviii)~~xix) Paragraph 18 of Schedule 3 to the NHS (Wales) Act 2006 provides

for NHS Trusts to enter into arrangements for the carrying out, on such terms as considered appropriate, of any of its functions jointly with any Strategic Health Authority, Local Health Board or other NHS Trust, or any other body or individual.

~~xix)~~xx) NHS Trusts are also bound by any other statutes and legal provisions which govern the way they do business. The powers of NHS Trusts established under statute shall be exercised by NHS Trusts meeting in public session, except as otherwise provided by these SOs.

NHS framework

~~xx)~~xxi) In addition to the statutory requirements set out above, NHS Trusts must carry out all business in a manner that enables them to contribute fully to the achievement of the Welsh Government's vision for the NHS in Wales and its standards for public service delivery. The governance standards set for the NHS in Wales are based upon the Welsh Government's Citizen Centred Governance principles. These principles provide the framework for good governance and embody the values and standards of behaviour that are expected at all levels of the service, locally and nationally.

~~xxi)~~xxii) Adoption of the principles will better equip NHS Trusts to take a balanced, holistic view of their organisations and their capacity to deliver high quality, safe healthcare services for all its citizens within the NHS framework set nationally.

~~xxii)~~xxiii) The overarching NHS governance and accountability framework incorporates these SOs; the Scheme of Reservation and Delegation of Powers; SFIs together with a range of other frameworks designed to cover specific aspects. These include the NHS Values and Standards of Behaviour Framework*; the ~~*'Doing Well, Doing Better: Standards for Health Services in Wales'* (formally the Healthcare Standards) Framework~~Health and Care Quality Standards 2023, the NHS Risk and Assurance Framework, and the NHS planning and performance management systems.

* The NHS Wales Values and Standards of Behaviour Framework can be accessed via the following link: https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/living-public-service-values/values-and-standards-of-behaviour-framework/

~~xxiii)~~xxiv) The Welsh Ministers, reflecting their constitutional obligations, and legal duties under the **Well-being of Future Generations (Wales) Act 2015 (2015/2)**, have stated that sustainable development should be the central organising principle for the public sector and a core objective for the NHS in all it does.

The Welsh Ambulance Service NHS Trust is not, at present, considered a public body under the Act but is committed to achieving the Well-being Goals and the sustainable development principle.

~~xxiv)~~xxv) Full, up to date details of the other requirements that fall within the NHS framework – as well as further information on the Welsh Government's Citizen Centred Governance principles - are provided on the NHS Wales Governance e-manual, which can be accessed at https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/. Directions or guidance on specific aspects of NHS Trust business are also issued electronically, usually under cover of a Welsh Health Circular.

NHS Trust framework

~~xxv)~~xxvi) Schedule 2 provides details of the key documents that, together with these SOs, make up the NHS Trust's governance and accountability framework. These documents must be read in conjunction with these SOs and will have the same effect as if the details within them were incorporated within the SOs themselves. The Standing Financial Instructions form Schedule 2.1 of these SOs.

~~xxvi)~~xxvii) NHS Trusts will from time to time agree and approve policy statements which apply to the Trust's Board of directors and/or all or specific groups of staff employed by the Welsh Ambulance Services National Health Service Trust and others. The decisions to approve these policies will be recorded and, where appropriate, will also be considered to be an integral part of the Trust's SOs and SFIs. *Details of the Trust's key policy statements are also included in Schedule 2.*

~~xxvii)~~xxviii) NHS Trusts shall ensure that an official is designated to undertake the role of the Board Secretary (the role of which is set out in paragraph xxxv) below).

~~xxviii)~~xxix) For the purposes of these SOs, the Trust Board of directors shall collectively to be known as "the Board" or "Board members"; the executive and non-executive directors shall be referred to as Executive Directors and Independent Members respectively; and the Chief Officer and the Chief Finance Officer shall respectively be known as the Chief Executive and the Director of Finance (hereafter referred to as Director of Finance and Corporate Resources) – SO 1.1.2 refers.

Applying Standing Orders

~~xxix)~~xxx) The SOs of NHS Trusts (together with SFIs and the Values and Standards of Behaviour Framework) will, as far as they are applicable, also apply to meetings of any formal Committees established by the Trust, including any sub-Committees and Advisory Groups. These SOs may be amended or adapted for the Committees as appropriate, with the approval of the Board. *Further details on committees may be found in Schedule 3 of these SOs.*

~~xxx)~~xxxi) Full details of any non-compliance with these SOs, including an explanation of the reasons and circumstances must be reported in the first instance to the Board Secretary, who will ask the Audit Committee to formally consider the matter and make proposals to the Board on any action to be taken. All Board members and Trust officers have a duty to report any non-compliance to the Board Secretary as soon as they are aware of any circumstance that has not previously been reported.

~~xxxi)~~xxxii) **Ultimately, failure to comply with SOs is a disciplinary matter that could result in an individual's dismissal from employment or removal from the Board.**

Variation and amendment of Standing Orders

~~xxxii)~~xxxiii) Although these SOs are subject to regular, annual review by the NHS Trust, there may, exceptionally, be an occasion where it is necessary to vary or amend the SOs during the year. In these circumstances, the Board Secretary shall advise the Board of the implications of any decision to vary or amend SOs, and such a decision may only be made if:

- The variation or amendment is in accordance with regulation 19 of the Membership Regulations and does not contravene a statutory

provision or direction made by the Welsh Ministers;

- The proposed variation or amendment has been considered and approved by the Audit Committee and is the subject of a formal report to the Board; and

- A notice of motion under Standing Order 7.5.14 has been given.

Interpretation

~~xxxiii)~~xxxiv) During any Board meeting where there is doubt as to the applicability or interpretation of the SOs, the Chair of the Trust shall have the final say, provided that his or her decision does not conflict with rights, liabilities or duties as prescribed by law. In doing so, the Chair shall take appropriate advice from the Board Secretary and, where appropriate the Chief Executive or the Director of Finance and Corporate Resources (in the case of SFIs).

~~xxxiv)~~xxxv) The terms and provisions contained within these SOs aim to reflect those covered within all applicable health legislation. The legislation takes precedence over these SOs when interpreting any term or provision covered by legislation.

The role of the Board Secretary

~~xxxv)~~xxxvi) The role of the Board Secretary is crucial to the ongoing development and maintenance of a strong governance framework within NHS Trusts, and is a key source of advice and support to the NHS Trust Chair and other Board members. Independent of the Board, the Board Secretary acts as the guardian of good governance within NHS Trusts. The Board Secretary is responsible for:

- Providing advice to the Board as a whole and to individual Board members on all aspects of governance;
- Facilitating the effective conduct of NHS Trust business through meetings of the Board, its Advisory Groups and Committees;
- Ensuring that Board members have the right information to enable them to make informed decisions and fulfil their responsibilities in accordance with the provisions of these SOs;
- Ensuring that in all its dealings, the Board acts fairly, with integrity,

and without prejudice or discrimination;

- Contributing to the development of an organisational culture that embodies NHS values and standards of behaviour; and
- Monitoring the NHS Trust compliance with the law, SOs and the governance and accountability framework set by the Welsh Ministers.

As advisor to the Board, the *Board Secretary's* role does not affect the specific responsibilities of Board members for governing the organisation. The Board Secretary is directly accountable for the conduct of their role to the Chair in respect of matters relating to responsibilities of the Board, its Committees and Advisory Groups, and reports on a day to day basis to the Chief Executive with regard to the wider governance of the organisation and their personal responsibilities.

Further details on the role of the Board Secretary within the Welsh Ambulance Services NHS Trust, including details on how to contact them, is available at Welsh Ambulance Service NHS Trust - Trust Board (wales.nhs.uk).

Section B – Standing Orders

1. THE TRUST

1.0.1 The Trust's principal role is:

(a) to manage ambulance and associated transport services;

(b) to manage such other services (including communications and training) relating to the provision of care as can reasonably be carried out in conjunction with the management of ambulance and associated transport services from Ambulance Headquarters at:

(i) Beacon House, William Brown Close, Cwmbran NP44 3AB
~~(i)~~(ii) Vantage Point House, Ty Coch Way, Cwmbran, NP44 7HF
~~(ii)~~(iii) Ty Elwy, St Asaph Business Park, St Asaph, LL17 0LJ,
~~(iii)~~(iv) Matrix One, Northern Boulevard, Swansea, SA6 8RE,

(c) to own the premises associated with the provision of the services in paragraphs (a) and (b);

(d) to perform the functions of the National Contact Point in Wales for the purposes of Directive 2011/24/EU as set out in regulations 3 to 6 of the National Health Service (Cross-Border Healthcare) Regulations 2013; and

(e) to provide—

(i) information about health conditions and availability of health services; and

(ii) remote access health advisory, triage and referral services,

for the purposes of the health service in Wales.

1.0.2 The Trust was established by, and its functions are contained in, the **Welsh Ambulance Services National Health Service Trust (Establishment) Order 1998** (S.I. 1998/678), as amended. The Trust must ensure that all its activities are in exercise of those functions or other statutory functions that are conferred on it.

1.0.3 To fulfil this role, the Trust will work with all its partners and stakeholders in the best interests of its population.

1.1 Membership of the Trust

1.1.1 The membership of the Trust shall comprise the Chair, Vice Chair, six~~7~~ non-executive directors and ~~5~~six executive directors.

1.1.2 For the purposes of these SOs, the Trust Board of directors shall collectively to be known as "the Board" or "Board members"; the executive and non-executive directors (which will include the Chair) shall be referred to as Executive Directors and Independent Members respectively. The Chief Officer and the Chief Finance Officer shall respectively be known as the Chief Executive and the Director of Finance and Corporate Resources. All such members shall have full voting rights.

1.1.3 The Minister for Health and Social Services shall appoint the Chair and non-officer members of the Trust.

1.1.4 The Trust will appoint a Committee whose members will be the Chair and non-executive directors of the Trust whose function will be to appoint the Chief Executive as a director of the Trust.

1.1.5 The Trust will appoint a Committee whose members will be the chair, the non-executive directors and the Chief Executive whose function will be to appoint the executive directors other than the Chief Executive.

Executive Directors

1.1.6 A total of ~~5~~six, appointed by the relevant committee, and consisting of the Chief Executive, the Director of Finance and Corporate Resources and ~~3~~four others. Executive Directors may have other responsibilities as determined by the Board and set out in the scheme of delegation to

officers.

Non-executive directors [to be known as Independent Members]

1.1.7 A total of six~~7~~ (excluding the Chair and Vice Chair) appointed by the Minister for Health and Social Services.

1.1.8 In addition to the eligibility, disqualification, suspension, and removal provisions contained within the Membership Regulations, an individual shall not normally serve concurrently as a non-officer member on the Board of more than one NHS body in Wales.

Use of the term 'Independent Members'

1.1.9 For the purposes of these SOs, use of the term 'Independent Members' refers to the following voting members of the Board:

- Chair
- Vice-Chair
- Non-Executive Directors

unless otherwise stated.

1.2 Joint Directors

1.2.1 Where a post of Executive Director of the Trust is shared between more than one person because of their being appointed jointly to a post:

(i) Either or both persons may attend and take part in Board meetings;
(ii) If both are present at a meeting they shall cast one vote if they agree;
(iii) In the case of disagreement no vote shall be cast; and
(iv) The presence of both or one person will count as one person in relation to the quorum.

1.3 Tenure of Board members

1.3.1 The Chair and Independent Members appointed by the Minister for Health and Social Services shall be appointed as Trust members for a period specified by the Welsh Ministers, but for no longer than four~~4~~ years in any one term. These members can be reappointed. Time served need not be

consecutive and will still be counted towards the total period even where there is a break in the term.

1.3.2 Executive Directors' tenure of office as Board members will be determined by their contract of appointment.

1.3.3 All Board members' tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements, so far as they are applicable, as specified in the Membership Regulations. Any member must inform the Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on their eligibility to hold office. The Chair will advise the Minister in writing of any such cases immediately.

1.3.4 The Trust will require Board members to confirm in writing their continued eligibility on an annual basis.

1.4 The Role of the Trust, its Board and responsibilities of individual members

Role

1.4.1 The principal role of the Trust is set out in SO 1.0.1. The Board's main role is to add value to the organisation through the exercise of strong leadership and control, including:

- Setting the organisation's strategic direction
- Establishing and upholding the organisation's governance and accountability framework, including its values and standards of behaviour
- Ensuring delivery of the organisation's aims and objectives through effective challenge and scrutiny of the Trust's performance across all areas of activity.

Responsibilities

1.4.2 The Board will function as a corporate decision-making body, Executive Directors and Independent Members being full and equal members and sharing corporate responsibility for all the decisions of the Board.

1.4.3 Independent Members who are appointed to bring a particular

perspective, skill or area of expertise to the Board must do so in a balanced manner, ensuring that any opinion expressed is objective and based upon the best interests of the health service. Similarly, Board members must not place an over reliance on those individual members with specialist expertise to cover specific aspects of Board business, and must be prepared to scrutinise and ask questions about any contribution that may be made by that member.

1.4.4 NHS Trusts shall issue an indemnity to any Chair and Independent Member in the following terms: "A Board [or Committee] member, who has acted honestly and in good faith, will not have to meet out of their personal resources any personal liability which is incurred in the execution of their Board function. Such cover excludes the reckless or those who have acted in bad faith".

1.4.5 All Board members must comply with their terms of appointment. They must equip themselves to fulfil the breadth of their responsibilities by participating in appropriate personal and organisational development programmes, engaging fully in Board activities and promoting the Trust within the communities it serves.

1.4.6 **The Chair** – The Chair is responsible for the effective operation of the Board, chairing Board meetings when present and ensuring that all Board business is conducted in accordance with these SOs. The Chair may have certain specific powers delegated by the Board and set out in the Scheme of Delegation.

1.4.7 The Chair shall work in close harmony with the Chief Executive and, supported by the Board Secretary, shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

1.4.8 **The Vice-Chair** – The Vice-Chair shall deputise for the Chair in their absence for any reason, and will do so until either the existing chair resumes their duties or a new chair is appointed.

1.4.9 **Chief Executive** – The Chief Executive is responsible for the overall performance of the executive functions of the Trust. They are the appointed Accountable Officer for the Trust and shall be responsible for

meeting all the responsibilities of that role, as set out in their Accountable Officer Memorandum.

1.4.10 **Lead roles for Board members** – The Chair will ensure that individual Board members are designated as lead roles or "champions" as required by the Welsh Ministers or as set out in any statutory or other guidance. Any such role must be clearly defined and must operate in accordance with the requirements set by the Trust, the Welsh Ministers or others. In particular, no operational responsibilities will be placed upon any Independent Member fulfilling such a role. The identification of a Board member in this way shall not make them more vulnerable to individual criticism, nor does it remove the corporate responsibility of the other Board members for that particular aspect of Board business.

2. RESERVATION AND DELEGATION OF TRUST FUNCTIONS

2.0.1 Subject to any directions that may be given by the Welsh Ministers, the Board shall make arrangements for certain functions to be carried out on its behalf so that the day to day business of the Trust may be carried out effectively and in a manner that secures the achievement of its aims and objectives. In doing so, the Board must set out clearly the terms and conditions upon which any delegation is being made.

2.0.2 The Board's determination of those matters that it will retain, and those that will be delegated to others shall be set out in a:

(i) Schedule of matters reserved to the Board;
(ii) Scheme of delegation to committees and others; and
(iii) Scheme of delegation to officers.

all of which must be formally adopted by the Board in full session and form part of these SOs.

2.0.3 The Trust retains full responsibility for any functions delegated to others to carry out on its behalf. Where Trusts and Local Health Boards have a joint duty the Trust remains fully responsible for its part, and shall agree the governance and assurance arrangements for the partnership, setting out respective responsibilities, ways of working, accountabilities and sources of assurance of the partner organisations.

2.1 Chair's action on urgent matters

2.1.1 There may, occasionally, be circumstances where decisions which would normally be made by the Board need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Board. In these circumstances, the Chair and the Chief Executive, supported by the Board Secretary as appropriate, may deal with the matter on behalf of the Board - after first consulting with at least two other Independent Members. The Board Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Board for consideration and ratification.

2.1.2 Chair's action may not be taken where either the Chair or the Chief Executive has a personal or business interest in an urgent matter requiring decision. In this circumstance, the Vice-Chair or the Executive Director acting on behalf of the Chief Executive will take a decision on the urgent matter, as appropriate.

2.2 Delegation of Board functions

2.2.1 The Board may agree the delegation of any of their functions, except for those set out within the 'Schedule of Matters Reserved for the Board' within the Model Standing Orders (see paragraph 2.0.2 (i), to Committees and others, setting any conditions and restrictions it considers necessary and in accordance with any directions or regulations given by the Welsh Ministers. These functions may be carried out:

(i) By a Committee, sub-Committee or officer of the Trust (or of another Trust); or
(ii) By another LHB; NHS Trust; Strategic Health Authority or Primary Care Trust in England; Special Health Authority; or
(iii) With one or more bodies including local authorities through a sub-Committee.]

2.2.2 The Board may agree and formally approve the delegation of specific executive powers to be exercised by Committees or sub-Committees which it has formally constituted.

2.3 Delegation to officers

2.3.1 The Board may delegate certain functions to the Chief Executive. For these aspects, the Chief Executive, when compiling the Scheme of Delegation to Officers, shall set out proposals for those functions they will perform personally and shall nominate other officers to undertake the remaining functions. The Chief Executive will still be accountable to the Board for all functions delegated to them irrespective of any further delegation to other officers.

2.3.2 This must be considered and approved by the Board (subject to any amendment agreed during the discussion). The Chief Executive may periodically propose amendments to the Scheme of Delegation to Officers and any such amendments must also be considered and approved by the Board.

2.3.3 Individual Executive Directors are in turn responsible for delegation within their own directorates/departments/localities in accordance with the framework established by the Chief Executive and agreed by the Board.

3. COMMITTEES

3.1 NHS Trust Committees

3.1.1 The Board may and, where directed by the Welsh Ministers must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees. The Board shall, wherever possible, require its Committees to hold meetings in public unless there are specific, valid reasons for not doing so.

Use of the term "Committee"

3.1.2 For the purposes of these SOs, use of the term 'Committee' incorporates the following:

- Board Committee

- Sub-Committee

unless otherwise stated.

3.2 Sub-Committees

3.2.1 A Committee appointed by the Board may establish a sub-Committee to assist it in the conduct of its business provided that the Board approves such action. Where the Board has authorised a Committee to establish sub-Committees they cannot delegate any executive powers to the sub-Committee unless authorised to do so by the Board.

3.3 Committees established by the Trust

3.3.1 The Board shall establish a Committee structure that it determines best meets its own needs, taking account of any regulatory or Welsh Government requirements. As a minimum, it must establish Committees which cover the following aspects of Board business:

- Quality and Safety;
- Audit;
- Information governance (as appropriate);
- Charitable Funds;
- Remuneration and Terms of Service; and
- Mental Health Act requirements (as appropriate).

3.3.2 In designing its Committee structure and operating arrangements, the Board shall take full account of the need to:

- Embed corporate standards, priorities and requirements, e.g., equality and human rights across all areas of activity;
- Maximise cohesion and integration across all aspects of governance and assurance.

3.3.3 Each Committee established by or on behalf of the Board must have its own SOs or detailed terms of reference and operating arrangements, which must be formally approved by the Board. These must establish its governance and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership and quorum;

- Meeting arrangements;
- Relationships and accountabilities with others (including the Board**,** its Committees and any Advisory Groups);
- Any budget and financial responsibility, where appropriate;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

3.3.4 In doing so, the Board shall specify which aspects of these SOs are not applicable to the operation of the Committee, keeping any such aspects to the minimum necessary.

3.3.5 The membership of any such Committees - including the designation of Chair; definition of member roles and powers and terms and conditions of appointment (including remuneration and reimbursement) - will usually be determined by the Board, based on the recommendation of the Trust Chair, and subject to any specific requirements, directions or regulations made by the Welsh Ministers. Depending on the Committee's defined role and remit, membership may be drawn from the Board, its staff (subject to the conditions set in Standing Order 3.4.6) or others not employed by the Trust.

3.3.6 Executive Directors or other Trust officers shall not be appointed as Committee Chairs, nor should they be appointed to serve as members on any Committee set up to review the exercise of functions delegated to officers or to review Mental Health Tribunals (in accordance with the Mental Health Act 1983). Designated Trust officers shall, however, be in attendance at such Committees, as appropriate.

Full details of the Committee structure established by the Board, including detailed terms of reference for each of these Committees are set out in Schedule 3.

3.3.7 Substitution arrangements – Should any Non-Executive Director on the Board be unable to attend a meeting of a Committee the member may consider appointing a substitute member to attend the meeting in his/her place. The substitute member will assume upon appointment, full delegated responsibility on behalf of the substituted member and will be eligible to vote, as necessary on any matter before the Committee and will be counted as part of the quorum for that meeting. To instigate a substitution arrangement, the member of the Committee must notify the

Board Secretary before the day of the meeting that he/she is unable to attend and the name of the member who will attend as the substitute

3.4 Other Committees

3.4.1 The Board may also establish other Committees to help the Trust in the conduct of its business.

3.5 Confidentiality

3.5.1 Committee members and attendees must not disclose any matter dealt with by or brought before a Committee in confidence without the permission of the Committee's Chair.

3.6 Reporting activity to the Board

3.6.1 The Board must ensure that the Chairs of all Committees operating on its behalf report formally, regularly and on a timely basis to the Board on their activities. Committee Chairs' shall bring to the Boards specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

4. NHS WALES SHARED SERVICES PARTNERSHIP

4.0.1 From 1 June 2012 the function of managing and providing Shared Services to the health service in Wales was given to Velindre NHS Trust. The Trust's Establishment Order has been amended to reflect the fact that the Shared Services function has been conferred on it.

4.0.2 The **Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012** (S.I. 2012/1261 (W.156)) ("the Shared Services Regulations") require the Trust to establish a Shared Services Committee which will be responsible for exercising the Trust's Shared Services functions. The Shared Services Regulations (as amended) prescribe the membership of the Shared Services Committee in order to ensure that all LHBs, Trusts and Special Health Authorities in Wales have a member on the Shared Services Committee and that the views of all the NHS organisations in Wales are taken into account when making decisions in respect of Shared Services activities.

4.0.3 The Director of Shared Services will be designated as Accountable Officer for Shared Services.

4.0.4 These arrangements necessitate putting in place a Memorandum of Co-operation Agreement and a Hosting Agreement between all LHBs, ~~and~~ Trusts and Special Health Authorities ~~-~~setting out the obligations of NHS bodies to participate in the Shared Services Committee and to take collective responsibility for setting the policy and delivery of the Shared Services to the health service in Wales. Responsibility for the exercise of the Shared Services functions will not rest with the Board of Velindre NHS Trust but will be a shared responsibility of all NHS bodies in Wales.

4.0.5 The Shared Services Committee is to be known as the Shared Services Partnership Committee for operational purposes.

5. ADVISORY GROUPS

5.0.1 The Trust may and where directed by the Welsh Ministers must, appoint Advisory Groups to the Trust to provide advice to the Board in the exercise of its functions.

5.0.2 *Details of the Trust's Advisory Groups, their membership and terms of reference are set out in Schedule 4.*

5.0.3 The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out by others to advise it in the conduct of its business. The Board shall, wherever possible, require its Advisory Groups to hold meetings in public unless there are specific, valid reasons for not doing so.

5.1 Advisory Groups established by the Trust

5.1.1 The Trust has established the following Advisory Group(s):

- Local Partnership Forum (known as the Welsh Ambulance Services Partnership Team – WASPT)

5.2 Terms of reference and operating arrangements

5.2.1 The Board must formally approve terms of reference and operating arrangements in respect of any Advisory Group it has established. These must establish its governance and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership (including member appointment and removal, role, responsibilities and accountabilities, and terms and conditions of office) and quorum;
- Meeting arrangements;
- Communications;
- Relationships with others (including the Board, its Committees and Advisory Groups) as well as other relevant local and national groups;
- Any budget and financial responsibility (where appropriate);
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

5.2.2 In doing so, the Board shall specify which of these SOs are not applicable to the operation of the Advisory Group, keeping any such aspects to the minimum necessary. The detailed terms of reference and operating arrangements for the Trust's Advisory Groups are set out in Schedule 4.

5.2.3 The Board may determine that any Advisory Group it has set up should be supported by sub-groups to assist it in the conduct of its work, or the Advisory Group may itself determine such arrangements, provided that the Board approves such action.

5.3 Support to Advisory Groups

5.3.1 The Trust's Board Secretary, on behalf of the Chair, will ensure that Advisory Groups are properly equipped to carry out their role by:

- Co-ordinating and facilitating appropriate induction and organisational development activity;
- Ensuring the provision of governance advice and support to the Advisory Group Chair on the conduct of its business and its relationship with the Trust Board and others;

- Ensuring the provision of secretariat support for Advisory Group meetings (for specific arrangements relating to Local Partnership Forum see 5.7 and Schedule 4);
- Ensuring that the Advisory Group receives the information it needs on a timely basis;
- Ensuring strong links to communities/groups/professionals as appropriate; and
- Facilitating effective reporting to the Board

enabling the Board to gain assurance that the conduct of business within the Advisory Group accords with the governance and operating framework it has set.

5.4 Confidentiality

5.4.1 Advisory Group members and attendees must not disclose any matter dealt with by or brought before a Group in confidence without the permission of the Advisory Group Chair.

5.5 Advice and feedback

5.5.1 The Trust may specifically request advice and feedback from the Advisory Group(s) on any aspect of its business and they may also offer advice and feedback even if not specifically requested by the Trust. The Group(s) may provide advice to the Board:

- In written advice;
- In any other form specified by the Board

5.6 Reporting activity

5.6.1 The Board shall ensure that the Chairs of all Advisory Groups report formally, regularly and on a timely basis to the Board on their activities. Advisory Group Chairs shall bring to the Board's specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

5.6.2 Each Advisory Group shall also submit an annual report to the Board through the Chair within 6 weeks of the end of the reporting year setting out its activities during the year and detailing the results of a review of its

performance and that of any sub-groups it has established.

5.6.3 Each Advisory Group shall report regularly on its activities to those whose interests they represent.

5.7 The Local Partnership Forum (LPF)

Role

5.7.1 The LPF's role is to provide a formal mechanism where the Trust, as employer, and trade unions/professional bodies representing Trust employees (hereafter referred to as staff organisations) work together to improve health services for the citizens served by the Trust - achieved through a regular and timely process of consultation, negotiation, and communication. In doing so, the LPF must effectively represent the views and interests of the Trust's workforce.

5.7.2 It is the forum where the Trust and staff organisations will engage with each other to inform, debate, and seek to agree local priorities on workforce and health service issues; and inform thinking around national priorities on health matters.

5.8 Relationship with the Board and others

5.8.1 The LPF's main link with the Board is through the Executive members of the LPF.

5.8.2 The Board may determine that designated Board members or Trust staff shall be in attendance at LPF meetings. The LPF's Chair may also request the attendance of Board members or Trust staff, subject to the agreement of the Trust Chair.

5.8.3 The Board shall determine the arrangements for any joint meetings between the Board and the LPF's staff representative members.

5.8.4 The Board's Chair shall put in place arrangements to meet with the LPF's Joint Chairs on a regular basis to discuss the LPF's activities and operation.

5.8.5 The LPF shall ensure effective links and relationships with other groups/fora at a local and, where appropriate, national level.

Refer to Schedule 4 for detailed Terms of Reference and Operating Arrangements.

6. WORKING IN PARTNERSHIP

6.0.1 The Trust shall work constructively in partnership with others to plan and secure the delivery of an equitable, high quality, whole system approach to health, well-being and social care for its citizens. This will be delivered in accordance with its statutory duties and any specific requirements or directions made by the Welsh Ministers.

6.0.2 The Chair shall ensure that the Board has identified all its key partners and other stakeholders and established clear mechanisms for engaging with and involving them in the work of the Trust through:

- The Trust's own structures and operating arrangements, e.g., Advisory Groups; and
- The involvement (at very local and community wide levels) in partnerships and community groups – such as Public Service Boards – of Board members and Trust officers with delegated authority to represent the Trust and, as appropriate, take decisions on its behalf.

6.0.3 The Social Services and Well-Being (Wales) Act 2014 sets out duties for working in partnership with local authorities complementing existing duties under section 82 of the NHS Act 2006 (duty to cooperate with local authorities) and sections 10 (arrangements with other bodies) and 38 (duty to make services available to enable the discharge of local authority functions) of the NHS (Wales) Act 2006. An advice note on partnership working – implications for health boards and NHS Trusts from the Social Services and Well-being (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015 has been published and it can be found here: https://socialcare.wales/cms_assets/hub-downloads/Partnership-working---implications-for-health-boards-and-NHS-Trusts.pdf

6.0.4 The Board shall keep under review its partnership arrangements to ensure continued clarity around purpose, desired outcomes and partner responsibilities. It must ensure timely action to change, adapt or end partnerships where they no longer serve a useful purpose, in accordance

with its statutory duties; any specific requirements or directions made by the Welsh Ministers; and the agreed terms and conditions for the partnership.

6.1 ~~Community Health Councils (CHCs~~The Citizen Voice Body for Health and Social Care Wales (known as Llais)

6.1.1 ~~The **Community Health Councils (Constitution, Membership and Procedures) (Wales) Regulations 2010** (S.I. 2010/288) and the **Community Health Councils (Establishment, Transfer of Functions and Abolition) (Wales) Order 2010** (S.I. 2010/289)~~ Part 4 of the **Health and Social Care (Quality and Engagement) (Wales) Act 2020 (2020 asc 1)** (the 2020 Act) places a range of duties on Trusts in relation to the engagement and involvement of ~~CHCs~~ LLais in its operations.

6.1.2 The 2020 Act places a statutory duty on the Trust to have regard to any representations made to them by Llais. Statutory Guidance on Representations has been published to guide NHS bodies, local authorities and Llais in how these representations should be made and considered.

The Statutory Guidance on Representations made by the Citizen Voice Body can be found at https://www.gov.wales/sites/default/files/publications/2023-04/statutory-guidance-on-representations-made-by-the-citizen-voice-body.pdf

6.1.3 The 2020 Act also places a statutory duty on the Trust to promote awareness of Llais and make arrangements to engage and co-operate with Llais with the view to supporting each other in the exercise of their relevant functions. Promoting and facilitating engagement between individuals and Llais through access to relevant premises can help strengthen the public's voice and participation in shaping the design and delivery of services. The Trust must have regard to the Code of Practice on Access to Premises and Engagement with Individuals (so far as the code is relevant)

~~6.1.2~~6.1.4 In discharging these duties, and given the all-Wales nature of the Trust's functions, the Board shall work constructively with the Board of ~~Community Health Councils in Wales~~Llais, to ensure that ~~CHCs~~ regional offices of Llais ~~across Wales~~ are involved, as appropriate, in:

- The planning of the provision of its healthcare services;

- The development and consideration of proposals for service changes and ~~in~~ the way in which those services are provided; and
- The Board's decisions affecting the operation of those healthcare services that it has responsibility for; and
- Engaging, ~~and~~ formally consulting and working jointly with the Board of ~~Community Health Councils and CHCs~~ Llais ~~as appropriate~~ on any proposals for substantial development or change of the services it is responsible for in line with the Guidance on Changes to Health Services in Wales 2023.

The Guidance on Changes to Health Services can be found at https://www.gov.wales/guidance-changes-health-services

~~6.1.3~~6.1.5 The Board shall ensure that Llais~~each relevant CHC~~ is provided with the information it needs on a timely basis to enable it to effectively discharge its functions.

Relationship with the Board

~~6.1.4~~6.1.6 The Board may determine that a designated ~~CHC~~ Llais ~~members~~ representative shall be invited to attend Board meetings.

~~6.1.5~~6.1.7 The Board ~~may make~~ shall ensure arrangements are in place for ~~to hold~~ regular meetings between Trust officers and representatives of Llais. ~~the Board of Community Health Councils and CHCs, as appropriate~~.

~~6.1.6~~6.1.8 The Board's Chair shall put in place arrangements to meet with the Chair or Deputy Chair and/or representatives of Llais~~Board of Community Health Councils Chair~~ on a regular basis to discuss matters of common interest.

7. MEETINGS

7.1 Putting Citizens first

7.1.1 The Trust's business will be carried out openly and transparently in a manner that encourages the active engagement of its citizens, community partners and other stakeholders. The Trust, through the planning and conduct of meetings held in public, shall facilitate this in a number of ways,

including:

- Active communication of forthcoming business and activities;
- The selection of accessible, suitable venues for meetings when these are not held via electronic means;
- The availability of papers in English and Welsh languages and in accessible formats, such as Braille, large print, easy read (where requested and required) and in electronic formats;
- Requesting that attendees notify the Trust of any access needs sufficiently in advance of a proposed meeting, and responding appropriately, e.g., arranging British Sign Language (BSL) interpretation at meetings; and
- Where appropriate, ensuring suitable translation arrangements are in place to enable the conduct of meetings in either English or Welsh,

in accordance with legislative requirements, e.g., Disability Discrimination Act, as well as its Communication Strategy and provisions made in response to the compliance notice issued by the Welsh Language Commissioner under section 44 of the Welsh Language (Wales) Measure 2011.

7.1.2 The Chair will ensure that, in determining the matters to be considered by the Board, full account is taken of the views and interests of the Trust's citizens and other stakeholders, including any views expressed formally to the Trust, e.g., through ~~CHCs~~Llais.

~~7.1.3 The Board at its meeting in March 2014 agreed to introduce audio recording of Board meetings with effect from 1 April 2014. The intention behind this proposal is for the Trust to be as open and transparent as possible about the way decisions are made, to use the recordings to write up the decision at the end of a debate and also for reference purposes should it be necessary to recall the precise wording of suggestions, advice and recommendations made at the meeting~~

7.2 Annual Plan of Board Business

7.2.1 The Board Secretary, on behalf of the Chair, shall produce an Annual Plan of Board business. This plan will include proposals on meeting dates, venues and coverage of business activity during the year, taking account that ordinary meetings of the Board will be held at regular intervals and as

a minimum six times a year. The Plan shall also set out any standing items that will appear on every Board agenda.

7.2.2 The plan shall set out the arrangements in place to enable the Trust to meet its obligations to its citizens as outlined in paragraph 6.1.1 whilst also allowing Board members to contribute in either English or Welsh languages, where appropriate.

7.2.3 The plan shall also incorporate formal Board meetings, regular Board Development sessions and, where appropriate, the planned activities of the Board's Committees and Advisory Groups.

7.2.4 The Board shall agree the plan for the forthcoming year by the end of March, and this plan will be published on the organisation's website.

Annual General Meeting (AGM)

7.2.5 The Trust must hold an AGM in public no later than the 31 July each year. [Note : this will be no later than 30 September in 2023 to take account of the timetable for audit and laying of the Accounts by Audit Wales.] At least 10 calendar days prior to the meeting a public notice of the intention to hold the meeting, the time and place of the meeting, and the agenda, shall be displayed bilingually (in English and Welsh) on the Trust's website.

The notice shall state that:

- Electronic or paper copies of the Annual Report and Accounts of the Trust are available, on request, prior to the meeting; and
- State how copies can be obtained, in what language and in what format, e.g. as Braille, large print, easy read etc.

7.2.6 The AGM must include presentation of the Annual Report and audited accounts, together with (where applicable), an audited abridged version of the annual accounts and funds held on trust accounts, and may also include presentation of other reports of interest to citizens and others.

7.2.7 A record of the meeting shall be submitted to the next ordinary meeting of the Board for agreement.

7.3 Calling Meetings

7.3.1 In addition to the planned meetings agreed by the Board, the Chair may call a meeting of the Board at any time. Individual Board members may also request that the Chair call a meeting provided that at least one third of the whole number of Board members, support such a request.

7.3.2 If the Chair does not call a meeting within seven days after receiving such a request from Board members, then those Board members may themselves call a meeting.

7.4 Preparing for Meetings

Setting the agenda

7.4.1 The Chair, in consultation with the Chief Executive and Board Secretary, will set the Agenda. In doing so, they will take account of the planned activity set in the annual cycle of Board business; any standing items agreed by the Board; any applicable items received from the Board's Committees and Advisory Groups; and the priorities facing the Trust. The Chair must ensure that all relevant matters are brought before the Board on a timely basis.

7.4.2 Any Board member may request that a matter is placed on the Agenda by writing to the Chair, copied to the Board Secretary, at least 12 calendar days before the meeting. The request must set out whether the item of business is proposed to be transacted in public and shall include appropriate supporting information. The Chair may, at their discretion, include items on the agenda that have been requested after the 12 day notice period if this would be beneficial to the conduct of board business.

Notifying and equipping Board members

7.4.3 Board members shall be sent an Agenda and a complete set of supporting papers at least ~~10~~ seven calendar days before a formal Board meeting. This information may be provided to Board members electronically or in paper form, in an accessible format, to the address provided, and in accordance with their stated preference. Supporting papers may, exceptionally, be provided, after this time provided that the Chair is satisfied that the Board's ability to consider the issues contained within the paper would not be impaired.

7.4.4 No papers will be included for consideration and decision by the Board unless the Chair is satisfied (subject to advice from the Board Secretary, as appropriate) that the information contained within it is sufficient to enable the Board to take a reasonable decision. This will include evidence that appropriate impact assessments have been undertaken and taken into consideration. Impact assessments shall be undertaken on all new or revised policies, strategies, guidance and or practice to be considered by the Board, and the outcome of that assessment shall accompany the report to the Board to enable the Board to make an informed decision.

7.4.5 In the event that at least half of the Board members do not receive the Agenda and papers for the meeting as set out above, the Chair must consider whether or not the Board would still be capable of fulfilling its role and meeting its responsibilities through the conduct of the meeting. Where the Chair determines that the meeting should go ahead, their decision, and the reason for it, shall be recorded in the minutes.

7.4.6 In the case of a meeting called by Board members, notice of that meeting must be signed by those members and the business conducted will be limited to that set out in the notice.

Notifying the public and others

7.4.7 Except for meetings called in accordance with Standing Order 6.3, at least 10 calendar days before each meeting of the Board a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed bilingually (in English and Welsh):

- On the Trust's website, together with the papers supporting the public part of the Agenda; as well as
- Through other methods of communication as set out in the Trust's communication strategy.

7.4.8 When providing notification of the forthcoming meeting, the Trust shall set out when and how the Agenda and the papers supporting the public part of the Agenda may be accessed, in what language and in what format, e.g., as Braille, large print, easy read, etc.

7.5 Conducting Board Meetings

Admission of the public, the press and other observers

7.5.1 The Trust shall encourage attendance at its formal Board meetings by the public and members of the press as well as Trust officers or representatives from organisations who have an interest in Trust business. The venue for such meetings shall be appropriate to facilitate easy access for attendees and translation services; and shall have appropriate facilities to maximise accessibility.

7.5.2 The Board and its committees shall conduct as much of its formal business in public as possible. There may be circumstances where it would not be in the public interest to discuss a matter in public, e.g., business that relates to a confidential matter. In such cases the Chair (advised by the Board Secretary where appropriate) shall schedule these issues accordingly and require that any observers withdraw from the meeting. In doing so, the Board shall resolve:

> *That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960 (c.67).*

7.5.3 In these circumstances, when the Board is not meeting in public session it shall operate in private session formally reporting any decisions taken to the next meeting of the Board in public session. Wherever possible, that reporting shall take place at the end of a private session, by reconvening a Board meeting held in public session.

7.5.4 The Board Secretary, on behalf of the Chair, shall keep under review the nature and volume of business conducted in private session to ensure such arrangements are adopted only when absolutely necessary.

7.5.5 In encouraging entry to formal Board Meetings from members of the public and others, the Board shall make clear that attendees are welcomed as observers. The Chair shall take all necessary steps to ensure that the Board's business is conducted without interruption and disruption. In exceptional circumstances, this may include a requirement that observers

leave the meeting.

7.5.6 Unless the Board has given prior and specific agreement, members of the public or other observers will not be allowed to record proceedings in any way other than in writing.

Addressing the Board, its Committees and Advisory Groups

7.5.7 The Board will decide what arrangements and terms and conditions it feels are appropriate in extending an invitation to observers to attend and address any meetings of the Board, its Committees and Advisory Groups, and may change, alter or vary these terms and conditions as it considers appropriate. In doing so, the Board will take account of its responsibility to actively encourage the engagement and, where appropriate, involvement of citizens and stakeholders in the work of the Trust, (whether directly or through the activities of bodies such as ~~CHC~~ Llais and the Trust's Advisory Groups representing citizens and other stakeholders) and to demonstrate openness and transparency in the conduct of business.

Chairing Board Meetings

7.5.8 The Chair of the Trust will preside at any meeting of the Board unless they are absent for any reason (including any temporary absence or disqualification from participation on the grounds of a conflict of interest). In these circumstances the Vice Chair shall preside. If both the Chair and Vice-Chair are absent or disqualified, the Independent Members present shall elect one of the Independent Members to preside.

7.5.9 The Chair must ensure that the meeting is handled in a manner that enables the Board to reach effective decisions on the matters before it. This includes ensuring that Board members' contributions are timely and relevant and move business along at an appropriate pace. In doing so, the Board must have access to appropriate advice on the conduct of the meeting through the attendance of the nominated Board Secretary. The Chair has the final say on any matter relating to the conduct of Board business.

Quorum

7.5.10 At least one-third of all Board members, at least one of whom is an

Executive Director and one is an Independent Members, must be present to allow any formal business to take place at a Board meeting.

7.5.11 If the Chief Executive or an Executive Director is unable to attend a Board meeting, then a nominated deputy may attend in their absence and may participate in the meeting, provided that the Chair has agreed the nomination before the meeting. However, Board members' voting rights cannot be delegated so the nominated deputy may not vote or be counted towards the quorum. If a deputy is already a Board member in their own right, e.g., a person deputising for the Chief Executive will usually be an Executive Director, they will be able to exercise their own vote in the usual way but they will not have any additional voting rights.

7.5.12 The quorum must be maintained during a meeting to allow formal business to be conducted, i.e., any decisions to be made. Any Board member disqualified through conflict of interest from participating in the discussion on any matter and/or from voting on any resolution will no longer count towards the quorum. If this results in the quorum not being met that particular matter or resolution cannot be considered further at that meeting, and must be noted in the minutes.

Dealing with motions

7.5.13 In the normal course of Board business items included on the agenda are subject to discussion and decisions based on consensus. Considering a motion is therefore not a routine matter and may be regarded as exceptional, e.g. where an aspect of service delivery is a cause for particular concern, a Board member may put forward a motion proposing that a formal review of that service area is undertaken by a Committee of the Board. The Board Secretary will advise the Chair on the formal process for dealing with motions. No motion or amendment to a motion will be considered by the Board unless moved by a Board member and seconded by another Board member (including the Chair).

7.5.14 **Proposing a formal notice of motion –** Any Board member wishing to propose a motion must notify the Chair in writing of the proposed motion at least 12 days before a planned meeting. Exceptionally, an emergency motion may be proposed up to one hour before the fixed start of the meeting, provided that the reasons for the urgency are clearly set out. Where sufficient notice has been provided, and the Chair has determined

that the proposed motion is relevant to the Board's business, the matter shall be included on the Agenda, or, where an emergency motion has been proposed, the Chair shall declare the motion at the start of the meeting as an additional item to be included on the agenda.

7.5.15 The Chair also has the discretion to accept a motion proposed during a meeting provided that the matter is considered of sufficient importance and its inclusion would not adversely affect the conduct of Board business.

7.5.16 **Amendments -** Any Board member may propose an amendment to the motion at any time before or during a meeting and this proposal must be considered by the Board alongside the motion.

7.5.17 If there are a number of proposed amendments to the motion, each amendment will be considered in turn, and if passed, the amended motion becomes the basis on which the further amendments are considered, i.e.., the substantive motion.

7.5.18 **Motions under discussion –** When a motion is under discussion, any Board member may propose that:

- The motion be amended;
- The meeting should be adjourned;
- The discussion should be adjourned and the meeting proceed to the next item of business;
- A Board member may not be heard further;
- The Board decides upon the motion before them;
- An ad hoc Committee should be appointed to deal with a specific item of business; or
- The public, including the press, should be excluded.

7.5.19 **Rights of reply to motions –** The mover of a motion (including an amendment) shall have a right of reply at the close of any debate on the motion or the amendment immediately prior to a vote on the proposal.

7.5.20 **Withdrawal of motion or amendments –** A motion or an amendment to a motion, once moved and seconded, may be withdrawn by the proposer with the agreement of the seconder and the Chair.

7.5.21 **Motion to rescind a resolution –** The Board may not consider a motion

to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six months unless the motion is supported by the (simple) majority of Board members.

7.5.22 A motion that has been decided upon by the Board cannot be proposed again within six months except by the Chair, unless the motion relates to the receipt of a report or the recommendations of a Committee/Chief Executive to which a matter has been referred.

Voting

7.5.23 The Chair will determine whether Board members' decisions should be expressed orally, through a show of hands, by secret ballot or by recorded vote. The Chair must require a secret ballot or recorded vote if the majority of voting Board members request it. Where voting on any question is conducted, a record of the vote shall be maintained. In the case of a secret ballot the decision shall record the number voting for, against or abstaining. Where a recorded vote has been used the Minutes shall record the name of the individual and the way in which they voted.

7.5.24 In determining every question at a meeting the Board members must take account, where relevant, of the views expressed and representations made by individuals or organisations who represent the interests of the Trust's citizens and stakeholders. Such views will usually be presented to the Board through the Chair*(s)* of the Trust's Advisory Group*(s)* and the ~~CHC~~ Llais representative(s).

7.5.25 The Board will make decisions based on a simple majority view held by the Board members present. In the event of a split decision, i.e., no majority view being expressed, the Chair shall have a second and casting vote.

7.5.26 In no circumstances may an absent Board member or nominated deputy vote by proxy. Absence is defined as being absent at the time of the vote.

7.6 Record of Proceedings

7.6.1 A record of the proceedings of formal Board meetings (and any other meetings of the board where the Board members determine) shall be drawn up as 'minutes'. These minutes shall include a record of Board member attendance (including the Chair) together with apologies for

absence, and shall be submitted for agreement at the next meeting of the Board, where any discussion shall be limited to matters of accuracy. Any agreed amendment to the minutes must be formally recorded.

7.6.2 Agreed minutes shall be circulated in accordance with Board members' wishes, and, where providing a record of a formal Board meeting shall be made available to the public both on the Trust's website and in hard copy or other accessible format on request, in accordance with any legislative requirements, e.g., Data Protection Act 2018, the General Data Protection Regulations 2018, and the Trust's Communication Strategy and Welsh language requirements.

7.7 Confidentiality

7.7.1 All Board members together with members of any Committee or Advisory Group established by or on behalf of the Board and Trust officials must respect the confidentiality of all matters considered by the Trust in private session or set out in documents which are not publicly available. Disclosure of any such matters may only be made with the express permission of the Chair of the Board or relevant Committee, as appropriate, and in accordance with any other requirements set out elsewhere, e.g., in contracts of employment, within the Values and Standards of Behaviour framework (including the Standards of Business Conduct Policy) or legislation such as the Freedom of Information Act 2000, etc.

8. VALUES AND STANDARDS OF BEHAVIOUR

8.0.1 The Board must adopt a set of values and standards of behaviour for the Trust that meets the requirements of the NHS Wales Values and Standards of Behaviour framework. These values and standards of behaviour will apply to all those conducting business by or on behalf of the Trust, including Board members, Trust officers and others, as appropriate. The framework adopted by the Board framework will form part of these SOs.

8.1 Declaring and recording Board members' interests

8.1.1 ***Declaration of interests –*** It is a requirement that all Board members must declare any personal or business interests they may have which may affect,

or be perceived to affect the conduct of their role as a Board member. This includes any interests that may influence or be perceived to influence their judgement in the course of conducting the Board's business. Board members must be familiar with the Values and Standards of Behaviour Framework, the Standards of Business Conduct Policy, and their statutory duties under the Membership Regulations. Board members must notify the Chair and Board Secretary of any such interests at the time of their appointment, and any further interests as they arise throughout their tenure as Board members.

8.1.2 Board members must also declare any interests held by family members or persons or bodies with which they are connected. The Board Secretary will provide advice to the Chair and the Board on what should be considered as an 'interest', taking account of the regulatory requirements and any further guidance, e.g., the Values and Standards of Behaviour framework. If individual Board members are in any doubt about what may be considered as an interest, they should seek advice from the Board Secretary. However, the onus regarding declaration will reside with the individual Board member.

8.1.3 ***Register of interests –*** The Chief Executive, through the Board Secretary will ensure that a Register of Interests is established and maintained as a formal record of interests declared by all Board members. The register will include details of all Directorships and other relevant and material interests which have been declared by Board members.

8.1.4 The register will be held by the Board Secretary, and will be updated during the year, as appropriate, to record any new interests, or changes to the interests declared by Board members. The Board Secretary will also arrange an annual review of the Register, through which Board members will be required to confirm the accuracy and completeness of the register relating to their own interests.

8.1.5 In line with the Board's commitment to openness and transparency, the Board Secretary must take reasonable steps to ensure that the citizens served by the Trust are made aware of, and have access to view the Trust's Register of Interests. This may include publication on the Trust's website.

8.1.6 ***Publication of declared interests in Annual Report –*** Board members' directorships of companies or positions in other organisations likely or

possibly seeking to do business with the NHS shall be published in the Trust's Annual Report.

8.2 Dealing with Members' interests during Board meetings

8.2.1 The Chair, advised by the Board Secretary, must ensure that the Board's decisions on all matters brought before it are taken in an open, balanced, objective and unbiased manner. In turn, individual Board members must demonstrate, through their actions, that their contribution to the Board's decision making is based upon the best interests of the Trust and the NHS in Wales.

8.2.2 Where individual Board members identify an interest in relation to any aspect of Board business set out in the Board's meeting agenda, that member must declare an interest at the start of the Board meeting. Board members should seek advice from the Chair, through the Board Secretary before the start of the Board meeting if they are in any doubt as to whether they should declare an interest at the meeting. All declarations of interest made at a meeting must be recorded in the Board minutes.

8.2.3 It is the responsibility of the Chair, on behalf of the Board, to determine the action to be taken in response to a declaration of interest, taking account of any regulatory requirements or directions made by the Welsh Ministers. The range of possible actions may include determination that:

(i) The declaration is formally noted and recorded, but that the Board member should participate fully in the Board's discussion and decision, including voting. This may be appropriate, for example where the Board is considering matters of strategy relating to a particular aspect of healthcare and an Independent Member is a healthcare professional whose profession may be affected by that strategy determined by the Board;

(ii) The declaration is formally noted and recorded, and the Board member participates fully in the Board's discussion, but takes no part in the Board's decision;

(iii) The declaration is formally noted and recorded, and the Board member takes no part in the Board discussion or decision;

(iv) The declaration is formally noted and recorded, and the Board member is excluded for that part of the meeting when the matter is being discussed. A Board member must be excluded, where that member has a direct or indirect financial interest in a matter being considered by the Board.

8.2.4 In extreme cases, it may be necessary for the member to reflect on whether their position as a Board member is compatible with an identified conflict of interest.

8.2.5 Where the Chair is the individual declaring an interest, any decision on the action to be taken shall be made by the Vice Chair, on behalf of the Board.

8.2.6 In all cases the decision of the Chair (or the Vice Chair in the case of an interest declared by the Chair) is binding on all Board members. The Chair should take advice from the Board Secretary when determining the action to take in response to declared interests; taking care to ensure their exercise of judgement is consistently applied.

8.2.7 ***Members with pecuniary (financial) interests –*** Where a Board member, or any person they are connected with[1] has any direct or indirect pecuniary interest in any matter being considered by the Board, including a contract or proposed contract, that member must not take part in the consideration or discussion of that matter or vote on any question related to it. The Board may determine that the Board member concerned shall be excluded from that part of the meeting.

8.2.8 The Membership Regulations define 'direct' and 'indirect' pecuniary interests and these definitions always apply when determining whether a member has an interest. These SOs must be interpreted in accordance with these definitions.

8.2.9 ***Members with Professional Interests*** **-** During the conduct of a Board meeting, an individual Board member may establish a clear conflict of interest between their role as a Trust Board member and that of their

[1] In the case of persons who are married to each other or in a civil partnership with each other or who are living together as if married or civil partners, the interest of one person shall, if known to the other, be deemed for the purpose of this Standing Order to be also an interest of the other.

professional role outside of the Board. In any such circumstance, the Board shall take action that is proportionate to the nature of the conflict, taking account of the advice provided by the Board Secretary.

8.3 Dealing with officers' interests

8.3.1 The Board must ensure that the Board Secretary, on behalf of the Chief Executive, establishes and maintains a system for the declaration, recording and handling of Trust officers' interests in accordance with the Values and Standards of Behaviour Framework.

8.4 Reviewing how Interests are handled

8.4.1 The Audit Committee will review and report to the Board upon the adequacy of the arrangements for declaring, registering and handling interests at least annually.

8.5 Dealing with offers of gifts[2], hospitality and sponsorship

8.5.1 The Values and Standards of Behaviour Framework (including the Standards of Business Conduct Policy) approved by the Board prohibits Board members and Trust officers from receiving gifts, hospitality or benefits in kind from a third party which may reasonably give rise to suspicion of conflict between their official duty and their private interest, or may reasonably be seen to compromise their personal integrity in any way.

8.5.2 Gifts, benefits or hospitality must never be solicited. Any Board member or Trust officer who is offered a gift, benefit or hospitality which may or may be seen to compromise their position must refuse to accept it. This may in certain circumstances also include a gift, benefit or hospitality offered to a family member of a Trust Board member or officer. Failure to observe this requirement may result in disciplinary and/or legal action.

8.5.3 In determining whether any offer of a gift or hospitality should be accepted, an individual must make an active assessment of the circumstances within which the offer is being made, seeking advice from

[2] The term gift refers also to any reward or benefit.

the Board Secretary as appropriate. In assessing whether an offer should be accepted, individuals must take into account:

- **Relationship:** Contacts which are made for the purpose of information gathering are generally less likely to cause problems than those which could result in a contractual relationship, in which case accepting a gift or hospitality could cause embarrassment or be seen as giving rise to an obligation;

- **Legitimate Interest:** Regard should be paid to the reason for the contact on both sides and whether it is a contact that is likely to benefit the Trust;

- **Value:** Gifts and benefits of a trivial or inexpensive seasonal nature, e.g., diaries/calendars, are more likely to be acceptable and can be distinguished from more substantial offers. Similarly, hospitality in the form of a working lunch would not be treated in the same way as more expensive social functions, travel or accommodation (although in some circumstances these may also be accepted);

- **Frequency:** Acceptance of frequent or regular invitations particularly from the same source would breach the required standards of conduct. Isolated acceptance of, for example, meals, tickets to public, cultural or social events would only be acceptable if attendance is justifiable in that it benefits the Trust; and

- **Reputation:** If the body concerned is known to be under investigation by or has been publicly criticised by a public body, regulators or inspectors, acceptance of a gift or hospitality might be seen as supporting the body or affecting in some way the investigation or negotiations and it should always be declined.

8.5.4 A distinction may be drawn between items offered as hospitality and items offered in substitution for fees for broadcasts, speeches, lectures or other work done. There may be circumstances where the latter may be accepted if they can be used for official purposes.

8.6 Sponsorship

8.6.1 In addition gifts and hospitality individuals and the organisation may also

receive sponsorship. Sponsorship is an offer of funding to an individual, department or the organisation as a whole from an external source whether in cash, goods, services or benefits. It could include an offer to sponsor a research or operational post, training, attendance at a conference, costs associated with meetings, conferences or a working visit. The sponsorship may cover some or all of the costs.

8.6.2 All sponsorship must be approved prior to acceptance in accordance with the Values and Standards of Behaviour Framework (including the Standards of Business Conduct Policy) and relevant procedures. A record of all sponsorship accepted or declined will also be maintained.

8.7 Register of Gifts, Hospitality and Sponsorship

8.7.1 The Board Secretary, on behalf of the Chair, will maintain a register of Gifts, Hospitality and Sponsorship to record offers of gifts, hospitality and sponsorship made to Board members. Executive Directors will adopt a similar mechanism in relation to Trust officers working within their Directorates.

8.7.2 Every Board member and Trust officer has a personal responsibility to volunteer information in relation to offers of gifts, hospitality and sponsorship, including those offers that have been refused. The Board Secretary, on behalf of the Chair and Chief Executive, will ensure the incidence and patterns of offers and receipt of gifts, hospitality and sponsorship are kept under active review, taking appropriate action where necessary.

8.7.3 When determining what should be included in the Register with regard to gifts and hospitality, individuals shall apply the following principles, subject to the considerations in Standing Order 8.5.3:

- **Gifts:** Generally, only gifts of material value should be recorded. Those with a nominal value, e.g., seasonal items such as diaries/calendars would not usually need to be recorded.

- **Hospitality:** Only significant hospitality offered or received should

be recorded. Occasional offers of 'modest and proportionate[3]' hospitality need not be included in the Register.

8.7.4 Board members and Trust officers may accept the occasional offer of modest and proportionate hospitality but in doing so must consider whether the following conditions are met:

- acceptance would further the aims of the Trust;
- the level of hospitality is reasonable in the circumstances;
- it has been openly offered; and,
- it could not be construed as any form of inducement and will not put the individual under any obligation to those offering it.

8.7.5 The Board Secretary will arrange for a full report of all offers of Gifts, Hospitality and Sponsorship recorded by the Trust to be submitted to the Audit Committee (or equivalent) at least annually. The Audit Committee will then review and report to the Board upon the adequacy of the Trust's arrangements for dealing with offers of gifts, hospitality and sponsorship.

9. SIGNING AND SEALING DOCUMENTS

9.0.1 The common seal of the Trust is primarily used to seal legal documents such as transfers of land, lease agreements and other important/key contracts. The seal may only be fixed to a document if the Board has determined it shall be sealed, or if a transaction to which the document relates has been approved by the Board or Committee of the Board.

9.02. Where it is decided that a document shall be sealed it shall be fixed in the presence of the Chair or Vice Chair (or other authorised independent Member) and the Chief Executive (or another authorised individual) both of whom must witness the seal.

9.1 Register of Sealing

[3] Examples of 'modest and proportionate' hospitality that need not be included in a Hospitality register include a working sandwich lunch or a buffet lunch incidental to a conference or seminar attended by a variety of participants.

9.1.1 The Board Secretary shall keep a register that records the sealing of every document. Each entry must be signed by the persons who approved and authorised the document and who witnessed the seal. A report of all sealings shall be presented to the Board at least bi-annually.

9.2 Signature of Documents

9.2.1 Where a signature is required for any document connected with legal proceedings involving the Trust, it shall be signed by the Chief Executive, except where the Board has authorised another person or has been otherwise directed to allow or require another person to provide a signature.

9.2.2 The Chief Executive or nominated officers may be authorised by the Board to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) where the subject matter has been approved either by the Board or a Committee to which the Board has delegated appropriate authority.

9.3 Custody of Seal

9.3.1 The Common Seal of the Trust shall be kept securely by the Board Secretary.

10. GAINING ASSURANCE ON THE CONDUCT OF TRUST BUSINESS

10.0.1 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.

10.0.2 The Board shall ensure that its assurance arrangements are operating effectively, advised by its Audit Committee (or equivalent).

10.0.3 Assurances in respect of services provided by the NHS Wales Shared Services Partnership shall primarily be achieved by the reports of the

Director of Shared Services to the Shared Services Partnership Committee, and reported back by the Chief Executive (or their nominated representative). Where appropriate, and by exception, the Board may seek assurances direct from the Director of Shared Services. The Director of Shared Services and the Shared Services Partnership Committee shall be under an obligation to comply with any internal or external audit functions being undertaken by or on behalf of the Trust.

10.0.4 Whilst the Trust is not a member of WHSSC or EASC the Chief Executive does attend the Committees as an Associate Member. Assurances in respect of the functions discharged by WHSSC and EASC shall achieved by the reports of the respective Joint Committee Chair, and reported back by the Chief Executive.

10.0.5 Arrangements for seeking and providing assurance is respect of any other services provided on behalf of or in association with the Trust shall be clearly identified and reflected within the practice of the organisation and within the relevant agreements.

10.1 The role of Internal Audit in providing independent internal assurance

10.1.1 The Board shall ensure the effective provision of an independent internal audit function as a key source of its internal assurance arrangements, in accordance with NHS Wales Internal Auditing Standards and any other requirements determined by the Welsh Ministers.

10.1.2 The Board shall set out the relationship between the Head of Internal Audit (HIA), the Audit Committee (or equivalent) and the Board. It shall:

- Approve the Internal Audit Charter (incorporating the definition of internal audit) and adopt the Internal Auditing Standards (incorporating the code of ethics);
- Ensure the HIA communicates and interacts directly with the Board, facilitating direct and unrestricted access;
- Require Internal Audit to confirm its independence annually; and
- Ensure that the Head of Internal Audit reports periodically to the Board on its activities, including its purpose, authority, responsibility and performance. Such reporting will include governance issues and significant risk exposures.

10.2 Reviewing the performance of the Board, its Committees and Advisory Groups

10.2.1 The Board shall introduce a process of regular and rigorous self-assessment and evaluation of its own operations and performance and that of its Committees and Advisory Groups. Where appropriate, the Board may determine that such evaluation may be independently facilitated.

10.2.2 Each Committee and, where appropriate, Advisory Group must also submit an annual report to the Board through the Chair within 6 weeks of the end of the reporting year setting out its activities during the year and including the review of its performance and that of any sub-Committees it has established.

10.2.3 The Board shall use the information from this evaluation activity to inform:

- the ongoing development of its governance arrangements, including its structures and processes;
- its Board Development Programme, as part of an overall Organisation Development framework; and
- the Board's report of its alignment with the Welsh Government's Citizen Centred Governance Principles.

10.3 External Assurance

10.3.1 The Board shall ensure it develops effective working arrangements and relationships with those bodies that have a role in providing independent, external assurance to the public and others on the Trust's operations, e.g., the Auditor General for Wales and Healthcare Inspectorate Wales.

10.3.2 The Board may be assured, from the work carried out by external audit and others, on the adequacy of its own assurance framework, but that external assurance activity shall not form part of, or replace its own internal assurance arrangements, except in relation to any additional work that the Board itself may commission specifically for that purpose.

10.3.3 The Board shall keep under review and ensure that, where appropriate, the Trust implements any recommendations relevant to its business made by

the Welsh Government's Audit Committee, the Senedd Cymru/Welsh Parliament's Public Accounts Committee or other appropriate bodies.

10.3.4 The Trust shall provide the Auditor General for Wales with any assistance, information and explanation which the Auditor General thinks necessary for the discharge of their statutory powers and responsibilities.

11. DEMONSTRATING ACCOUNTABILITY

11.0.1 Taking account of the arrangements set out within these SOs, the Board shall demonstrate to the communities it serves and to the Welsh Ministers a clear framework of accountability within which it:

- Conducts its business internally;
- Works collaboratively with NHS colleagues, partners, service providers and others; and
- Responds to the views and representations made by those who represent the interests of citizens and other stakeholders, including its officers and healthcare professionals.

11.0.2 The Board shall, in publishing its strategic and operational level plans, set out how those plans have been developed taking account of the views of others, and how they will be delivered by working with their partners.

11.0.3 The Board shall also facilitate effective scrutiny of the Trust's operations through the publication of regular reports on activity and performance, including publication of an Annual Report.

11.0.4 The Board shall ensure that within the Trust, individuals at all levels are supported in their roles, and held to account for their personal performance through effective performance management arrangements.

12. REVIEW OF STANDING ORDERS

12.0.1 The Board Secretary shall arrange for ~~an~~ appropriate impact assessments to be carried out on a draft of these SOs prior to their formal adoption by the Board, the results of which shall be presented to the Board for consideration and action, as appropriate. The fact that an assessment has been carried out shall be noted in the SOs.

12.0.2 These SOs shall be reviewed annually by the Audit Committee, which shall report any proposed amendments to the Board for consideration. The requirement for review extends to all documents having the effect as if incorporated in SOs, including the appropriate impact assessments.

Appendix 1

Six Principles of Partnership Working

- a shared commitment to the success of the organisation
- a focus on the quality of working life
- recognition of the legitimate roles of the employer and the trade union
- a commitment by the employer to employment security
- openness on both sides and a willingness by the employer to share information and discuss the future plans for the organisation
- adding value – a shared understanding that the partnership is delivering measurable improvements for the employer, the union and employees

Appendix 2

Code of Conduct

A code of conduct for meetings sets ground rules for all participants:

- Respect the meeting start time and arrive punctually
- Attend the meeting well-prepared, willing to contribute and with a positive attitude
- Listen actively. Allow others to explain or clarify when necessary
- Observe the requirement that only one person speaks at a time
- Avoid 'put downs' of views or points made by colleagues
- Respect a colleague's point of view
- Avoid using negative behaviours e.g. sarcasm, point-scoring, personalisation
- Try not to react negatively to criticism or take as a personal slight
- Put forward criticism in a positive way
- Be mindful that decisions have to be made and it is not possible to accommodate all individual views
- No 'side-meetings' to take place
- Respect the Chair
- Failure to adhere to the Code of Conduct may result in the suspension or removal of the LPF member.

Appendix 3

List of Recognised Trade Unions/Professional Bodies referred to as 'staff organisations' within these Standing Orders

- British Medical Association (BMA)
- Royal College of Nursing (RCN)
- Royal College of Midwives (RCN)
- UNISON
- UNITE
- GMB
- British Orthoptic Society
- Society of Radiographers
- British Dental Association
- Society of Chiropodists and Podiatrists
- Federation of Clinical Scientists
- Chartered Society of Physiotherapy (CSP)
- British Dietetic Association
- British Association of Occupational Therapists (BAOT)

Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services
NHS Trust

Schedule 2.1

STANDING FINANCIAL INSTRUCTIONS

This Schedule forms part of, and shall have effect as if incorporated in the NHS Trust Standing Orders (incorporated as Schedule 2.1 of SOs)

Foreword

These Model Standing Financial Instructions are issued by Welsh Ministers to NHS Trusts using powers of direction provided in section 19 (1) of the National Health Service (Wales) Act 2006. NHS Trusts in Wales must agree Standing Financial Instructions (SFIs) for the regulation of their financial proceedings and business. Designed to achieve probity, accuracy, economy, efficiency, effectiveness and sustainability in the conduct of business, they translate statutory and Welsh Government financial requirements for the NHS in Wales into day to day operating practice. Together with the adoption of Standing Orders (SOs), a Schedule of decisions reserved to the Board and a Scheme of delegations to officers and others, they provide the regulatory framework for the business conduct of the Trust.

These documents form the basis upon which the Trust's governance and accountability framework is developed and, together with the adoption of the Trust's Values and Standards of Behaviour framework, is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

All Trust Board members and officers must be made aware of these Standing Financial Instructions and, where appropriate, should be familiar with their detailed content. The Executive Director of Finance and Corporate Resources will be able to provide further advice and guidance on any aspect of the Standing Financial Instructions. The Board Secretary will be able to provide further advice and guidance on the wider governance arrangements within the Trust. Further information on

governance in the NHS in Wales may be accessed at https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/

Contents

WELSH AMBULANCE SERVICES NHS TRUST

1. INTRODUCTION

1.1 General

1.1.1 These Model Standing Financial Instructions are issued by Welsh Ministers to NHS Trusts using powers of direction provided in section 19 (1) of the National Health Service (Wales) Act 2006. NHS Trusts in Wales must agree Standing Financial Instructions (SFIs) for the regulation of their financial proceedings and business. They shall have effect as if incorporated in the Standing Orders (SOs) (incorporated as Schedule 2.1of SOs).

1.1.2 These SFIs detail the financial responsibilities, policies and procedures adopted by **the Welsh Ambulance Services National Health Service Trust** "the Trust". They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Welsh Government policy in order to achieve probity, accuracy, economy, efficiency, effectiveness and sustainability. They should be used in conjunction with the Schedule of decisions reserved to the Board and the Scheme of delegation adopted by the Trust.

1.1.3 These SFIs identify the financial responsibilities which apply to everyone working for the Trust and its constituent organisations. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial control procedure notes. All financial procedures must be approved by the Executive Director of Finance and Corporate Resources and Audit Committee.

1.1.4 Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Board Secretary or Executive Director of Finance and Corporate Resources must be sought before acting. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's SOs.

1.2 Overriding Standing Financial Instructions

1.2.1 Full details of any non compliance with these SFIs, including an explanation of the reasons and circumstances must be reported in the first instance to the Executive Director of Finance and Corporate Resources and the Board Secretary, who will ask the Audit Committee to formally consider the matter

and make proposals to the Board on any action to be taken. All Board members and Trust officers have a duty to report any non compliance to the Executive Director of Finance and Corporate Resources and Board Secretary as soon as they are aware of any circumstances that has not previously been reported.

1.2.2 **Ultimately, the failure to comply with SFIs and SOs is a disciplinary matter that could result in an individual's dismissal from employment or removal from the Board.**

1.3 Financial provisions and obligations of NHS Trusts

1.3.1 The financial provisions and obligations for NHS Trusts are set out under Schedule 4 to the National Health Service (Wales) Act 2006 (c. 42). The Board as a whole and the Chief Executive in particular, in their role as the Accountable Officer for the organisation, must ensure the Trust meets its statutory obligation to perform its functions within the available financial resources.

1.3.2 The financial obligation as set out in paragraph 2 of Schedule 4 is as follows:

(1) Each NHS trust must ensure that its revenue is not less than sufficient, taking one financial year with another, to meet outgoings properly chargeable to revenue account.

(2) Each NHS trust must achieve such financial objectives as may from time to time be set by the Welsh Ministers with the consent of the Treasury and as are applicable to it.

(3) Any such objectives may be made applicable to NHS trusts generally, or to a particular NHS trust or to NHS trusts of a particular description.

2. RESPONSIBILITIES AND DELEGATION

2.1 The Board

2.1.1 The Board exercises financial supervision and control by:

a) Formulating and approving the Medium Term Financial Plan (MTFP) as part of developing and approving the Integrated Medium Term Plan (IMTP);

b) Requiring the submission and approval of balanced budgets within approved allocations/overall income;

c) Defining and approving essential features in respect of important financial policies, systems and financial controls (including the need to obtain value for money and sustainability); and

d) Defining specific responsibilities placed on Board members and Trust officers, and Trust committees and Advisory Groups as indicated in the 'Scheme of delegation' document.

2.1.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the 'Schedule of matters reserved to the Board' document. The Board, subject to any directions that may be made by Welsh Ministers, shall make appropriate arrangements for certain functions to be carried out on its behalf so that the day to day business of the Trust may be carried out effectively, and in a manner that secures the achievement of the organisation's aims and objectives. This will be via powers and authority delegated to committees or sub-committees that the Trust has established or to an officer of the Trust in accordance with the 'Scheme of delegation' document adopted by the Trust.

2.2 The Chief Executive and Executive Director of Finance and Corporate Resources

2.2.1 The Chief Executive and Executive Director of Finance and Corporate Resources will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

2.2.2 Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as Accountable Officer, to the Welsh Government, for ensuring that the Board meets its obligation to perform its

functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chair and the Board for ensuring that financial provisions, obligations and targets are met; and has overall responsibility for the Trust's system of internal control.

2.2.3 It is a duty of the Chief Executive to ensure that Board members and Trust officers, and all new appointees are notified of, and put in a position to understand their responsibilities within these SFIs.

2.3 The Executive Director of Finance and Corporate Resources

2.3.1 The Executive Director of Finance and Corporate Resources is responsible for:

a) Implementing the Trust's financial policies and for co-coordinating any corrective action necessary to further these policies;

b) Maintaining an effective system of internal financial control including ensuring that detailed financial control procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

c) Ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time; and

d) Without prejudice to any other functions of the Trust, and Board members and Trust officers, the duties of the Executive Director of Finance and Corporate Resources include:

(i) the provision of financial advice to other Board members and Trust officers, and to Trust committees and Advisory Groups,

(ii) the design, implementation and supervision of systems of internal financial control, and

(iii) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

2.3.2 The Executive Director of Finance and Corporate Resources is responsible for ensuring an ongoing training and communication programme is in place to

affect these SFIs.

2.4 Board members and Trust officers, and Trust Committees

2.4.1 All Board members and Trust officers, and Trust committees, severally and collectively, are responsible for:

a) The security of the property of the Trust;

b) Avoiding loss;

c) Exercising economy, efficiency and sustainability in the use of resources; and

d) Conforming to the requirements of SOs, SFIs, Financial Control Procedures and the Scheme of delegation.

2.4.2 For all Board members and Trust officers, and Trust committees who carry out a financial function, the form in which financial records are kept and the manner in which Trust Board members and officers, and Trust committees, Advisory Groups and employees discharge their duties must be to the satisfaction of the Executive Director of Finance and Corporate Resources .

2.5 Contractors and their employees

2.5.1 Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

3. AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT

3.1 Audit Committee

3.1.1 An independent Audit Committee is a central means by which a Board ensures effective internal control arrangements are in place. In addition, the Audit Committee provides a form of independent check upon the executive arm of the Board. In accordance with SOs the Board shall formally establish an Audit Committee with clearly defined terms of reference. Detailed terms of reference and operating arrangements for the Audit Committee are set out in Schedule 3 to the SOs. This committee will follow the guidance set out in the NHS Wales Audit Committee Handbook.

~~http://www.wales.nhs.uk/sitesplus/documents/1064/NHS%20Wales%20Audit%20Committee%20Handbook%20%28June%202012%29.pdf~~
nwssp.nhs.wales/a-wp/governance-e-manual/governance-e-manual-documents/useful-documents/nhs-wales-audit-committee-handbook-june-2012/

3.2 Chief Executive

3.2.1 The Chief Executive is responsible for:

a) Ensuring there are arrangements in place to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;

b) Ensuring that the Internal Audit function meets the Public Sector Internal Audit Standards and provides sufficient independent and objective assurance to the Audit Committee and the Accountable Officer; https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/641252/PSAIS_1_April_2017.pdf

c) Deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption;

d) Ensuring that an annual Internal Audit report is prepared for the consideration of the Audit Committee and the Board. The report must cover:

- a clear opinion on the effectiveness of internal control in accordance with the requirements of the Public Sector Internal Audit Standards.

- major internal financial control weaknesses discovered,
- progress on the implementation of Internal Audit recommendations,
- progress against plan over the previous year,
- a strategic audit plan covering the coming three years, and
- a detailed plan for the coming year.

3.2.2 The designated internal and external audit representatives are entitled (subject to provisions in the Data Protection Act 2018 and the UK General Data Protection Legislation) without necessarily giving prior notice to require and receive:

a) Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

b) Access at all reasonable times to any land or property owned or leased by the Trust;

c) Access at all reasonable times to Board members and officers;

d) The production of any cash, stores or other property of the Trust under a Board member or a Trust official's control; and

e) Explanations concerning any matter under investigation.

3.3 Internal Audit

3.3.1 The Accountable Officer Memorandum requires the Chief Executive to have an internal audit function that operates in accordance with the standards and framework set for the provision of Internal Audit in the NHS in Wales. This framework is defined within an Internal Audit Charter that incorporates a definition of internal audit, a code of ethics and Public Sector Internal Audit Standards. Standing Order 10.1 details the relationship between the Head of Internal Audit and the Board. The role of the Audit Committee in relation to Internal Audit is set out within its Terms of Reference, incorporated in Schedule 3 of the SOs, and the NHS Wales Audit Committee Handbook.

3.4 External Audit

3.4.1 Pursuant to the Public Audit (Wales) Act 2004 (c. 23), the Auditor General for Wales (Auditor General) is the external auditor of the Trust. The Auditor General may nominate his representative to represent him within the Trust and to undertake the required audit work. The cost of the audit is paid for by the Trust. The Trust's Audit Committee must ensure that a cost-efficient external audit service is delivered. If there are any problems relating to the service provided, this should be raised with the Auditor General's representative and referred on to the Auditor General if the issue cannot be resolved.

3.4.2 The objectives of the external audit fall under three broad headings, to review and report on:

a) Whether the expenditure to which the financial statements relate has been incurred lawfully and in accordance with the authority that governs it;

b) The audited body's financial statements, and on its Annual Governance Statement and remuneration report [1];

c) Whether the audited body has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

3.4.3 The Auditor General's representatives will prepare a risk-based annual audit plan, designed to deliver the Auditor General's objectives, for consideration by the Audit Committee. The annual plan will set out details of the work to be carried out, providing sufficient detail for the Audit Committee and other recipients to understand the purpose and scope of the defined work and their level of priority. The Audit Committee should review the annual plan and the associated fees, although in so doing it needs to recognise the statutory duties of the Auditor General. The annual audit plan should be kept under review to identify any amendment needed to reflect changing priorities and emerging audit needs. The Audit Committee should consider material changes to the annual audit plan.

3.4.4 The Auditor General's representative should be invited to attend every Audit Committee meeting. The cycle of approving and monitoring the progress of external audit plans and reports, culminating in the opinion on the annual

[1] The Healthcare Inspectorate Wales will review and report on the Annual Quality Statement.

report and accounts, is central to the core work of the Audit Committee.

3.4.5 The Auditor General's representatives will liaise with Internal Audit when developing the external audit plan. The Auditor General's representative will ensure that planned external audit work takes into account the work of Internal Audit to avoid duplication wherever possible and considers where Internal Audit work can be relied upon for opinion purposes.

3.4.6 The Auditor General and his representatives shall have a right of access to the Chair of the Audit Committee at any time.

3.4.7 The Government of Wales Act 2006 (GOWA) provides that the Auditor General has statutory rights of access to all documents and information, as set out in paragraph 3.2.2a of these SFIs, that relate to the exercise of many of his core functions, including his statutory audits of accounts, value for money examinations and improvement studies. The rights of access include access to confidential information; personal information as defined by the Data Protection Act 2018 and the UK General Data Protection Legislation; information subject to legal privilege; personal information and sensitive personal information that may otherwise be subject to protection under the European Convention of Human Rights; information held by third parties; and electronic files and IT systems. Paragraph 17 of Schedule 8 to GOWA operates to provide the Auditor General with a right of access to every document relating to the Trust that appears to him to be necessary for the discharge of any of these functions. Paragraph 17(3) of Schedule 8 also requires any person that the Auditor General thinks has information related to the discharge of his functions to give any assistance, information and explanation that he thinks necessary. It also requires such persons to attend before the Auditor General and to provide any facility that he and his representatives may reasonably require, such as audit accommodation and access to IT facilities. The rights apply not just to the Trust and its officers and staff, but also to, among others, suppliers to the Trust.

3.4.8 The Auditor General's independence in the exercise of his audit functions is protected by statute (section 8 of the Public Audit (Wales) Act 2013), and audit independence is required by professional and ethical standards. Accordingly, the Trust (including its Audit Committee) must be careful not to seek to fetter the Auditor General's discretion in the exercise of his functions. While the Trust may offer comments on the plans and outputs of the Auditor General, it must not seek to direct the Auditor General.

3.4.9 The Auditor General will issue a number of reports over the year, some of which are specified in the Auditor General's Code of Audit and Inspection

Practice and International Standards on Auditing. Other reports will depend on the contents of the audit plan.

The main mandatory reports are:

- Report to those charged with governance (incorporating the report required under ISA 260) that sets out the main issues arising from the audit of the financial statements and use of resources work
- Statutory report and opinion on the financial statements
- Annual audit report.

In addition to these reports, the Auditor General may prepare a report on a matter the Auditor General considers would be in the public interest to bring to the public's attention; or make a referral to the Welsh Ministers if significant breaches occur.

3.4.10 The Auditor General also has statutory powers to undertake Value for Money Examinations and Improvement Studies within the Trust and other public sector bodies. At the Trust he also undertakes a Structured Assessment to help him assess whether there are proper arrangements for securing economy, efficiency and effectiveness in the use of resources. The Auditor General will take account of audit work when planning and undertaking such examinations and studies. The Auditor General and his representatives have the same access rights in relation to these examinations and studies as they do in relation to annual audit work.

3.5 Fraud and Corruption

3.5.1 In line with their responsibilities, the Chief Executive and Executive Director of Finance and Corporate Resources shall monitor and ensure compliance with Directions issued by the Welsh Ministers on fraud and corruption.

3.5.2 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist (LCFS) as specified by Directions to NHS bodies on Counter Fraud Measures 2005.

~~http://www.wales.nhs.uk/sitesplus/documents/1064/WHC%282005%2995%20%28Revised%29%20Directions%20to%20National%20Health%20Service%20bodies%20on%20Counter%20Fraud%20Measures%202005.pdf~~
https://nwssp.nhs.wales/a-wp/governance-e-manual/knowing-who-does-

what-why/supporting-good-governance/nhs-counter-fraud-service-wales/

3.5.3 The LCFS shall report to the Trust Executive Director of Finance and Corporate Resources and the LCFS must work with NHS Counter Fraud Authority (NHSCFA) and the NHS Counter Fraud Service Wales (CFSW) Team in accordance with the Directions to NHS bodies on Counter Fraud Measures 2005.

3.5.4 The LCFS will provide a written report to the Executive Director of Finance and Corporate Resources and Audit Committee, at least annually, on proactive and reactive counter fraud work within the Trust.

3.5.5 The Trust must participate in the annual National Fraud Initiative (NFI) led by Audit Wales and must provide the necessary data for the mandatory element of the NFI by the due dates. The Trust should participate in appropriate risk measurement or additional dataset matching exercise in order to support the detection of fraud across the whole public sector.

3.6 Security Management

3.6.1 In line with their responsibilities, the Chief Executive will monitor and ensure compliance with Directions issued by the Welsh Ministers on NHS security management.

3.6.2 The Chief Executive has overall responsibility for controlling and coordinating security.

4. FINANCIAL DUTIES

4.1 Legislation and Directions

4.1.1 The Trust has two statutory financial duties, to:

- First Duty - A breakeven duty, to ensure that its revenue is not less than sufficient to meet outgoings properly chargeable to revenue account in respect of each rolling three-year accounting period
- Second Duty - A duty to prepare a plan to secure compliance with the first duty and for that plan to be submitted to and approved by the Welsh Ministers

~~4.1.2~~ The first duty is provided for under paragraph 2(1) of Schedule 4 of the National Health Service (Wales) Act 2006, although this should be read in conjunction with 'Welsh Health Circular 2016/054 – Statutory Financial Duties of Local Health Boards and NHS Trusts' which sets out the duty to break even over a three-year period. The second duty arises as a result of the Welsh Ministers' powers to set financial objectives for the Trust under paragraph 2(2) of Schedule 4 of the National Health Service (Wales) 2006 Act. The planning requirement, which by virtue of being set as a financial objective becomes a statutory financial duty, was previously set by the Welsh Ministers and has been retained by Welsh Health Circular 2016/054 – Statutory Financial Duties of Local Health Boards and NHS Trusts. Further details of the WHC can be obtained from the HSSG Director of Finance' hywel.jones38@gov.wales~~A link to the relevant Welsh Health Circular is below.~~

~~5.1.2~~

~~6.1.2 http://www.wales.nhs.uk/sitesplus/documents/863/12b%29%20Statutory%20Duties%20of%20Welsh%20Health%20Boards.pdf~~

4.2 First Financial Duty – The Breakeven Duty

4.2.1 The Trust has a statutory duty to ensure that its revenue is not less than sufficient to meet outgoings properly chargeable to revenue account in respect of each rolling three-year accounting period, that is to breakeven over a 3-year rolling period.

4.2.2 Trusts must ensure their boards approve balanced revenue and capital plans before the start of each financial year.

4.2.3 The Executive Director of Finance and Corporate Resources of the Trust will:

a) Prior to the start of each financial year submit to the Board for approval a report showing the total funding received, assumed in-year funding and other adjustments and their proposed distribution to delegated budgets, including any sums to be held in reserve;

b) Ensure that any ring-fenced or non-discretionary funding are disbursed in accordance with Welsh Ministers' requirements;

c) Periodically review any assumed in-year funding to ensure that these are reasonable and realistic; and

d) Regularly update the Board on significant changes to the initial funding and the application of such funds.

4.2.4 The Chief Executive has overall executive responsibility for the Trust's activities and is responsible to the Board for ensuring that it meets its First Financial Duty.

4.3. Second Financial Duty – The Planning Duty

4.3.1 The Trust has a statutory duty to prepare a plan, the Integrated Medium Term Plan (IMTP), to secure compliance with the first duty, and for that plan to be submitted to and approved by the Welsh Ministers.

4.3.2 The Integrated Medium Term Plan must reflect longer-term planning and delivery objectives and should be continually reviewed based on latest Welsh Government policy and local priority requirements. The Integrated Medium Term Plan, produced and approved annually, will be 3 year rolling plans. In particular the Integrated Medium Term Plan must reflect the Welsh Ministers' priorities and commitments as detailed in the NHS Planning Framework published annually by Welsh Government.
~~https://gov.wales/sites/default/files/publications/2019-09/nhs-wales-planning-framework-2020-23%20.pdf~~

4.3.3 The NHS Planning Framework directs Trusts to develop, approve and submit an Integrated Medium Term Plan (IMTP) for approval by Welsh Ministers. The plan must

- describe the context within which the Trust will deliver key policy directives from Welsh Government.
- demonstrate how the Health Board are
  - delivering their well-being objectives, including how the five ways of working have been applied
  - contributing to the seven Well-being Goals,

- establishing preventative approaches across all care and services
- demonstrate how the Trust will utilise its existing services and resources, and planned service changes, to deliver improvements in population health and clinical services, and at the same time demonstrate improvements to efficiency of services.
- demonstrate how the three-year rolling financial breakeven duty is to be achieved.

4.3.4 An Integrated Medium Term Plans should be based on a reasonable expectation of future income, service changes, performance improvements, workforce changes, demographic changes, capital, quality, funding, income, expenditure, cost pressures and savings plans to ensure that the Integrated Medium Term Plan (including a balanced Medium Term Financial Plan) is balanced and sustainable and supports the safe and sustainable delivery of patient centred quality services.

4.3.5 The Integrated Medium Term Plan will be the overarching planning document enveloping component plans and service delivery plans. The Integrated Medium Term Plan will incorporate the balanced Medium Term Financial Plan and will incorporate the Trusts response to delivering the

- NHS Planning Framework,
- Quality, governance and risk frameworks and plans, and
- Outcomes Framework

4.3.6 The Integrated Medium Term Plan will be developed in line with the NHS Planning Framework and include:

- A statement of significant strategies and assumptions on which the plans are based;
- Details of major changes in activity, service delivery, service and performance improvements, workforce, revenue and capital resources required to achieve the plans; and
- Profiled activity, service, quality, workforce and financial schedules.
- Detailed plans to deliver the NHS Planning Framework and quality, governance and risk requirements and outcome measures;

4.3.7 The Chief Executive has overall executive responsibility to develop and submit to the Board, on an annual basis, the rolling 3 year Integrated Medium Term Plan (IMTP).

4.3.8 The Board will:

a) Approve the Integrated Medium Term Plan prior to the beginning of the

financial year of implementation and in accordance with the guidance issued annually by Welsh Government. Following Board approval the Plan will be submitted to Welsh Government prior to the beginning of the financial year of implementation.

b) Approve a balanced Medium Term Financial Plan as part of the Integrated Medium Term Plan, which meets all financial duties, probity and value for money requirements; and

c) Prepare and agree with the Welsh Government a robust and sustainable recovery plan in accordance with Welsh Ministers' guidance where the Trust plan is not in place or in balance.

4.3.9 The Board approved Integrated Medium Term Plan will be submitted to Welsh Government, for approval by the Minister, in line with the requirements set out in the NHS Planning Framework.

4.3.10 The finalised approved Integrated Medium Term Plan will form the basis of the Performance Agreement between the Trust and Welsh Government.

5. FINANCIAL MANAGEMENT AND BUDGETARY CONTROL

5.1 Budget Setting

5.1.1 Prior to the start of the financial year the Executive Director of Finance and Corporate Resources will, on behalf of the Chief Executive, prepare and submit budgets for approval and delegation by the Board. Such budgets will:

a) Be in accordance with the aims and objectives set out in the Board approved Integrated Medium Term Plan, and Medium Term Financial Plan, and focussed on delivery of safe patient centred quality services;

b) Be in line with Revenue, Capital, Commissioner, Activity, Service, Quality, Performance, and Workforce plans contained within the Board approved balanced IMTP;

c) Take account of approved business cases and associated revenue costs and funding;

d) Be produced following discussion with appropriate Directors and budget holders;

e) Be prepared within the limits of available funds;

f) Take account of ring-fenced or specified funding;

g) Include both financial budgets (£) and workforce establishment budgets (budgeted whole time equivalents);

h) Be within the scope of activities and authority defined by the National Health Service (Wales) Act 2006, including pooled budget arrangements;

i) Take account of the principles of Well-being of Future Generations (Wales) Act 2015 including the seven Well-being Goals and the five ways of working; and

j) Identify potential risks and opportunities.

5.2 Budgetary Delegation

5.2.1 The Chief Executive may delegate, via the Executive Director of Finance and Corporate Resources , the management of a budget to permit the performance of a defined range of activities, including pooled budget arrangements under Regulations made in accordance with section 33 of the National Health Service (Wales) Act 2006 (c. 42). This delegation must be in writing, in the form of a letter of accountability, and be accompanied by a clear definition of:

a) The amount of the budget;
b) The purpose(s) of each budget heading;
c) Individual or committee responsibilities;
d) Arrangements during periods of absence;
e) Authority to exercise virement;
f) Achievement of planned levels of service; and
g) The provision of regular reports.

The budget holder must sign the accountability letter formally delegating the budget.

5.2.2 The Chief Executive, Executive Director of Finance and Corporate Resources and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

5.2.3 Budgets must only be used for the purposes designated, and any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

5.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Executive Director of Finance and Corporate Resources .

5.2.5 All budget holders must provide information as required by the Executive Director of Finance and Corporate Resources to enable budgets to be compiled and managed appropriately.

5.2.6 All budget holders will sign up to their allocated budgets at the commencement of the financial year.

5.2.7 The Executive Director of Finance and Corporate Resources has a responsibility to ensure that appropriate and timely financial information is provided to budget holders and that adequate training is delivered on an on-going basis to assist budget holders managing their budgets successfully.

5.3 Financial Management, Reporting and Budgetary Control

5.3.1 The Executive Director of Finance and Corporate Resources shall monitor financial performance against budget and plans and report the current and forecast position, and financial risks, on a monthly basis and at every Board meeting. Any significant variances should be reported to Trust Board as soon as they come to light and the Board shall be advised on any recommendations and action to be taken in respect of such variances.

5.3.2 The Executive Director of Finance and Corporate Resources will devise and maintain systems of financial management performance reporting and budgetary control. These will include:

a) Regular financial reports, for revenue and capital, to the Board in a form approved by the Board containing sufficient information for the Board to:
- Understand the current and forecast financial position
- Evaluate risks and opportunities
- Use insight to make informed decisions
- Be consistent with other Board reports

As a minimum the reports will cover:
- Current and forecast year end position on statutory financial duties
- Actual income and expenditure to date compared to budget and showing trends and run rates
- Forecast year end positions
- A statement of assets and liabilities, including analysis of cash flow and movements in working capital.
- Explanations of material variances from plan
- Capital expenditure and projected outturn against plan
- Investigations and reporting of variances from financial, activity and workforce budgets.
- Details of corrective actions being taken, as advised by the relevant budget holder and the Chief Executive's and/or Executive Director of Finance and Corporate Resources ' view of whether such actions are sufficient to correct the situation;
- Statement of performance against savings targets
- Key workforce and other cost drivers
- Income and expenditure run rates, historic trends, extrapolation and explanations
- Clear assessment of risks and opportunities
- Provide a rounded and holistic view of financial and wider organisational performance.

b) The issue of regular, timely, accurate and comprehensible advice and financial reports to each delegated budget holder, covering the areas for which they are responsible;

c) An accountability and escalation framework to be established for the organisation to formally address material budget variances

d) Investigation and reporting of variances from financial, activity and workforce budgets;

e) Monitoring of management action to correct variances;

f) Arrangements for the authorisation of budget transfers and virements.

5.3.3 Each Budget Holder will

- be held to account for managing services within the delegated budget
- investigate causes of expenditure and budget variances using information from activity, workforce and other relevant sources
- develop plans to address adverse budget variances.

5.3.4 Each Budget Holder is responsible for ensuring that:

a) Any likely overspending or reduction of income that cannot be met by virement is not incurred without the prior consent of the Chief Executive subject to the Board's scheme of delegation;

b) The amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised, subject to the rules of virement;

c) No permanent employees are appointed without the approval of the Chief Executive other than those provided for within the available resources and workforce establishment as approved by the Board.

5.3.5 The Chief Executive is responsible for identifying and implementing cost and efficiency improvements and income generation initiatives in accordance with the requirements of the Medium Term Financial Plans and SFI 9.1.

5.4 Capital Financial Management, Reporting and Budgetary Control

5.4.1 The general rules applying to revenue Financial Management, Reporting and Budgetary Control delegation and reporting shall also apply to capital plans,

budgets and expenditure subject to any specific reporting requirements required by the Welsh Ministers.

5.5 Reporting to Welsh Government - Monitoring Returns

5.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring returns are submitted to the Welsh Ministers in accordance with published guidance and timescales.

~~https://gov.wales/health-boards-and-trusts-financial-monitoring-guidance-2019-2020-whc-2019013~~

5.5.2 All monitoring returns must be supported by a detailed commentary signed by the Executive Director of Finance and Corporate Resources and Chief Executive. This commentary should also highlight and quantify any significant risks with an assessment of the impact and likelihood of these risks maturing.

5.5.3 All information made available to the Welsh Ministers should also be made available to the Board. There must be consistency between the Medium Term Financial Plan, budgets, expenditure, forecast position and risks as reported in the monitoring returns and monthly Board reports.

6. ANNUAL ACCOUNTS AND REPORTS

6.1 The Board must approve the Trust's annual accounts prior to submission to the Welsh Ministers and the Auditor General for Wales in accordance with the annual timetable.

6.2 The Chair and Chief Executive have responsibility for signing the accounts on behalf of the Trust. The Chief Executive has responsibility for signing the Performance Report, Accountability Report, Statement of Financial Position and the ~~Annual~~ Governance Statement ~~and the Annual Quality Statement~~.

6.3 The Executive Director of Finance and Corporate Resources , on behalf of the Trust, is responsible for ensuring that financial reports and returns are prepared in accordance with the accounting policies, guidance and timetable determined by the Welsh Ministers, as per Welsh Government's Manual for Accounts, and consistent with Financial Reporting Manual (FReM) and International Financial Reporting Standards.

6.4 The Trust's annual accounts must be audited by the Auditor General for Wales. The Trust's audited annual accounts must be adopted by the Board at a public meeting and made available to the public.

6.5 The Trust will publish an annual report, in accordance with guidelines on local accountability, and present it at its Annual General Meeting. The annual report must also be sent to the Welsh Ministers. The Board Secretary will ensure that the Annual Report is prepared in line with the Welsh Government's Manual for Accounts. The Annual Report will include

- The Accountability Report containing:
  - Corporate Governance Report
  - Remuneration Report and Staff Report
  - Accountability and Audit Report

- The Performance Report, which must include:
  - An overview
  - A performance Analysis

7. BANKING ARRANGEMENTS

7.1 General

7.1.1 The Executive Director of Finance and Corporate Resources is responsible for managing the Trust's banking arrangements and for advising the Board on the provision of banking services and operation of accounts. This advice will take into account guidance/ Directions issued from time to time by the Welsh Ministers. NHS Trusts are required to use the Government Banking Service (GBS) for its banking services.

7.1.2 The Board shall approve the banking arrangements.

7.2 Bank Accounts

7.2.1 The Executive Director of Finance and Corporate Resources is responsible for:

a) Establishing bank accounts and ensuring that the Government Banking Service is utilised for main Trust business transactions;

b) Establishing additional commercial accounts only exceptionally and where there is a clear rationale for not utilising the Government Banking Service;

c) Establishing separate bank accounts for the Trust's non-exchequer funds;

d) Ensuring payments made from bank accounts do not exceed the amount credited to the account except where arrangements have been made;

e) Ensuring accounts are not overdrawn except in exceptional and planned situations.

f) Reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn;

g) Monitoring compliance with Welsh Ministers' guidance on the level of cleared funds.

7.2.2 With the exception of Project Bank Accounts, all bank accounts should be held in the name of the Trust. No officer other than the Executive Director of

Finance and Corporate Resources shall open any account in the name of the Trust or for the purposes of furthering Trust activities.

7.2.3 Any Project Bank Account that is required may be held jointly in the name of the Trust and the relevant third party contractor.

7.3 Banking Procedures

7.3.1 The Executive Director of Finance and Corporate Resources will prepare detailed instructions on the operation of bank accounts, that ensure there are sound controls over the day-to-day operation of bank accounts, which must include:

a) The conditions under which each bank account is to be operated;

b) Those authorised to sign cheques or other orders drawn on the Trust's accounts.

c) Effective divisions of duty for employees working within the banking and treasury management function to minimise the risk of fraud and error.

d) Authorised signatories are identified with sufficient seniority, and in the case of e banking approvers, together with an appropriate payment approval hierarchy.

e) Procedures are in place for prompt banking of money received.

f) Ensure there are physical security arrangements in place for cheque stationery, e banking access devices and payment cards.

g) Cheques and payable orders are treated as controlled stationery with management responsibility given to a duly designated employee.

h) Frequent reconciliations are undertaken between cash books, bank statements and the general ledger so that all differences are fully understood and accounted appropriately.

i) Commercial bank accounts should only be used exceptionally where there is a sound rationale and demonstrates value for money. Commercial accounts should be procured through a tendering exercise and the outcome reported to the Audit Committee on behalf of the Board.

7.3.2 The Executive Director of Finance and Corporate Resources must advise the

Trust's bankers in writing of the conditions under which each account will be operated.

7.3.3 The Executive Director of Finance and Corporate Resources shall approve security procedures for any payable orders issued without a hand-written signature e.g. automatically printed. All Payable Orders shall be treated as controlled stationery, in the charge of a duly designated officer controlling their issue.

7.4 Review

7.4.1 The Executive Director of Finance and Corporate Resources will review banking arrangements of the Trust at regular intervals to ensure they reflect best practice, that they are efficient and effective and represent best value for money. The results of the review should be reported to the Audit Committee.

8. CASH, CHEQUES, PAYMENT CARDS AND OTHER NEGOTIABLE INSTRUMENTS

8.1 General

8.1.1 The Executive Director of Finance and Corporate Resources is responsible for:

a) Approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

b) Ordering and securely controlling any such stationery, ensuring all cash related stationery treated as controlled stationery with management responsibility given to a duly designated employee;

c) The provision of adequate physical facilities and systems for officers whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

d) Establishing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

e) Ensuring effective control systems are in place for the use of payment cards,

f) Ensuring that there are adequate control systems in place to minimise the risk of cash/card misappropriation.

8.1.2 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs (informal documents acknowledging debt).

8.1.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Executive Director of Finance and Corporate Resources .

8.1.4 The holders of safe/cash box combinations/keys shall not accept unofficial funds for depositing in their safe/cash box unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

8.1.5 The opening of coin operated machines (including telephone, if applicable) and the counting and recording of takings shall be undertaken by two officers together, except as may be authorised in writing by the Executive Director of Finance and Corporate Resources and the coin box keys shall be held by a nominated officer.

8.1.6 During the absence (for example, on holiday) of the holder of a safe/cash box combination/key, the officer who acts in their place shall be subject to the same controls as the normal holder of the combination/key. There shall be written discharge for the safe and/or cash box contents on the transfer of responsibilities and the discharge document must be retained for inspection.

8.2 Petty Cash

8.2.1 The Executive Director of Finance and Corporate Resources will issue instructions restricting the use and value of petty cash purchases.

8.2.3 Petty cash use should be minimised and be subject to regular cash balance reviews in order to minimise cash levels held.

8.2.3 Petty cash should be operated under an imprest system and be subject to regular checks to ensure physical and book cash levels are consistent.

9. INCOME, FEES AND CHARGES

9.1 Income Generation and Participation in/Formation of Companies

9.1.1 The Trust shall only generate income for those goods and services that are approved by the Welsh Ministers. Any income generating activities must be complementary to the provision of NHS services and must be in accordance with the Welsh Ministers' policy and powers to raise money as set out in section 169 of the National Health Service (Wales) Act 2006 (c. 42).

9.1.2 The Trust can only form or participate in a company for income generation, improving health, healthcare care and health services, purposes with the consent and/or direction of Welsh Ministers. The Trust should obtain advice from Welsh Government officials prior to undertaking substantive work on formation or participation in any company.

9.2 Income Systems

9.2.1 The Executive Director of Finance and Corporate Resources is responsible for designing and maintaining procedures to ensure compliance with systems for the proper recording, invoicing, and collection and coding of all monies due.

9.2.2 The Executive Director of Finance and Corporate Resources is also responsible for ensuring that systems are in place for the prompt banking of all monies received.

9.3 Fees and Charges

9.3.1 The Executive Director of Finance and Corporate Resources is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Welsh Ministers or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

9.3.2 All officers must inform the Executive Director of Finance and Corporate Resources promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

9.4 Income Due and Debt Recovery

9.4.1 Delegated budget holders and managers are responsible for informing the

Executive Director of Finance and Corporate Resources of any income due that arises from any contracts, service levels agreements, leases, activities such as private patients or other transactions.

9.4.2 Delegated budget holders and managers must inform the Executive Director of Finance and Corporate Resources when overpayment of salary or expenses have been made, in order that recovery can be made.

9.4.3 The Executive Director of Finance and Corporate Resources is responsible for recovering income due and for ensuring debt recovery procedures are in place to secure early payment and minimise bad debt risk on all outstanding debts.

9.4.4 Income not received should be dealt with in accordance with losses procedures.

9.4.5 Overpayments should be detected (or preferably prevented) and recovery initiated.

9.4.6 The Chief Executive and the Executive Director of Finance and Corporate Resources are responsible for ensuring the Welsh Ministers' guidance on disputed debt arbitration is strictly adhered to.

10. NON PAY EXPENDITURE

10.1 Scheme of Delegation, Non Pay Expenditure Limits and Accountability

10.1.1. The Board must agree a Scheme of Delegation in line with that set out in its Standing Orders Scheme of Reservation and Delegation of Powers.

10.1.2. The Chief Executive will approve the level of non-pay expenditure and the operational scheme of delegation and authorisation to budget holders and managers within the parameters set out in the Trust's scheme of delegation.

10.1.3. The Chief Executive will set out in the operational scheme of delegation and authorisation:

- The list of managers who are authorised to place requisitions for the supply of goods, services and works and for the awarding of contracts; and
- The maximum level of each requisition and the system for authorisation above that level.

10.2 The Executive Director of Finance and Corporate Resources 's responsibilities

10.2.1 The Executive Director of Finance and Corporate Resources will:

a) Advise the Board regarding the NHS Wales national procurement and payment systems thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in SOs and SFIs;

b) Prepare procedural instructions or guidance within the Scheme of Delegation on non-pay expenditure;

c) Ensure systems are in place for the authorisation of all accounts and claims;

d) Ensure Directors and officers strictly follow NHS Wales system and procedures of verification, recording and payment of all amounts payable.

e) Maintain a list of Executive Directors and officers (including specimens of their signatures) authorised to certify invoices.

f) Be responsible for ensuring compliance with the Public Sector Payment

policy ensuring that a minimum of 95 percent of creditors are paid within 30 days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed.

g) Ensure that where consultancy advice is being obtained, the procurement of such advice must be in accordance with applicable procurement legislation, guidance issued by the Welsh Ministers and SFIs;

h) Be responsible for Petty Cash system, procedures, authorisation and record keeping, and ensure purchases from petty cash are restricted in value and by type of purchase in accordance with procedures

10.3 Duties of Budget Holders and Managers

10.3.1 Budget holders and managers must ensure that they comply fully with the Scheme of Delegation, guidance and limits specified by the Chief Executive and Executive Director of Finance and Corporate Resources , and that:

a) All contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Executive Director of Finance and Corporate Resources in advance of both any commitment being made and NWSSP Procurement Services being engaged;

b) Contracts above specified thresholds are advertised and awarded, through NWSSP Procurement Services, in accordance with EU and HM Treasury rules on public procurement;

c) Contracts above specified thresholds are approved by the Welsh Ministers prior to any commitment being made;

d) goods have been duly received, examined and are in accordance with specification and order,

e) work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct,

f) No requisition/order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to Board members or Trust officers, other than:

(i) Isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars,

(ii) Conventional hospitality, such as lunches in the course of working visits;

This provision needs to be read in conjunction with Standing Order 8.5, 8.6 and 8.7.

g) No requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Executive Director of Finance and Corporate Resources on behalf of the Chief Executive;

h) All goods, services, or works are ordered on official orders

i) Requisitions/orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

j) Goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

10.3.2 The Chief Executive and Executive Director of Finance and Corporate Resources shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance issued by the Welsh Ministers. The technical audit of these contracts shall be the responsibility of the relevant Director as set out in the Trust's scheme of delegation.

10.4 Departures from SFI's

10.4.1 Departing from the application of Chapters 10 and 11 of these SFI's is only possible in very exceptional circumstances. Trusts must consult with NWSSP Procurement Services, Executive Director of Finance and Corporate Resources and Board Secretary prior to any such action undertaken. Any expenditure committed under these departures must receive prior approval in accordance with the Trust's Scheme of Delegation.

10.5 Accounts Payable

10.5.1 NWSSP Finance, shall on behalf of the Trust, maintain and deliver detailed policies, procedures systems and processes for all aspects of accounts payable

10.6 Prepayments

10.6.1 Prepayment should be exceptional, and should only be considered if a good value for money case can be made for them (i.e. that "need" can be demonstrated). Prepayments are only permitted where either:

- The financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to Net Present Value (NPV) using the National Loans Fund (NLF) rate plus 2%);
- It is the industry norm e.g. courses and conferences;
- In line with requirements of Managing Welsh Public Money
- There is specific Welsh Ministers' approval to do so e.g. voluntary services compact.

10.6.2 In **exceptional** circumstances prepayments can be made subject to:

a) The appropriate Executive Director providing, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet their commitments;

b) The Executive Director of Finance and Corporate Resources will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the Public Contracts Regulations 2015 where the contract is above a stipulated financial threshold); and

c) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

11. PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES

General Information

11.1 Procurement Services

11.1.1 While the Chief Executive is ultimately responsible for procurement the service is delivered by NWSSP Procurement Services.

11.1.2 Procurement staff are employed by NHS Wales Shared Services Partnership (NWSSP) and provide a procurement support function to all health organisations in NHS Wales. Although NWSSP is responsible for the provision of a Procure to Pay service and provision of appropriate professional procurement and commercial advice, ultimate responsibility for compliance with legislation and policy guidelines remains with the Trust. Where the term Procurement staff or department is used in this chapter it should be read as equally applying to those departments where the procurement function is undertaken locally and outside of NWSSP Procurement Department, for example pharmacy and works who undertake procurement on a devolved basis.

11.2 Policies and procedures

11.2.1 NWSSP Procurement Services shall, on behalf of the Trust, maintain detailed policies and procedures for all aspects of procurement including tendering and contracting processes. The policies and procedures shall comply with these SFIs, Procurement Manual, and the Contract Notification Arrangements, included as **Schedule 1** of these SFIs.

11.2.2 The Chief Executive is ultimately responsible for ensuring that the Trust's Executive Directors, Independent Members and officers within the organisation strictly follow procurement, tendering and contracting procedures.

11.2.3 NWSSP Director of Procurement Services is responsible for ensuring that procurement, tendering and contracting policies and procedures

- Are kept up to date;
- Conform to statutory requirements and regulations;
- Adhere to guidance issued by the Welsh Ministers;
- Are consistent with the principles of sustainable development.

11.2.4 All procurement guidance issued by the Welsh Ministers should have the effect as if incorporated in these SFIs.

11.3 Procurement Principles

11.3.1 The term "procurement" embraces the complete process from planning, sourcing to taking delivery of all works, goods and services required by the Trust to perform its functions, and furthermore embrace all building, equipment, consumables and services including health services. Procurement further embraces contract and/or supplier management, including market engagement and industry monitoring.

11.3.2 The main legal and governing principles guiding public procurement and which are incorporated into these SFIs are:

- Transparency: public bodies should ensure that there is openness and clarity on procurement processes and how they are implemented;
- Non-discrimination: public bodies may not discriminate between suppliers or products on grounds of their origin;
- Equal treatment: suppliers should be treated fairly and without discrimination, including in particular equality of opportunity and access to information;
- Proportionality: requirements and conditions in the procurement should be reasonable in proportion to the object of procurement and measures taken should not go beyond what is necessary;
- Legality: public bodies must conform to European Community and other legal requirements;
- Integrity: there should be no corruption or collusion with suppliers or others;
- Effectiveness and efficiency: public bodies should meet the commercial, regulatory and socio-economic goals of government in a balanced manner appropriate to the procurement requirement;
- Efficiency: procurement processes should be carried out as cost effectively as possible and secure value for money.

11.4 Legislation Governing Public Procurement

11.4.1 There are a range of EU Directives which set out the EU legal framework for public procurement. These EU Directives have been implemented into UK law by statutory regulations which govern public sector procurement, the primary statutory regulations in Wales being 'The Public Contracts Regulations 2015 No. 102.' From 1 January 2021, all aspects of EU law in respect of the EU Directives relating to public procurement, except where expressly stated

otherwise by domestic legislation, will continue to govern public sector procurement, although further amendments or developments of EU related procurement law following this will not be incorporated into domestic law. The Welsh Government policy framework and the Wales Procurement Policy Statement (WPPS) also govern this area. One of the key objectives of governing legislation is to ensure public procurement markets are open and that there is free movement of supplies, services and works. Legislation, policy and guidance setting out procedures for awarding all forms of regulated contracts shall have effect as if incorporated in the Trust's SFIs.

11.4.2 The main Regulations (the Public Contracts Regulations 2015 No. 102) cover the whole field of procurement, including thresholds above which special and demanding procurement protocols and legal requirements apply. All Directors and their staff are responsible for seeing that those Regulations are understood and fully implemented. The protocols set out in the Regulations, and any Procurement Policy Notices, are the model upon which all formal procurement shall be based.

11.4.3 Procurement advice should be sought in the first instance from Procurement Services. The commissioning of further specialist advice shall be jointly agreed between the Trust and Procurement Services e.g. Engagement of NWSSP Legal and Risk Services prior to 3rd party Legal Service providers.

11.4.4 Other relevant legislation and policy include:

- The Well-being of Future Generations (Wales) Act 2015
- Welsh Language (Wales) Measure 2011
- Modern Slavery Act 2015
- Bribery Act 2010
- Equality Act 2010
- Welsh Government's Code of Practice for Ethical Employment in Supply Chains.
- The Producer Responsibility Obligations (Packaging Waste) Regulations 2007
- Welsh Government 'Towards zero waste: our waste strategy'
- The Welsh Government Policy Framework
- The Wales Procurement Policy Statement (WPPS)

11.5 Procurement Procedures

11.5.1 To ensure that the Trust is fully compliant with UK Procurement Regulations, EU Procurement Directives and Welsh Ministers' guidance and policy, the Trust shall, through NWSSP Procurement Services, ensure that it shall have procedures that set out:

a) Requirements and exceptions to formal competitive tendering requirements;
b) Tendering processes including post tender discussions;
c) Requirements and exceptions to obtaining quotations;
d) Evaluation and scoring methodologies
e) Approval of firms for providing goods and services.

11.5.2 All procurement procedures shall reflect the Welsh Ministers' guidance and the Trust's delegation arrangements and approval processes.

11.6 Procurement Consent and Notification

11.6.1 Paragraph 14(2) of Schedule 3 to the National Health Service (Wales) Act 2006 allows the Trust to:

- Acquire and dispose of property;
- Enter into contracts; and
- Accept gifts of property (including property to be held on trust, either for the general or any specific purposes of the NHS trust or for any purpose relating to the health service).

11.6.2 **Schedule 1** details the requirement process for contract notification for Trusts.

Planning

11.7 Sustainable Procurement

11.7.4 To further nurture the Welsh economy, in support of social, environmental and economic regeneration, Trusts must also be mindful to structure requirements ensuring Welsh companies have the opportunity to transparently and fairly compete to deliver services regionally or across Wales where possible. The principles of the Well-being of Future Generations (Wales) Act 2015 (WBFGA 2015) should be adopted at the earliest stage of planning. Procurement solutions must be developed embracing the five ways of working described within the Act and capture how they will deliver against the seven goals set out in the Act.

11.7.2 The WBFGA 2015 requires that bodies listed under the Act must operate in a manner that embraces sustainability. The Act requires public bodies in Wales to think about the long-term impact of their decisions, to work better with

people, communities and each other, and to prevent persistent problems such as poverty, health inequalities and climate change.

11.7.3 The 7 Wellbeing goals are:

- a prosperous Wales;
- a resilient Wales;
- a healthier Wales;
- a more equal Wales;
- a Wales of cohesive communities;
- a Wales of vibrant culture and thriving Welsh language; and
- a globally responsible Wales.

These goals have been put in place to improve the social, economic, environmental, and cultural well-being of Wales.

11.7.4 Public bodies need to make sure that when making their decisions they take into account the impact they could have on people living their lives in Wales in the future. The Act expects them to:

- work together better
- involve people reflecting the diversity of our communities
- look to the long term as well as focusing on now
- take action to try and stop problems getting worse - or even stop them happening in the first place.

11.7.5 The Trust is required to consider the Welsh Government Guidance on Ethical Procurement and the new Code of Practice on Ethical Employment in supply chains which commit public, private and third sector organisations to a set of actions that tackle illegal and unfair employment practices including blacklisting, modern slavery and living wage.

11.7.6 The Trust shall make use of the tools developed by Value Wales in implementing the principles of the WBFGA 2015. The Trust shall benchmark its performance against the WBFGA 2015. For all contracts over £25,000, the Trust shall take account of social, economic and environmental issues when making procurement decisions using the Sustainable Risk Assessment Template (SRA).

11.8 Small and Medium Sized Enterprises (SMEs), Third Sector Organisations (TSOs) and Supported Factories and Businesses (SFBs)

11.8.1 In accordance with Welsh Government commitments policy set out in the current WPPS and subsequent versions of this statement, the Trust shall ensure that it provides opportunities for these organisations to quote or tender for its business.

11.9 Planning Procurements

11.9.1 Trust must ensure that all staff with delegated budgetary responsibility or who are part of the procurement process for goods, services and works are aware of the legislative and policy frameworks governing public procurement and the requirement of open competition.

11.9.2 Depending on the value of the procurement, a process of planning the procurement must be undertaken with the Procurement Services and appropriate representative from the service and other appropriate stakeholders. The purpose of a planning phase is to determine:

- the likely financial value of the procurement, , including whole life cost
- the likely 'route to market' which will consider the legislative and policy framework set out above.
- The availability of funding to be able to award a contract following a successful procurement process.
- That the procurement follows current legislative and policy frameworks including Value Based Procurement.

11.9.3 The procurement specification should factor in the 4 principles of prudent healthcare:

- Equal partners through co-production;
- Care for those with the greatest health need first;
- Do only what is needed; and
- Reduce inappropriate variation.

Value based outcome/experience/delivery principles must also be included where appropriate ensuring best value for money, sustainability of services and the future financial position. Value for money is defined as the optimum combination of whole-life cost and quality to meet the requirement**.**

11.9.4 Where free of charge services are made available to the Trust, NWSSP Procurement Services must be consulted to ensure that any competition requirements are not breached, particularly in the case of pilot activity to ensure that the Trust does not unintentionally commit itself to a single provider or longer term commitment. Regular reports on free of charge services provided to the Trust should be submitted by Board Secretary to Audit Committee.

11.9.5 Trusts are required to participate in all-Wales collaborative planning activity

where the potential to do so is identified by the procurement professional involved in the planning process. Cross sector collaboration may also be required.

Joint or Collaborative Initiatives

11.9.6 Specialist advice should be obtained from Welsh Government and the opinions of NWSSP Procurement Services and NWSSP Legal and Risk prior to external opinion being sought where there is an undertaking to commence joint or collaborative initiatives which may be deemed as novel or contentious.

11.10 Procurement Process

11.10.1 Where there is a requirement for goods or services, the manager must source those goods or services from the Trust's approved catalogue. Where a required item is not included within the catalogue, advice must be sought from the Procurement Services on opportunities to source those goods or services through public sector contract framework, such as National Procurement Service, NHS Supply Chain or Crown Commercial Services. The use of suitable Welsh frameworks where access is permissible shall take precedence over frameworks led by Public Sector Bodies outside of Wales.

11.10.2 In the absence of an existing suitable procurement framework to source the required item, a competition must be run in accordance with the table below. Trust's must ensure the value of their requirement considers cumulative spend across the Trust for like requirements and opportunity for collaboration with other Trusts and Health Boards:

11.10.3 Agreements awarded are required to deliver best value for money over the whole life of the agreement. Value for money is defined as the optimum combination of whole-life cost and quality to meet the requirement.

Competition Requirements

11.11 Procurement Thresholds

11.11.1 The following table summarises the minimum thresholds for quotes and competitive tendering arrangements. The total value of the contract, whole life cost, over its entire period is the qualifying sum that should be applied (except in specific circumstances relating to aggregation and contracts of

an indeterminate duration) as set out below, and in EU Procurement Directives and UK Procurement Regulations.

Goods/Services/Works Whole Life Cost Contract value (excl. VAT)	Minimum competition[1]	Form of Contract
<£5,000	Evidence of value for money has been achieved	Purchase Order
>£5,000 - <£25,000	Evidence of 3 written quotations	Simple Form of Contract/Purchase Order
>£25,000 – Prevailing OJEU threshold	Advertised open call for competition. Minimum of 4 tenders received if available.	Formal contract and Purchase Order
>OJEU threshold	Advertised open call for competition. Minimum of 5 tenders received if available or appropriate to the procurement route.	Formal contract and Purchase Order
Contracts above £1 million	Welsh Government approval required[2]	Formal contract and Purchase Order

[1] subject to the existence of suitable suppliers
[2] in accordance with the requirements set out in SO 11.6.

11.11.2 Advice from the Procurement Services must be sought for all requirements in excess of £5,000.

11.11.3 The deliberate sub-dividing of contracts to fall below a specific threshold is strictly prohibited. Any attempt to avoid these limits may expose the Board to risk of legal challenge and could result in disciplinary action against an individual[s].

11.11.4 Deliberate re-engagement of a supplier, where the value of the individual engagement is less than £5,000, must not be undertaken where the total value of engagements taken as a whole would exceed £5,000 and require competition.

11.12 Designing Competitions

11.12.1 The budget holder or manager responsible for the procurement is required to engage with the Procurement team to ensure:

- Required timescales are achievable
- Specifications are drafted which:
  - are fit for inclusion in competition documents;
  - are drafted in a manner encouraging innovation by the market;
  - are capable of being responded to and do not narrow competition;
  - deliver in line with legislative and policy frameworks;
  - include robust performance measures to effectively measure and manage supplier performance; and
  - consider the ability of the market to deliver.

11.12.2 Appropriate performance measures are included in agreements awarded, thus ensuring best value for money decisions taken that return maximum benefit for the organisation and ultimately the improvement of patient outcomes and wider health and social care communities.

11.12.3 Criteria for selecting suppliers and achieving an award recommendation must:

- be appropriately weighted in consideration of quality/price;
- consider cost of change where relevant;
- be transparent and proportionate;
- deliver value for money outcomes;
- fully explore complexity/risk; and
- consider whole life cost.

11.13 Single Quotation Application or Single Tender Application

11.13.1 In exceptional circumstances, there may be a need to secure goods/services/works from a single supplier. This may concern securing requirements from a single supplier, due to a special character of the firm, or a proprietary item or service of a special character. Such circumstances may include:

- Follow-up work where a provider has already undertaken initial work in the same area (and where the initial work was awarded from open competition);
- A technical compatibility issue which needs to be met e.g. specific

equipment required, or compliance with a warranty cover clause;
- a need to retain a particular contractor for genuine business continuity issues (not just preferences); or
- When joining collaborative agreements where there is no formal agreement in place. Request for such a departure must be supported by written evidence from the Procurement Service confirming local agreements will be replaced by an all Wales competition/National strategy.

11.13.2 Procurement Services must be consulted prior to any such application being submitted for approval. The Executive Director of Finance and Corporate Resources must approve such applications up to £25,000, the Chief Executive or designated deputy, and Executive Director of Finance and Corporate Resources , are required to approve applications exceeding £25,000. A register must be kept for monitoring purposes and all single tender actions must be reported to the Audit Committee.

11.13.3 In all applications, through Single Quotation Application or Single Tender Application (SQA or STA) forms, the applicant must demonstrate adequate consideration to the Chief Executive and Executive Director of Finance and Corporate Resources , as advised by the Head of Procurement, that securing best value for money is a priority. The Head of Procurement will scrutinise and endorse each request to ensure:

- Robust justification is provided;
- A value for money test has been undertaken;
- No bias towards a particular supplier;
- Future competitive processes are not adversely affected;
- No distortion of the market is intended;
- An acceptable level of assurance is available before presentation for approval in line with the Trust Scheme of Delegation; and
- An "or equivalent" test has been considered proving the request is justified.

11.13.4 Under no circumstances will Procurement Services endorse a retrospective SQA/STA, where the Trust has already entered into an arrangement directly.

11.13.5 As SQA/ STAs are only used in exceptional circumstances, the Trust, through the Chief Executive, must report each, including the specifics of the exceptional circumstances and the total financial commitment, in sufficient detail to its Audit Committee. The report will include any corrective action/advice provided by the Chief Executive, Executive Director of Finance and Corporate Resources or NWSSP Director of Procurement Services to

prevent recurrence by the Trust.

11.13.6 The Audit Committee may consider further steps to be appropriate, such as:

- Instruct a representative of the Trust to attend Audit Committee;
- Escalate to the Board;
- Request an internal Audit Review;
- Request further training; or
- Take internal disciplinary action.

11.13.7 No SQA/STA is required where the seeking of competition is not possible, nor would the application of the SQA/STA procedure add value to the process/aid the delivery of a value for money outcome. Procurement Manual details schedule of departures from SQA/STA where competition not possible.

11.13.8 For performance monitoring purposes, the NWSSP Procurement Service will retain a central register of all such activity including SQA/STA's not endorsed by Procurement or any exceptional matters.

11.14 Disposals

11.14.1 Disposal of surplus, obsolete equipment/consumables is also subject to the competition rules.

11.14.2 Obsolete or condemned articles and stores, which may be disposed of in accordance with applicable regulations and law at the prevailing time (e.g. Waste Electrical and Electronic Equipment (WEEE)) and the procedures of the Trust making use of any agreements covering the disposal of such items.

11.14.3 The Trust must obtain the best possible market price.

Approval & Award

11.15 Evaluation, Approval and Award

11.15.1 The evaluation of competitions via quotation or tender, must be undertaken by a minimum of 2 evaluators from within the operational service of the Trust. Evaluation Teams for competitions of greater complexity and value must be multi-disciplinary and reach a consensus recommendation for internal approval.

11.15.2 The internal approval of any recommendation to award a competition must follow the Board's Scheme of Delegation.

11.15.3 The communication of the external notification to the market to award the contract must be managed by the Procurement Service.

11.15.4 Information throughout the process must be handled and retained as 'commercial in confidence' and not shared outside of staff directly involved in the competition process.

11.15.5 All associated communication throughout the competition process must also be managed by the Procurement Service.

Implementation & Contract Management

11.16 Contract Management

11.16.1 Contract Management is the process which ensures that both parties to a contract fully meet their respective obligations as effectively and efficiently as possible, in order to deliver the business and operational objectives required by the contract and in particular, to achieve value for money. The relevant budget holder shall oversee and manage each contract on behalf of the Trust so as to ensure that these implicit obligations are met. This contract management will include:

- Retaining accurate records;
- Monitoring contract performance measures;
- Engaging suppliers to ensure performance delivery;
- Implementing contractual sanctions in the event of poor performance in conjunction with advice from Procurement Services; and
- Permitting stage payments as part of a formally agreed implementation/delivery plan which must be supported by written evidence issued by the budget holder.

11.16.2 Contract management on All Wales contracts will be provided by NWSSP Procurement Services.

11.16.3 Advice on best practice on Contract Management is available from NWSSP Procurement Services.

11.17 Extending and Varying Contracts

11.17.1 Extending, modifying or varying the scope of an existing contract is possible,

if the provision to do so was included as an option in the original awarded contract, e.g. scope of requirement, further expenditure due to unforeseen circumstances, change in regulatory requirements, etc.

11.17.2 If there is no such provision, the Public Contracts Regulations 2015 define such limitations.

11.17.3 The Public Contracts Regulations 2015 provide further constraints on this matter, under which modifications/variations/extensions are capped at 50% of the original award value.

11.17.4 Further approval is not required to extend an agreement beyond the original term/scope where prior approval was granted as part of the procurement process.

11.17.5 If there was no provision to extend, further approvals are required from the Trust budget holder and the local Head of Procurement. Budget holders must also be mindful of the threshold under which the original contract was awarded. Any increase in the contract value may require a more senior level of approval in line with the Scheme of Delegation.

11.17.6 This ensures an appropriate identification and assessment of potential risks to the Trusts compliance of approvals being granted within the Scheme of Delegation and assurance that value for money continues to be delivered from public funds.

11.17.7 The budget holder must seek advice from NWSSP Procurement Services in advance of committing further expenditure to ensure the contract is reflective of requirements. The budget holder must assess whether there is sufficient evidence to support the justification and whether the budget is available to support the additional requirements.

Transactional Processes

11.18 Requisitioning

11.18.1 The budget manager in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. The budget holder will source those goods or services from the approved catalogue. Where a required item is not included within the catalogue, advice must be sought from the Procurement Services on opportunities to source those goods or services through public sector contract framework, such as National Procurement Service, NHS Supply Chain or Crown

Commercial Services.

11.18.2 Where a required item is not on catalogue or on framework contract, the budget manager shall request the NWSSP Procurement Services to undertake quotation / tendering exercises on their behalf in line with SFI 11.11 thresholds.

11.18.3 All orders for goods and services must be accompanied by an official order number, available from the Procurement Department. In no circumstances must a requisition number be used as an order number.

11.19 No Purchase Order, No Pay

11.19.1 The Trust will ensure compliance with the 'No Purchase Order, No Pay' policy, the All Wales policy introduced to ensure that Procure to Pay continues to provide world-class services on a 'Once for Wales' basis.

11.19.2 The policy ensures that a purchase order is raised at the beginning of a purchase in circumstances where a purchase order is required under the policy. This follows industry standard best practice as it provides a commitment as to what is likely to be spent. The supplier must obtain a purchase order number for their invoice in order for it to be processed for payment.

11.20 Official Orders

11.20.1 Official Orders, issued following approved requisition and sourcing, must:

a) Be consecutively numbered;
b) State the Trust's terms and conditions of trade.

11.20.2 Official Orders will be issued on behalf of the Trust by NWSSP Procurement Services.

12. HEALTH CARE AGREEMENTS AND CONTRACTS FOR HEALTH CARE SERVICES

12.1 Health Care Agreements

12.1.1 The Chief Executive is responsible for ensuring the Trust enters into suitable Health Care Agreements (or Individual Patient Commissioning Agreements, where appropriate) for its provision of health care services.

12.1.2 All Health Care Agreements should aim to implement the agreed priorities

contained within the Integrated Medium Term Plan and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

- The standards of service quality expected;
- The relevant quality, governance and risk frameworks and plans;
- The relevant national service framework (if any);
- The provision of reliable information on quality, volume and cost of service; and
- That the agreements are based on integrated care pathways.

12.1.3 All agreements must be in accordance with the functions conferred on the Trust by the Welsh Ministers.

12.2 Statutory provisions

The National Health Service (Wales) Act 2006 (c. 42) enables NHS Trusts to commission certain healthcare services. Section 7 sets out the definition of an NHS contract, being an arrangement under which one health service body arranges for the provision to it by another of goods or services which it reasonably requires for the purposes of its functions. It also provides a definition of a health service body.

12.3 Reports to Board on Health Care Agreements (HCAs)

12.3.1 The Chief Executive will need to ensure that regular reports are provided to the Board detailing performance, quality and associated financial implications of all health care agreements. These reports will be linked to, and consistent with, other Board reports on quality and financial performance.

13. GRANT FUNDING

It is a matter for Trusts to determine whether individual activities should be procured, or be eligible to receive grant funding, seeking legal advice as necessary. (Grants are defined as all non-procured payments to external bodies or individuals for activities which are linked to delivering policy objectives and statutory obligations. Payments are made to fund or reimburse expenditure on agreed items or functions in accordance with legally binding conditions.)

13.1 Legal Advice

13.1.1 Before the award of funding is made, legal advice where necessary must be sought to ensure that:

- The award does not breach the Trust's functions or its regularity of expenditure duty (that is, the activities for which the grant is made are within the scope of activities that the Trust has a legal remit to undertake);
- The activities would not be deemed to be normally subject to procurement legislation and policy; and
- A legally binding agreement is made with all delivery organisations.

See attached toolkit for grants v procurement:

Grant v Procurement.doc

13.2 Policies and procedures

13.2.1 The Trust shall maintain detailed policies and procedures for all aspects of grant funding. The policies and procedures shall comply with these SFIs, and where appropriate the Minister's Code of Practice to funding the third sector:

https://gov.wales/sites/default/files/publications/2019-01/third-sector-scheme-2014.pdf

13.2.2 The Chief Executive is ultimately responsible for ensuring that the Trust's grant procedures:

- Are kept up to date;
- Conform to statutory requirements;
- Adhere to guidance issued by the Welsh Ministers;

- Are consistent with the principles of sustainable development; and
- Are strictly followed by all Executive Directors, Independent Members and staff within the organisation.

13.2.3 The award of grant funding must comply with the policy and principles set out in the Procurement section of these SFIs and ensure that the award meets the requirements of regularity, propriety and value for money.

13.2.4 All grant guidance issued by the Welsh Ministers should have the effect as if incorporated in these SFIs.

13.3 Corporate Principles underpinning Grants Management

13.3.1 While there is a need to make the financial arrangements for awarding funding as simple and streamlined as possible, Trusts should also ensure that taxpayers' money is spent appropriately and that it provides good value for money.

13.3.2 The overarching principles for managing public resources in Wales are set out in Managing Welsh Public Money. The document states that the award of funding should be made in accordance with the law and the requirements of propriety, regularity and value for money.

13.3.3 Regularity requires compliance with appropriate authorities, regulations and legislation. Propriety requires both public authorities and funded bodies to deliver appropriate standards of conduct, behaviour and corporate governance. In addition, the public expects official decisions to be made fairly and impartially with public money spent wisely and appropriately, delivering value for money and ensuring that best use is made of resources.

13.3.4 The **corporate principles** of grants management are:

- The development of grant management processes and procedures that are transparent, accountable, proportionate and consistent;
- The delivery of a high quality regulatory framework that responds to demands but does not place unnecessary administrative burdens on Trusts or funded bodies;
- A regulatory framework that will take into consideration the need for proportionality, balancing the need for governance with the burden of administration, thus striking an appropriate balance between accountability and simplicity;
- An effective grant management process to ensure funded bodies spend the funding efficiently, transparently and for the purpose intended, with a

view to maximising the impact and outcome from budgets;

- An appropriate evidence-based approach to underpin the design and development of all new funding programmes to ensure efficient and effective use of public funds, ensuring that the funding programme is the optimal solution and that funding is targeted where it is most needed and where it can have most impact;
- A consistent framework that will reinforce respect and effectiveness of the rules for both administrators and funded bodies; and
- Compliance of the grant funding with State aid requirements in accordance with the State aid rules.

13.4 Grant Procedures

13.4.1 It is vital that money is put to use in a way that delivers the maximum benefit to the people of Wales. Grants funding programmes need to be managed as efficiently and cost effectively as possible to make sure that every penny is spent appropriately and in an accountable manner. When establishing grant funding programmes, Trusts should ensure principles of good practice, available from a number of external sources, are considered and reflected in grant programmes. ~~Information on grants management is available on the Audit Wales website at:~~

~~https://www.audit.wales/good-practice/grants-management-miniguides~~

13.4.2 Trusts must agree a clear purpose for each grant and how it will measure the delivery organisation's success in delivering those purposes. It should also agree appropriate targets with the delivery organisation.

13.4.3 For grant programmes that span a number of financial years, the Trust is responsible for evaluating the programmes to ensure they are fit for purpose, are achieving required outcomes and continue to provide value for money.

13.4.4 Trusts are responsible for ensuring that appropriate procedures exist in relation to all the grants and funding for which they are accountable. **They are also responsible for ensuring that any grant provided to an entity that engages in economic activity complies with the State aid rules.**

13.4.5 Trusts are required to undertake due diligence checks on all potential delivery organisations to determine the economic and financial viability of any organisation(s) to administer public funds, and the reliability of the organisation(s). These checks are important in order to identify any risks or issues that could expose the Trust to potential financial loss, fraud or

reputational damage. A proportionate level of due diligence should be carried out, both prior to the award of any grant funding and throughout the life of the award.

13.4.6 The Trust must enter into legally binding funding agreements with all delivery organisations. When developing funding agreements, the Trust should ensure principles of good practice, available from a number of external sources, are considered and reflected.

13.4.7 The Trust is responsible for ensuring that all third party delivery organisations comply with and adhere to the terms and conditions of the Funding Agreement.

14. PAY EXPENDITURE

14.1 Remuneration and Terms of Service Committee

14.1.1 In accordance with SOs, the Board shall establish a Remuneration and Terms of Service Committee, with clearly defined terms of reference and operating arrangements that specify which posts fall within its area of responsibility. This Standing Financial Instruction should be read in conjunction with Standing Order 3.4.

14.1.2 The Committee shall report in writing to the Board the basis for its recommendations. The Board shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of Directors and other senior employees, in accordance with the framework set by the Welsh Ministers. Minutes of the Board's meetings should record such decisions.

14.1.3 The Board will, after due consideration and amendment, if appropriate, approve proposals presented by the Chief Executive for the setting of remuneration and terms of service for those employees and officers not covered by the Committee.

14.1.4 The Trust will remunerate the Chair, Chief Executive, Executive Directors and Independent Members of the Board in accordance with instructions issued by the Welsh Ministers. Welsh Ministers approval will be required in the exceptional event that remuneration needs to be above the maximum of the salary band range, administratively this approval will be exercised by the Director General HSSG.

14.1.5 The Remuneration and Terms of Service Committee will consider cases of redundancy and Voluntary Early Release applications. The Remuneration and Terms of Service Committee will consider any novel employment and pay cases, such as compromise agreements and non-disclosure agreements, ensuring Welsh Government advice has been sought and considered.

14.2 Funded Establishment

14.2.1 The workforce plans incorporated within the approved Integrated Medium Term Plan will form the funded establishment, i.e, the budget for all approved posts. (The financial budgets (£) and workforce establishment budgets (budgeted whole time equivalents) as per SFI 5.1.1 g)

14.2.2 The funded establishment of any department may not be varied without the approval of the Chief Executive or an officer with delegated authority.

14.3 Staff Appointments

14.3.1 Staff must only be engaged by authorised managers, in accordance with the Board's Scheme of Delegation. The engagement must be within the approved budget and funded establishment.

14.3.2 No Board member or Trust official may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration outside the limit of their approved budget and funded establishment unless authorised to do so by the Chief Executive.

14.4 Pay Rates and Terms and Conditions

14.4.1 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc, for employees in accordance with pay, terms and conditions set out in Ministerial directions on Agenda for Change and Medical and Dental pay, and any staff with pre-existing terms and conditions of service, following a TUPE transfer into employment or ad hoc salaried staff.

14.4.2 The Remuneration Committee will determine pay rates and conditions of services for board members, and other senior employees, in accordance with ministerial instructions.

14.5 Payroll

14.5.1 The Director of Workforce and Organisational Development has responsibility for securing an efficient, well-controlled payroll service from NHS Wales Shared Services Partnership that:

- pays the correct staff with the correct amount,
- all payments are supported by properly authorised documentation.

14.5.2 The Director of Workforce and Organisational Development has responsibility for:

a) The control framework and detailed procedures which are in place to:
   - To ensure all payments comply with HMRC, Pensions Agency and other

regulation in relation to the deduction and payment of tax, national insurance, pension or other payments,
- reduce the risk of fraud and error within the payroll function.

b) Specifying timetables for submission of properly authorised time records and other notifications;

c) The final determination of pay and allowances including verification that the rate of pay and relevant conditions of service are in accordance with current agreements;

d) Agreeing the timing and method of payment with the payroll service;

e) Authorising the release of payroll data where in accordance with the provisions of the applicable Data Protection Legislation (the Data Protection Act 2018 and the UK General Data Protection Legislation);

f) Verification and documentation of data;

g) The timetable for receipt and preparation of payroll data and the payment of employees and allowances;

h) Maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

i) Security and confidentiality of payroll information;

j) Checks to be applied to completed payroll before and after payment; and

k) A system to ensure the recovery from those leaving the employment of the Trust of sums of money and property due by them to the Trust.

14.5.3 The Chief Executive is responsible for:

a) Ensuring that arrangements for a payroll service from NHS Wales Shared Services Partnership (NWSSP) is supported by appropriate Service Level Agreements, terms and conditions, adequate internal controls and internal audit review procedures;

b) Ensuring a sound system of internal control and audit review of any internally provided payroll service; and

c) Maintenance and/or the authorisation of regular and independent

reconciliation of pay control accounts.

14.5.4 Appropriately nominated managers have delegated responsibility for:

a) Submitting time records and other notifications in accordance with agreed timetables;

b) Completing time records and other notifications in accordance with the Service Level Agreements; and

c) Submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Director of Workforce and Organisational Development and/or Chief Executive must be informed immediately. In circumstances where fraud is suspected, this must be reported to the Executive Director of Finance and Corporate Resources .

14.6 Contracts of Employment

14.6.1 The Director of Workforce and Organisational Development must:

a) Ensure that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and

b) Deal with variations to, or termination of, contracts of employment.

15. CAPITAL PLAN, CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

15.1 Capital Plan

15.1.1 Capital plans, and annual capital programmes, must be approved by the Board before the commencement of a financial year and should be in line with the objectives set out in the approved Integrated Medium Term Plan (IMTP) for the organisation. The capital plan and programmes must be delivered within Welsh Government capital external financing limit.

15.1.2 The Director of Planning (or nominated responsible director) will develop a capital plan, and detailed capital programme, for the organisation that sets out a detailed capital investment plan to support the objectives set out in the IMTP. The capital programme must be affordable and within the external financing limit, as set out by Welsh Government (WG) for the year, and the Trust must not exceed the external financing limit. There must be an approved revenue funding plan in place to support any revenue costs associated with the capital plan. Regular updates must be provided to the Board, and relevant Board Committees, during the financial year.

15.1.3 The Board must approve a three year Capital Plan, and an annual Capital Programme, as set out in the Integrated Medium Term Plan and Budgetary Control chapters of these SFI.

15.2 Capital Investment Decisions

15.2.1 Robust business case and capital investment appraisal must be undertaken prior to formal submission to Welsh Government, the level of detail within the appraisal commensurate with the value and risk of the investment. Capital investment decisions should be undertaken in line with Welsh Government requirements and guidance for the development of business cases as set out in:

- NHS Wales Infrastructure Investment Guidance (Welsh Health Circular WHC (2018) 043) **https://gov.wales/nhs-wales-infrastructure-investment-guidance**
- Better business cases: investment decision-making framework **https://gov.wales/better-business-cases-investment-decision-making-framework**

15.2.2 The Executive Director of Finance and Corporate Resources must provide a professional opinion on the financial elements of the business case. Capital

investment decisions will be taken by the organisation in line with the financial thresholds specified by Welsh Government and in the Trust's Scheme of Delegation.

15.3 Capital Projects

15.3.1 The Chief Executive shall ensure that any capital investment above the Welsh Ministers' delegated limit is not undertaken without approval of the Welsh Ministers and that confirmation of capital resources has been received.

15.3.2 When capital investment decisions are taken and a Capital Programme is approved the project cannot be initiated until the authority to commit expenditure is formally delegated to a manager, in line with the organisation's Scheme of Delegation. The capital project must then be procured in line with normal procurement procedures or the Designed for Life or other approved procurement framework and in line with Welsh Government requirements and guidance and the applicable procurement legislation. Management control and financial reporting systems must be established to ensure that the project is:

- delivered on time;
- on budget; and
- within contractual obligations.

15.3.3 Project management controls and financial reporting systems must be established to ensure these objectives are met. Reporting requirements to Welsh Government will be set out in the approval letter provided post Ministerial approval.

15.3.4 Regular updates must be provided to the Board, and relevant Board Committees, during the financial year.

15.4 Capital Procedures and Responsibilities

15.4.1 The Chief Executive:

a) Shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon plans;

b) Is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;

c) Shall ensure that any capital investment above the Welsh Ministers'

delegated limit is not undertaken without approval of the Welsh Ministers and that confirmation of capital resources has been received;

d) Shall ensure that the three year Capital Plan, and detailed annual Capital Programme is adopted by the Board, as part of the IMTP, prior to the commencement of the financial year;

e) Shall ensure the availability of resources to finance all revenue consequences of the investment, including capital charges; and

f) Shall ensure that any 3rd party use of NHS estate is properly controlled, reimbursed and reported. This will include ensuring that appropriate security, insurance and indemnity arrangements are in place and that there is a written agreement as to each party's responsibilities and liabilities.

15.4.2 For every capital expenditure proposal the Chief Executive shall ensure:

a) That a business case is produced in line with Welsh Ministers' guidance and where appropriate the 5-case Model;

b) That the Executive Director of Finance and Corporate Resources has certified professionally to the costs and revenue consequences detailed in the business case and involved appropriate Trust personnel and external agencies in the process.

15.4.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management in accordance with the Welsh Ministers' guidance.

15.4.4 The approval of a capital programme shall not constitute approval for the initiation of expenditure on any scheme.

15.4.5 The Chief Executive shall issue to the manager responsible for any scheme:

a) Specific authority to commit expenditure;

b) Authority to proceed to tender; and

c) Approval to accept a successful tender.

15.4.6 The Chief Executive will issue a scheme of delegation for capital investment management in accordance with the Welsh Ministers' guidance and the

Trust's SOs.

15.4.7 The Director of Planning and Executive Director of Finance and Corporate Resources shall issue detailed procedures governing the project, financial and contractual management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account the requirements and delegated limits for capital schemes set out in Welsh Ministers' guidance and approval letters. The procedures will also cover post project benefits realisation to ensure benefits set out in the business case supporting the investment are delivered. The Executive Director of Finance and Corporate Resources shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

15.4.8 The Executive Director of Finance and Corporate Resources shall ensure, for each capital project over £2m, that the Welsh Government Project Bank Accounts policy is applied unless there are compelling reasons not to do so. The Executive Director of Finance and Corporate Resources should apply to Welsh Government officials for exemption from use of Project Bank Accounts, setting out the compelling reasons.

15.5 Capital Financing with the Private Sector

15.5.1 The Trust must not enter into any new capital financing arrangements with the private sector, including Private Financing Initiatives, Mutual Investment Model and 3rd Party Developments, without the consent of the Welsh Ministers.

15.6 Asset Registers

15.6.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Director of Planning and Executive Director of Finance and Corporate Resources , concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted periodically.

15.6.2 The Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be in accordance with the Welsh Ministers' guidance and to satisfy the financial disclosure requirements for the Annual Accounts.

15.6.3 Additions to the fixed asset register must be clearly identified to the operational or departmental manager or delegated budget holder and be

validated by reference to appropriate documentation to provide evidence of the financial value recorded, including:

a) Properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

b) Stores, requisitions and wages records for own materials and labour including appropriate overheads; and

c) Lease agreements in respect of assets held under a finance lease and included on the Trust's balance sheet.

15.6.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate). Disposal receipts are to be treated in accordance with the Welsh Ministers' guidance and clearly set out in the over-arching business case.

15.6.5 The Executive Director of Finance and Corporate Resources shall apply accounting policies for fixed assets in line with Welsh Government guidance and accounting standards and values recorded in the asset register, including depreciation and revaluations. The Executive Director of Finance and Corporate Resources shall approve procedures for reconciling balances on fixed assets accounts in general ledgers against balances on fixed asset registers.

15.6.6 The value of each asset, and depreciation, shall be considered annually in accordance with valuation guidance and methods specified by the Welsh Ministers. Assets should be considered for early revaluation where there is the likelihood of impairment as a result in a change of valuation or asset life.

15.7 Security of Assets

15.7.1 The overall control of fixed assets is the responsibility of the Chief Executive.

15.7.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Executive Director of Finance and Corporate Resources . This procedure shall make provision for:

a) Recording managerial responsibility for each asset;

b) Identification of additions and disposals;

c) Identification of all repairs and maintenance expenses;

d) Physical security of assets;

e) Regular verification of the existence of, condition of, and title to, assets recorded;

f) Identification and reporting of all costs associated with the retention of an asset; and

g) Reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

15.7.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Planning and Executive Director of Finance and Corporate Resources .

15.7.4 Whilst individual officers have a responsibility for the security of property of the Trust, it is the responsibility of Board members and senior Trust officers in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

15.7.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and Trust officers in accordance with the procedure for reporting losses.

15.7.6 Where practical, assets should be marked as Trust property.

16. STORES AND RECEIPT OF GOODS

16.1 General position

16.1.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

a) Kept to a minimum;
b) Subjected to annual stock take; and
c) Valued at the lower of cost and net realisable value.

16.2 Control of Stores, Stocktaking, condemnations and disposal

16.2.1 Subject to the responsibility of the Executive Director of Finance and Corporate Resources for the systems of financial control, overall responsibility for the control of stores shall be delegated to a senior officer by the Chief Executive. The day-to-day responsibility may be delegated by them to departmental officers/managers and stores managers/keepers, subject to such delegation being entered in a record available to the Executive Director of Finance and Corporate Resources . The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Manager; the control of any fuel oil and coal of a designated estates manager~~, including the control of vehicle fuel stocks by Fleet~~.

16.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Manager. Wherever practicable, stocks should be marked as health service property.

16.2.3 The Executive Director of Finance and Corporate Resources is responsible for developing financial control systems and procedures for the regulation and operation of the stores, to include the accounting arrangements including records for receipt, issues, and returns of goods to stores and losses.

16.2.4 Stocktaking arrangements shall be agreed with the Executive Director of Finance and Corporate Resources and there shall be a physical check covering all items in store at least once a year.

16.2.5 Where a complete system of controlled stores is not justified, alternative stores arrangements shall require the approval of the Executive Director of Finance and Corporate Resources .

16.2.6 The designated officer/manager shall be responsible for a system approved by the Executive Director of Finance and Corporate Resources for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated officer/manager shall report to the Executive Director of Finance and Corporate Resources any evidence of significant overstocking and of any negligence or malpractice (see also overlap with SFI 17, Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

16.3 Goods supplied by an NHS supplies agency

16.3.1 For goods supplied via NHS Wales Shared Services Partnership – Procurement Services (NWSSP-PS) or any other NHS purchasing and supplies agency central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the Executive Director of Finance and Corporate Resources or authorised officer who shall satisfy himself that the goods have been received before accepting the recharge.

17. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

17.1 Disposals and Condemnations

17.1.1 The Executive Director of Finance and Corporate Resources must prepare detailed procedures for the disposal of assets and goods, including condemnations, and ensure that these are notified to managers.

17.1.2 When it is decided to dispose of a Trust asset and goods, the head of department or authorised deputy will determine and advise the Executive Director of Finance and Corporate Resources of the estimated market value of the item, taking account of professional advice where appropriate.

17.1.3 All unserviceable assets and goods shall be:

a) Condemned or otherwise disposed of by an officer, the Condemning Officer, authorised for that purpose by the Executive Director of Finance and Corporate Resources ;

b) Recorded by the Condemning Officer in a form approved by the Executive Director of Finance and Corporate Resources which will indicate whether the assets and good are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second officer authorised for the purpose by the Executive Director of Finance and Corporate Resources .

17.1.4 The Condemning Officer shall satisfy themselves as to whether or not there is evidence of negligence in use and shall report any such evidence to the Executive Director of Finance and Corporate Resources who will take the appropriate action.

17.2 Losses and Special Payments

17.2.1 Losses and special payments are items that the Welsh Government would not have contemplated when it agreed funds for NHS Wales or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments, and special notation in the accounts to draw them to the attention of the Welsh Government.

17.2.2 The Executive Director of Finance and Corporate Resources is responsible for ensuring procedural instructions on the recording of and accounting for losses

and special payments are in place; and that all losses or special payments cases are properly managed in accordance with the guidance set out in the Welsh Government's Manual for Accounts.

17.2.3 Any officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and/or the Executive Director of Finance and Corporate Resources or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Executive Director of Finance and Corporate Resources and/or the Chief Executive.

17.2.4 Where a criminal offence is suspected, the Executive Director of Finance and Corporate Resources must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Executive Director of Finance and Corporate Resources must inform the Local Counter Fraud Specialist (LCFS) and the CFS Wales Team in accordance with Directions issued by the Welsh Ministers on fraud and corruption.

17.2.5 The Executive Director of Finance and Corporate Resources or the LCFS must notify the Audit Committee, the Auditor General's representative and the fraud liaison officer within the Welsh Government's Health and Social Services Group Finance Directorate of all frauds.

17.2.6 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Executive Director of Finance and Corporate Resources must notify:

a) The Audit Committee on behalf of the Board, and

b) An Auditor General's representative.

17.2.7 The Executive Director of Finance and Corporate Resources shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

17.2.8 The Executive Director of Finance and Corporate Resources shall ensure all financial aspects of losses and special payments cases are properly registered and maintained on the centralised Losses and Special Payments Register and that 'case write-off' action is recorded on the system (i.e. case closure date, case status, etc.).

17.2.9 The Audit Committee shall approve the writing-off of losses or the making of special payments within delegated limits determined by the Welsh Ministers and as set out by Welsh Government in its Losses and Special Payments guidance as detailed in Schedule 3 of the SOs.

17.2.10 For any loss or special payments, the Executive Director of Finance and Corporate Resources should consider whether any insurance claim could be made from the Welsh Risk Pool or from other commercial insurance arrangements.

17.2.11 No losses or special payments exceeding delegated limits shall be authorised or made without the prior approval of the Health and Social Services Group Executive Director of Finance and Corporate Resources .

17.2.12 All novel, contentious and repercussive cases must be referred to the Welsh Government's Health and Social Services Group Finance Directorate, irrespective of the delegated limit.

17.2.13 The Executive Director of Finance and Corporate Resources shall ensure all losses and special payments are reported to the Audit Committee at every meeting.

17.2.14 The Trust must obtain the Health and Social Services Group Director General's approval for special severance payments.

18. DIGITAL, DATA and TECHNOLOGY

18.1 Digital Data and Technology Strategy

18.1.1 The Board shall approve a Digital Data and Technology Strategy which sets out the development needs of the Trust for the medium term based on an appropriate assessment of risk. The Integrated Medium Term Plan shall include costed implementation plans of the strategy. The Board shall also ensure that a Director has responsibility for Digital Data and Technology .

18.1.2 The Trust shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the Information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about the Trust that are made publicly available.

18.2 Responsibilities and duties of the responsible Director

18.2.1 The responsible Director for Digital Data and Technology has responsibility for the accuracy, availability and security of the Trust digital systems and data and shall:

a) Devise and implement any necessary procedures to ensure adequate (reasonable) protection and availability of the Trust's digital systems and data for which they are responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Network and Information Systems Regulations 2018, the UK General Data Protection Legislation and any relevant domestic law considerations via the Data Protection Act 2018;

b) Ensure that, following risk assessment of threats, adequate (reasonable) controls exist over access to systems, data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

c) Ensure that an adequate management (audit) trail is maintained of access to digital systems and data and that such audit reviews as the Director may consider necessary to meet the organisational requirements under the Network and Information Systems Regulations 2018 are being carried out;

d) Shall ensure that policies, procedures and training arrangements are in place to ensure compliance with information governance law and the Network and Information Systems Regulations 2018; and

e) Shall ensure comprehensive incident reporting.

18.3 Responsibilities and duties of the Executive Director of Finance and Corporate Resources

18.3.1 The Executive Director of Finance and Corporate Resources shall need to ensure that new financial data and systems and amendments to current financial data and systems are developed in a controlled manner and thoroughly tested prior to implementation and business as usual phases. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation and business as usual phases.

18.4 Contracts for data and digital services with other health bodies or outside agencies

18.4.1 The responsible Director for Digital Data and Technology shall ensure that contracts for data and digital services for clinical, management and financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for:

- the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage, and
- the availability of the service including the resilience required to maintain continuity of the service.

The contract should also ensure rights of access for audit purposes.

18.4.2 Where another health organisation or any other agency provides a data or digital service for clinical, management and financial applications, the responsible Director for Informatics and Digital shall, to maintain the confidentiality, integrity and availability of the service provided, periodically seek assurances that adequate controls, based on risk assessment, are in operation.

18.5 Risk assurance

18.5.1 The responsible Director for Digital Data and Technology shall ensure that the risks to the Trust arising from the use of data, information and IT are effectively identified and considered and that appropriate action is taken to mitigate or control risk. This shall include the preparation and testing of

appropriate resilience plans, including both a business continuity and disaster recovery plan.

19. PATIENTS' PROPERTY

19.1 NHS Trust Responsibility

19.1.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of patients that lack capacity, or found in the possession of patients dead on arrival.

19.1.2 Where the Welsh Ministers' instructions require the opening of separate accounts for patient monies, these shall be opened and operated under arrangements agreed by the Executive Director of Finance and Corporate Resources .

19.1.3 In all cases where property, including cash and valuables, of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates (Small Payments) Act 1965 (c. 32)), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

19.1.4 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

19.1.5 Where patient property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

19.2 Responsibilities of the Chief Executive

19.2.1 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission, that the Trust will not accept responsibility or liability for patient property brought onto health service premises, unless it is handed in for safe custody and a copy of an official patient property record is retained as a receipt, by:

a) Notices and information booklets;

b) Hospital admission documentation and property records; and

c) The oral advice of administrative and nursing staff responsible for admissions.

19.3 Responsibilities of the Executive Director of Finance and Corporate Resources

19.3.1 The Executive Director of Finance and Corporate Resources must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patient property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

20. FUNDS HELD ON TRUST (CHARITABLE FUNDS)

20.1 Corporate Trustee

20.1.1 All business shall be conducted in the name of Welsh Ambulance Services National Health Service Trust Charity, and all funds received in trust shall be held in the name of the Trust as a corporate Trustee. SFI 20.2 defines the need for compliance with Charities Commission latest guidance and best practice.

20.1.2 The discharge of the Trust's corporate trustee responsibilities for funds held on trust are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.

20.1.3 The Trust shall establish a Charity~~able Funds~~ Committee as set out in Standing Order 3.4 to ensure that each fund held on trust which the Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

20.2 Accountability to Charity Commission and the Welsh Ministers

20.2.1 The trustee responsibilities must be discharged separately and full recognition given to the Trust's dual accountabilities to the Charity Commission for charitable funds and to the Welsh Ministers for exchequer funds.

20.2.2 The Schedule of Matters Reserved to the Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Board members and Trust officers must take account of that guidance before taking action.

20.2.3 The Trust shall make appropriate arrangements for the Annual Accounts and audit of Funds held on Trust in accordance with Charity Commission requirements.

20.3 Applicability of Standing Financial Instructions to funds held on Trust

20.3.1 In so far as it is possible to do so, most of the sections of these SFIs will apply to the management of funds held on trust.

20.3.2 The over-riding principle is that the integrity of each Trust must be maintained and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

21. RETENTION OF RECORDS

21.1 Responsibilities of the Chief Executive

21.1.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with the Welsh Ministers' guidance, the UK General Data Protection Legislation and any relevant domestic law considerations via the Data Protection Act 2018 and the Freedom of Information Act 2000 (c. 36).

21.1.2 The records held in archives shall be capable of retrieval by authorised persons.

21.1.3 Records held shall only be destroyed in accordance with the applicable data protection laws and at the express instigation of the Chief Executive. Details shall be maintained of records so destroyed.

SCHEDULE 1

Y Grŵp Iechyd a Gwasanaethau Cymdeithasol
Health & Social Services Group

Llywodraeth Cymru
Welsh Government

Directors of Finance
Deputy Directors of Finance
Local Health Boards, NHS Trusts Wales & HEIW

Our Ref: SE&IG/

Date: 30 November, 2020

Dear All

RE: PROCESSES FOR LOCAL HEALTH BOARDS AND NHS TRUSTS CONTRACTS, AND INTERESTS IN PROPERTY EXCEEDING £0.5M

Paragraph 13(3) of Schedule 2 to the National Health Service (Wales) Act 2006 places a requirement on Local Health Boards (LHBs) to obtain the consent of Welsh Ministers before:

- Acquiring and disposing of property;
- Entering into contracts; and
- Accepting gifts of property (including property to be held on trust).

Acquiring and disposing of property

WHC (2018) 043 NHS Wales Infrastructure Investment Guidance issued 22 October 2018 sets out at section 10.1:

LHBs and HEIW

Contract approvals over £1m for individual schemes will be sought as part of the normal business case submission process where funding from the NHS Capital Programme is required. For schemes funded via discretionary allocations, a request for approval will need to be submitted to Chief Executive NHS Wales, copying in the Deputy Director of Capital, Estates & Facilities Division.

Detailed arrangements in respect of approval process linked to the acquisition and

disposal of leases, where consent does not form part of the business case process will be included in a Welsh Health Circular WHC(2015)031. Organisations should ensure that the monitoring arrangements and the requisite forms and returns are included as part of their own assurance arrangements.

NHS Trusts

Whilst formal Ministerial consent is not required for Trusts as detailed above, general consent arrangements are still applicable in terms of relevant transactions. Detailed requirements in terms of appropriate notifications were sent in the Welsh Health Circular referenced above.

Guidance on disposals is contained in Section 11

WHC (2015) 031 issued 22 June 2015 clarified the approval process linked to the acquisition or disposal of a lease, where approval does not form part of a business case process. A lease being a property right requires the consent of the Welsh Ministers in accordance with paragraph 13(2) (a). The WHC set out for NHS Trusts and LHBs a notification and consent process mirroring the contract processes noted below.

Entering into contracts

Guidance was issued to NHS Wales bodies on 27th January 2017 in a letter to Directors of Finance issued jointly by the Deputy Directors of Finance and Capital Estates and Facilities. This letter now updates that guidance to reconfirm to all NHS Wales bodies that the authorisation and consideration of notified contracts and applications for the acquisitions or disposals of a lease or any interest in property are delegated to the Director General, Health and Social Services Group.

The Director General may, as with any other matter relating to the operation of the NHS in Wales, brief the Minister for Health and Social Services on any arrangement of particular policy note, or with a novel, contentious or innovative nature.

Accordingly any issues relevant to the exercise of the Minister for Health and Social Service's consent will, as a matter of course, be drawn to his attention.

The process which NHS Wales bodies entering into contracts must follow is:

- All NHS contracts (unless exempt) >£1m in total to be notified to the Director General HSSG prior to tendering for the contract;

- All eligible LHB and HEIW contracts >£1m in total to be submitted to the Director General HSSG for consent prior to award;
- All eligible NHS Trust contracts >£1m in total to be submitted to the Director General HSSG for notification prior to award; and
- All eligible NHS contracts >£0.5m in total to be submitted to the Director General HSSG for notification prior to award.

The requirement for consent does not apply to any contracts entered into pursuant to a specific statutory power, and therefore does not apply to:

(i) Contracts of employment between LHBs and their staff;
(ii) Transfers of land or contracts effected by Statutory Instrument following the creation of LHBs;
(iii) Out of Hours contracts; and
(iv) All NHS contracts; that is where one health services body contracts with another health service body.

For non- capital contracts requiring DG approval, the request for approval or notification should be sent to Rob Eveleigh in the Financial Control and Governance team : Robert.Eveleigh@gov.wales

Kind regards,

Steve Elliot & Ian Gunney
Diprwy Cyfarwyddwr Cyllid - Deputy Executive Director of Finance and Corporate Resources
Dirprwy Gyfarwyddwr, Cyfalaf Ystadau a Cyfleusterau - Deputy Director Capital Estates & Facilities
Finance Directorate / Cyfarwyddiaeth Cyllid
Y Grwp Iechyd a Gwasanaethau/Health and Social Services Group

SCHEDULE 1

REVISED GENERAL CONSENT TO ENTER INDIVIDUAL CONTRACTS

Y Grŵp Iechyd a Gwasanaethau Cymdeithasol
Health & Social Services Group

Llywodraeth Cymru
Welsh Government

Directors of Finance
Deputy Directors of Finance
Local Health Boards, NHS Trusts Wales, HEIW and DHCW

Our Ref: SE&IG/

Date: 31 March, 2022

Dear All,

This letter supercedes the consent guidance issued in our joint letter on 30 November 2020.

RE: PROCESSES FOR LOCAL HEALTH BOARDS AND NHS TRUSTS CONTRACTS, AND INTERESTS IN PROPERTY EXCEEDING £0.5M

Paragraph 13(3) of Schedule 2 to the National Health Service (Wales) Act 2006 places a requirement on Local Health Boards (LHBs) to obtain the consent of Welsh Ministers before:

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BUDDSODDWYR MEWN POBL | INVESTORS IN PEOPLE

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Steve.elliot@gov.wales
Gwefan • website:
www.gov.wales

LHBs and HEIW

Contract approvals over £1m for individual schemes will be sought as part of the normal business case submission process where funding from the NHS Capital Programme is required. For schemes funded via discretionary allocations, a request for approval will need to be submitted to Chief Executive NHS Wales, copying in the Deputy Director of Capital, Estates & Facilities Division.

Detailed arrangements in respect of approval process linked to the acquisition and disposal of leases, where consent does not form part of the business case process will be included in a Welsh Health Circular WHC(2015)031. Organisations should ensure that the monitoring arrangements and the requisite forms and returns are included as part of their own assurance arrangements.

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The Director General may, as with any other matter relating to the operation of the NHS in Wales, brief the Minister for Health and Social Services on any arrangement of particular policy note, or with a novel, contentious or innovative nature.

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- All eligible NHS contracts >£0.5m in total to be submitted to the Director General HSSG for notification prior to award.

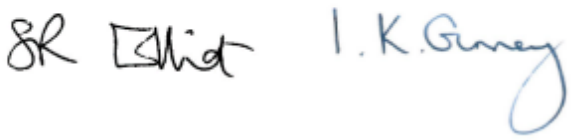
The requirement for consent does not apply to any contracts entered into pursuant to a specific statutory power, and therefore does not apply to:

(i) Contracts of employment between LHBs and their staff;
(ii) Transfers of land or contracts effected by Statutory Instrument following the creation of LHBs;
(iii) Out of Hours contracts; and
(iv) All NHS contracts; that is where one health services body contracts with another health service body.

Contracts entered into by HEIW for services which are the consequences of annual commissioning approved by the Minister e.g. annual education and training commissioning do not require further Ministerial notification or consent.

For non- capital contracts requiring DG approval, the request for approval or notification should be sent to Rob Eveleigh in the Financial Control and Governance team : Robert.Eveleigh@gov.wales

Kind regards,



Steve Elliot & Ian Gunney
Cyfarwyddwr Cyllid dros dro - Interim Director of Finance
Dirprwy Gyfarwyddwr, Cyfalaf Ystadau a Cyfleusterau - Deputy Director Capital Estates & Facilities
Finance Directorate / Cyfarwyddiaeth Cyllid
Y Grwp Iechyd a Gwasanaethau/Health and Social Services Group

Schedule 1

SCHEME OF RESERVATION AND DELEGATION OF POWERS

This Schedule forms part of, and shall have effect as if incorporated in the NHS Trust Standing Orders

Introduction

As set out in Standing Order 2, the Board - subject to any directions that may be made by the Welsh Ministers - shall make appropriate arrangements for certain functions to be carried out on its behalf so that the day to day business of the Trust may be carried out effectively, and in a manner that secures the achievement of the organisation's aims and objectives. The Board may delegate functions to:

(i) A Committee, e.g., Quality and Safety Committee;

(ii) A sub-Committee e.g., a locality based Quality and Safety Committee taking forward matters within a defined area. Any such delegation would, subject to the Board's authority, usually be via a main Committee of the Board; and

(iii) Officers of the Trust (who may, subject to the Board's authority, delegate further to other officers and, where appropriate, other third parties, e.g. shared/support services, through a formal scheme of delegation)

and in doing so, must set out clearly the terms and conditions upon which any delegation is being made. These terms and conditions must include a requirement that the Board is notified of any matters that may affect the operation and/or reputation of the Trust.

The Board's determination of those matters that it will retain, and those that will be delegated to others are set out in the following:

- Schedule of matters reserved to the Board;
- Scheme of delegation to Committees and others; and
- Scheme of delegation to officers.

all of which form part of the Trust's Standing Orders.

DECIDING WHAT TO RETAIN AND WHAT TO DELEGATE: GUIDING PRINCIPLES

The Board will take full account of the following principles when determining those matters that it reserves, and those which it will delegate to others to carry out on its behalf:

- ***Everything is retained by the Board unless it is specifically delegated in accordance with the requirements set out in SOs or SFIs***

- ***The Board must retain that which it is required to retain (whether by statute or as determined by the Welsh Ministers) as well as that which it considers is essential to enable it to fulfil its role in setting the organisation's direction, equipping the organisation to deliver and ensuring achievement of its aims and objectives through effective performance management***

- ***Any decision made by the Board to delegate functions must be based upon an assessment of the capacity and capability of those to whom it is delegating responsibility***

- ***The Board must ensure that those to whom it has delegated powers (whether a Committee, partnership or individuals) remain equipped to deliver on those responsibilities through an ongoing programme of personal, professional and organisational development***

- ***The Board must take appropriate action to assure itself that all matters delegated are effectively carried out***

- ***The framework of delegation will be kept under active review and, where appropriate, will be revised to take account of organisational developments, review findings or other changes***

- ***Except where explicitly set out, the Board retains the right to decide upon any matter for which it has statutory responsibility, even if that matter has been delegated to others***

- ***The Board may delegate authority to act, but retains overall responsibility and accountability***

- ***When delegating powers, the Board will determine whether (and the extent to which) those to whom it is delegating will, in turn, have powers to further delegate those functions to others.***

HANDLING ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS: WHO DOES WHAT

The Board

The Board will formally agree, review and, where appropriate revise schedules of reservation and delegation of powers in accordance with the guiding principles set out earlier.

The Chief Executive

The Chief Executive will propose a Scheme of Delegation to Officers, setting out the functions they will perform personally and which functions will be delegated to other officers. The Board must formally agree this scheme.

In preparing the scheme of delegation to officers, the Chief Executive will take account of:

- The guiding principles set out earlier (including any specific statutory responsibilities designated to individual roles)
- Their personal responsibility and accountability to the Chief Executive, NHS Wales in relation to their role as designated Accountable Officer
- Associated arrangements for the delegation of financial authority to equip officers to deliver on their delegated responsibilities (and set out in SFIs).

The Chief Executive may re-assume any of the powers they have delegated to others at any time.

The Board Secretary

The Board Secretary will support the Board in its handling of reservations and delegations by ensuring that:

- A proposed schedule of matters reserved for decision by the Board is presented to the Board for its formal agreement;
- Effective arrangements are in place for the delegation of Trust functions within the organisation and to others, as appropriate; and
- Arrangements for reservation and delegation are kept under review and presented to the Board for revision, as appropriate.

The Audit Committee

The Audit Committee will provide assurance to the Board of the effectiveness of its arrangements for handling reservations and delegations.

Individuals to who powers have been delegated

Individuals will be personally responsible for:

- Equipping themselves to deliver on any matter delegated to them, through the conduct of appropriate training and development activity; and
- Exercising any powers delegated to them in a manner that accords with the Trust's values and standards of behaviour.

Where an individual does not feel that they are equipped to deliver on a matter delegated to them, they must notify the Board Secretary of their concern as soon as possible in so that an appropriate and timely decision may be made on the matter.

In the absence of an officer to whom powers have been delegated, those powers will be exercised by the individual to whom that officer reports, unless the Board has set out alternative arrangements.

If the Chief Executive is absent their nominated Deputy may exercise those powers delegated to the Chief Executive on their behalf. However, the guiding principles governing delegations will still apply, and so the Board may determine that it will reassume certain powers delegated to the Chief Executive or reallocate powers, e.g., to a Committee or another officer.

SCOPE OF THESE ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS

The Scheme of Delegation to officers referred to here shows only the "top level" of delegation within the Trust. The Scheme is to be used in conjunction with the system of control and other established procedures within the Trust.

SCHEDULE OF MATTERS RESERVED TO THE BOARD[1]

NO.	BOARD /COMMITTEE	AREA	DECISIONS RESERVED
1	Board	General	The Board may determine any matter for which it has statutory or delegated authority, in accordance with SOs.
2	Board	General	The Board must determine any matter that will be reserved to the whole Board.
3	Board	General	Approve the Trust's Governance Framework
4	Board	Operating Arrangements	Approve, vary and amend: ▪ SOs; ▪ SFIs; ▪ Schedule of matters reserved to the Trust; ▪ Scheme of delegation to Committees and others; and ▪ Scheme of delegation to officers. In accordance with any directions set by the Welsh Ministers.
5	Board	Operating Arrangements	Ratify any urgent decisions taken by the Chair and the Chief Executive in accordance with Standing Order requirements.
6	Audit Committee	Operating Arrangements	Formal consideration of report of Board Secretary on any non-compliance with Standing Orders, making proposals to the Board on any action to be taken.

[1] Any decision to reserve a matter, and the manner in which that retained responsibility is carried out will be in accordance with any regulatory and/or ~~Assembly~~ Welsh Government requirements.

NO.	BOARD /COMMITTEE	AREA	DECISIONS RESERVED
7	Board	Operating Arrangements	Receive report and proposals regarding any non-compliance with Standing Orders, and where required ratify in public session any action required in response to failure to comply with SOs.
8	Board	Operating Arrangements	Authorise use of the Trust's official seal.
9	Board	Operating Arrangements	Approve the Trust's Values and Standards of Behaviour framework.
10	Chair on behalf of Board/Joint Committee, Vice-Chair on behalf of Joint Committee Board if Chair is declaring interest	Organisation Structure and Staffing	Require, receive, and determine action in response to the declaration of Board members' interests, in accordance with advice received, e.g. From Audit Committee or Board Secretary
11	Board	Strategy Planning	Determine the Trust's strategic aims, objectives and priorities
12	Board	Strategy Planning	Approve the Trust's key strategies and programmes related to: ▪ The development and delivery of patient and population centred health and care/clinical services ▪ Improving quality and patient safety outcomes ▪ Workforce and Organisational Development ▪ Infrastructure, including IM &T, Estates and Capital (including major capital investment and disposal plans)
13	Board	Strategy Planning	Approve the Trust's Integrated Medium Term Plan, including the balanced Medium Term Financial Plan
14	Board	Strategy Planning	Approve the Trust's budget and financial framework (including overall distribution and unbudgeted expenditure)
15	Board	Operating Arrangements	Approve the Trust's framework and strategy for performance management.
16	Board	Strategy and Planning	Approve the Trust's framework and strategy for risk management and assurance.
17	Board	Operating Arrangements	Ratify policies for dealing with raising concerns, complaints and incidents in accordance with the Putting Things Right and health and safety requirements.

NO.	BOARD /COMMITTEE	AREA	DECISIONS RESERVED
18	Board	Operating Arrangements	Agree the arrangements for ensuring the adoption of standards of governance and performance (including the quality and safety of healthcare, and the patient experience) to be met by the Trust, including standards/ requirements determined by Welsh Government, regulators, professional bodies/others, e.g. National Institute of Health and Care Excellence (NICE).
19	Board	Strategy and Planning	Approve the Trust's patient, public, staff, partnership and stakeholder engagement and co-production strategies.
20	Board	Operating Arrangements	Approve the introduction or discontinuance of any significant activity or operation. Any activity or operation shall be regarded as significant if the Board determines it so based upon its contribution/impact on the achievement of the Trust's aims, objectives and priorities.
21	Remuneration Committee. (For Chief Executive, Committee to consist of Chair and non-Officer Members. For all others officer members as above and to include Chief Executive)	Organisation Structure and Staffing	Appointment of the Chief Executive and Executive Directors (officer members of the Board)
22	Remuneration Committee	Organisation Structure and Staffing	Approve the appointment, appraisal, discipline and dismissal of any other Board level appointments and other senior employees, in accordance with Ministerial instructions e.g. the Board Secretary.
23	Remuneration Committee	Organisation Structure and Staffing	Termination of appointment and suspension of officer members in accordance with the provisions of Regulations
24	Remuneration	Organisation Structure	Consider appraisal of officer members of the Board

NO.	BOARD /COMMITTEE	AREA	DECISIONS RESERVED
	Committee	and Staffing	
25	Remuneration Committee	Organisation Structure and Staffing	Consider and approve redundancy and Early Release Applications, noting that where the settlement is £50,000 or above subsequent agreement of Welsh Government is required.
26	Board	Organisation Structure and Staffing	Approve, [arrange the] review, and revise the Trust's top level organisation structure and corporate policies
27	Board	Organisation Structure and Staffing	Appoint, [arrange the] review, revise and dismiss Trust Committees directly accountable to the Board
28	Board	Organisation Structure and Staffing	Appoint, equip, review and (where appropriate) dismiss the Chair and members of any Committee or Group set up by the Board
29	Board	Organisation Structure and Staffing	Appoint, equip, review and (where appropriate) dismiss individuals appointed to represent the Board on outside bodies and groups
30	Board	Organisation Structure and Staffing	Approve the standing orders and terms of reference and reporting arrangements of all Committees and groups established by the Board
31	Audit Committee	Operating Arrangements	Approve arrangements relating to the discharge of the Trust's responsibility as a bailee for patients' property
32	Board Except where Chapter 6 specifies appropriate to delegate to a committee, Chief Executive or Officers	Operating Arrangements	Approve individual compensation payments in line with the provisions of Annex 4 to Chapter 6 of the Welsh Government Manual for Accounts
33	Board	Operating Arrangements	Approve individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and officers

NO.	BOARD /COMMITTEE	AREA	DECISIONS RESERVED
	Except where Chapter 6 specifies appropriate to delegate to a committee, Chief Executive or Officers		
34	Board	Operating Arrangements	Approve proposals for action on litigation on behalf of the Trust
35	Board	Organisation Structure and Staffing	Approve the arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee of funds held on trust in accordance with the provision of Paragraph 20 of the Standing Financial Instructions.
36	Board	Strategy and Planning	Approve individual contracts (other than NHS contracts) above the limit delegated to the Chief Executive set out in the Standing Financial Instructions
37	Board	Performance and Assurance	Approve the Trust's audit and assurance arrangements
38	Board	Performance and Assurance	Receive reports from the Trust's Executive on progress and performance in the delivery of the Trust's strategic aims, objectives and priorities and approve action required, including improvement plans, as appropriate.
39	Board	Performance and Assurance	Receive reports from the Trusts Committees, groups and other internal sources on the Trust's performance and approve action required, including improvement plans, as appropriate
40	Board	Performance and Assurance	Receive reports on the Trust's performance produced by external regulators and inspectors (including, e.g., Audit Wales~~, HIW,~~ etc.) that raise significant issue or concerns impacting on the Trust's ability to achieve its aims and objectives and approve action required, including improvement plans, taking account of the advice of Trust Committees (as appropriate)
41	Board	Performance and Assurance	Receive the annual opinion of the Trust's Chief Internal Auditor and approve action required, including improvement plans
42	Board	Performance and Assurance	Receive the annual management report from the Auditor General for Wales and approve action required, including improvement plans

NO.	BOARD /COMMITTEE	AREA	DECISIONS RESERVED
43	Board	Performance and Assurance	Receive assurance regarding the Trust's performance against the Health and Care Standards for Wales and the arrangements for approving required action, including improvement plans.
44	Board	Reporting	Approve the Trust's Reporting Arrangements, including reports on activity and performance to citizens, partners and stakeholders and nationally to the Welsh Government where required.
45	Board	Reporting	Receive, approve and ensure the publication of Trust reports, including its Annual Report and annual financial accounts in accordance with directions and guidance issued.
~~46~~	~~Board~~	~~Strategy and Planning~~	~~Ratify proposals for the acquisition, disposal or change of use of land and/or buildings. (see also Schedule 1 to SFIs)~~

ADDITIONAL AREAS OF RESPONSIBILITY DELEGATED TO CHAIR, VICE CHAIR AND INDEPENDENT MEMBERS			
1.	Chair		In accordance with statutory and Welsh Government requirements
2.	Vice Chair		In accordance with statutory and Welsh Government requirements
3.	Champion/ Nominated Lead		In accordance with statutory and Welsh Government requirements

DELEGATION OF POWERS TO COMMITTEES AND OTHERS[2]

Standing Order 2 provides that the Board may delegate powers to Committees and others. In doing so, the Board has formally determined:

- The composition, terms of reference and reporting requirements in respect of any such Committees; and
- The governance arrangements, terms and conditions and reporting requirements in respect of any delegation to others

in accordance with any regulatory requirements and any directions set by the Welsh Ministers.

The Board has delegated a range of its powers to the following Committees and others:

- Audit Committee
- Quality Patient Experience and Safety Committee
- Remuneration Committee
- Finance and Performance Committee
- People and Culture
- Charity Committee
- Academic Partnerships Committee

The scope of the powers delegated, together with the requirements set by the Board in relation to the exercise of those powers are as set out in i) Committee terms of reference, and ii) Formal arrangements for the delegation of powers to others. Collectively, these documents form the Trust's Scheme of Delegation to Committees. The Committee terms of reference appear in Schedule 3 to these Standing Orders.

In the event the Chief Executive Officer is absent they will appoint a ~~the~~ Deputy Chief Executive Officer to take~~s~~ on full responsibility of the Chief Executive Officer. If the Deputy Chief Executive is the Director of Finance and Corporate Resources then the Director of Finance and Corporate Resources responsibilities is delegated to the Deputy Director of Finance.

[2] As defined in Standing Orders.

SCHEME OF DELEGATION TO EXECUTIVE DIRECTORS, DIRECTORS AND OFFICERS

The Trust SOs and SFIs specify certain key responsibilities of the Chief Executive, the Director of Finance and Corporate Resources and other officers. The Chief Executive's Job Description, together with their Accountable Officer Memorandum sets out their specific responsibilities, and the individual job descriptions determined for Executive Director level posts also define in detail the specific responsibilities assigned to those post holders.

These documents, together with the schedule of additional delegations below and the associated financial delegations set out in the SFIs form the basis of the Trust's Scheme of Delegation to Officers.

Table A – Delegated Matters

Note for Table A, where a delegation is made to more than one post holder:

- '/' signifies that either post holder may act individually, or they may act jointly.
- 'and' signifies they must act jointly

Delegated Matter	Responsible Officer/Committee	Delegated To
1. Audit arrangements		
1.1. Ensure that there is an adequate provision of internal and external audit services	Audit Committee	Board Secretary
1.2. Implement recommendations	Chief Executive	Relevant Director
1.3. Ensure the financial accounts of the Trust are audited annually	Chief Executive	Executive Director of Finance and Corporate Resources
2. Authorisation of new drugs	Chief Executive	Medical Director and Director of Paramedicine
3. Bank/OPG Accounts/Cash (Excluding Charitable Funds (Funds Held on Trust Accounts))	Chief Executive	Executive Director of Finance & Corporate Resources

Delegated Matter	Responsible Officer/Committee	Delegated To
Refer to SFIs for banking arrangements		
4. Capital investment (Refer to SFIs)		
4.1. Programme		
(a) Preparation of Capital Investment for submission to Board	Chief Executive	Executive Director of Finance & Corporate Resources and Director of Strategy, Planning & Performance
(b) Financial monitoring and reporting on all capital scheme expenditure including variations to contract	Chief Executive	Executive Director of Finance & Corporate Resources
(c) Variation to capital programme (up to delegated limits)	Chief Executive	Executive Director of Finance & Corporate Resources and Director of Strategy, Planning & Performance
4.2. Leases – granting and termination of leases subject to the limits set out in Table B	Chief Executive	Executive Director of Finance & Corporate Resources
5. Clinical		
5.1. Clinical governance arrangements	Chief Executive	Medical Director, Executive Director of Quality & Nursing and Director of Paramedicine
5.2. Clinical leadership	Chief Executive	Medical Director, Executive Director of Quality & Nursing and Director of Paramedicine
5.3. Programmes of clinical education	Chief Executive	Executive Director of People and Culture with Executive Director of Quality & Nursing and Director of Paramedicine
5.4. Clinical staffing rotas	Chief Executive	Executive Director of Operations
5.5. Clinical trials and research projects (authorisation of) In accordance with JRCALC guidelines	Chief Executive	Director of Paramedicine unless specified as Medical Director
5.6. Responsible officer for medical revalidation	Chief Executive	Medical Director
5.7. Clinical Audit To ensure there is a programme in place	Chief Executive	Medical Director
6. Clinical Practice and Registration		

Delegated Matter	Responsible Officer/Committee	Delegated To
6.1. Compliance with statutory and regulatory arrangements relating to professional practice and/or breaches of clinical standards		
(a) Nursing	Chief Executive	Executive Director of Quality and Nursing
(b) Medical	Chief Executive	Medical Director
(c) Paramedicine and affiliated roles	Chief Executive	Director of Paramedicine
(d) Community First Responders	Chief Executive	Director of Paramedicine
7. Complaints/concerns (patients and relatives) – Putting Things Right/the NHS (Concerns, Complaints and Redress Arrangements (Wales)) Regs 2011	Chief Executive	Executive Director of Quality & Nursing
8. Confidential information		
8.1. Monitoring of the Trust's compliance with the Caldicott report on protecting patient confidentiality in the NHS	Chief Executive	Executive Director of Quality and Nursing
8.2. Freedom of Information Act compliance code	Chief Executive	Board Secretary
9. Data Protection Act and General Data Protection Regulations		
9.1. Monitoring of Trust's compliance	Chief Executive	Director of Digital Services
9.2. Senior Information Risk Owner (SIRO)	Chief Executive	Director of Digital Services
10. Declarations of interest		
10.1. Maintaining a register	Chief Executive	Board Secretary
11. Disposal and condemnations		
11.1. Items obsolete, redundant, irreparable or cannot be repaired cost effectively	Chief Executive	Executive Director of Finance & Corporate Resources
11.2. Develop arrangements for the sale of assets	Chief Executive	Executive Director of Finance & Corporate Resources
11.3. Disposal of protected property (as defined in the terms of authorisation)	Chief Executive	Executive Director of Finance & Corporate Resources

Delegated Matter	Responsible Officer/Committee	Delegated To
12. Environmental Regulations		
12.1. Monitoring of compliance and ensuring compliance with environmental regulations, for example those relating to clean air and waste disposal	Chief Executive	Executive Director of Finance and Corporate Resources
13. External Borrowing		
13.1. Advise Trust Board of the requirements to repay / draw down Public Dividend Capital	Executive Director of Finance & Corporate Resources	Deputy Director of Finance and Corporate Resources
13.2. Approve a list of employees authorised to make short term borrowings on behalf of the Trust	Trust Board	Chief Executive and Executive Director of Finance & Corporate Resources
13.3. Application for draw down of Public Dividend Capital, overdrafts, and other forms of external borrowing	Chief Executive	Executive Director of Finance & Corporate Resources
14. Financial Planning/Budgetary Responsibility		
14.1. Develop and submit to Trust Board a financial plan in accordance with priorities and objectives as set out in the IMTP	Chief Executive	Executive Director of Finance & Corporate Resources
14.2. Budgetary responsibility	Chief Executive	Executive Director of Finance & Corporate Resources
14.3. Prior to the start of the financial year, prepare and submit to Trust Board for approval balanced budgets that delivers the financial plan as contained within the IMTP	Chief Executive	Executive Director of Finance & Corporate Resources
14.4. Monitoring and report to Trust Board on performance against the financial plan	Chief Executive	Executive Director of Finance & Corporate Resources
14.5. Devise and maintain systems of budgetary control	Chief Executive	Executive Director of Finance & Corporate Resources
14.6. Monitor performance against budget	Chief Executive	Executive Director of Finance & Corporate Resources
14.7. Delegate budgets to budget holders	Chief Executive	Executive Director of Finance & Corporate Resources

Delegated Matter	Responsible Officer/Committee	Delegated To
14.8. Ensure adequate training is delivered to budget holders to facilitate their management of allocated budget	Chief Executive	Executive Director of Finance & Corporate Resources
14.9. Submit in accordance with the independent regulators' requirements for financial monitoring returns	Chief Executive	Executive Director of Finance & Corporate Resources
14.10. Identify and implement cost improvements and income generating activities in line with the business plan	Chief Executive	All budget holders
14.11. Preparation of		
(a) Annual accounts	Executive Director of Finance & Corporate Resources	Deputy Director of Finance and Corporate Resources
(b) Annual report	Chief Executive	Board Secretary
14.12. Budget Responsibilities. Ensure that:		
(a) No overspend or reduction of income that cannot be met from virement is incurred without prior consent of Board	Chief Executive and Executive Director of Finance & Corporate Resources	Deputy Director of Finance and Corporate Resources
(b) Approved budget is not used for any other than specified purpose subject to rules of virement	Chief Executive and Executive Director of Finance & Corporate Resources	Deputy Director of Finance and Corporate Resources
(c) No permanent employees are appointed without the approval of the Chief Executive other than those provided for within available resources and workforce establishment	Chief Executive and Executive Director of Finance & Corporate Resources	Deputy Director of Finance and Corporate Resources
14.13. Authorisation of Virement The Chief Executive, Executive Director of Finance & Corporate Resources and delegated budget holders must not exceed the	Chief Executive	Executive Director of Finance & Corporate Resources

Delegated Matter	Responsible Officer/Committee	Delegated To
budgetary total or virement limits set by the Board.		
Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement		
15. Financial Procedures and Systems Development and maintenance of systems and procedures	Chief Executive	Executive Director of Finance & Corporate Resources
16. Fire Precautions Ensure that the Fire Precautions and prevention policies and procedures are adequate and that fire safety and integrity of the estate is intact.	Chief Executive	Executive Director of Finance & Corporate Resources
17. Fixed Assets		
17.1. Maintenance of asset register including asset identification and monitoring	Chief Executive	Executive Director of Finance & Corporate Resources
17.2. Ensuring arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with CONCODE and ESTATECODE.	Chief Executive	Executive Director of Finance & Corporate Resources
17.3. Calculate and pay capital charges in accordance with the requirements of the Independent Regulator	Chief Executive	Executive Director of Finance & Corporate Resources
17.4. Responsibility for security of Trust's assets including notifying discrepancies to the Executive Director of Finance and Corporate Services, and reporting losses in accordance with Trust's procedures	Chief Executive	All Staff
18. Fraud (see also 26 and 36) Monitor and ensure compliance with Welsh Government Directions on fraud and corruption including the appointment of the Local Counter Fraud Specialist.	Chief Executive	Executive Director of Finance & Corporate Resources
19. Funds Held on Trust Charitable Funds Charitable Funds held are managed and scrutinised appropriately	Charitable Funds Committee	Executive Director of Finance & Corporate Resources

Delegated Matter	Responsible Officer/Committee	Delegated To
20. Gifts and Hospitality		
20.1. Maintaining the gifts and hospitality register	Chief Executive	Board Secretary
20.2. Process for declaring gifts and hospitality	Chief Executive	Board Secretary
21. Health and Safety Monitor and ensure statutory compliance with all legislation and Health and Safety requirements including control of Substances Hazardous to Health Regulations	Chief Executive	Executive Director of Quality & Nursing
22. Infectious Diseases and Notifiable Outbreaks	Chief Executive	Executive Director of Quality & Nursing
23. Integrated Medium Term Plan (IMTP)		
23.1. Develop and present to Trust Board for approval an IMTP that sets out the Trust Strategies and objectives and meets Welsh Government requirement	Chief Executive	Executive Director of Strategy, Planning & Performance
24. IT Systems		
24.1. Ensuring integrity of system e.g. security, privacy, accuracy, completeness and storage	Chief Executive	Director of Digital Services
24.2. Maintain & replacement of i) business critical systems ii) All other systems	Chief Executive	Director of Digital Services
24.3. Disaster recovery systems	Chief Executive	Director of Digital Services
24.4. Developing Business Critical Systems in accordance with the Trust's IM&T Strategy	Chief Executive	Director of Digital Services
24.5. Developing new systems to ensure they are developed in a controlled manner and thoroughly tested	Chief Executive	Director of Digital Services
24.6. Seeking third party assurances regarding Business Critical Systems operated externally	Chief Executive	Director of Digital Services
25. Losses, Write Offs and Compensation		

Delegated Matter	Responsible Officer/Committee	Delegated To
25.1. Prepare procedures for recording accounting and reporting to Audit Committee for losses and special payments, including clinical negligence and personal injury claims	Chief Executive	Executive Director of Finance & Corporate Resources
25.2. Ex-gratia payments	Chief Executive	Executive Director of Finance & Corporate Resources and relevant Director
26. Patients' Property (in conjunction with financial advice) Ensuring patients and guardians are informed about patients' monies and property procedures	Chief Executive	Executive Director of Operations
27. Patient Services Agreements Negotiation, agreement, and monitoring of external non-clinical patient transport contracts	Chief Executive	Executive Director of Finance & Corporate Resources/Executive Director of Operations
28. Procuring Goods and Services		
28.1. Maintenance of a list of managers authorised to place requisitions/orders and accept goods in accordance with Table B	Chief Executive	Executive Director of Finance & Corporate Resources
28.2. Obtain the best value for money when requisitioning goods/services	Chief Executive	Executive Director of Finance & Corporate Resources
28.3. Prompt payment to suppliers (pspp)	Chief Executive	Executive Director of Finance & Corporate Resources
28.4. Financial limits for ordering/requisitioning goods and services Refer to Table B for delegated limits	Chief Executive	Executive Director of Finance & Corporate Resources
29. Quotation, Tendering and Contract Procedures		
29.1. Services:		
(a) Best value for money is demonstrated for all services provided under contract or in-house	Chief Executive	Executive Director of Finance & Corporate Resources
(b) Nominate officers to oversee and manage the contract on behalf of the Trust	Chief Executive	Heads of Department

Delegated Matter	Responsible Officer/Committee	Delegated To
29.2. Competitive Tenders:		
(a) Authorisation Limits Refer to Table B for delegated limits	Chief Executive	Executive Director of Finance & Corporate Resources
(b) Maintain a register to show each set of competitive tender invitations despatched	Chief Executive	Executive Director of Finance & Corporate Resources
(c) Receipt and custody of tenders prior to opening	Chief Executive	Executive Director of Finance & Corporate Resources
(d) Opening tenders	Chief Executive	Executive Director of Finance & Corporate Resources
(e) Decide if late tenders should be considered	Chief Executive	Executive Director of Finance & Corporate Resources/Board Secretary
(f) Ensure that appropriate checks are carried out as to the technical and financial capability of the firms invited to tender or quote	Chief Executive	Executive Director of Finance & Corporate Resources
29.3. Quotations Refer to Table B for delegated limits	Chief Executive	Executive Director of Finance & Corporate Resources
29.4. Waiving the requirement to request		
(a) Tenders – subject to Standing Orders (reporting to the Board) Refer to Table B for delegated limits	Chief Executive	Executive Director of Finance & Corporate Resources
(b) Quotes – subject to Standing Orders	Chief Executive	Executive Director of Finance & Corporate Resources
30. Reporting of Non-Urgent Incidents to the Police	Chief Executive	Relevant Director
31. Risk Management		
31.1. Ensuring the Trust has a Risk Management Strategy and a programme of risk management	Chief Executive	Board Secretary
31.2. Developing systems for the management and reporting of risks and incidents	Chief Executive	Board Secretary (risk) and Executive Director of Quality & Nursing (incidents)
32. Seal	Chief Executive	Board Secretary

Delegated Matter	Responsible Officer/Committee	Delegated To
The keeping of a register of seal and safekeeping of the seal		
33. Signing of Documents		
33.1. Legal Proceedings/Advice		
(a) Engage Trust's solicitors/legal advisor	Chief Executive	Relevant Director or Board Secretary
(b) Documents connected with legal proceedings[3]	Chief Executive	Relevant Director or Board Secretary
33.2. Documents which are required to be executed as a Deed[4]	Chief Executive	Relevant Director and Board Secretary
33.3. Other Agreements not required to be executed as a Deed	Chief Executive	Relevant Director
33.4. Lease Agreements[5]	Chief Executive	Director of Finance and Corporate Resources and Board Secretary
34. Security Management Provide an oversight and assurance within the context of security management within NHS Wales; working in conjunction with the following leads on specific functional areas of security management:		
34.1. Finance, fraud etc.	Chief Executive	Director of Finance & Corporate Resources
34.2. Estates, premises security etc.	Chief Executive	Director of Finance and Corporate Resources
34.3. ICT	Chief Executive	Director of Digital Services
34.4. Information/data security/records management	Chief Executive	Director of Digital Services
34.5. Violence and aggression	Chief Executive	Director of People and Culture
34.6. Patient Confidentiality	Chief Executive	Caldicott Guardian (Executive Director of Quality and Nursing)
35. Setting of Fees and Charges (Income)		
35.1. Income generation	Chief Executive	Executive Director of Finance & Corporate Resources

3 May include but not be limited to consent orders, defences, and settlement agreements)

4 Where the Trust Seal is required on a Deed, it must be affixed to the document in the presence of the Chair or Vice Chair (or an Independent Member authorised by them in writing where they are unavailable) and the Chief Executive (or an Executive Director nominated by them where they are unavailable)

5 Copies of all leases are to be kept once signed by the Estates Manager for property related leases and by the Board Secretary for all other leases/contracts

Delegated Matter	Responsible Officer/Committee	Delegated To
35.2. Non-patient care income (e.g., research)	Chief Executive	Executive Director of Finance & Corporate Resources
36. Stores and Receipt of Goods		
36.1. Responsibility for systems of control over stores and receipt of goods, issues and returns	Chief Executive	Relevant Director
36.2. Stocktaking arrangements	Executive Director of Finance & Corporate Resources	Deputy Director of Finance and Corporate Resources
36.3. Responsibility for controls of pharmaceutical supplies	Medical Director	Heads of Department as appropriate
37. Workforce and Pay		
37.1. Nomination of officers to enter into staff contracts of employment	Chief Executive	Director of People and Culture
37.2. Develop Workforce policies and strategies for approval by the Board including but not limited to training and industrial relations	Chief Executive	Director of People and Culture
37.3. Renewal of Fixed Term Contract	Chief Executive	Director of People and Culture
37.4. The granting of additional increments to staff upon initial appointment within the parameters of existing agreements	Chief Executive	Director of People and Culture
37.5. Establishments		
(a) Additional staff to the agreed establishment with specifically allocated finance	Chief Executive	Executive Director of Finance & Corporate Resources/ Director of People and Culture
(b) Additional staff to the agreed establishment without specifically allocated finance	Chief Executive	Executive Director of Finance & Corporate Resources/ Director of People and Culture
(c) Self-financing changes to the establishment	Chief Executive	Relevant Director
(d) Self-financing changes to an establishment which involves movement between pay and other types of expenditure	Chief Executive	Executive Director of Finance & Corporate Resources
37.6. Pay	Chief Executive	Director of People and Culture

Delegated Matter	Responsible Officer/Committee	Delegated To
Preparation of proposals for the Trust Board for the setting of remuneration and conditions of service for those staff not covered by Agenda for Change		
37.7. Annual Leave		
(a) Approval of annual leave	Chief Executive	Relevant Directors
(b) Annual leave - approval of carry forward up to maximum of 5 days (and pro rata for part time staff)	Chief Executive	Relevant Directors
(c) Annual leave – approval of carry forward over 5 days (and pro rata for part time staff) (to occur in exceptional circumstances only)	Chief Executive	Director of People and Culture/ Executive Director of Finance & Corporate Resources
37.8. Special Leave To be applied in accordance with Trust Policy. Departure from policy will be as follows:		
(a) Compassionate leave	Chief Executive	Director of People and Culture
(b) Special leave arrangements for domestic/personal/family reasons: • Paternity leave • Carers leave • Adoption leave	Chief Executive	Director of People and Culture
(c) Special leave – this includes: • Jury service • Armed services • School governor To be applied in accordance with Trust Policy	Chief Executive	Director of People and Culture
(d) Leave without pay	Chief Executive	Director of People and Culture
(e) Time off in lieu	Executive Director of People and Culture	Line/Departmental Manager

Delegated Matter	Responsible Officer/Committee	Delegated To
(f) Maternity leave – paid and unpaid	Executive Director of People and Culture	Automatic approval within approved guidance
37.9. Sick Leave		
(a) Extension of sick leave on pay due to: • Delays in process • Exceptional circumstances	Chief Executive	Director of People and Culture
(b) Return to work part-time on full pay to assist recovery	Chief Executive	Heads of Department/Heads of Service in conjunction with WOD Business Partners
37.10. Study Leave	Chief Executive	Director of People and Culture
37.11. Removal expenses, excess rent and house purchases in accordance with Table B	Chief Executive	Director of People and Culture
37.12. Authorised – car users leased car	Chief Executive	Executive Director of Finance & Corporate Resources
37.13. Approval of secondary employment (also subject to a declaration of interest)	Chief Executive	Director of People and Culture
37.14. Putting proposal to Remuneration Committee in respect of Redundancy/ Severance/ VERS/ Settlement Payments within Trust limits and, where necessary, subject to WG approval	Chief Executive	Director of People and Culture/ Executive Director of Finance & Corporate Resources
37.15. Disciplinary procedures (excluding Executive Directors)	Chief Executive	To be applied in accordance with the Trust's disciplinary procedure
37.16. Booking of bank staff		
(a) Nursing	Chief Executive	Executive Director of Quality & Nursing
(b) Clinical (excluding nursing)	Chief Executive	Medical Director/Executive Director of Operations/Director of Paramedicine
(c) Other	Chief Executive	Relevant Director
37.17. Booking of agency and locum staff		
(a) Nursing	Chief Executive	Executive Director of Operations

Delegated Matter	Responsible Officer/Committee	Delegated To
(b) Medical	Chief Executive	Medical Director
(c) Paramedicine and affiliated roles	Chief Executive	Executive Director of Operations
(d) Other	Chief Executive	Relevant Director

Table B – Delegated Financial Limits

NB Thresholds are inclusive of VAT irrespective of recovery arrangements with the exception of procurement thresholds which are provided net of VAT.

Category	Welsh Govt Delegated Limit - Approval Required[6]	Trust Board	Chief Executive	Exec Director Finance & Corporate Resources	Exec Director Workforce & OD	Exec Director Quality and Nursing	Exec Directors / Directors	Heads of service/ Heads of Dept/ Board Secretary	Budget Holders	Notes[7]
1. LOSSES										
1.1. Losses of Cash due to:										
(a) Theft, fraud, arson, sabotage, neglect of duty or gross carelessness	50,000	Over 50,000[8]	50,000	10,000						See Annex 1 to Chapter 6 of Welsh Govt Manual for Accounts (WGMFA)
(b) Overpayment of salaries, wages, fees & allowances	50,000	Over 50,000[8]	50,000	10,000						See Annex 1 to Chapter 6 of WGMFA
(c) Other causes, including un-vouched or completely vouched payments, overpayments other than those included under 1b; physical losses of cash and cash equivalents e.g. postage stamps due to fire (other than arson), accident and similar cause	50,000	Over 50,000[8]	50,000	10,000						See Annex 1 to Chapter 6 of WGMFA
1.2. Fruitless Payments, including abandoned capital schemes	250,000	Over 250,000[8]	250,000				100,000	50,000	10,000	A "fruitless payment" is a payment for which liability ought not to have been incurred, or where the demand for the goods and service in question could have been cancelled in time to avoid liability. See further info at annex 1 to Chapter 6 of WGMFA

6 NHS Wales health bodies do not have unlimited powers to make special payments or to write-off losses. They must obtain the written approval of the Welsh Government H&SSG Finance Director before writing-off a loss or making, or undertaking to make, any special payment that exceeds their delegated limit. The limits are listed in this column.
7 These notes are intended to guide the reader. They must be read in conjunction with the SO/SoRD/SFIs and those related to losses and special payments with respect to the Welsh Government Manual of Accounts
8 Does not negate the need for WG Approval which is also required

Category	Welsh Govt Delegated Limit - Approval Required[6]	Trust Board	Chief Executive	Exec Director Finance & Corporate Resources	Exec Director Workforce & OD	Exec Director Quality and Nursing	Exec Directors / Directors	Heads of service/ Heads of Dept/ Board Secretary	Budget Holders	Notes[7]
1.3. Bad Debts and Claims Abandoned										See Annex 1 to Chapter 6 of WGMFA
(a) Private patients	50,000	Over 50,000[8]	50,000	10,000						
(b) Overseas visitors	50,000	Over 50,000[8]	50,000	10,000						
(c) Causes other than (a) and (b) above	50,000	Over 50,000[8]	50,000	10,000						
1.4. Damage to buildings, their fittings, furniture and equipment and loss of equipment and property in stores and in use due to:										
(a) Culpable causes, e.g., theft, arson or sabotage whether proved or suspected, neglect of duty or gross carelessness	50,000	Over 50,000[8]	50,000	10,000						
(b) Other causes	50,000	Over 50,000[8]	50,000	10,000						May include losses by fire (other than arson); losses by weather damage or by accident beyond the control of any responsible person; losses due to deterioration. See Annex 1 to Chapter 6 of WGMFA for further info
2. SPECIAL PAYMENTS										
2.1. Compensation payments under legal obligation	N/A	Board to be made aware of payment over 25K	Over 100,000	100,000	25,000	25,000				Payments fall into this category only if a clear liability exists as a result of a Court Order or a legally binding arbitration award. This category can include compensation for injuries to persons, damage to property and unfair dismissal. Payments into court, and out of court settlements, are not payments made under legal obligation.

Category	Welsh Govt Delegated Limit - Approval Required[6]	Trust Board	Chief Executive	Exec Director Finance & Corporate Resources	Exec Director Workforce & OD	Exec Director Quality and Nursing	Exec Directors / Directors	Heads of service/ Heads of Dept/ Board Secretary	Budget Holders	Notes[7]
2.2. Extra contractual payments to contractors	50,000	Over 50,000[8]	50,000	10,000						An extra contractual payment is one which, although not legally due under the original contract or subsequent amendments, appears to be an obligation which the Courts may uphold. Such an obligation will usually be attributable to action or inaction by a health body in relation to the contract. See Annex 2 to Chapter 6 of WGMFA for further info
2.3. Ex gratia payment										Ex gratia payments are payments which a health body is not obliged to make or for which there is no statutory cover or legal liability. An example is a payment to compensate for financial loss resulting from an act or failure of the body or its servants which does not give rise to a legal liability or the payment of compensation claims or damages. See Annex 2 to Chapter 6 of WGMFA for further info
(a) To patients and staff for loss of personal effects	50,000	Over 50,000[8]	50,000	10,000	10,000					
(b) For clinical negligence (negotiated settlements following legal advice) where the guidance relating to such payment has been applied	1,000,000	Over 500,000[8]	500,000			100,000		50,000	10,000	Delegations are inclusive of plaintiff's costs. Many clinical negligence and personal injury cases are settled out of Court and are, therefore, classified as ex gratia payments. Provided the relevant guidance has been followed and appropriate legal advice has been obtained, in cases involving negligence the delegated limits are much higher than those which apply to other ex gratia payments

Category	Welsh Govt Delegated Limit - Approval Required[6]	Trust Board	Chief Executive	Exec Director Finance & Corporate Resources	Exec Director Workforce & OD	Exec Director Quality and Nursing	Exec Directors / Directors	Heads of service/ Heads of Dept/ Board Secretary	Budget Holders	Notes[7]
(c) For personal injury claims where legal advice obtained and relevant guidance has been applied	1,000,000	Over 500,000[8]	500,000			100,000		50,000	10,000	Delegations are inclusive of plaintiff's costs. Many clinical negligence and personal injury cases are settled out of Court and are, therefore, classified as ex gratia payments. Provided the relevant guidance has been followed and appropriate legal advice has been obtained, in cases involving negligence the delegated limits are much higher than those which apply to other ex gratia payments
(d) Other clinical negligence and personal injury claims including Putting Things Right arrangements	50,000	Over 50,000[8]	50,000			10,000				
(e) Other[9] Except cases for maladministration where there was no financial loss by claimant	50,000	RemCom Over 50,000[8]	50,000		10,000					Other ex-gratia payments include: Voluntary Early Release Scheme payments which must be approved by RemCom regardless of value (SoR 25). Special severance payments when staff leave public service employment should be exceptional. They are usually novel contentious and potentially repercussive and **ALL must be referred to WG for approval, even if they are within delegated limits** which must be approved by RemCom regardless of value (SoR 25) Settlements on termination of employment. Most payments to staff on termination of their employment will be contractual, but ex gratia payments will sometimes arise (for example to settle a claim against the health body for breach

9 ALL special severance payments (novel, contentious and potentially repercussive) of whatever value must be referred to WG for approval, even if they are within delegated limits

Category	Welsh Govt Delegated Limit - Approval Required[6]	Trust Board	Chief Executive	Exec Director Finance & Corporate Resources	Exec Director Workforce & OD	Exec Director Quality and Nursing	Exec Directors / Directors	Heads of service/ Heads of Dept/ Board Secretary	Budget Holders	Notes[7]
										of contract). Only payments made in excess of that which is paid under contractual obligation should be recorded as ex-gratia in the losses and special payments register. *These payments may be made by Chief Executive (up to £50K) and Executive Director of Workforce and OD (up to £10K) and reported to the next RemCom. They are also included in the report to AC on losses and special payments.
(f) Maladministration where there was no financial loss by claimant	N/A	Over 50,000	50,000	10,000						In most cases of maladministration there is unlikely to be any legal obligation to pay compensation, and any payment would, as a result, be ex gratia. Such payments may arise: • as a result of a recommendation by the Public Services Ombudsman Wales (PSOW). • in cases, not involving the PSOW, where NHS Wales health bodies consider that the effect of official failure may justify a payment
(g) Patient referrals outside UK and EEA guidelines	N/A	Over 50,000	50,000	10,000						
2.4. Extra statutory and extra regulatory Payments	N/A	Over 50,000	50,000	10,000						These are payments considered to be within the broad intention of a statute or statutory regulation but which go beyond a strict interpretation of its terms. In some cases WG will advise to classify the payments as extra statutory. In all other cases WG must be informed and will advise whether the payments may be treated as extra statutory See Annex 2 of WGMOA for more info.

Category	Welsh Govt Delegated Limit - Approval Required[6]	Trust Board	Chief Executive	Exec Director Finance & Corporate Resources	Exec Director Workforce & OD	Exec Director Quality and Nursing	Exec Directors / Directors	Heads of service/ Heads of Dept/ Board Secretary	Budget Holders	Notes[7]
3. REQUISITIONING GOODS AND SERVICES AND APPROVING PAYMENT										
3.1. Agency staff and private providers	N/A	Over 500,000	500,000	200,000	200,000	200,000	200,000	50,000 (100,000 for Assistant Director of Operations, Ambulance Care for private providers only)	10,000	Any agency staff, including medical locums. No other managers can authorise use of agency staff.
3.2. Building and engineering works (non-capital)	N/A	Over 500,000	500,000	100,000	100,000	100,000	100,000	50,000	10,000	
3.3. Call off orders (annual value)	N/A	Over 500,000	500,000	100,000	100,000	100,000	100,000	50,000	10,000	High cost medical consumables, provisions, routine supplies, excluding locums or agency staff
3.4. Capital expenditure (subject to annual programme being approved by Trust Board)	N/A	Over 500,000	500,000	100,000	100,000	100,000	100,000	50,000	10,000	The Board to approve cases outside discretionary allowances. Capital programme agreed annually by Board.
3.5. Information Technology	N/A	Over 500,000	500,000	100,000	100,000	100,000	100,000	50,000	10,000	Major IT systems, software purchase, PC and printer purchase, networking, computer consumables. Includes software or hardware maintenance contracts
3.6. Management consultants (including professional services)	N/A	Over 200,000	200,000	10,000	10,000	10,000	10,000			
3.7. Periodic payments (invoice value)	N/A	Over 500,000	500,000 *750,000 for utilities/ fuel	100,000 *750,000 for utilities/ fuel	100,000	100,000	100,000	50,000	10,000	*In relation to Gas, Electricity, Council tax, Telephone, Water and Fleet Fuel invoices, due to the high level of expenditure on a recurring basis, payments up to a value not exceeding £750,000 can be authorised by the Director of Finance or the Chief

Category	Welsh Govt Delegated Limit - Approval Required[6]	Trust Board	Chief Executive	Exec Director Finance & Corporate Resources	Exec Director Workforce & OD	Exec Director Quality and Nursing	Exec Directors / Directors	Heads of service/ Heads of Dept/ Board Secretary	Budget Holders	Notes[7]
										Executive. For the provision of clarity, payments of PIBS (Personal Injury Benefit Scheme) invoices do not require authorisation on the basis that these quarterly payments are a reimbursement of pension payments made that have already been authorised.
3.8. Removal expenses	N/A	N/A			8,000					Allowance of £6,000 per relevant staff member
3.9. Services (including maintenance contracts) over lifetime of contract	N/A	Over 500,000	500,000	100,000	100,000	100,000	100,000	50,000	10,000	Routine maintenance contracts, clinical services (e.g. MRI), legal services, audit, clinical waste etc.
3.10. All other requisitions	N/A	Over 500,000	500,000	100,000	100,000	100,000	100,000	50,000	10,000	
4. QUOTATIONS AND TENDERS										
4.1. Authorisation of tenders and competitive quotations	N/A	Over 500,000	500,000	100,000	100,000	100,000	100,000	50,000	10,000	Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation and awarding of a contract may be decided by these staff to the value of the contract. The Chair of the Trust in this instance will have the same limit as that for the CEO. Quotations- a minimum of 3 written quotations for goods/services must be sought where the anticipated value is likely to be above £5,000. Competitive Tenders- a minimum of 3 written competitive tenders for goods/services must be sought where the anticipated value is likely to be above £25,000.

Category	Welsh Govt Delegated Limit - Approval Required[6]	Trust Board	Chief Executive	Exec Director Finance & Corporate Resources	Exec Director Workforce & OD	Exec Director Quality and Nursing	Exec Directors / Directors	Heads of service/ Heads of Dept/ Board Secretary	Budget Holders	Notes[7]
										Tenders for Supplies and Services above the limit set EU Procurement matters for works above set limits must be sought in compliance with EC Directives (Updated Jan 2008) (OJEU Regulations) as appropriate. **All Tenders and Quotations must be sought, registered, and opened via the SSP**. These levels of authorisation may be varied or changed and need to be read in conjunction with the Trust Board's Scheme of Delegation Formal authorisation must be put in writing. In the case of authorisation by the Trust Board this shall be recorded in their minutes. Exceptions and Instances where formal tendering need not be applied will require authorisation in the form of a request to waive SFIs (pre numbered document from SSP) and authorisation in advance from the Director of Finance or Deputy Director of Finance (or in their absence the Board Secretary)
5. VIREMENT	N/A	Over 100,000	100,000	25,000						Trust must still meet financial targets and the total Trust budget must remain underspent
6. LEASE AGREEMENTS	**	Over 500,000	500,000	100,000 (with Board Secretary)						**See Schedule 1 to SFIs Copies of all leases are to be kept once signed by the Estates Manager for property related leases and by the Board Secretary for all other leases/contracts

Category	Welsh Govt Delegated Limit - Approval Required	Board of Trustees/ Trust Board	Charitable Funds Committee	Bids Panel	Bursary Panel					Notes
7. CHARITABLE FUNDS	N/A	N/A	Over 50,000	50,000	N/A					

Unless otherwise stated, sub-delegations to others are permitted. It is for individual Directors to ensure that a system of sub-delegations are in place for their respective directorates.

This scheme only relates to matters delegated by the Board to the Chief Executive and their Executive Directors, together with certain other specific matters referred to in SFIs. Each Executive Director is responsible for delegation within their department. They shall produce a scheme of delegation for matters within their department, which shall also set out how departmental budget and procedures for approval of expenditure are delegated.

AGENDA ITEM No	**8**
OPEN or CLOSED	**OPEN**
No of ANNEXES	**1**

REVISED AUDIT PROCESS

MEETING	Audit Committee
DATE	14 September 2023
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Trish Mills, Board Secretary
CONTACT	trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. A draft Audit Process and Reporting Handbook has been developed (Annex 1) to support the Trust in understanding the cradle-to-grave process and rationale for internal and external audit reviews. It is intended that this broader view will support improvements in internal audit completion, acceptance of recommendations, formation of management actions, tracking and reporting.

2. Revisions to the manual excel audit tracker have also been made and this 'Tracker 2.0' will be in use following this meeting pending a more automated solution being developed during Q3 and Q4 with the support of DHCW (Tracker 3.0).

RECOMMENDATION

3. The Committee is requested to:

   (a) Approve the Audit Process and Reporting Handbook
   (b) Approve the ELT and Audit Committee reporting to inform development of Tracker 3.0

KEY ISSUES/IMPLICATIONS

As set out above.

REPORT APPROVAL ROUTE

7 August 2023 – feedback from Internal Audit 14 August 2023 – feedback from ADLT 6 September – Executive Leadership Team

REPORT APPENDICIES
Annex 1 – Draft Audit Process and Reporting Handbook

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

AUDIT GUIDANCE AND PROCESS HANDBOOK

SITUATION

1. This paper updates the Committee on the changes to the audit tracker and approach to its reporting as well as the recently developed Audit Process and Reporting Handbook.

BACKGROUND

2. The audit recommendation and action tracker is in place for the purpose of tracking progress across the Trust to ensure that recommendations contained in internal and external audit review reports are actioned in a timely manner.

3. The manual nature of the tracker means a significant amount of time is required in its maintenance. This includes the transposing of the information from PDF copies of internal audit reports, and dialogue with the owners of management actions to obtain updates on closures of actions. A new approach is therefore being developed to bring automation and clearer reporting to the tracker and to embed ownership of the actions within already existing directorate processes. We are working with Internal Audit in the development of the new process and tracker.

ASSESSMENT

4. The audit tracker, which includes both Internal Audit and Audit Wales recommendations and management actions, enables the Executive Leadership Team (ELT) and the Board through its Audit and other Committees to see where recommendations have been completed, therefore positioning them to see the impact of changes to systems or processes. Likewise, it provides a mechanism to see where actions have been delayed and to discuss the risks to such delayed actions and gain assurance on any remedial action.

5. However, the tracker is highly manual and resource intensive, therefore new and automated solutions for tracking the progress of audits are being developed.

6. A Handbook (Annex 1) has been developed to provide our people with the wider context on why we conduct audits, internal audits and structured assessments in particular. It is intended that this broader view will support improvements in internal audit completion, acceptance of recommendations, formation of management actions, tracking and reporting.

7. The primary focus is on the audits that are transposed to the audit tracker, therefore whilst the audit of our financial statements is mentioned, the process is not detailed in the Handbook.

8. Roles and responsibilities for the various stakeholders are set out in section 5. Key areas include:

   (a) The Assistant Directors Leadership Team (ADLT) as the forum to agree closure of actions, taking a check and challenge role, and to serve as an escalation point for overdue actions.
   (b) Different reporting for the Audit Committee and ELT to that provided to Committees, with the latter focused more on individual audits, progress and impact, and Audit Committee and ELT on the broader audit framework, progress and exposure.
   (c) The introduction of a point of contact in directorates for audits. This person(s) would steer the audit with the Director and Assistant Directors/Deputies, ensuring internal audits featured on the directorate agenda monthly, update the tracker, and escalate issues as appropriate.

9. A revised excel tracker (Tracker 2.0) will be introduced pending a Microsoft 365 solution that will be developed between September 2023 and March 2024 (Tracker 3.0). The Corporate Governance Team will work with Internal Audit and Audit Wales to ensure they are comfortable with the changes with the intention of transposing any open audit actions to that tracker over the course of the coming weeks and close down the current tracker. Tracker 2.0 will be available for action owners/points of contact to update directly.

10. The tracker will require owners of management actions to make clear the reasons why some actions have become overdue, what/whether progress has been achieved and/or whether actions have a new proposed completion date. This was a point raised by Audit Wales in their 2022 Structured Assessment.

11. The Handbook makes it clear that management actions must be SMART and that the drafter of those actions is focused on the evidence that will be available to support closure of the action. Evidence of closure was a point raised in the 2023 Follow Up Audit by Internal Audit.

12. Tracker 3.0 will be developed with the reporting to ELT and Audit Committee in mind. As can been seen from section 5.5 and 5.7 of the Handbook it is not intended that that tracker will come to those forums, but that they would receive oversight and escalation reporting instead. Proposed reporting which will be generated by Power BI could include:

(a) *Number of substantial/reasonable/limited/no assurance/advisory audit reports per year.*
Gives a general overview throughout the year and over audit years

(b) *Number of audit reports per committee oversight*
Gives a general overview of the spread of oversight of audit reports and those who may not be monitoring any reports

(c) *Number of high rated recommendations with actions more than 3 months past their original date*
High rated actions should be closed off immediately due to their risk profile. This will allow for escalations.

(d) *Number of actions for limited assurance audit reports more than 3 months past their original date*
Due to the issues that will arise in a limited assurance report they should be closed off asap and before follow-up reviews. This will allow for escalations.

(e) *Number of actions that have 'met' and 'not met' the original due date*
Gives an indication of the realistic nature of the original dates leading to a change in behaviour
Provides oversight of progress over audit years

(f) *Number of individual actions that have 'not met' revised dates*
Will indicate a potential issue in meeting an action or lack of progress for some other reason. Will need to be sure this is not a double count with some of the other metrics.

RECOMMENDATION: The Committee is requested to:

(1) Provide feedback on the draft Audit Process and Reporting Handbook; and

(2) Approve the ELT and Audit Committee reporting to inform development of Tracker 3.0.

Corporate Governance Directorate Audit Process and Reporting Handbook

[insert date] 2023

This Handbook is intended to equip WAST colleagues with the knowledge you need should you be involved in an audit at the Trust, whether that is an internal audit or external audit. It also sets out roles and responsibilities including those for senior management and the Trust Board Committees.

Internal audit and external audit are both important components of the Trust's financial and operational processes, but they serve different purposes and have distinct characteristics.

All NHS Wales organisations must have an internal audit function and that is provided by NWSSP Audit and Assurance Services (herein referred to as Internal Audit). Internal audit provides independent, objective assurance and advisory activities designed to add value and improve governance and operational efficiency, risk management and control for all NHS Wales bodies.

External Audit services are provided by Audit Wales under the direction of the Auditor General for Wales. An annual Structured Assessment reviews whether the Trust's corporate arrangements support good governance and the efficient, effective and economical use of resources. Audit Wales also verifies the accuracy and fairness of the financial statements for the Trust and the WAST Charity.

Both types of audits play crucial roles in ensuring transparency, accountability, and good governance within an organization. The findings from internal audit reviews are taken into account by Audit Wales when conducting their audits, and likewise structured assessments are also relied upon by Internal Audit when conducting internal audit reviews.

This Handbook does not include other forms of audit such as clinical or quality audits that are undertaken at the Trust.

It is intended that this Handbook will be reviewed within twelve months of its approval date to reflect any changes in process as a result of revisions to the Audit Tracker including automation, repository and reporting.

Ref: 001
Approved by: Audit Committee
[insert date]

Contents

1. Why we audit

Routine internal audits are an important part of organizational learning and development. They provide valuable assurance to the Board and our key stakeholders on performance. It is important to understand that an audit is not a fault-finding exercise. Audits are designed to support you and your teams to identify areas of noncompliance and provide opportunities for improvement. They can be a great celebration of success, particularly where a substantial assurance rating is provided. Also, when a reasonable assurance rating is given to an audit there are often areas of excellent work recognised.

The insights that internal audits generate provide you and your team with tangible opportunities for improvement. Because they serve as an additional quality control step, you will be able to pinpoint the root causes of any operational or process issues. Knowing this, you will then be able to take your processes to the next level.

By conducting audits on a regular basis, we are demonstrating to our people, our patients and our stakeholders that WAST takes issues of quality, patient safety, health and safety, and regulatory compliance seriously.

Internal audit reports contribute to our end of year Head of Internal Audit Opinion (see section 3.2).

2. Internal Audit

3.1. What is an internal audit

Internal audit is an independent assessment of a system or process through an objective examination of evidence. The aim is to give management and the Audit Committee confidence (assurance) that:

- appropriate mechanisms are in place to manage risk and increase the likelihood that organisational goals and objectives will be achieved; and
- those mechanisms, usually set out in organisational policies, procedures and processes, are being complied with.

We have included an Internal Audit Jargon Buster at **Annex xx** to aid in your interpretation of this Handbook and of any internal audits you may review.

3.2. Who are Internal Audit and what do they do

As set out above, WAST's internal audit services are not carried out 'in house' but by the NWSSP Audit and Assurance Services. They deliver their work primarily through the following:

Annual Audit plan
Annually a plan is developed which sets out a range of internal audit reviews that will be conducted at the Trust that financial year. The plan is aligned to the Trust's principal risks and is developed in conjunction with your Director and the Executive Management Team and following consideration of the key documents such as the principal risk register and Integrated Medium Term Plan. In proposing areas to audit, Directorates are encouraged not to focus on areas we feel we have robust processes, but those that we believe can be improved or made more efficient. You can find the list of audits planned for each year here [intranet link to be inserted]. Where necessary, particularly to address emerging risks in year, the plan may be adjusted. The plan is approved by the Audit Committee.

Individual audits and advisory reviews
Throughout the year Internal Audit undertake audit and consultancy (or advisory) reviews in line with the annual audit plan. Each report aims to provide an assurance opinion (audit report) or advice (consultancy reports) over a specific system or process.

Recommendations are agreed with management before presenting our reports to the Audit Committee.

Head of Internal Audit Opinion
The Head of Internal Audit Opinion (HOIA Opinion) is provided to the Trust annually. It is based on the outcome of audit and consultancy work undertaken during the year and other information available to Internal Audit. The HOIA Opinion contributes to assurances available to the Board to underpin the Board's assessment of the effectiveness of governance and control. It is an integral piece of the Trust's governance framework, providing assurance to inform the annual governance statement and identifying improvement opportunities.

There is more information on Internal Audit 'who we are?' at **Annex 2.**

3.3. Why is the particular audit happening?

You may be wondering why a particular area or process in your Directorate is being audited. You will see above that an annual audit plan is developed so it is likely that this process or area of work was identified during the annual risk-based planning process or has become an emerging risk during the year. It may also have been specifically requested, e.g., by management, the Audit Committee, a third party, etc.

3.4. The stages of an internal audit

There are a number of stages to an internal audit review. Before work starts on your audit be sure to understand the various roles and responsibilities and your part in it (see section 5).

We have set out below the various stages your internal audit will take. You may be involved in all or some of them. The Internal Audit flow chart at **Annex 2** provides more detail on the stages your internal audit will take for additional reference.

(a) Planning

Whilst the area for the audit will have been identified in the annual audit plan, the specifics of what the audit will cover will be agreed with your Director at this first step in the internal audit.

A meeting will take place with internal auditor assigned to the audit and the Director and an audit brief will then be agreed.

You should consider appointing a person as the central point of contact (POC) for the audit in your Directorate. That person should be involved at this planning stage and throughout to ensure Internal Audit have everything they need, and those that need to contribute to the process are fully informed.

(b) Fieldwork

Fieldwork is the process of examining evidence to form an opinion, with respect to the area being audited, systems are designed to mitigate risks identified in the brief, and the mechanisms in place to mitigate those risks are operating effectively.

A kick off meeting will be held with Internal Audit and the Director, and it is advisable to have your POC at that meeting also.

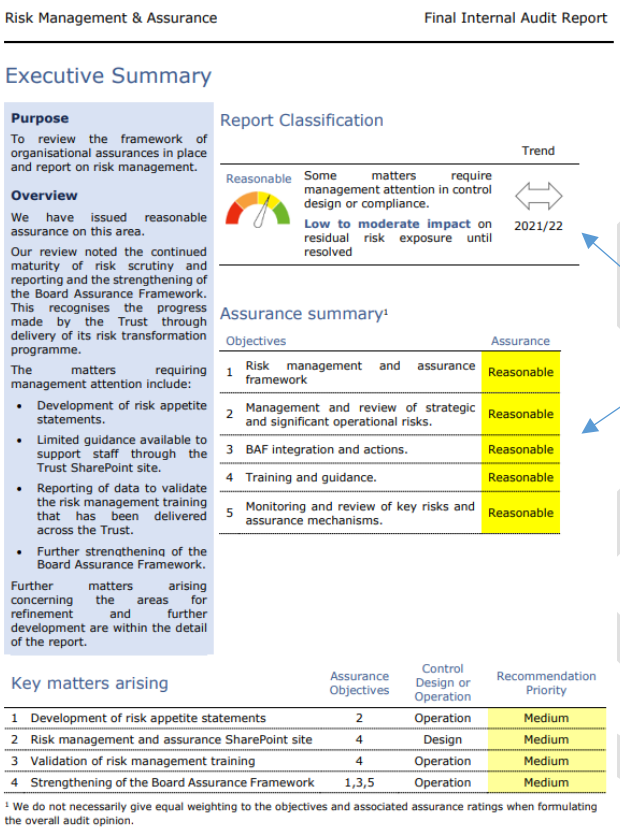
Internal Audit may request a number of documents or interviews with subject matter experts within WAST. Your POC should coordinate these interviews and provide internal audit with all documents they request. The POC should keep a log of documents provided.

Ensure a timeframe for completion of the fieldwork is agreed. The POC will ensure they are aware of that timeframe and the date the draft report is planned to be released.

(c) The Internal Audit Report (draft to final)

At the end of the fieldwork a draft report will be prepared. The Trust has 15 working days to check the accuracy of the report and agree, or otherwise, the recommendations in the report and develop actions to address recommendations.

The report itself will set out the agreed purpose and audit objectives agreed at the planning stage. The executive summary provides a snapshot of the purpose of the audit, an overview of main issues, the overall risk rating, and a breakdown of ratings for the objectives and recommendations. It may look something like this:



Risk Management & Assurance — Final Internal Audit Report

Executive Summary

Purpose

To review the framework of organisational assurances in place and report on risk management.

Overview

We have issued reasonable assurance on this area.

Our review noted the continued maturity of risk scrutiny and reporting and the strengthening of the Board Assurance Framework. This recognises the progress made by the Trust through delivery of its risk transformation programme.

The matters requiring management attention include:

- Development of risk appetite statements.
- Limited guidance available to support staff through the Trust SharePoint site.
- Reporting of data to validate the risk management training that has been delivered across the Trust.
- Further strengthening of the Board Assurance Framework.

Further matters arising concerning the areas for refinement and further development are within the detail of the report.

Report Classification

		Trend
Reasonable	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved	2021/22

Assurance summary[1]

Objectives		Assurance
1	Risk management and assurance framework	Reasonable
2	Management and review of strategic and significant operational risks.	Reasonable
3	BAF integration and actions.	Reasonable
4	Training and guidance.	Reasonable
5	Monitoring and review of key risks and assurance mechanisms.	Reasonable

Key matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
1	Development of risk appetite statements	2	Operation	Medium
2	Risk management and assurance SharePoint site	4	Design	Medium
3	Validation of risk management training	4	Operation	Medium
4	Strengthening of the Board Assurance Framework	1,3,5	Operation	Medium

[1] We do not necessarily give equal weighting to the objectives and associated assurance ratings when formulating the overall audit opinion.

Annex 3 provides a breakdown of the various assurance ratings

Internal Audit will provide a conclusion and separate assurance rating on each of the audit objectives agreed at the planning stage, based on the evidence it has looked at and the interviews it has conducted during the fieldwork?

Recommendations made under each objective are then summarised in the appendix.

Risk Management & Assurance — Final Internal Audit Report, Appendix A

Appendix A: Management Action Plan

Matter Arising 1: Development of risk appetite statements (Operation)	Impact
The development of risk appetite statements is a deliverable that is ongoing as part of the Trust's risk management transformation programme. A risk appetite matrix has been developed, where currently risks scoring as high (15-25) are expected to be reviewed monthly, medium risks (8-12) quarterly, and low risks (1-6) every 6 months. The reviews should take place with the risk owners, supported by the risk team. In addition, the Trust's risk appetite is risk averse in two key areas. This means that risks will be eliminated or reduced to the lowest practical level should they impact negatively upon the quality and safety of its patients, workforce, and the public, and compliance with statutory duty, regulatory compliance, or accreditation. We note the progress made in this area with plans in place to scope and develop the risk appetite statements with the Chair.	Potential risk of: • Unintegrated and inconsistent approaches to managing and escalating risks resulting in ineffective and inefficient use of resources.

Recommendations		Priority
1.1	Following the development of the risk appetite matrix, the Trust should develop and finalise its risk appetite statements.	Medium

Agreed Management Action	Target Date	Responsible Officer

Whilst the recommendations from auditors will be based on the evidence provided, it may be necessary to highlight any concerns about the wording, practicality or relevance of audit recommendations. This is particularly the case where the recommendation cannot be completed fully by WAST alone and where the closing of the recommendation would require involvement on and dependency of third parties. Third party actions may cause significant delays in closing an action, seeing an impact in any improvements, and may require escalation to the Audit Committee.

Recommendations are categorised according to their level of priority and the timeframe within which management actions should be completed. The prioritisation table is set out in Annex 4.

Each recommendation must be met with an agreed management action. You will have to respond with a management response within the 15 day window mentioned above.

Management actions are an important consideration and usually the last step in finalising the audit report. Often they will be obvious and likely a plan or action you already have in train or were planning. Sometimes actions will require careful planning and resourcing.

It is important to remember that the actions you promise to deliver and the dates within which you indicate they will be completed by will be monitored closely not only by your Directorate, but also by the Executive Management Team and the Audit Committee. This is primarily done via the audit tracker which is regularly reported into those forums. It is therefore crucial that management actions are:

- Approved by the Director and actions assigned to suitably senior members of the team to enable them to close off actions and escalate them

- Framed in a way which broadly meets the requirements of SMART principles:
  - Specific – is there an output or a process that is required to address the recommendation
  - Measurable – what evidence will you be able to provide to demonstrate the action is closed
  - Achievable – are there resourcing or other challenges that may prohibit the action being completed, or is a third party involvement required which may provide challenging
  - Realistic – will the action address the recommendation, does it provide value for money and will it have the desired impact
  - Timebound – do not over promise and underdeliver. Take account of pressures during the winter and annual leave, as well as the required governance routes for the action before suggesting a date by which the action will be closed off

All dates included for completion of actions must be expressed in terms dd/mm/yy.

Recommendations that are rated 'high' must be given priority and should where possible receive a shorter turnaround time to close the recommendation.

Any **differences of opinion** regarding the applicability, relevance, practicality or timeliness of recommendations should be fully discussed between auditors and the Director prior to it being submitted for consideration by the EMT and the Audit and other Board Committees. If an agreed way forward cannot be found, the issue(s) should be referred to the Board Secretary.

Internal audit will aim to provide the final report within ten working days of receipt of the management responses.

(d) Follow Up

Internal Audit conduct a follow up audit annually to verify if agreed actions have been implemented and whether the actions taken have been effective in mitigating risk.

3.5. Review and Monitoring or Internal Audits

Once the internal audit report is finalised it is reviewed and discussed by the Executive Management Team and the Audit Committee. Reports relevant to Board Committees are also presented to their next meeting. Section 5 on Roles and Responsibilities goes into more detail on the focus of these various groups.

Audit recommendations and actions are transposed to the Audit Tracker. Further detail on Audit Tracker appears at section 4 below.

3. Audit Wales (External Audit)

The Auditor General is the statutory external auditor of most of the Welsh public sector. This means that they audit the accounts of county and county borough councils, police, fire and rescue authorities, national parks and community councils, as well as the Welsh Government, its sponsored and related public bodies, the Senedd Commission and National Health Service bodies.

The Auditor General has a statutory requirement to satisfy themselves that the Trust has proper arrangements in place to secure economy, efficiency, and effectiveness in the use of their resource. To help in the discharge of this responsibility, the Auditor General undertakes annual Structured Assessment work at each NHS body.

Structured Assessment

The Structured Assessment takes place annually and primarily examines corporate arrangements relating to governance, systems of assurance, planning, and financial management.

A project brief is agreed with the Executive Management Team and the Board and follows similar stages to that of an internal audit above.

The Structured Assessment Report assures the Board, our people, the public and key stakeholder that the Trust has sound corporate governance arrangements and that the necessary action is being taken to deliver high quality, safe and responsive services, and that public money is being spent wisely.

In addition to the core work under the Structured Assessment, Audit Wales may also review certain arrangements at the Trust in more depth. This is often a topic which will be examined across all NHS bodies in Wales. For example, in 2023 that area is digital arrangements, with a particular focus on how NHS bodies are investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency.

The Structured Assessment and any addition reviews are presented to the Audit Committee and the Board by Audit Wales. Similar to Internal Audit, management actions will be provided to address audit recommendations and these will be monitored via the Audit Tracker.

Audited Financial Accounts
Audit Wales also audits the financial statements of the Trust and the WAST Charity annually. Audit Wales aim is to verify that the financial statements are prepared in accordance with relevant accounting standards and provide reasonable assurance that they are free from material misstatements. These audited financial statements are filed with the Welsh Government (Trust accounts) and Charities Commission (WAST Charity) along with the accompanying respective annual reports.

The Welsh Government Manual for Accounts guides the preparation of the financial statements and the Finance and Corporate Resources Directorate oversees their preparation and liaises with Audit Wales throughout.

4. The Audit Tracker

A tracker is maintained by the Corporate Governance Team to provide a central overview on progress against management actions on Internal Audits and Audit Wales reports. From time to time regulator reports may also be included.

Directors and the POC or action owner must ensure the actions are completed by the agreed dates. Of course, it is understandable that sometimes that is not possible and changes to agreed completion dates are warranted. The Audit Tracker enables a Director to propose up

to three changes in completion dates. This should not be required if realistic dates are provided in the original audit but where it is needed justification must be provided. The Director should include in the justification the progress to date as well as any risks to a delay in completion of the action.

Directorates should conduct monthly reviews of the Audit Tracker by including a monthly audit update on their Directorate agenda. This agenda item would also include the initial review of any new internal audit reports. The Audit Tracker can then be updated by the POC or action owner ensuring:

- Where an action is proposed for closure evidence demonstrating that is provided or signposted;
- Where a date change is required an update is required the rationale for that including progress made since the date of the last review, obstacles to further progress and confirmation, or otherwise, that the revised date is achievable.
- Early warning of any actions not yet due but which may be at risk of delay

Any changes to dates due must be approved by the Director.

The Board Secretary will undertake a formal quarterly review of the Audit Tracker and will review the evidence provided to support closure of an action. The cycle for review will be as follows:

- 5th working day of the first month in the new quarter (=T) tracker finalised for Committees and sent to IA or AW
- T-9 working days = ADLT review and escalation
- T-13 working days = closure of tracker for ADLT submission
- T-23 working days = send out tracker to POC (or ADLT) and Directors and business partners rep for directorates (however if Directorates are conducting regular monthly reviews the tracker may already be updated)

Where it is no longer possible to complete the action the Board Secretary can support the Directorate to propose amendments to Internal and External Audit.

Where the implementation of a 'high risk' action is delayed beyond 3 months of the originally agreed date the responsible Executive Lead may be invited to attend the next meeting of the Audit Committee to discuss the various issues involved.

Once all recommendations have been implemented to the satisfaction of the Committee they will be classified as closed.

5. Roles and responsibilities

5.1 Director

- Agree the internal audit brief;
- Agree recommendations and develop management responses;
- Ensure all relevant individuals (including any not in your team) are aware the audit is taking place, including sharing the brief with them;
- Support and empower your team to provide all requested audit evidence in a timely manner;
- Agree a directorate process to track management actions;
- Oversee the implementation of agreed actions;
- Attend Audit Committee to provide assurance to members relating to a no or limited assurance internal audit report;
- Lead a discussion of their audit report in the Board Committees where the subject of the audit is in the remit of that Committee; and
- Ensure monthly review of audits as a standard agenda item on directorate meetings.

5.2 Point of Contact (may be action owner or business manager in directorate)

- Communicate any issues to auditors which may impact on the audit, e.g., service pressures, known leave, availability of staff, difficulties around availability of /access to information, etc;
- Provide auditors with the contact details for everyone involved in the system / process being audited, even if from a different team or division; and
- Update the audit tracker monthly.

5.3 Audit interviewees

- Cooperate and be open and honest with the audit team;
- Clearly explain the process and / or system being audited providing any evidence such as meeting minutes etc as may give wider context;
- Provide audit evidence requested and respond to auditor queries throughout the audit in a timely manner;
- Communicate challenges in providing information and / or pressures within the point of contact in your directorate; and
- Answer to the best of your ability – Auditors know that people can be nervous, and sometimes will forget the answer to a question. It is acceptable to say: "I forget that right now, but here is where I can find that information," and then to show the auditor the procedure or other information they need. If an employee doesn't know an answer, it is far worse to make up the answer than to just say, "I don't know, but I can find out."

5.4 Board Secretary

- Ensure there is an adequate provision of internal and external audit services;
- Coordinate the development and approval of the annual audit plan;
- Provide final audit reports to EMT, Audit and other relevant Committees;
- Maintenance of audit tracker;

- Coordinate quarterly review of tracker;
- Review evidence of closed actions;
- Prepare progress and tracker reports to ADLT, EMT, AC and Committees;
- Facilitate escalations from Internal Audit or on tracker; and
- Lodge quarterly Welsh Government return of audits.

5.5 Audit Committee

- Facilitate direct and unrestricted access for the Head of Internal Audit and Auditor General for Wales to the Board;
- Review and recommend Internal Audit Charter for approval by Board;
- Receives the Internal Audit confirmation of independence annually;
- Receives regular reports from Audit Wales and Head of Internal Audit on its activities;
- Agree annual Internal Audit plan;
- Review internal audit reports, Structured Assessments and other Audit Wales reports, and scrutinise of the adequacy of management actions in response to recommendations;
- Scrutinise the progress of audits overall, escalating to the Board any issues of concern; and
- Receive and review Head of Internal Audit Opinion.

5.6 Board Committees

- Receive audits in their remit;
- Monitor management actions to address recommendations; and
- 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.

5.7 Executive Management Team

- Develop proposal for annual Internal Audit plan;
- Scrutinise the progress of audits overall (dashboard 3.0);
- Review Structured Assessment briefs;
- Receive and review all final Internal Audit reports, Structured Assessment and Audit Wales reports;
- Oversight of the audit framework by way of quarterly dashboard reports; and
- Receive and review Head of Internal Audit Opinion.

5.8 Assistant Directors Leadership Team

- Receive and review audit tracker quarterly;
- Act as a check and challenge forum, agreeing closure of actions; and
- Escalation forum where updates have not been provided by Directorates.

5.9 Internal Audit

- Provide independent assurance that an organisation's risk management, governance and internal control processes are operating effectively;
- Provide annual Head of Internal Audit Opinion to Audit Committee;
- Provide regular reports on progress to Audit Committee;
- Present annual Internal Audit plan;
- Present finalised Internal Audit reports to Audit Committee;
- Review tracker and raise concerns regarding changes to completion dates for actions to Board Secretary and/or Audit Committee; and
- Agree timeframes for the various stages of internal audit work with the Board Secretary.

5.10 Audit Wales

- Provide independent assurance on the financial statements and the corporate arrangements relating to governance, systems of assurance, planning, and financial management.
- Agree the briefs for Structured Assessment and other reports with the Board Secretary and/or relevant Director
- Provide regular reports on progress to Audit Committee;
- Present annual Audit plan to Audit Committee;
- Present finalised Audit reports to Audit Committee;
- Review tracker and raise concerns regarding changes to completion dates for actions to Board Secretary and/or Audit Committee; and
- Agree timeframes for the various stages of audit work with the Board Secretary and for the financial statements with the Executive Director of Finance and Corporate Resources.

6. Annexures

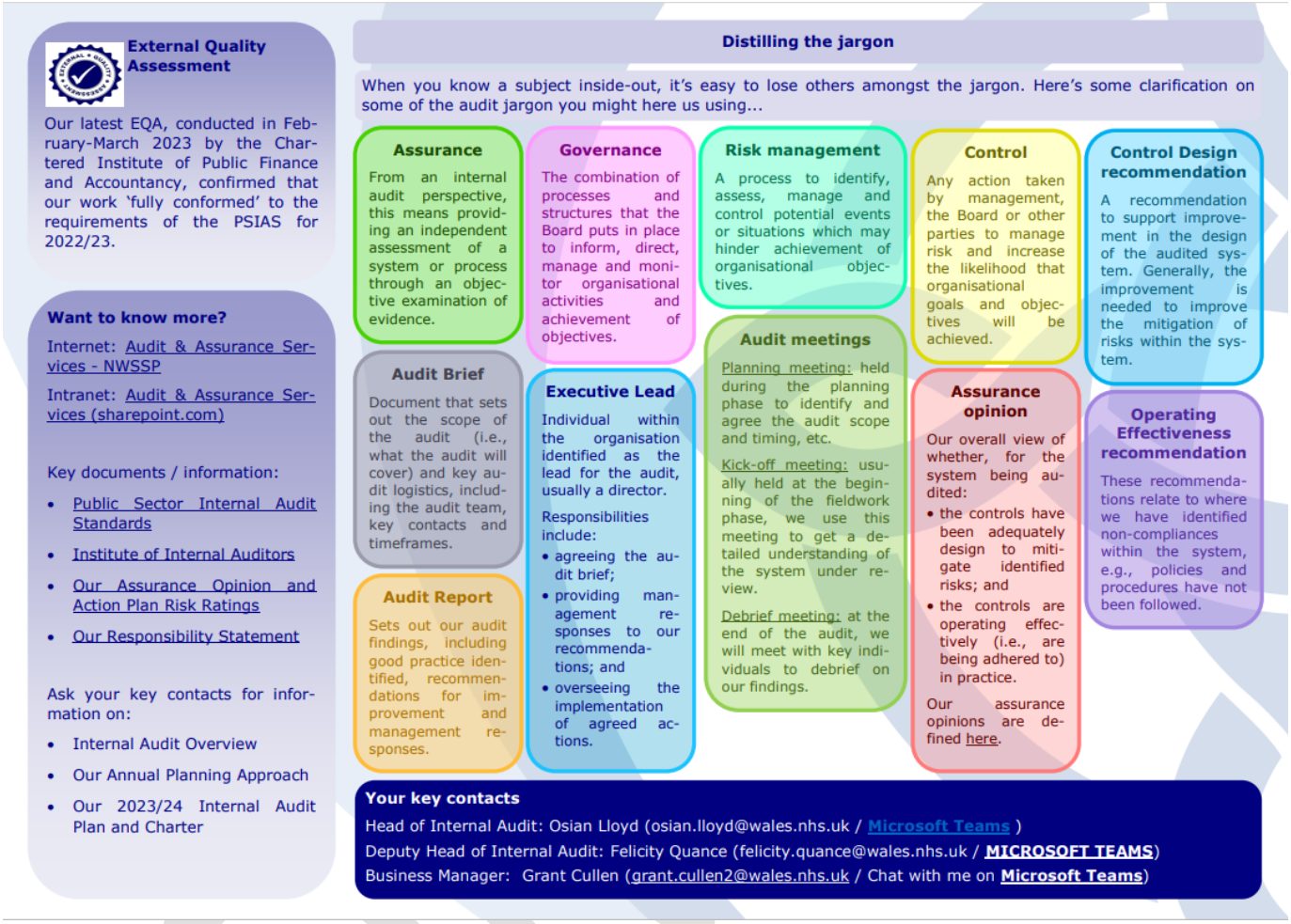
Annex 1 – Internal Audit Jargon
Annex 2 – Internal Audit Guidance Infographic
Annex 3 – Audit Assurance Ratings

7. Version History and Document Control

Version	Date	Author	Summary of changes	Document Status
v.01	TBC	Trish Mills	First version for consultation: Internal Audit: 7 August 2023 Audit Wales: [date] ADLT: 14 August 2023 EMT: [date]	Draft for consultation

Version	Date	Author	Summary of changes	Document Status
v.02		Trish Mills	Audit Handbook for Audit Committee	
v.1		As above	Approval by Audit Committee – Handbook Ref 001	

Annex 1 – [This is currently a draft release of the NWSSP Internal Audit Jargon Buster]



External Quality Assessment

Our latest EQA, conducted in February-March 2023 by the Chartered Institute of Public Finance and Accountancy, confirmed that our work 'fully conformed' to the requirements of the PSIAS for 2022/23.

Want to know more?

Internet: Audit & Assurance Services - NWSSP

Intranet: Audit & Assurance Services (sharepoint.com)

Key documents / information:

- Public Sector Internal Audit Standards
- Institute of Internal Auditors
- Our Assurance Opinion and Action Plan Risk Ratings
- Our Responsibility Statement

Ask your key contacts for information on:

- Internal Audit Overview
- Our Annual Planning Approach
- Our 2023/24 Internal Audit Plan and Charter

Distilling the jargon

When you know a subject inside-out, it's easy to lose others amongst the jargon. Here's some clarification on some of the audit jargon you might here us using...

Assurance

From an internal audit perspective, this means providing an independent assessment of a system or process through an objective examination of evidence.

Governance

The combination of processes and structures that the Board puts in place to inform, direct, manage and monitor organisational activities and achievement of objectives.

Risk management

A process to identify, assess, manage and control potential events or situations which may hinder achievement of organisational objectives.

Control

Any action taken by management, the Board or other parties to manage risk and increase the likelihood that organisational goals and objectives will be achieved.

Control Design recommendation

A recommendation to support improvement in the design of the audited system. Generally, the improvement is needed to improve the mitigation of risks within the system.

Audit Brief

Document that sets out the scope of the audit (i.e., what the audit will cover) and key audit logistics, including the audit team, key contacts and timeframes.

Executive Lead

Individual within the organisation identified as the lead for the audit, usually a director.

Responsibilities include:

- agreeing the audit brief;
- providing management responses to our recommendations; and
- overseeing the implementation of agreed actions.

Audit meetings

Planning meeting: held during the planning phase to identify and agree the audit scope and timing, etc.

Kick-off meeting: usually held at the beginning of the fieldwork phase, we use this meeting to get a detailed understanding of the system under review.

Debrief meeting: at the end of the audit, we will meet with key individuals to debrief on our findings.

Assurance opinion

Our overall view of whether, for the system being audited:

- the controls have been adequately design to mitigate identified risks; and
- the controls are operating effectively (i.e., are being adhered to) in practice.

Our assurance opinions are defined here.

Operating Effectiveness recommendation

These recommendations relate to where we have identified non-compliances within the system, e.g., policies and procedures have not been followed.

Audit Report

Sets out our audit findings, including good practice identified, recommendations for improvement and management responses.

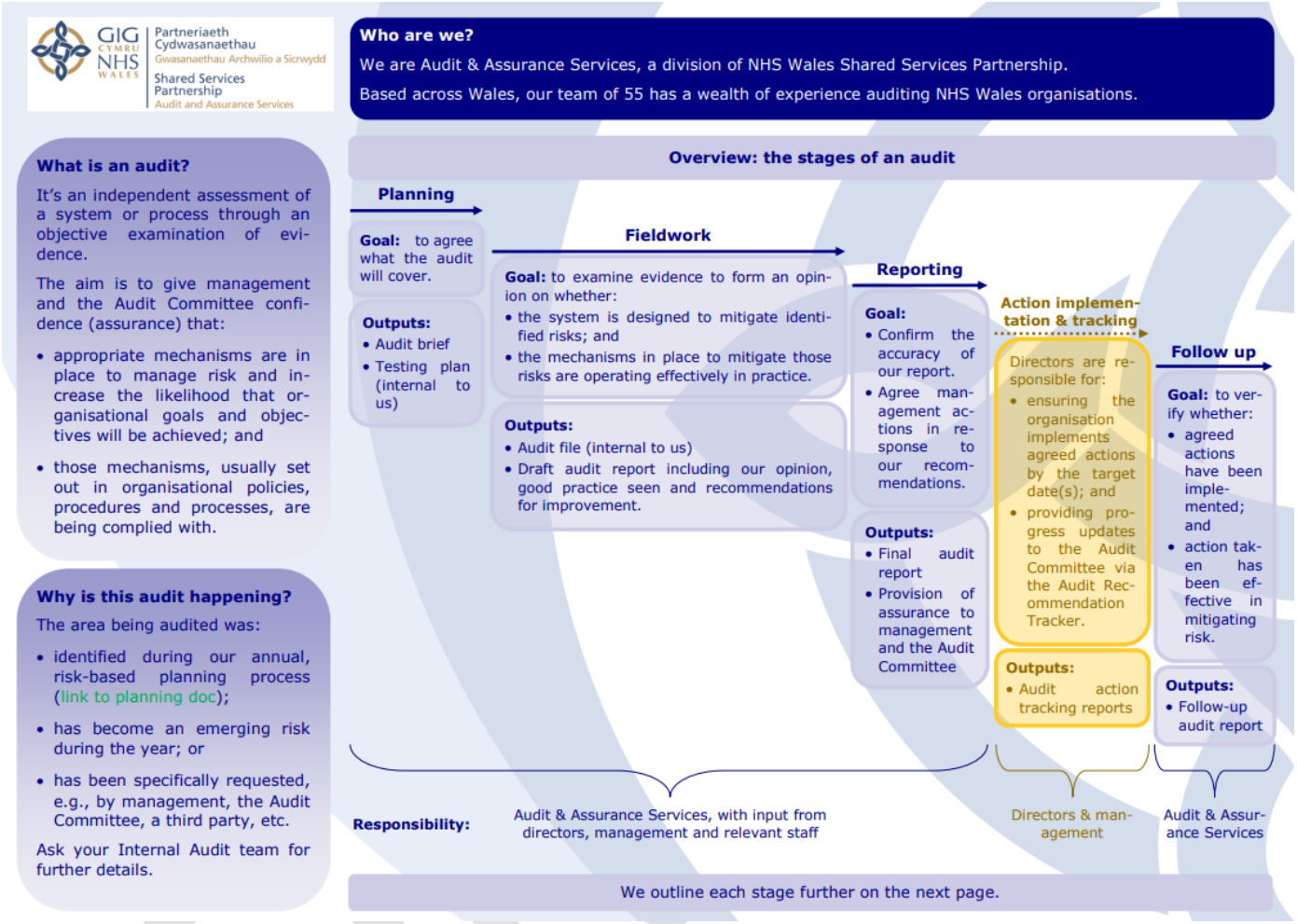
Your key contacts

Head of Internal Audit: Osian Lloyd (osian.lloyd@wales.nhs.uk / Microsoft Teams)

Deputy Head of Internal Audit: Felicity Quance (felicity.quance@wales.nhs.uk / MICROSOFT TEAMS)

Business Manager: Grant Cullen (grant.cullen2@wales.nhs.uk / Chat with me on Microsoft Teams)

Annex 2 – [This is currently a draft release of the NWSSP Internal Audit guidance notes]



Why am I being asked lots of questions and / or for various documents?

The Public Sector Internal Audit Standards require that we must identify sufficient, reliable, relevant and useful information to achieve the objectives of the audit. To do this, we:

- require robust audit evidence to be provided in a timely manner; and
- must critically examine this evidence.

We then may need to:

- ask further questions to clarify our understanding or verify the robustness of the evidence; or
- request further evidence to ensure the above requirements are met.

Why is there sometimes a short delay between the fieldwork ending and the issue of the draft report?

Our fieldwork must be clearly documented to evidence our work. This, along with drafting reports, can take time after we have finished speaking with you.

Additionally, all audit fieldwork and draft reports are reviewed by a senior member of our team to ensure our quality standards are met.

Planning stage

What we do for each audit:

- Meet with management to identify and agree the audit scope—this is set out in the audit brief.
- Understand the systems in place, e.g., through review of policies and procedures, understanding relevant laws, regulations and good practice, considering similar audits done at other Welsh health bodies, etc.
- Identify mechanisms in place (a.k.a., controls) that mitigate identified risks and develop a plan to test these.

Fieldwork stage

What we do for each audit:

- Meet with management and operational staff (a.k.a., the kick-off meeting) to verify our understanding and gain further detail on the system under review.
- Consider whether the system is adequately designed to mitigate identified risks.
- Request and critically examine audit evidence to test whether the identified controls are being operated in practice; depending on the audit, this may include reports, meeting agendas and minutes, evidence of approvals, patient or staff records, etc.
- Address queries arising from our examination of the audit evidence through discussions with management / operational staff and / or requesting and examining further audit evidence.
- Discuss our initial findings with management before writing our draft report.

Reporting stage

What we do for each audit:

- Issue our draft report and hold a meeting (a.k.a., the debrief meeting) with directors, management and / or operational staff to formally discuss our findings.
- Confirm the accuracy of our report.
- Agree management actions to address our recommendations (a.k.a., the management response), including responsible individuals and deadlines.
- Issue our final report to management and present this at the next Audit Committee meeting.

Action tracking & implementation

What the organisation must do for all actions:

- Add our recommendations and agreed management actions to the organisation's Recommendation (or Action) Tracker.
- Implement the agreed actions and provide regular progress updates on implementation status to the Audit Committee via the Recommendation Tracker.

Follow-up audits

What we do annually:

- Examine evidence to verify the implementation status of agreed actions and benefits realised for a defined sample of previous reports and / or recommendations.
- Report our follow-up findings to the Audit Committee.

What governs our work?

Public Sector Internal Audit Standards (PSIAS)

Internal Audit Charter—approved by the Audit Committee each year

Quality Manual and Consulting Protocol—our internal procedures setting out how we carry our work and comply with the PSIAS.

Quality assurance

All audit fieldwork and draft reports are reviewed by a senior member of our team to ensure:

- the work has been undertaken to an appropriate standard; and
- the opinion provided is consistent with the audit evidence.

Reports are also reviewed by the Head of Internal Audit to ensure alignment with our understanding of the wider organisation.

Additionally, we have:

- an Annual Quality Assurance and Improvement Programme undertaken by the Director of Audit & Assurance to confirm our compliance with the PSIAS and identify improvements;
- an annual assessment by Audit Wales; and
- a five-yearly External Quality Assessment (EQA) to provide independent assurance over PSIAS compliance.

What to expect and what's expected

What to expect: we will:

- agree clear communication lines / methods;
- be clear in our requests to you;
- agree clear timeframes and deadlines for our work;
- be available to answer any queries or concerns you may have at any point in the audit;
- keep you up to date on our progress and findings throughout the audit; and
- be understanding of your workload, service pressures, team absences, etc.

What's expected of you as an auditee: we need you to:

- cooperate and be open and honest with the audit team;
- clearly explain the process and / or system being audited;
- provide audit evidence requested and respond to auditor queries throughout the audit in a timely manner; and
- communicate challenges in providing information and / or pressures within your team.

What's expected of you as a senior manager (director, head of service, etc) of an area being audited: we need you to:

- ensure all relevant individuals (including any not in your team) are aware the audit is taking place, including sharing the brief with them;
- provide us with the contact details for everyone involved in the system / process being audited, even if from a different team or division
- support and empower your team to provide all requested audit evidence in a timely manner; and
- communicate any issues to us which may impact on the audit, e.g., service pressures, known leave, availability of staff, difficulties around availability of /access to information, etc.

Timelines and key performance indicators

Audit Committee reporting: the Audit Committee we intend to report the audit to is agreed during the audit planning phase and is set out in the Audit Brief.

The timeframe for the audit will revolve around the Audit Committee papers deadline, which is usually **two weeks** before the date of the Audit Committee.

We need to have issued our final report by the Audit Committee papers deadline, considering the three key performance indicators identified to the right.

If necessary, we can agree shorter report turnaround periods with management.

Draft report: we aim to issue our draft report within **10 working days** of completing the fieldwork.

Management response: we ask that management responses to audit recommendations in the draft report are provided within **10 working days** of the draft report being issued.

Final report: we aim to issue our final report within **10 working days** of receipt of the management responses.

Annex 3 – Audit Assurance Ratings

Internal Audit 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.

Annex 4 – Prioritisation of Recommendations

In order to assist management in using internal audit reports, they are categorised 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

AGENDA ITEM No	**9**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**5**

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

MEETING	Audit Committee
DATE	14th September 2023
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.

2. A summary of these risks is set out in Annex 1 with a detailed description contained within the Board Assurance Framework (BAF) in Annex 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 were presented to the Trust Board on 27th July 2023 and are updated as at 1st September 2023. Each risk has 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 the mitigating actions identified and taken to ensure risks achieve their target score.

5. Specific updates made in respect of actions, controls and assurances are highlighted in blue on the BAF.

6. In addition, this paper provides a progress update in respect of the Risk Transformation Programme as detailed in the Integrated Medium Term Plan (IMTP) (2022/25).

RECOMMENDATION:

7. Members are asked to consider and discuss the contents of the report and:
   (a) Note the review of each high rated principal risk including ratings and mitigating actions.

(b) Note that there have been no material changes to the risks or scores during this period.
(c) Note the update on the Risk Management Transformation Programme.

KEY ISSUES/IMPLICATIONS
The key issues and implications are set out in the Executive Summary above.

REPORT APPROVAL ROUTE
Each of the Principal Risks have been or are due to be considered by the following Committees, as relevant to their remit, during the forthcoming reporting period: ADLT (14 August 2023) EMT (30 August 2023) Finance & Performance Committee (18 September 2023) Charity Committee (9 October 2023) Quality, Safety & Patient Experience (31 October 2023) People & Culture Committee (16 November 2023)

REPORT ANNEXES
SBAR report. Annex 1 - Summary table describing the Trust's Principal Risks. Annex 2 – Scoring Matrix Annex 3 – Frequency of Risk review Annex 4 - Board Assurance Framework Annex 5 – Guidance on Interpreting the Board Assurance Framework

REPORT CHECKLIST

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

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

SITUATION

1. The purpose of the report is to provide assurance in respect of the management of the Trust's principal risks.

2. A summary of the Trust's 15 principal risks on the Corporate Risk Register (CRR) is detailed in Annex 1; each of the risks have been fully and formally reviewed in line with the review schedule.

BACKGROUND

1. 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 Management Team (EMT) in relation to risk escalation, changes in ratings, and any new risks for inclusion on the CRR.

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

ASSESSMENT

3. The summary of the Trust's 15 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 2.

4. The EMT has approved the principal risk activity described in this paper and considered the full review of each risk undertaken throughout August 2023 by Risk Owners and the ADLT.

<u>Principal Risks</u>

5. The principal risks were presented to the Trust Board on 27th July 2023 and are updated as at 1st September 2023. 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.

6. Specifically, The Trust's highest rated Risks 223 and 224, scoring 25, remain unchanged despite a series of mitigating actions being in place. These risks continue to be closely monitored by management, Board Committees, and the Trust Board.

7. All current mitigating actions within WAST's control have been completed or superseded in relation to Risk 223. Work has been undertaken by the Operations Senior Leadership Team in relation to regional modelling and a breakdown of risk scores by Health Board. This will be included in the risk report and BAF for the December 2023 Trust Board. Additionally, the Board will continue to receive an update against the Avoidable Harm paper and action plan at each meeting and updates are included against the mitigations for this risk.

8. Several updates have been made to the controls and assurances in relation to Risk 224 during this period and these are highlighted on the BAF to address gaps in assurance.

9. The EMT discussed additional mitigating actions that will be included against Risk 163 during the review in September 2023 and acknowledged that a review is required against Risk 424 in light of the current financial climate.

10. Risk 199 will be considered during September 2023 with the potential reduction in score given the demonstrable work that has been undertaken across the Trust in relation to the Working Safely Programme and Health & Safety.

Further Review of Risks

11. Work continues to consider and develop potential new Risks for inclusion on the CRR in the following areas:

    a. Capacity to handle volume of complex concerns and requests i.e. Putting Things Right Team.
    b. Decarbonisation programme.
    c. Salus (IIS, CAS, Symptom Checkers, Website, Clinical Workforce training and funding).
    d. Covid-19 Inquiry risks
    e. Volunteer Fundraising Risk

Risk Management Transformation Programme

12. The Risk Management Transformation Programme has been designed to further strengthen and positively impact the development of the Trust's future strategic

ambition which is highlighted in our 2023-26 IMTP as one of the fundamentals of a quality driven, clinically led, value focussed organisation.

13. The elements of the programme are detailed in the table below and those highlighted are specific deliverables agreed within the Integrated Medium Term Plan (IMTP).

Risk Management Transformation Programme Elements	Date due to commence	Date due to be completed
Develop and deliver a risk management framework including policy and procedures	Q2 August 2023 (Already in draft)	March 2024 (Approval at AC)
Transition to a strategic BAF reflecting strategic objectives and risks	Q3 September 2023	March 2024
Development of strategic risks aligned to the long term strategy	Q3 September 2023	March 2024
Development of risk appetite statements	Q3 September 2023	February 2024 (BDD Session)
Review and rearticulation of directorate risks	Q2 August 2023	December 2024 (18 month programme)
Develop and deliver programme of training and education for the Trust	Q3/Q4 (ESR basic & tier 2)	March 2024
Deliver Board education on risk management (BAF process and risk appetite)	Q3/Q4	February 2024 (BDD Session)
Once for Wales Datix implementation	TBC	November 2024 (not yet confirmed)

14. 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. This is in addition to designing and delivering a programme of training and education on both the risk management framework and the BAF.

15. This programme is overseen by the Audit Committee.

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

(a) Note the review of each high rated principal risk including ratings and mitigating actions.

(b) Note that there have been no material changes to the risks or scores during this period.

(c) Note the update on the Risk Management Transformation Programme.

Annex 1 – Corporate Risk Register Summary

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
223 QuEST	The Trust's inability to reach patients in the community causing patient harm and death	**IF** significant internal and external system pressures continue **THEN** there is a risk of an inability and/or a delay in ambulances reaching patients in the community **RESULTING IN** patient harm and death	Director of Operations	**25 (5x5)** →
224 QuEST	Significant handover delays outside A&E departments impacts on access to definitive care being delayed and affects the trust's ability to provide a safe and effective service	**IF** patients are significantly delayed in ambulances outside A&E departments **THEN** there is a risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised **RESULTING IN** patients potentially coming to harm and a poor patient experience	Director of Quality & Nursing	**25 (5x5)** →
160 PCC	High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service	**IF** there are high levels of absence **THEN** there is a risk that there is a reduced resource capacity **RESULTING IN** an inability to deliver services which adversely impacts on quality, safety and patient/staff experience	Director of Workforce & Organisational Development	**20 (5x4)** →
201 PCC	Damage to Trust reputation following a loss of stakeholder confidence	**IF** the stability of the Trust deteriorates to a level where service delivery fails to meet patient safety, national standards and contractual obligations	Director of Partnerships & Engagement	**20 (4x5)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		THEN there is a risk of a loss of stakeholder confidence in the Trust **RESULTING IN** damage to reputation and increased external scrutiny		
139 FPC	Failure to Deliver our Statutory Financial Duties in accordance with legislation	**IF** the Trust does: • not achieve financial breakeven and/or • does not meet the planning framework requirements and/or • does not work within the EFL and/or • fails to meet the 95% PSPP target and/or • does not receive an agreement with commissioners on funding (linked to 458) **THEN** there is a risk that the Trust will fail to achieve all its statutory financial obligations and the requirements as set out within the Standing Financial Instructions (SFIs) **RESULTING IN** potential interventions by the regulators, qualified accounts and impact on delivery of services and reputational damage	Director of Finance & Corporate Resources	**16 (4x4)** →
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	Director of Workforce & Organisational Development	**16 (4x4)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		THEN there is a risk that Trade Union partnership relationships increase in fragility and the ability to effectively deliver change is compromised **RESULTING IN** a negative impact on colleague experience and/or services to patients.		
424 FPC	Prioritisation or Availability of Resources to Deliver the Trust's IMTP	**IF** resources are not forthcoming within the funding envelope available to WAST (link to risk 139) **THEN** there is a risk that there is insufficient capacity to deliver the IMTP **RESULTING IN** delay or non-delivery of IMTP deliverables which will adversely impact on the Trust's ability to deliver its strategic objectives and improvement in patient safety and staff wellbeing	Director of Strategy Planning and Performance	**16 (4x4)** →
458 FPC	A confirmed commitment from EASC and/or Welsh Government is required in relation to funding for recurrent costs of commissioning	**IF** sufficient recurrent funding is not forthcoming there is a risk that the Trust will be committed to additional expenditure through delivery of the IMTP and in year developments which are only recognised by commissioners on a cost recovery basis **THEN** there is a risk that the Trust may not be able to deliver services and there will be a lack of funding certainty when making recurrent cost commitments. Any	Director of Finance & Corporate Resources	**16 (4x4)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		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.		
199 PCC	Failure to embed an interdependent and mature health and safety culture which could cause harm and a breach in compliance with Health & Safety statutory legislation	**IF** there is a failure to embed an interdependent and mature health and safety culture, effective arrangements and associated governance **THEN** there is a risk of a potential breach in compliance with the requirements of the Health & Safety at Work etc. Act 1974 and associated regulations and other statutory instruments **RESULTING IN** death or serious injury, and punitive actions from multiple enforcement agencies including penalties and adverse publicity leading to damage to reputation	Director of Quality & Nursing	**15 (3x5)** →
260 FPC	A significant and sustained cyber-attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems	**IF** there is a large-scale cyber-attack on WAST, NHS Wales and interdependent networks which shuts down the IT network and there are insufficient information security arrangements in place **THEN** there is a risk of a significant information security incident	Director of Digital Services	**15 (3x5)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		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)** →
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	Director of Operations	**15 (3x5)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		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.		
100 FPC	Failure to persuade EASC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience	**IF** WAST fails to persuade EASC/Health Boards about WAST ambitions **THEN** there is a risk of a delay or failure to receive funding and support **RESULTING IN** a catastrophic impact on services to patients and staff and key outcomes within the IMTP not being delivered	Director of Strategy Planning & Performance	**12 (3x4)** →
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)** →

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:	08/08/2023	TREND	25 (5x5)
		Date of Next Review:	08/09/2023	➡	

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: 3, 7,9,11, 12, 14,16, 18, 21, 22, 26

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

Risk Commentary Q2 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 as a result of the Trust not being able to reach patients in the community.

There were over 28,000 hours lost outside EDs in March 2023, a comparable figure to the pre Christmas delays. Whilst there has been improvement in some Health Board areas (Cardiff and Vale where there has been a corresponding improvement in red performance), other Health Board continue to experience protracted delays. 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 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 educes emergency department handover lost hours by 25% (E)
d) NHS Wales eradicates all emergency department handover delays in excess of 4 hours (E)
e) Alterative capacity equivalent to 1000 beds (E)
f) Implement nationwide approach to emergency department 'Fit 2 Sit' (E)
g) Implementation of Same Day Emergency Care services in each Health Board (E)
h) National Six Goals programme for Urgent and Emergency Car (E)

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.
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. Gold/Strategic, Silver/Tactical and Bronze/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.
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. Monitoring CSD rates through AQIs. Consult and Close volumes form part of EMS CCC weekly reports to SLT. Regular reporting of incident volumes to Operational Review Groups. Summary level information about Consult and Close volumes, targets, trends and recontact rates reported to TB and sub-committees. Metrics relating to Ambulance Quality Indicators (AQI) published on a quarterly basis by EASC. Bi-monthly EASC Provider reports. Consult and Close performance reported in Joint Executive Team meeting every 6 months with Welsh Government. NWSSP Information Management Internal Audit report February 2022 (External Assurance). Consult and Close rate has increased from 12% to circa 15% March 2023.

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	08/08/2023	TREND	25 (5x5)
		Date of Next Review:	08/09/2023	➡	

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

8. Advanced Paramedic Practitioner (APP) deployment model / APP Navigation	8. Qlik sense APP dashboard monitors performance and provides assurance that APPs are flowing patients into alternatives to emergency department. Qlik sense is a national report and can drill down into regional, local and individual performance as required. APP Navigation – Test of Change Framework (Swansea Bay & Hywel Dda). Review of despatch criteria for APPs. EMT have agreed to offer contracts to the 22 APPs who are about to complete their Masters programme. This will take our APP headcount to 88.7FTE. An investment proposal has been submitted to Welsh Government AHP in primary and community care pot. I think that there is low expectation that the bid will be successful. We are currently workforce planning to increase our APP headcount by 40 per year.
9. Clinical Safety Plan	9. Clinical agreement – agreeing escalation to higher levels, ODU dashboard, AACE paper through National Director of Operations group
10. Recruitment and deployment of CFRs	10. Volunteers are another resource for response, Volunteer
11. ETA scripting	11. The ETA Dashboard is a tactic that was signed off by EMT – there is a dashboard that supports scripting analysed by comparing with real time data
12. Clinical Contact Centre (CCC) emergency rule	12. CCC Emergency Rule is policy that has been signed off by Execs.
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.	14.
15. Summer/Winter initiatives	15. Monitoring through SLT and STB
16. CHARU implementation	16. Monitored via the EMS project Board
17. National Transfer & Discharge Model	17.
18. Conveyance Reduction	18. This is part of the weekly performance review and aligned to Care Closer to Home Programme
19. Access to Same Day Emergency Care (SDEC) for paramedic referrals	19. This forms part of the handover improvement plans in place with Health Boards, however assurance is limited given that the acceptance of paramedic referrals is low (less than 1%) and inconsistent.
20. Mental Health Practitioners in cars	20.
21. Roll out of ECNS	21. Reported through QuEST
22. Clinical Model and clinical review of code sets	22. Reported through QuEST
23. Remote Clinical Support Strategy	23. Strategic Transformation Board – IMTP deliverable
24. 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)	24. Formally documented action plan – actions captured are contained within and monitored via the Performance Improvement Plan (PIP)
25. Information sharing	25. Information Sharing: Patient Safety Reports, Chief Operating Officer (COO) Data Pack, Immediate Release Declined (IRD) Reports.
26. Completed EMS Roster Review	26. Helps to ensure that we have the maximum available capacity to respond to dispatch to 999 calls received in a timely manner
27. Work underway to reduce the number of multiple attendances dispatched to red calls	27. This will increase vehicle availability generally across the Trust

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	08/08/2023	TREND	25 (5x5)
		Date of Next Review:	08/09/2023	➡	

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

28. Transfer of Care	28. 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
29. New 2023 EMS Demand and Capacity (roster) review	29. **To commence in order to ensure we continue to match capacity and demand to our best ability**
30. Connected Support Cymru – an innovative approach to supporting patients to remain at home with clinically appropriate support mechanisms, thus avoiding admission to hospital where appropriate.	30. **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.**
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
2. Blockages in system e.g. internal capacity within Health Boards which affect patient flow	
3. Covid capacity streaming	
4. Transition Plan/Inverted Triangle – bid for transition plan has been put in and is now subject to funding	
5. Local delivery units mirroring WAST ODU	
6. Handover delays link to risk 224	
7.	
8. During industrial action days, Health Boards demonstrated compliance with reducing handover delays in order to maximise WAST resources. Despite a reduced volume of conveyance as a result of the industrial action, there is however a demonstration that reduced handover delays are achievable, and this therefore warrants a triangulation of data.	
9. There is an ambition that no handover should exceed 4 hours and for lost hours to handover to be reduced by 25% but given the track record over last 6 months there is a low confidence in attaining this.	
10. Outputs from the NHS System Reset – it is a closer collaboration to address some of the system blockages and reduce system pressures. This is the aspiration	
11.	
12. 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
18. National Transfer & Discharge Model	18. National Transfer & Discharge model is yet to be determined. A task and finish has been established to progress this piece of work
21. Mental Health Practitioners	21. Mental Health Practitioners – not yet implemented but part of the Care Closer to Home workstream

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	08/08/2023	TREND	25 (5x5)
		Date of Next Review:	08/09/2023	➡	

IF	THEN	RESULTING IN		Likelihood	Consequence	Score
significant internal and external system pressures continue	there is a risk of an inability and/or a delay in ambulances reaching patients in the community	patient harm and death	Inherent	4	5	20
			Current	5	5	25
			Target	2	5	10

Please note that the gaps listed are not WAST's and are therefore outside of the control of WAST

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Exploring Rural model options (Paused during Pandemic Response) – subject to funding through IMTP. Now refreshed to wider rural model opportunities to include recruitment of CFRs. Additional funding has been sourced to increase posts within the volunteer function.	Assistant Director of Operations EMS / Assistant Director of Operations – National Operations & Support	Superseded	Rural model superseded by Action 9 below (Recruitment and deployment of CFRs)
2. Leading Change Together (forum to progress workforce related work streams jointly with TUPs)	ADLT Sub-Group	30.09.22 - Superseded	
3. EMS Demand & Capacity i.e. review and implementation of new EMS rosters	Assistant Director of Operations EMS	Complete	Majority of EMS rosters complete and implemented
4. Transition arrangements post pandemic	Executive Pandemic Team / Assistant Director of Strategic Planning (BCRT Chair)	Complete 30/08/22	Transition complete
5. Recruit and train more Advanced Paramedic Practitioners – Value Based Healthcare Fund bid for up to 50 WTE (I) [Source: Action Plan presented to Trust Board 28/07/22]	Director of Paramedicine / Director of People & Culture	**30.07.23 Checkpoint**	Offers to 22 in July 2023. 13.33 FTE uplift. Continue to seek opportunities for funding APPs to improve service delivery.
6. Maximise the opportunity from Consult and Close – stretch to 15% and beyond (I) [Source: Action Plan presented to Trust Board 28/07/22]	Assistant Director of Operations, Integrated Care	31.03.23 Complete	Work undertaken to map influences and progress towards each. Current % of Consult and Close increased from 12% to 15% at March 2023.
7. 24/7 operational oversight by ODU with dynamic CSP review and system escalation as required (I) [Source: Action Plan presented to Trust Board 28/07/22]	Assistant Director of Operations, National Operations & Support	Complete	System in place and ongoing.
8. Weekly REAP review by senior Operations Directorate team with assessment of action compliance (I) Source: Action Plan presented to Trust Board 28/07/22]	Director of Operations / Operations Senior Leadership Team	Complete	In place and ongoing - Weekly Performance Meetings occur every Tuesday lunchtime to review performance, etc. and determine REAP level.
9. Recruitment and deployment of new CFRs (I) [Source: Action Plan presented to Trust Board 28/07/22]	Assistant Director of Operations, National Operations & Support / National Volunteer Manager	Complete 21.03.23	Additional CFR Trainers and Operations Assistants appointed to support recruitment and training of new CFRs. Volunteer Management Team, supported by the Volunteer Steering Group, now embarking on volunteer recruitment programme and increasing public engagement to raise awareness about volunteering opportunities available within WAST. Volunteer team has recruited and trained 173 additional volunteers between November and March 2023.
10. Transition Plan (I) [Source: Action Plan presented to Trust Board 28/07/22]		Superseded	
11. Overnight Falls Service extension (I) [Source: Action Plan presented to Trust Board 28/07/22]	Assistant Director of Quality & Governance / Head of Quality Improvement	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.

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:	03/08/2023	TREND	25 (5x5)
		Date of Next Review:	11/09/2023	➡	

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

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

IMTP Deliverable Numbers: 7,9, 10, 11, 12, 13, 14, 15, 16, 23, 24, 25, 26, 33, 35

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

Risk Commentary Q1 2023/24

The risk score remains constant at 25 for quarter 1 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 over **1,440** +4 hour patient handover delays in **June 2023**; the target being 0 from September 2022 has now moved to the end of 2023/24. **In June 2023, over 18,000 hours were lost to hospital handover, equivalent to 21% of the Trust's conveying capacity.** 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 received two Prevention of Future Death Reports (Regulation 28) from HM Coroner in North Wales in June 2023, both citing concerns regarding system delays and one case related specifically to the patient being significantly delayed outside of the hospital on arrival.**

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). **The Trust adopted the National Patient Safety Policy and supporting appendices at the Clinical Quality Governance Group in June 2023.**

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 in excess of 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.

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:	03/08/2023	TREND	25 (5x5)
		Date of Next Review:	11/09/2023	➡	

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

4. WAST Clinical Notice in place - Escalating a clinical concern with a deteriorating patient outside the Emergency Department (11.02.2021). National Early Warning Score (NEWS) trigger of 5 or above for escalation to hospital clinicians. NEWS data available via EPCR (electronic patient care record).	4. NEWS data now available via ePCR and escalation system in place via local managers and the Operational Delivery Unit.
5. Workstreams put in place to meet requirements of *Right care, right place, first time Six Goals for Urgent and Emergency Care A policy handbook 2021–2026.* Goal 4 incorporates the reduction of handover of care delays through collective system partnership. 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.
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 CSP 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
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.
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 (**June 2023 overall 77%** - Safeguarding and dementia over 90%.
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	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 July 2023 and Board sub-committee oversight and escalation through 'Alert, Advise and Assure' reports.

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

Service's statement of 19 May 2022 on urgent and emergency care and the Six Goals Programme to eradicate ambulance patient handover delays of more than four hours and reduce the average ambulance time lost per arrival by 25 per cent (from the October 2021 level) have been set. It should also confirm the target dates for the achievement of these targets."	
16. Implementation of Duty of Quality, Duty of Candour and new Quality Standards requirements in April 2023.	16. Welsh Government Road Map in place (soft launch) with milestones for organisations – baseline assessment and monthly updates (RAG ratings) in place with Trust Board oversight. The current internal assessment overall as of July 2023 is 'Implementing and operationalising'. The Trust has representation on the All Wales Duty of Candour Implementation Group and is actively engaged in developing resources.
	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. A number of overdue patient safety investigations remain presenting a risk to patient safety across the system. The Trust has **25** overdue nationally reportable incident investigations. **Shared system learning from the Joint Investigation Framework is currently limited.**
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 **June 2023**, **18,000** hours were lost with **1,440 +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.	5.
6. Variation pan Wales / England as position not implemented across all emergency departments*.	6.
7.	7.
8. Variation pan Wales / England as position not implemented across all emergency departments*.	8. New Quality Management System in development which will include monitoring of the new Quality Standards & Enablers and underpinning governance structure.
9. Variable response pan Wales / England. WAST have minimal control on this at patient level*.	9.
10.	10.
11. Variable response pan Wales / England. WAST have minimal control on this at patient level*.	11.
12.	12.
13. Transition to ePCR impacting on data temporarily	13.

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14. National steer required to confirm the accountability arrangements regarding patients in ambulances outside of the emergency departments. The seven Local Health Boards (LHBs) in Wales are responsible for planning and securing delivery of primary, community, secondary care services, and also the specialist services for their areas*.	14. HIW approve and sign off WAST elements of recommendations.
15.	15.
	External Gaps in Assurance 1. Lack of escalation and response to AQIs by the wider urgent care system and regulators

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Handover checklist implementation – Nationally WAST Quality Improvement (QI) Project	WAST QI Team (QSPE)	• TBC - Paused	• Timeframes awaited via Emergency Department Quality & Delivery Framework (EDQDF).
2. Implement patient safety dashboards (live and look back data) triangulating quality metrics / KPIs and performance data sourcing health informatics resource.	Assistant Director of Quality & Nursing	• 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	• Bid not successful. However, Trust decision to proceed with 18 MSC places. • **RAG status reframed around the new timelines /programme.** • **22 trainee APPs expected to complete training in Jun-23.** • **EMT has agreed to offer places to these 22 trainee APPs funded from a reduction in technician posts 1/2s i.e. internal movement.** • **The Trust submitted a national bid to support APP expansion as part of the £5million additional Welsh Government funding for AHP expansion in Primary & Community Care.** • **In June-23 the Trust were informed that the bid was not successful. The funding had been allocated to health boards based on the initial funding allocation specified by Welsh Government. WAST is involved with two health board bids in BCU and C&V which require the Trust to support for delivery.**
5. Overnight falls service extension	Executive Director of Quality & Nursing	• **June 2023**	• Night Car Scheme extension agreed to 31 March **2024** (2 regional resources) • **Nighttime falls assistance 64% Utilisation (Apr 2023 -Jun 2023)** • **Day resources progress continuing toward 60% utilisation target. April – June responded to 1,845 incidents an 18% increase on same period 2022.** • **Falls level 1 and 2 impact evaluation report completed - and presented to Clinical Quality Governance Group (CQGG) Jan 2023.** • **Optima modelling underway to examine optimal resourcing level. The has been delayed due to prioritisation of Executive requests.**
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.

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			• **National Policy on Patient Safety Incident Reporting & Management adopted in June 2023.** • Participation in the All Wales Duty of Candour implementation group by Patient Safety Team – monthly. • Quality Management System workshop to be held 12 June 2023.
7. Virtual Ward now Connected Support Cymru	Executive Director of Quality & Nursing	• Q3 2023/24	• **Service live.** • **Currently identifying a 48% EA avoidance rate.** • **Staff absence and roster gaps in SJA (provider) an issue currently.** • **Funding also obtained to support the capacity to recruit volunteers (600 in total).**
8. Organisational change process of Putting Things Right Team (PTR) to enable increased capacity across all functions to manage increasing complexity and demands.	Executive Director of Quality & Nursing	• Q3 2023/24	• Informal consultation phase commenced May 2023.
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	• Q2 2023/24	• Meeting planned August 2023 with the Chair of the TVN Network.
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**	• **Q3 2023/24**	• **Terms of reference drafted.**

Completed Actions	Action Owner	When /Milestone	Progress Notes:
1. HIW Improvement Plan / Workshop – WAST inputs / influencing improvements. Response and improvement actions to Healthcare Inspectorate Wales Inspection report (2021) 'Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover' which links to Fundamentals of Care.	Assistant Director of Quality & Nursing	Completed	
2. Representation at the Right care, right place, first time Six Goals for Urgent and Emergency Care Delivery Boards and Clinical Advisory Board.	Chief Executive Officer	Completed	• Led by the NHS Wales Deputy Chief Executive this programme seeks to modernise access to and the provision of Urgent and Emergency Care across Wales • WAST will be represented on the Clinical Reference Group by Andy Swinburn with first meeting now held. • The Trust recently reported to EASC that is has further updated how it maps into six goals programmes. The programme structure nationally is being embedded and the Trust now has presence on goals 2, 5 & 6 at delivery board level and on the clinical advisory board.
3. Participation in the CASC led workshop to reform the Framework for the Investigation of Patient Safety Serious Incidents (SIs) V2.2, dated July 2019.	Executive Director of Quality & Nursing	Completed	• Revised joint investigation approach agreed and now formalised.
4. Recruit additional frontline capacity – additional £3m non recurrent 22/23 allocation	Director of People & Culture	Completed	• Strong focus from Executives with detailed updates to EMT every two weeks. • Year-end position is +85 FTEs, with a vacancy factor of just 1%, rather than the often used 5%, which would produce a figure of -88 FTEs rather than the estimated - 15 FTEs. • Further non recurrent funding has been secured for 2023/24

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Current	5	5	25
Target	3	2	6

5. Transition Plan	Chief Executive Officer	Completed	• Action complete, but the Trust will continue to undertake strategic and technical workforce planning in support of the Trust's ambition e.g. inverting the triangle etc.
6. Consideration of additional WAST schemes to support overall risk mitigation through winter	Director of Operations	Completed	• Winter ended. Focus now on forecasting and modelling for the summer, but Trust not aiming to produce specific Summer Plan (the Trust did during the pandemic linked to travel restrictions). • The Trust needs to determine whether there is value in producing a specific winter plan, particularly, within the context of the financial constraints NHS Wales is not operating in.
7. National 111 awareness campaign	Director of Partnerships and Engagement Director of Digital	Completed	• The national awareness campaign was undertaken as planned and ended in March 2023. An evaluation will be provided to the 111 Board.

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:	13/08/2023	TREND	20 (5x4)
		Date of Next Review:	13/09/2023	➡	

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

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

IMTP Deliverable Numbers: 1,5, 9, 10, 12, 17, 18, 19, 20, 26, 34

EXECUTIVE OWNER	Director of People & Culture	**ASSURANCE COMMITTEE**	People and Culture Committee

CONTROLS	**ASSURANCES**
	Internal Management (1st Line of Assurance)
1. Managing Attendance at Work Policy/Procedures in place	1. (a) Policy reviews to ensure policies and procedures are fit for purpose (b) Audits by People Services on sickness
2. Respect and Resolution Policy- recognising issues at work may contribute to sick absence	2. Policy reviews to ensure policies and procedures are fit for purpose in line with agreed time frames and contribute to All Wales forum on this policy
3. 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
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
5. Operational Workforce Recruitment Plans- provide evidence of sufficient resources and identify any gaps or potential areas of increased workload pressure	5. Local plans link to the wider organisational workforce plan and provide intelligence regarding any particular pinch points in terms of resources
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 receives 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.
13. Suicide first aiders- additional layer of support	13. Quarterly reporting of numbers of trained suicide first aiders and numbers who have accessed.
14. TRiM- additional layer of support	14. Quarterly reporting on access to TRiM and promotion of service
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
17. Staff surveys- assess levels of engagement and wellbeing	17. New **HIVE** survey tool will provide data on overall engagement and wellbeing
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
19. Sickness statistics are reported to SLT, SOT, People & Culture Committee, Trust Board and the CASC	19. Sickness forms part of Workforce Scorecard to People & Culture Committee
20. External agency support e.g. St John Ambulance, Fire and Rescue- if needed at times of increased pressure	20. Standard procedures in place to access additional resource capacity
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. Fortnightly report on absence to EMT and report to every meeting of People & Culture Committee	23. Minuted meetings and action logs for EMT & People & Culture Committee
24. Sickness audits for localities- provides additional level of detail	24. Audits carried out and actions taken forward

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:	13/08/2023	TREND	20 (5x4)
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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

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 on a monthly basis	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 eg – mental health and causes
28 2023 10 point action plan shared with EMT for assurance and RAG rated to track progress quarter	28. **Offers assurance to EMT on the activities and measures in place.**
	External Management (2nd Line of Assurance)
	1a. All Wales review of All Wales Attendance at Work Policy
	Independent Assurance (3rd Line of Assurance)
	1b. Internal Audits scheduled through Shared Services Partnership (controls 1 - 24)
	2. Audit Wales – Taking Care of the Carers report in October 2021 (controls 1 - 24)
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. (a) Consistency and Application in Managing Attendance at Work Policy	1. There are other factors that impact on sickness which can't be controlled
9 and 10 It is not known what is undertaken with respect to the data covered in assurances 9 and 10 once it is received	9, 10 and 19 Absence data is not updated in a timely manner into ESR by managers
1 – 22 Education and communication with managers about resources available and how to implement it e.g. stress risk assessments	
	External Gaps in Assurance None identified at the present moment

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Implementation of Improving Attendance project	Deputy Director of People & Culture	31.09.23 Completed 2022/23	Underway and ongoing, 2022/23 actions complete or embedded as BAU. May data 7.6%. Trajectory continues to be positive. 10 point plan for 2023/24 agreed by EMT and being implemented.
2. Implementation of Behaviours Refresh Plan	Assistant Director – Inclusion, Culture and Wellbeing	31.10.22 Extended to 31.05.23 CLOSED	Underway and ongoing. Captured in the IMTP for the service. Impacted by IA. New approach adopted from April 2023 to focus on a new behaviour every 6 weeks and continue conversations. Directly linked to people and culture plan. Closed
3. Long term sickness absence deep dive	Deputy Director of People & Culture	31.07.23 **Extend to 31.01.24 based on new plan for 2023/24**	Underway and ongoing. Downward trajectory in levels of long term absence- proposed that this is extended until 31/12/23 to enable more detailed work of reasons, measures being implemented and impact.
4. Develop guidance for line managers to support addressing challenging conversations and change	Deputy Director of People & Culture	31.07.22 Complete	Training produced and rolled out. Now BAU
5. Roll out platform for raising concerns (in relation to Freedom to Speak Up Arrangements)	Freedom to Speak Up Arrangements Task & Finish Group Ownership moving to DWOD	Extended from 31.07.22 to 31.03.23. Extended to 31.05.23	Extended date in terms of project plans and impact of Industrial Action.

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:	13/08/2023	TREND	20 (5x4)
		Date of Next Review:	13/09/2023	➡	

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

		Extended to 31.08.23	21.3 The task and finish group has completed its work and the project is now going to be handed to DWOD as SRO for the work. 21.06 soft launch of the platform in August with official launch in September in line with Practice Ethically behaviour. **03/08/23 - Soft launch commenced 1 August 2023, full launch moved to October as it is freedom to speak up month.**
6. Strengthen Freedom to Speak Up Arrangements policy and advice	Assistant Director of Inclusion, Culture and Wellbeing	**31.05.23** **Extended to 31/08/23**	Deadline extended to coincide with launch of new platform, although Guardians are in place and weekly review meetings taking place. They are receiving the highly confidential Datix and concerns raised through networks and attendance at ER monthly review from July. SharePoint page constructed and comms plan being finalised following refresher demos to key stakeholders. Behaviours reinforced via culture champions group, rotating through behaviours, currently broaden our understanding. Head of Culture and OD in post from August to further this work. **03/08/23 - Share point page published, comms plan in place.** **complete**
7. Create a Manager and Staff training plan for Freedom to Speak Up Arrangements	Assistant Director Inclusion, Culture and Wellbeing	**31.05.23 extended to 30/9/23**	Ongoing – extended until 30/9/23 to enable soft launch with feedback and policy and advice to be shared. Training plan will be produced with an emphasis on making the platform and use of freedom to speak up as simple and accessible as possible. SharePoint page constructed and comms plan being finalised following refresher demos to key stakeholders. Head of Culture and OD in post from August to further this work. **03/08/23 - Training plan identified**
8. Accountability meetings with senior ops managers	Deputy Director of People & Culture	30.09.22 Complete and ongoing BAU	Underway, conversations re sickness absence well established and continuing
9. Attendance Management training for managers	Deputy Director of People & Culture	31.12.22 Complete and BAU	Underway and ongoing – now BAU 1.11.22

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:	13/08/2023	TREND	20 (5x4)
		Date of Next Review:	13/09/2023	➡	

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

10. PADR review including wellness questions	Assistant Director – Inclusion, Culture and Wellbeing	Complete	Complete. New PADR distributed October 22.
11. Restart the Health and Wellbeing Steering Group	Assistant Director – Inclusion, Culture and Wellbeing	Complete **Aug 23 - Paused**	Complete – group started 17.10.22 and will meet quarterly. **03/08/23 - Paused until key vacant posts, i.e. Head of Workplace Wellbeing and OH Manager, are filled**
12. Review of top 100 cases by the team on a monthly basis	Deputy Director of People & Culture	Commenced and ongoing – review 30.06.23 BAU	Underway and now BAU
13. Actions identified from the Managing Attendance Audit	Deputy Director, People and Culture	Commenced and ongoing. Completion 31.12.23	Delivery of the actions underway and partially complete. All will be completed by 31.12.2023.

Risk ID 201	Damage to Trust reputation following a loss of stakeholder confidence	Date of Review:	09/08/2023	TREND	20 (4x5)
		Date of Next Review:	09/09/2023	➡	

IF the stability of the Trust deteriorates to a level where service delivery fails to meet patient safety, national standards and contractual obligations	THEN there is a risk of a loss of stakeholder confidence in the Trust	RESULTING IN damage to reputation and increased external scrutiny

	Likelihood	Consequence	Score
Inherent	4	5	20
Current	4	5	20
Target	3	5	15

IMTP Deliverable Numbers: 2,18, 26, 34, 38

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

Risk Commentary Q4 2022/23

a) 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 (including the impact of extended handover delays at hospitals), the impact of recent industrial action and the levels of patient harm 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, media relations work, patient experience and internal communication and engagement continue, but are not sufficient to outweigh the impact of the core issues which affect reputation. 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.

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. Regular engagement with senior stakeholders e.g. Ministers, senior Welsh Government officials, commissioners, elected politicians and NHS Wales organisational system leaders	1. Agendas, minutes and documents of engagement events
2. Challenging of media reports to ensure accuracy	2. Programme of daily media engagement
3. Media liaison to ensure relationships developed with key media stakeholders	3. Programme of daily media engagement
4. Engagement Framework approved by the Board July 2022	4. Issues of reputation monitored at EMT via weekly Forward Look item – minuted meetings and action logs.
5. Engagement Framework Delivery Plan approved by the Board January 2023	5. The Director of Partnerships and the Head of Strategy are working closely with colleagues from PWC to inform further detail regarding future engagement including stakeholder analysis, case for change etc. Routine stakeholder and staff engagement continues, including the recent round of Executive roadshows and WAST Live.
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. EMT, FPC, PCC, QuEST & Audit Committee – minuted meetings and action logs. Outcome of recent reputation audit to be reported through EMT in April and onward, as a minimum, to PCC.
7. Escalation procedure for issues to the Board	7. Minuted meetings, action logs and Board papers
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1.	1.
2.	2.
3.	3.
4.	4.
5. The delivery plan is in abeyance pending outcome of the work underway by PWC in relation to the Trust's strategic ambitions.	5.
6.	6.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Submit refreshed Board Engagement Framework to Trust Board for approval	Director of Partnerships & Engagement	26.05.22 Complete	Approved July 2022
2. Roll out of the Engagement Framework Delivery Plan	Director of Partnerships & Engagement	Paused	Pending outcome of PWC work
3. Board oversight, scrutiny and challenge of performance, concerns, quality	CEO / Executive Management Team	Ongoing	

Risk ID 201	Damage to Trust reputation following a loss of stakeholder confidence	Date of Review:	09/08/2023	TREND	20 (4x5)
		Date of Next Review:	09/09/2023	➡	

IF the stability of the Trust deteriorates to a level where service delivery fails to meet patient safety, national standards and contractual obligations	THEN there is a risk of a loss of stakeholder confidence in the Trust	RESULTING IN damage to reputation and increased external scrutiny

	Likelihood	Consequence	Score
Inherent	4	5	20
Current	4	5	20
Target	3	5	15

4. Monitoring internal Quality and Performance of Trust and raising system issues	Executive Management Team, Finance and Performance Committee Quality, Safety and Patient Experience Committee, People and Culture Committee, Audit Committee	Ongoing	
5. Engaging with internal and external stakeholders to develop confidence	CEO & Director of Partnerships & Engagement	Ongoing BAU	Regular engagement continued with staff, TU partners and a range of external stakeholders such as AMs, MPs, Local Authorities etc. BAU.
6. Monitoring external factors that may affect the Trust	CEO & Director of Partnerships & Engagement	Ongoing BAU	
7. Llais (the new Citizens Voice Body attending October 2023 Board Development	Director of Partnerships & Engagement	October 2023	
8. Reputation Audit deep dive on findings to be presented at Board Development	Director of Partnerships & Engagement	October 2023	

Risk ID 139	Failure to deliver our Statutory Financial Duties in accordance with Legislation	Date of Review:	31/07/2023	TREND	16 (4x4)
		Date of Next Review:	31/08/2023		

IF the Trust does:	THEN there is a risk that the Trust will fail to achieve all of its statutory financial obligations and the requirements as set out within the Standing Financial Instructions (SFIs)	RESULTING IN potential interventions by the regulators, qualified accounts and impact on delivery of services and reputational damage

- not achieve financial breakeven and/or
- does not meet the planning framework requirements and/or
- does not work within the EFL and/or
- fails to meet the 95% PSPP target and/or
- does not receive an agreement with commissioners on funding (linked to 458)

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

IMTP Deliverable Numbers: 10, 18, 28, 30, 34. 35, 37,38

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

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. Financial governance and reporting structures in place	1. Risk is reviewed quarterly at F&P and a report is submitted bi-monthly to Trust Board
2. Financial policies and procedures in place	2.
3. Budget management meetings	3. Diarised dates for budget management meetings
4. Regular financial reporting to ADLT, EFG, EMT, FPC and Trust Board in place	4. Diarised dates for EFG and FPC and monthly reports
5. Welsh government reporting	5.
6. Monthly review of savings targets	6. ADLT monthly review
7. Regular review monitoring and challenge via WAST and CASC quality and delivery meeting with commissioners.	7.
8. Monthly ICMB (Internal Capital Monitoring Board) meetings to monitor and review progress against capital programme and engagement with WG and capital leads.	8. Diarised dates for ICMB meetings with regular monthly report
9. PSPP monthly reporting and regular engagement with P2P colleagues and periodic Trust Wide communications	9. Regular PSPP communications (Trust wide) on Siren
10. Forecasting of revenue and capital budgets	10. (a) Monthly monitoring returns to ADLT, EFG, EMT and FPC (b) Reliance on available intelligence to inform future forecasting.
11. Business cases and benefits realisation (both revenue and capital)	11. Business cases – scrutiny and approval at senior management team which are submitted to ADLT, EMT, FPC prior to Trust Board for approval as appropriate according to value.
	External Assurances Management (1st Line of Assurance)
	5. Monthly Monitoring Returns to Welsh Government
	7. EASC management meetings. Monthly meetings with EASC and DAG for NEPTS.
	8. Bi-monthly Capital CRL meetings with Trust and WG capital leads
	9. Regular P2P meetings diarised (bi-monthly)
	10. Monthly monitoring returns into Welsh Government
	Independent Assurances (3rd Line of Assurance)
	1-10 Internal audit reviews covering
	1-10 External audit reviews
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
• Lack of formalised service contracts between Commissioner and WAST as a commissioned body	None identified.

Risk ID 139	Failure to deliver our Statutory Financial Duties in accordance with Legislation	Date of Review:	31/07/2023	TREND	16 (4x4)
		Date of Next Review:	31/08/2023		

IF the Trust does:	**THEN** there is a risk that the Trust will fail to achieve all of its statutory financial obligations and the requirements as set out within the Standing Financial Instructions (SFIs)	**RESULTING IN** potential interventions by the regulators, qualified accounts and impact on delivery of services and reputational damage
• not achieve financial breakeven and/or • does not meet the planning framework requirements and/or • does not work within the EFL and/or • fails to meet the 95% PSPP target and/or • does not receive an agreement with commissioners on funding (linked to 458)		

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

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	22/23 Finances have been agreed as part of year end agreement of balances. Issue currently around the 100 WTE £6m funding and negotiations continue.
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.
3. Embed value-based healthcare working through the organisation	Executive Management 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 vfm 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.

Risk ID 163	Maintaining Effective & Strong Trade Union Partnerships	Date of Review:	03/08/2023	TREND	16 (4x4)
		Date of Next Review:	03/09/2023	→	

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

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

IMTP Deliverable Numbers: 2, 4, 6, 11, 20, 34

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

CONTROLS	**ASSURANCES**
	Internal **Management (1st Line of Assurance)**
1. Agreed (Refreshed) TU Facilities Agreement developed in partnership	1. Agreed document which states governance arrangements and the criteria for time off for TU activity etc.
2. Go Together Go Far (GTGF) statement and CEO/TU Partners statement	2. Both parties refer to the documents and are signed up/committed to it
3. IPA Workshops	3. Meetings completed with participation from TUs and senior managers. Attendance lists are available
4. Trade Union representation at Trust Board, Committees	4. Committee or Board ask TU representative for feedback or whether they have been consulted. Big issues items progress as planned as a result of TU partner buy in
5. Monthly Informal Lead TU representatives and Chief Executive meetings	5. Diarised meetings
6. Staff representative management in Task & Finish Groups	6. Good attendance and commitment is observed at the meetings. TU partners listed as members in terms of reference
7. 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	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 to be signed off at next WASPT meeting in June 2023	10.
	External - Not applicable

GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Need to move back to business-as-usual footing	None identified
2. Facility to manage situations where there is a failure to agree, to avoid grievance and disputes from occurring	

Actions to reduce risk score or address gaps in controls and assurances	**Action Owner**	**By When/Milestone**	**Progress Notes:**
1. Develop an action plan from the recommendations of the ACAS report	Deputy Director of People & Culture	Completed 12/01/23	Action Plan for delivery created and shared with TU Secretary for feedback from TUPs
2. Agree the ToR for refreshed Partnership Forum meeting and move back to a business-as-usual footing	Deputy Director of People & Culture	Completed 12/01/23	WASPT re-established. Third meeting scheduled T&F group undertaking work on the engagement model below WASPT through SLT and SOT is in progress with TU engagement. TU cell stood down.
3. Proposed externally facilitated mediation session(s) building on the IPA workshops and specifically to address the thorny issue of what happens when we fail to agree	Deputy Director of 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

Risk ID 163	Maintaining Effective & Strong Trade Union Partnerships	Date of Review:	03/08/2023	TREND	16 (4x4)
		Date of Next Review:	03/09/2023	→	

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

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

4. Minutes of formal Partnership Forum should be reported to PCC or Board in future (return to BAU).	Deputy Director of People & Culture	Completed 12/01/23	WASPT feeding into PCC
5. Establish formal meeting structures below WASPT	Deputy Director of People & Culture	30.06.2023 Completed	Structure agreed with TUs. Sign off at next WASPT meeting. Highlight reports to be shared at WASPT. Completed structures for Local Partnership Forums and SOT/ SLT for operations and Partnership Meeting for Corporate Services agreed, ToR for SOT /SLT and LFP agreed.
6. Refresh of engagement programme post Industrial Action and establish work	Deputy Director of People & Culture	30/08/23	

Risk ID 424	Resource availability (capital) to deliver the organisation's Integrated Medium-Term Plan (IMTP)	Date of Review:	11/08/2023	TREND	16 (4x4)
		Date of Next Review:	11/09/2023	➡	

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

	Likelihood	Consequence	Score
Inherent	4	4	16
Current	4	4	16
Target	1	4	4

IMTP Deliverable Numbers: 5,9,10, 17, 28

EXECUTIVE OWNER	Director of Strategy, Planning & Performance	ASSURANCE COMMITTEE	Strategic Transformation Board and Finance and Performance Committee

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. Prioritisation of IMTP deliverables	1. Prioritisation detailed in IMTP and reviewed and agreed at Strategic Transformation Board
2. Financial policy and procedures	2.
3. Governance and reporting structures e.g. Strategic Transformation Board (STB)	3. IMTP sets out delivery structures and meeting minutes are available
4. Assurance meetings with Welsh Government and Commissioners	4. Agendas, minutes and slide decks available
5. Transformation Support Office (TSO) which supports the major delivery programmes	5. Paper on TSO to Strategic Transformation Board
6. Project and programme management framework	6. PowerPoint pack detailing PPM
7. Regular engagement with key stakeholders	7. Stakeholder Engagement Framework
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 PPM	Head of Transformation	Extended from 31.03.23 – To 31.06.23 and then to 30.09.23 in line with milestone for delivery	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.**
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	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.
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 checkpoint date to 31.03.2023 on basis of new financial allocations for 2023 to be worked through with Commissioner

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:	08/08/2023	TREND	16 (4x4)
		Date of Next Review:	08/09/2023	➡	

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

IMTP Deliverable Numbers: 2, 12, 16, 18, 23, 24, 25, 26, 28,30, 34, 37, 38

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

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

Actions to reduce risk score or address gaps in controls and assurances	**Action Owner**	**By When/Milestone**	**Progress Notes:**
1. A formal approach to service change to be developed providing secure recurrent funding with commissioners.	Executive Management Team	31.12.23	Update: 22/23 Recurrent & non-recurrent Finances have been agreed as part of year end agreement of balances. Issue currently around the 100 WTE £6m funding and negotiations continue. **Recent letter from Commissioners indicates funding will be forthcoming however with conditions.**
5. Develop a Value Based Healthcare system approach with commissioners. This would mean that funding would flow more seamlessly between organisations and would go some way to mitigating the risk of not receiving recurrent funding.	Deputy Director of Finance	31.12.23	Update: Work to identify the PROMS & PREMS evaluation criteria for Emergency based services via the Value-Based Healthcare working group continues.

Risk ID 199	Failure to embed an interdependent and mature health and safety culture which could cause harm and a breach in compliance with Health & Safety statutory legislation	Date of Review:	04/08/2023	TREND	15 (3x5)
		Date of Next Review:	04/09/2023	➡	

IF there is a failure to embed an interdependent and mature health and safety culture, effective arrangements and associated governance	THEN there is a risk of a potential breach in compliance with the requirements of the Health & Safety at Work etc. Act 1974 and associated regulations and other statutory instruments	RESULTING IN death or serious injury, and punitive actions from multiple enforcement agencies including penalties and adverse publicity leading to damage to reputation

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

IMTP Deliverable Numbers: 1, 7, 9, 12, 16, 17, 24, 25, 26, 33, 35, 38

EXECUTIVE OWNER	Director of Quality and Nursing	ASSURANCE COMMITTEE	People and Culture Committee

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1 Systematic review and assessment of Health and Safety arrangements and Governance (All NHS Wales Health & Safety Management System - HSMS).	1. Assessment criteria set for health and safety management system (HSMS) All Wales system). HSMS approved at ADLT in 2022. ADLT members sponsorship for all 11 management principles.
1. Health & Safety Governance and reporting arrangements – National Health, Safety and Welfare Committee. Reporting into People and Culture Committee. (PCC)	2. Trusts Legislative Compliance Register in place **and assessment approved by SOT and ADLT in April 23. Position landed as 1.98/3 providing a Moderate level of Assurance.** Monthly, Quarterly and Annual H&S performance reports to ADLT and H&S National Health, Safety and Welfare Committee. Quarterly performance reports to ADLT, EMT and PCC **- commencing presentation at SOT in Q2 23.** Reports published on H&S webpage. H&S climate cultural survey developed to determine perception of Trust position against Bradley Curve.
2. Provision of dedicated health and safety expertise and advice to meet the requirements of the Management of Health and Safety at Work Regulations 1999, - Regulation 7 'Health and Safety Assistance'.	3. H&S Policy approved in 2018. Following landing of business case, Policy reviewed and **substantial consultation process completed in Q2 23. Policy expected to go to EMT for approval in Q2 -Q3 23.** Violence and Aggression Policy in place. Risk Assessment Procedure, Display Screen Equipment Procedure, Workplace Premise Audits Inspection Procedure in place. Control of Substances Hazardous to Health (COSHH), New and Expectant Mothers Risk Assessment Procedure approved at ADLT in February 2023. Lifting Operations Lifting Equipment / Provision and Use of Workplace Equipment (PUWER) combined Procedure in draft with an expectation of commencing the approval process approval during Q2-Q3 2023. Lone Worker Procedure ongoing - expectation of second draft Q2-**Q3** 2023. Trust wide Hazard register in place. Reviewed by ADLT in Q1 2023 and **approved by SOT and ADLT in April 23 Q1 2023.**
3. Health & Safety Policy and Corporate level Procedures.	4. H&S Policy approved in 2018. Following landing of business case, Policy review underway Q4 2022-Q1 2023. Violence and Aggression Policy, Risk Assessment Procedure, Display Screen Equipment Procedure, Workplace Premise Audits inspection Procedure in place. Control of Substances Hazardous to Health (COSHH), New and Expectant Mothers Risk Assessment Procedure approved at ADLT in February 2023. Dangerous Substances Explosive Atmospheres (DSEAR) Procedure, Lifting Operations Lifting Equipment / Provision and Use of Workplace Equipment (PUWER) combined Procedure in draft with an expectation of commencing the approval process approval during Q1 2023. Lone Worker Procedure ongoing - expectation of second draft Q1 2023. Trust wide Hazard register framework in place. Reviewed by ADLT in Q1 2023 with expectation of approval Q1 2023.
4. Mandatory Health and Safety training for all staff on ESR. Induction training in place for all new operational staff.	5. Quarterly statistics provided by ESR support team and incorporated into Health and Safety Quarterly Performance reports. Induction training compliance held on ESR
5. 2 year rolling programme of scheduled H&S premise audits.	6. Inspections are being undertaken in line with schedule. Live action.
6. Risk assessments (including local risk assessments, Covid 19, Workplace Risk Assessments, risk assessments covering EMS and NEPTs activities, operations risk assessments).	7. Workplace risk assessments are undertaken by local management teams, reviewed by H&S team and previously monitored by BCRT. These are being monitored by local operations mangers. Other operational risk assessments and SOPs are held on dedicated Share-point sections. Performance metrics in place **and monitored via SOT and Quarterly Performance Reports.**

Risk ID 199	Failure to embed an interdependent and mature health and safety culture which could cause harm and a breach in compliance with Health & Safety statutory legislation	Date of Review:	04/08/2023	TREND	15 (3x5)
		Date of Next Review:	04/09/2023	➡	

IF there is a failure to embed an interdependent and mature health and safety culture, effective arrangements and associated governance	THEN there is a risk of a potential breach in compliance with the requirements of the Health & Safety at Work etc. Act 1974 and associated regulations and other statutory instruments	RESULTING IN death or serious injury, and punitive actions from multiple enforcement agencies including penalties and adverse publicity leading to damage to reputation

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

7. Working Safely Strategic Programme Board (STB) to provide oversight of the Working Safely Action plan. Dynamic Delivery Action Group to continue to undertake actions on the Working Safely Action Plan.	8. Working Safely Action Plan has been agreed and this is being held to account by Strategic Transformation Board. Deliverables are being monitored through the Dynamic Delivery Group meeting. Terms of reference for Dynamic Delivery Group are approved. **Live action.**
8. Rolling programme of IOSH Managing Safely- for Managers- scheduled training programme in place.	9. Attendance and competency figures provided in a quarterly **04** to ADLT, National Health, Safety and Welfare Committee and People and Culture Committee.
9. IOSH Leading Safely for Directors and Senior Managers training in place.	10. Attendance and figures provided in monthly report to ADLT. Personal safety commitments are to be monitored on a quarterly basis **following discussions to be held with Board Secretary, Executive Director for Quality and Safety and Head of Health & Safety in Q2-3 2023.**
10. Board Development Day covering Health & Safety Management and Culture Awareness training undertaken in April 2022.	11. Diarised meeting.
11. Health and Safety Management System recognised document approval routes for health and safety documentation.	12. Approved and minuted at ADLT meeting in 2022. **HSMS document approval process to be reviewed to include SOT approval Q2 2023.**
12. IOSH Leading Safely training delivered to majority of Board and Executive Team on 26 July 2022.	13. Compliance metrics held on H&S team database.
13. IOSH Leading Safely additional sessions for new Board /EMT members and ADLT to be scheduled for 2023.	14.
14. Leading Safely, Safety Positive conversations training to be delivered to Board and EMT to be rescheduled from June 2023.	15. **Discussions scheduled with Board Secretary and Head of H&S in August 23 on options for delivery.**
15.	16. Internal Audit to be undertaken in Q1-**Q2** 23/24 (controls 1– 10). **Audit position landed as 'Reasonable' level of assurance. (External Independent Assurance (3rd Line of Assurance)**

GAPS IN CONTROLS	GAPS IN ASSURANCE
1.	**1.** Baseline audit for HSMS not to be commenced till Q**3** 2023 (***being addressed in Action 1)***
2. Subgroups of National H&S and Welfare Committee currently under review. **(being addressed in Action 2)**	2. H&S Climate Cultural survey to be rolled out once political pressures (IA) reduce**.** Expectation of roll out **Q3-Q4** 2023/24 (***being addressed in Action 3)***
3.	3.
4. The Health and Safety Policy and some procedures are due to be reviewed by the end of Q4 2022 in Q1 2022 (***being addressed in Action 4***)	4. (a) Review of H&S Policy has been undertaken, **and substantial consultation process ceased in August 23. Policy to be presented at EMT in Q2-Q3 20203 for approval before commencing to PCC for final approval.** (***being addressed in Action 4)*** (b) Workforce Transformational change has influenced some content within H&S policy (***being addressed in Action 4)***
5. Poor uptake in statutory and mandatory H&S training ***(being addressed as part of Actions 5)***	5.
6.	6. Two-year Schedule for H&S inspections and visits commenced September 2022. Compliance metrics, themes and trends are to be included within Monthly and Quarterly and Annual Performance Reports. ***(being addressed as part of Actions 6)***
7.	7. (a) Current copies of risk assessments and SOPs are not available at all stations. ***(being addressed as part of Actions 7)*** (b) Lack of clarification over many SOPs are required until HSMS baseline audit has been completed. ***(being addressed as part of Actions 7)***
8. Operational pressures and Industrial Action on service impacting on Working Safely Programme delivery **(being addressed in Action 8)**	8.
9. Staff availability to attend training ***(being addressed in Action 5)***	9. Work ongoing to determine how many Managers require IOSH Manging Safely. ***(being addressed in Action 9).*** A H&S Training needs analysis has been developed and incorporated into the H&S Policy.

Risk ID 199	Failure to embed an interdependent and mature health and safety culture which could cause harm and a breach in compliance with Health & Safety statutory legislation	Date of Review:	04/08/2023	TREND	15 (3x5)
		Date of Next Review:	04/09/2023	➡	

IF	THEN	RESULTING IN
there is a failure to embed an interdependent and mature health and safety culture, effective arrangements and associated governance	there is a risk of a potential breach in compliance with the requirements of the Health & Safety at Work etc. Act 1974 and associated regulations and other statutory instruments	death or serious injury, and punitive actions from multiple enforcement agencies including penalties and adverse publicity leading to damage to reputation

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

10. Effective learning from events to be documented ***(being addressed in Action 8)***	10. Currently there is no structured monitoring process in place to ensure attendance on the IOSH Leading Safely course. ***(being addressed in Action 5)***
11.	11.
12.	12.
13.	13.
14.	14.
15.	15.
16.	16.
17.	17.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Meetings to be scheduled to undertake baseline assessment and feedback to EMT.	Head of Health and Safety	Q2-Q3 2023	
2. Meetings to be held with TU partners and AD/Head of H&S to agree arrangements for sub-groups.	Head of Health and Safety	**Q1 2023**	ToR Developed and presented at National HSW Committee in Q2 2022. Further discussions requested a Charter arrangement. Draft Charter developed and presented in National HSW committee in Q3 2022. Further discussions requested by TU partners. Following discussions held with OD in April 2023 to provide consideration of integrating subgroups into WASTP, 23.06.23- H&S to be incorporated into WASTP sub-groups LPF.
3. Assessment to be undertaken in Q1 2023 of political pressure to determine viability of conducting culture survey	Head of Health and Safety	Q2-Q3 2023	Political pressures still present. Survey to be rolled out once eased. Watching brief.
4. **Revised** H&S Policy **to achieve ratification**	Head of Health and Safety	**Q1 2023**	Initial meeting held in December 2022 first draft to be presented at Policy Group Meeting in January 2023 for comments from key stakeholders. Challenges with attendance due to IA. Expectation of draft Policy being presented at Policy Group to propose full consultation in May 2023. Policy presented at Policy Group in June 23 and commences substantial consultation process on 30.06.23. **Policy expected to be presented to EMT for approval in Q2-3 2023.**
5. IT solution being investigated to collate data from inspections to enable trending and monitoring of actions generated	Deputy Head of Health and Safety	Q4 2023	The audit proforma has been migrated onto MS Forms to allow for improved data collection. Meeting held with I.T. provider in Q4 2022 provide consideration for the development of utilisation of Power B.I systems. Ongoing.
6. H&S advisors will liaise with local management teams to identify risk assessments and SOP's in place and ensure visibility on SharePoint	Deputy Head of Health and safety	Q2-Q3 2023	Ongoing action. Assessment against the HSMS Principle 3- Compliance Assurance will assist in determining what RA/SOPS are required. **Live action.**
7. Priority Elements of Working Safely Action Plan to be identified and programme schedule presented to STB to ensure sufficient support from Operational Teams. Migrate into Annual Health and Safety Improvement Plan.	Head of Health and Safety	Q2 2023	Priority actions for 2023-24 identified as Culture, Manual Handling, Violence and Aggression, Incident investigation training. 05.04.23 Development of Health and Safety Improvement Plan **developed Q1 2023 and monitored via Monthly H&S team meetings.**.
8. Review of number of line managers within the Trust to put in place a suitable schedule to roll out appropriate H&S training as determined within the training needs analysis within the H&S Policy.	Deputy Head of Health and Safety	Q2 2023	Interim schedule in place to address known line managers. Further work required with other Directorates to allow for performance metrics to be generated.
Completed Actions	**Action Owner**	**When /Milestone**	**Progress Notes:**

Risk ID 199	Failure to embed an interdependent and mature health and safety culture which could cause harm and a breach in compliance with Health & Safety statutory legislation	Date of Review:	04/08/2023	TREND	15 (3x5)
		Date of Next Review:	04/09/2023	➡	

IF there is a failure to embed an interdependent and mature health and safety culture, effective arrangements and associated governance	THEN there is a risk of a potential breach in compliance with the requirements of the Health & Safety at Work etc. Act 1974 and associated regulations and other statutory instruments	RESULTING IN death or serious injury, and punitive actions from multiple enforcement agencies including penalties and adverse publicity leading to damage to reputation

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

1. Delivery of the Working Safely Action Plan (WSAP) (Priority top 25)	Head of Health & Safety	31.09.22 **Partially completed.** Long term action.	Pump and Prime phase commenced 01.09.21. Closure report for PPP presented to EMT during Q3 2022/23. Working Safely Programme to continue being monitored by STB. Four priorities determined for 2023/24- Violence & Aggression, Culture, Manual Handling and Incident Investigation.
2. IOSH Leading Safely training to be delivered to Exec Team and Board (forms part of WSAP)	Head of Health & Safety	31.12.22 **Partially completed.**	Training delivered to Board and Executive team on 26.07.22. IA and operational pressures impacted on availability to attend during Q4 2022.Further sessions to be scheduled for Q1 2023/4- Q2 2023/24 for new members.
3. WAST Leading Safely Behavioural Audit training to Exec Team and Board (forms part of WSAP)	Head of Health & Safety	31.12.22 Scheduled	Initially scheduled for BDD - February 2023. Rescheduled to June 2023. **Discussions to be held with Board Secretary and Head of H&S in August 23 around alternative delivery style of training.**
4. H&S team workforce review (accompanying Business Case forms part of this) (this forms part of WSAP)	Head of Health & Safety	31.03.22 Completed	Completed- Workforce review fully implemented 03.10.22
5. Culture survey to all members of staff (forms part of WSAP)	Head of Health & Safety	30.09.22 **Partially completed**	Survey developed and to be presented at National H&S Committee on 02.11.22 and SOT in December for feedback. Decision made during Q3 2022/23 to postpone survey unit political pressures ease. Expectation of roll out Q4 2023-Q1 2023/24. Political unease impacted on the roll out of the survey roll out. Expectation that survey will be rolled out during Q1-Q2 2023/4
6. A compliance register that describes the requirements of the various Health & Safety legislation that the Trust needs to comply with (part of WSAP)	Deputy Head of H&S	30.06.22 Completed	Compliance Register framework developed, **and assessment approved as providing a moderate level of assurance Q1 2022.**
7. An initial assessment will provide assurance on how we are complying with the legislation.	Deputy Head of H&S	**Partially completed.** Assurance - 01.06.22 Rolling programme of assessments – 31.12.22	Assessments undertaken. Some outstanding estates assessments scheduled January 2023. Compliance register presented to ADLT members on 04.04.23. **Further legislation in relation to V&A , Road Safety Traffic Act and the and Civil Contingencies Act to be added and assessed Q3-Q4 2023.**
8. Quarterly report on training compliance to be presented to ADLT for actioning within respective Directorates	Head of Health and Safety	Q3 2022 - Complete	Report is a standard section of Quarterly H&S Performance report to ADLT

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:	04/08/2023	TREND	15 (3x5)
		Date of Next Review:	08/09/2023		

IF	THEN	RESULTING IN
there is a large-scale cyber-attack on WAST, NHS Wales and interdependent networks which shuts down the IT network and there are insufficient information security arrangements in place	there is a risk of a significant information security incident	a partial or total interruption in WAST's ability to deliver essential services, loss or theft of personal/patient data and patient harm or loss of life

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

IMTP Deliverable Numbers: 7,8,9,10,12, 16,18,21,23, 24,25, 26, 38

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

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1. Appropriate policy and procedures in place for Information/Cyber Security	1. Information Security Policy reviewed every 3 years (currently due for renewal). Incident Policy and Procedure put in place in February 2022 – renewed annually.
2. Trust Business Continuity Procedure and Incident Response Plan	2. Debrief from significant business continuity incidents captured within organisational learning spreadsheet. Governance with respect to this goes through SOTs. Full review of Incident Response plan every 3 years - currently undergoing a partial review. BCPs and BIAs should be reviewed annually by their owners. Annual schedule of testing
3. IT Disaster Recovery Plan	3. Organisation-wide tabletop exercise undertaken in March 2022 with all BC leads and Digital teams.
4. Relevant expertise in Trust with respect to information security	4. Staff undertake relevant training courses e.g. CISSP to increase knowledge and expertise
5. Data Protection Officer in post	5. In job description of Head of ICT
6. Cyber and information security training and awareness	6. Training statistics are available on ESR and from Phish threat module
7. Mandatory Information Governance training which includes GDPR	7. Training statistics reported on by Information Governance department
8. ICT tests and monitoring on networks & servers	8. Any issues would be identified and flagged and actioned
9. Information Governance framework	9. WAST self-assesses its Information Governance Framework against the Welsh Information Governance toolkit.
10. Internal and NHS Wales governance reporting structures in place	10. Internal WAST Information Governance Steering Group & All Wales Information Governance Management Advisory Group (IGMAG) meets quarterly, National Ambulance Information Governance Group (NIAG) meets every 2 weeks, Operational Security and Service Management Board (OSSMB) (national) – daily/weekly meetings and minuted meetings every 2 months. Minutes and actions logs available for meetings.
11. Checks undertaken on inactive user accounts	11. Software in place to run check on inactive accounts as and when
12. Business Continuity exercises	12. Annual schedule of testing
13. Operational ICT controls e.g. penetration testing, firewalls, patching	13. Monthly scans on infrastructure. Penetration testing has occurred for different systems. 2 physical firewalls on networks to monitor traffic. Monthly patching occurs or as and when. **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
	External Independent Assurance NHS Wales Cyber Response Unit independent view of Network and Information Systems (NIS) Directive compliance within last 4 – 5 months (covering controls 1 -,3 – 11, 13 – 14
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Not all information security procedures are documented	1. No regular Cyber/Info Security KPIs are reported to senior management committees. **04/08/23 – Monthly KPI reports now being generated routinely and fed into the Digital Leadership Group. Needs to transfer to assurance – no longer gap?**

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:	04/08/2023	TREND	15 (3x5)
		Date of Next Review:	08/09/2023		

IF	THEN	RESULTING IN
there is a large-scale cyber-attack on WAST, NHS Wales and interdependent networks which shuts down the IT network and there are insufficient information security arrangements in place	there is a risk of a significant information security incident	a partial or total interruption in WAST's ability to deliver essential services, loss or theft of personal/patient data and patient harm or loss of life

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

2. Lack of understanding and compliance with policy and procedures by all staff members	2. Cyber awareness campaigns could be undertaken more regularly e.g. bi-monthly. **04/08/23 – Latest campaign commenced 01/08/23 to raise staff awareness. Needs to transfer to assurance – no longer gap?**
3. No organisational information security management system in place	
4. IT Disaster Recovery Plan does not include a cyber response	
5. Departments do not communicate in a timely manner with Digital Services around putting in new processes, new projects and procurement and this has a cyber security, information governance and resource impact	

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Establish Cyber and Information Security KPIs	Director of Digital Services	31.03.23 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 - Ongoing	Exercise reports being drafted.
5. Formalise Cyber Incident Response Plan	Head of ICT	30.06.23 – complete Checkpoint Date 31.12.2023	Cyber Incident Response Plan adopted, and CRU Assessment conducted during May 2023 with report expected by end June 2023. Review of CRU Cyber assessment and development of action plan in response to any recommendations.
6. Implement Meta Compliance Policy Solution	Senior ICT Security Specialist	**30.06.23 – Checkpoint Date**	Additional learning modules purchased, and both will be rolled out from Q1 2023-24. **04/08/23 – Latest campaign commenced 01/08/23 to raise staff awareness.**

Risk ID 543	Major disruptive incident resulting in a loss of critical IT systems	Date of Review:	08/08/2023	TREND	15 (3x5)
		Date of Next Review:	08/09/2023	➡	

				Likelihood	Consequence	Score
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	**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

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 • 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	Evidence submitted to assessor – further works required to meet requirement. Review of CRU Cyber

Risk ID 543	Major disruptive incident resulting in a loss of critical IT systems		Date of Review:	08/08/2023	TREND	15 (3x5)
			Date of Next Review:	08/09/2023		

IF	THEN	RESULTING IN		Likelihood	Consequence	Score
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	Inherent	4	5	20
			Current	3	5	15
			Target	2	5	10
			Extend to 31.12.23	assessment and development of action plan in response to any recommendations		

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:**	03/08/2023	TREND	15 (3x5)
		Date of Next Review:	03/09/2023	➡	

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

IMTP Deliverable Numbers: TBC

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

CONTROLS	**ASSURANCES**
	Internal Management (1st Line of Assurance)
1. Health and wellbeing strategy in place and shared across the Trust.	1. Review undertaken of the Health and Wellbeing Strategy by Assistant Director annually.
2. People Services & Occupational Health & Wellbeing support/Employee Assistance Programme	2. Regular review meetings with all external providers to ensure they meet requirements of the SLA contracts. Regular management information received so that trends can be monitored.
3. Self-referrals or managerial referrals to Occupational Health	3. Regular reports submitted by Occupational Health team to WOD Business Meetings for monitoring.
4. Wellbeing support and training for line managers	4. Diarised meetings, webinars and workshops in place through a rolling programme.
5. Development of range of wellbeing resources for staff and line manager	5. Tools are available on WAST intranet. Occupational Health and Wellbeing teams visit stations, A&E , CCCs and other locations regularly where operational staff are based to promote the occupational health and wellbeing offer.
6. Peer support network forum	6. Agendas and minutes of meetings produced for each meeting.
7. WAST Keep Talking (mental health portal) 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.
11. HSE stress risk assessments	11. Undertaken by managers and advice is provided on how to use them by Occupational Health team.
12. KPIs are reported monthly to WOD regarding Occupational Health and Wellbeing activity	12. Received at WOD Business Meetings monthly.
13. Wellbeing drop-in sessions for CCC and 111 staff	13. Diarised sessions in place as part of the programme.
14. Fast track physiotherapy	14. Regular review meetings with physiotherapy provider and monthly monitoring information received at WOD Business meetings.
15. Specialist trauma counselling service	15. Same as 15.
16. Regular psycho-educational sessions with managers and staff	16. Diarised sessions
17. Compassionate leadership training sessions	17. Same as 17 in place as part of the programme.
18. Chaplaincy programme	18. Training plan and minutes of meetings produced quarterly for the Wellbeing Team – to be reviewed.
19. Occupational Health team inclusion in sickness and absence meetings	19. Diarised meetings in place.
20. Procure a pulse survey tool to benchmark how colleagues are feeling and get feedback on the employee experience	20. **HIVE due to go live in September 2023.**
	External - Independent Assurance - Audit Wales – Taking Care of the Carers report in October 2021

GAPS IN CONTROLS	**GAPS IN ASSURANCE**
	4. Reporting on wellbeing training take up
11. Need to increase the education and communication with managers about stress risk assessments. Presentation developed and shared with people services. Delivery dates being agreed in conjunction with Health and Safety.	Lack of awareness about staff wellbeing services

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:	03/08/2023	TREND	15 (3x5)
		Date of Next Review:	03/09/2023	➡	

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

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.**	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.**
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.
3. Deliver the employee engagement tool into WAST	Deputy Director of People and Culture	**30.09.23**	Software has been procured. Planning for rollout is underway. First survey delivery in July 2023. **03/08/23 - Working on the timing of launch based on the rollout of the Freedom to Speak up platform.**

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:	11/07/2023	TREND	15 (3x5)
		Date of Next Review:	11/08/2023	NEW	

				Likelihood	Consequence	Score
IF a major incident or mass casualty incident is declared	**THEN** there is a risk that the Trust cannot provide its pre-determined attendance as set out in the Incident Response Plan and provide an effective, timely or safe response to patients due to vehicles not being released from hospital sites	**RESULTING IN** catastrophic harm (death) and a breach of the Trust's legal obligation as a Category 1 responder under the Civil Contingency Act 2004	**Inherent**	4	5	20
			Current	3	5	15
			Target	2	5	10

IMTP Deliverable Numbers: TBC

EXECUTIVE OWNER	Director of Operations	**ASSURANCE COMMITTEE**	Finance & Performance Committee

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.
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
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
8. In hours and Out of hours command cover	8. Civil Contingency requirement as set out in the Command Policy and Incident Response Plan
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 emphasises at the face to face COO Peer Group meeting on 14 April 2023.
	External Independent Assurance N/A

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.

Actions to reduce risk score or address gaps in controls and assurances	**Action Owner**	**By When/Milestone**	**Progress Notes:**
1. 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	CEO/DOO	3 Jan 2023 Complete	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 in excess of 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.
2. Multi Agency Exercise to be arranged	4 x LRF	Dec 2023	

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:	11/07/2023	TREND	15 (3x5)
		Date of Next Review:	11/08/2023	NEW	

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

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

3. Review of Manchester Arena Inquiry	EPRR Team	Dec 2023	
4. Health boards are asked to provide assurance of existing and tested plans to immediately reduce emergency ambulances on incident declaration	DOO	Feb 2023 Complete	All Health Boards responded with assurance of plans except BCU and HDUHB.

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:	04/08/2023	TREND	12 (3x4)
		Date of Next Review:	03/11/2023	➡	

IF	THEN	RESULTING IN		Likelihood	Consequence	Score
WAST fails to persuade EASC/Health Boards about WAST ambitions	there is a risk of a delay or failure to receive funding and support	a catastrophic impact on services to patients & staff and key outcomes in the IMTP not being delivered	Inherent	4	4	16
			Current	3	4	12
			Target	2	4	8

IMTP Deliverable Numbers: 2, 3, 4, 6, 11, 14, 29, 34

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

CONTROLS	ASSURANCES
	Internal & External Management (1st Line of Assurance)
1. EASC/WAST Forward Plan for EMS and NEPTS in place and monitored at EASC meetings	1. Minutes of meetings and a standard agenda item
2. EASC and its 2 sub-committees established as a forum to discuss WAST's strategy	2. Minutes of meetings and a standard agenda item
3. Weekly catch up between CASC/CEO	3. Meetings are diarised every week
4. Collaboration between EASC and WAST on specific projects e.g. Amber Review, EMS Operational Transformation Programme, Ambulance Care Programme	4. Representatives are co-opted onto meetings and frequency is between 3–6 weeks. Set agendas with NCCU reps co-opted.
5. Monthly CASC Quality and Delivery Meeting established	5. Formal meeting with agendas, minutes and action logs available.
6. Patient Safety information e.g. Appendix B incidents, weekly/monthly patient safety reports produced	6. These reports supplied to Director of Quality and Nursing in Health Boards and other senior stakeholders fortnightly
7. Programme structure has been established for 'inverting the triangles' including EASC	7. It exists and has had its first meeting
	External Management (1st Line of Assurance) 1. Plans go to every bi-monthly meeting 2. Meet bi-monthly and agendas, minutes and action logs available
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. EASC meetings focus largely on EMS and cursory note of NEPTS	**1. 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. HB to reboot.
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**
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 Jan-24.**

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.**
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.**
3. Increased understanding of NEPTS by EASC	Director of Strategy Planning and Performance	02/08/23 Checkpoint Date	30.09.22 "Focus on" session at 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.**
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.**

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:	04/08/2023	TREND	12 (3x4)
		Date of Next Review:	03/11/2023	➡	

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

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

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.**

Risk ID 283	Failure to implement the EMS Operational Transformation Programme	Date of Review:	03/08/2023	TREND	12 (3x4)
		Date of Next Review:	03/11/2023	➡	

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: 3, 7, 17, 18, 19, 20, 27

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

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. Implementation Programme Board in place – meetings held every 3 weeks with the DASC and TU reps on the membership	1. Minutes and papers of Implementation Programme Board
2. Executive sponsor and Senior Responsible Owner (SRO) for programme in place	2. Project Initiation Document (PID) detailing structure and minutes of Implementation Programme Board
3. Programme Manager and Programme support office in place (for delivery of the programme)	3. Same as 2
4. Programme risk register	4. Highlight reports showing key risks reported to STB every 6 weeks
5. Assurance meetings held with Strategic Transformation Board (STB) every 6 weeks and with CEO every 3 weeks	5. Highlight reports presented to STB every 6 weeks
6. Programme budget in place (including additional £3m funding for 22/23)	6. Programme budget monitoring report is provided to the Implementation Programme Board – every 6 weeks and letter received from CASC on £3m funding for 22/23
7. Programme documentation and reporting is in place to Programme Board every 3 weeks and STB receives highlight report	7. PID and Programme Plan Summary kept up to date**.** PID is presented to the STB if there is a significant change in the programme deliverables. Programme Plan Summary reported to the Implementation Programme Board every 3 weeks.
8. Regular engagement with the Commissioner and Trade Unions and representation	8. Commissioner and TU participation at the Implementation Programme Board
9. Management of external stakeholder and political concerns	9. Communications and Engagement Plan sets out WAST's arrangements for engagement with stakeholders
10. Secured specialist consultancy to support decision making	10. Reports and contractual compliance
	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.
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.

Risk ID 283	Failure to implement the EMS Operational Transformation Programme	Date of Review:	03/08/2023	TREND	12 (3x4)
		Date of Next Review:	03/11/2023		

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. 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 of the gains that the Trust has made. **03.08.23 More capacity unlikely within current** financial pressures, but Trust has recently started the next iteration of the strategic EMS Demand & Capacity Review.
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.**
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%**
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 nees to be signed off by Executive Sponsors. **28.07.23 PID updated and programme aligned to new arrangements required by HoT.**

AGENDA ITEM No	**10**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**1**

LOSSES AND SPECIAL PAYMENTS - PAYMENTS FOR THE PERIOD FROM 1ST APRIL 2023 TO 31st AUGUST 2023

MEETING	**Audit Committee**
DATE	**14th Sept 2023**
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 details of Losses and Special Payments made between the months of April and August 2023 (**Annex 1**)

KEY ISSUES/IMPLICATIONS

Total net Losses and Special Payments made were as follows: -

- period 1st April 2023 to 31st August 2023 – £66.5k – Net payments

REPORT APPROVAL ROUTE
Audit Committee 14th Sept 2023 – no action required for information under SFI's only.

REPORT APPENDICES
Annex 1 – Summary and details of payments made for the five months to 31st August 2023

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

WELSH AMBULANCE SERVICES NHS TRUST
AUDIT COMMITTEE
LOSSES AND SPECIAL PAYMENTS - PAYMENTS FOR THE PERIOD FROM 1st APRIL 2022 TO 31st AUGUST 2023

SITUATION

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

BACKGROUND

2. This report presents to the Committee details of Losses and Special Payments made during the five months from 1st April 2023 to 31st August 2023 (**Annex 1**)

ASSESSMENT

3. Total net Losses and Special Payments made during the period 1st April 2023 to 31st August 2023 amounted to £66.5k 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 five months to 31st August 2023 payments made exceeded the reimbursements received by £66.5k.

5. During August you will note the total damages paid amounted to £36k and this was for 5 payments. One of these five payments amounting to £21k was in respect of damages for clinical negligence claims and costs on accounts paid in respect of a patient.

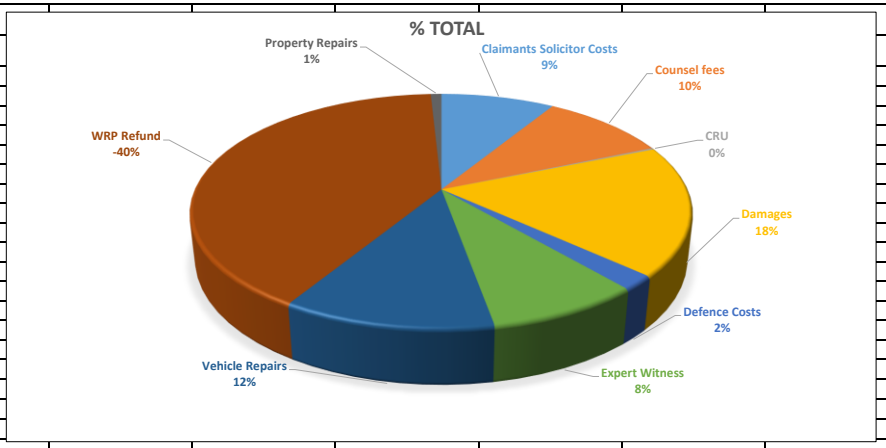
6. During August you will also note claimant's solicitors' costs incurred of £10.8k, these also relate to part of the medical negligence case(s) referred to above

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

Welsh Ambulance Services NHS Trust

Losses and Special Payments

Annex 1



Summary of payments for the five month to 31st August 2023:

	£
April 2023	-69261.75
May 2023	28671.21
June 2023	1571.34
July 2023	16364.51
August 2023	89145.51
September 2023	0.00
October 2023	0.00
November 2023	0.00
December 2023	0.00
January 2024	0.00
February 2024	0.00
March 2024	0.00
	£66,490.82

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	0.00	0.00	0.00	0.00	0.00	0.00	0.00	£30,391.90
Counsel fees	8,912.79	2,123.91	9,387.22	1,250.00	12,505.84	0.00	0.00	0.00	0.00	0.00	0.00	0.00	£34,179.76
CRU	0.00	0.00	688.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	£688.00
Damages	8,448.00	14,200.45	3,550.00	0.00	36,119.97	0.00	0.00	0.00	0.00	0.00	0.00	0.00	£62,318.42
Defence Costs	3,713.72	521.58	1,501.84	212.38	854.55	0.00	0.00	0.00	0.00	0.00	0.00	0.00	£6,804.07
Expert Witness	4,680.00	2,319.00	6,581.50	4,000.00	11,772.26	0.00	0.00	0.00	0.00	0.00	0.00	0.00	£29,352.76
Vehicle Repairs	3,520.77	4,506.27	16,058.18	10,848.43	5,256.61	0.00	0.00	0.00	0.00	0.00	0.00	0.00	£40,190.26
WRP Refund	-107,908.53	0.00	-41,461.40	0.00	9,066.88	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-£140,303.05
Property Repairs	0.00	0.00	0.00	53.70	2,815.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	£2,868.70
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**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**£66,490.82**

Welsh Ambulance Services NHS Trust	Key		
Losses and Special Payments	MN	Medical Negligence	
	PI	Personal Injury	
Summary of payments for the five months to 31st August 2023:	DP	Damage To Property	
	£		
PI cases < £1,000	3,018.74	8 CASES	
DP cases < £1,000	8,962.01	31 CASES	
24RT4MN0001	25.83		
22RT4MN0010	30.00		
22RT4MN0012	62.50		
22RT4MN0002	137.50		
21RT4MN0009	190.00		
20RT4MN0008	260.00		
20RT4MN0011	390.00		
20RT4MN0018	920.00		
23RT4GN0037	1,000.00		
24RT4GN0009	1,000.00		
24RT4DP0007	1,113.10		
18RT4MN0016	1,137.50		
21RT4PI0006	1,200.00		
24RT4DP0008	1,215.00		
24RT4EG0005	1,250.00		
24RT4DP0020	1,285.00		
22RT4MN0011	1,300.00		
22RT4MN0018	1,300.00		
23RT4MN0011	1,300.00		
24RT4DP0019	1,310.00		
24RT4DP0006	1,320.00		
24RT4DP0001	1,322.35		
22RT4MN0013	1,430.00		
24RT4DP0016	1,530.00		
24RT4DP0009	1,573.39		
22RT4GN0031	1,600.00		
23RT4DP0079	1,627.94		
22RT4DP0085	1,632.84		
19RT4MN0008	1,633.23		
23RT4EG0019	1,650.00		
21RT4PI0023	1,650.00		
24RT4DP0003	1,784.17		
24RT4DP0015	1,919.29		
23RT4PI0035	2,100.00		
21RT4GN0011	2,448.00		
24RT4EG0007	2,500.00		
24RT4DP0013	2,513.69		
24RT4DP0010	2,555.88		
24RT4PI0001	2,587.95		
25RT4EG0009	3,000.00		
22RT4DP0094	3,013.14		
24RT4DP0012	3,234.28		
23RT4EG0017	3,575.00		
21RT4GN0023	3,600.00		
22RT4MN0003	4,425.00		
22RT4PI0017	4,766.00		
19RT4PI0037	5,100.84		
20RT4PI0025	5,155.50		
23RT4EG0018	5,175.29		
23RT4MN0012	6,422.75		
21RT4PI0017	7,980.00		
23RT4DP0032	8,576.15		
23RT4PI0003	8,616.00		
22RT4PI0039	9,256.37		
22RT4PI0023	9,568.00		
21RT4MN0011	11,562.50		
22RT4MN0001	13,431.14		
21RT4PI0035	26,550.00		
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	
23RT4GN0032	- 2,300.00	WRP Refund	
19RT4PI0028	-5,955.00	WRP refund	
21RT4PI0001	-32,956.58	WRP refund	
19RT4PI0008	-107,908.53	WRP refund	
Total	**66,490.82**		

Jun-23		
Case Reference	**Details**	**Amount (£)**
18RT4MN0016	COUNSEL FEES	100.00
18RT4MN0016	EXPERT WITNESS	150.00
18RT4MN0016	COUNSEL FEES	50.00
19RT4MN0008	COUNSEL FEES	637.50
19RT4MN0008	COUNSEL FEES	912.50
19RT4PI0028	WRP REFUND	- 5,955.00
19RT4PI0038	CRU	688.00
20RT4PI0004	WRP REFUND	- 2,364.29
21RT4GN0023	EXPERT WITNESS	900.00
21RT4PI0001	WRP REFUND	- 28,281.85
21RT4PI0017	CLAIMANTS SOLICITOR COSTS	2,500.00
21RT4PI0017	DEFENCE COSTS	480.00
21RT4PI0034	WRP REFUND	- 249.82
22RT4DP0085	VEHICLE REPAIRS	1,632.84
22RT4MN0001	EXPERT WITNESS	720.00
22RT4MN0001	EXPERT WITNESS	500.00
22RT4MN0001	COUNSEL FEES	62.22
22RT4MN0001	EXPERT WITNESS	375.00
22RT4MN0002	EXPERT WITNESS	137.50
22RT4MN0003	EXPERT WITNESS	1,750.00
22RT4MN0003	EXPERT WITNESS	250.00
22RT4MN0003	COUNSEL FEES	1,825.00
22RT4MN0010	DEFENCE COSTS	30.00
22RT4PI0017	DAMAGES	2,000.00
22RT4PI0017	CLAIMANTS SOLICITOR COSTS	2,766.00
22RT4PI0024	COUNSEL FEES	300.00
23RT4DP0016	WRP REFUND	- 2,310.44
23RT4DP0037	VEHICLE REPAIRS	900.00
23RT4GN0032	WRP REFUND	- 2,300.00
23RT4GN0037	DAMAGES	1,000.00
23RT4MN0012	EXPERT WITNESS	550.00
23RT4MN0012	EXPERT WITNESS	1,249.00
23RT4MN0012	COUNSEL FEES	3,000.00
24RT4DP0006	VEHICLE REPAIRS	1,320.00
24RT4DP0007	VEHICLE REPAIRS	1,113.10
24RT4DP0008	VEHICLE REPAIRS	1,215.00
24RT4DP0009	VEHICLE REPAIRS	1,573.39
24RT4DP0010	VEHICLE REPAIRS	2,555.88
24RT4DP0012	VEHICLE REPAIRS	3,234.28
24RT4DP0013	VEHICLE REPAIRS	2,470.83
24RT4DP0013	VEHICLE REPAIRS	42.86
24RT4EG0005	COUNSEL FEES	1,250.00
24RT4EG0006	DEFENCE COSTS	45.92
24RT4EG0007	COUNSEL FEES	1,250.00
24RT4EG0008	DEFENCE COSTS	20.09
24RT4GN0003	DAMAGES	50.00
24RT4GN0004	DEFENCE COSTS	900.00
24RT4MN0001	DEFENCE COSTS	25.83
24RT4PI0002	DAMAGES	500.00
Totals		**1,571.34**

Jul-23		
Case Reference	**Details**	**Amount (£)**
19RT4MN0008	DEFENCE COSTS	83.23
21RT4GN0023	EXPERT WITNESS	2,700.00
23RT4DP0032	VEHICLE REPAIRS	8,576.15
23RT4EG0012	DEFENCE COSTS	60.27
23RT4MN0011	EXPERT WITNESS	1,300.00
24RT4DP0011	VEHICLE REPAIRS	352.99
24RT4DP0014	PROPERTY REPAIRS	53.70
24RT4DP0015	VEHICLE REPAIRS	1,919.29
24RT4EG0007	COUNSEL FEES	1,250.00
24RT4PI0015	DEFENCE COSTS	68.88
Totals		**16,364.51**

Aug-23			
Case Reference	**Details**	**Amount (£)**	
19RT4PI0037	Expert Witness	747.50	
19RT4PI0037	Counsel Fees	1,916.67	
19RT4PI0037	Expert Witness	395.00	
19RT4PI0037	Counsel Fees	1,041.67	
21RT4PI0006	Counsel Fees	300.00	
21RT4PI0023	Counsel Fees	1,650.00	
23RT4PI0035	Counsel Fees	2,100.00	
24RT4PI0024	Defence Costs	51.66	
18RT4MN0016	Expert Witness	250.00	
18RT4MN0016	Counsel Fees	587.50	
20RT4MN0018	Counsel Fees	920.00	
21RT4MN0009	Counsel Fees	190.00	
22RT4MN0001	Expert Witness	1,900.00	
22RT4MN0001	Expert Witness	200.00	
22RT4MN0001	Expert Witness	600.00	
22RT4MN0001	Counsel Fees	600.00	
22RT4MN0001	Expert Witness	2,311.00	
22RT4MN0001	Expert Witness	1,200.00	
22RT4MN0001	Expert Witness	800.00	
22RT4MN0001	Expert Witness	533.34	
22RT4MN0001	Expert Witness	2,266.67	
23RT4MN0012	Counsel Fees	200.00	
23RT4MN0012	Expert Witness	568.75	
24RT4DP0016	Property Repairs	1,530.00	
24RT4DP0017	Vehicle Repairs	250.00	
22RT4DP0094	Vehicle Repairs	3,013.14	
25RT4EG0009	Counsel Fees	3,000.00	
24RT4DP0018	Vehicle Repairs	576.38	
24RT4DP0019	Vehicle Repairs	1,310.00	
24RT4EG0010	Defence Costs	148.90	
24RT4EG0011	Defence Costs	34.44	
24RT4DP0021	Vehicle Repairs	203.15	
24RT4FE0001	Vehicle Repairs	- 164.24	
24RT4DP0018	Vehicle Repairs	- 96.06	
24RT4FE0001	Vehicle Repairs	164.24	
22RT4DP0013	Defence Costs	619.55	
24RT4DP0020	Property Repairs	1,285.00	
21RT4PI0035	Claimants Solicitor Costs	5,550.00	
21RT4PI0035	Damages	21,000.00	
22RT4PI0023	Claimants Solicitor Costs	2,568.00	
22RT4PI0023	Damages	7,000.00	
22RT4PI0039	Claimants Solicitor Costs	2,636.40	
22RT4PI0039	Damages	6,619.97	
24RT4GN0007	Damages	500.00	
24RT4GN0009	Damages	1,000.00	
20RT4PI0025	WRP Refund	11,316.88	
23RT4GN0010	Wrp Refund	- 200.00	
22RT4GN0020	Wrp Refund	- 500.00	
22RT4GN0027	Wrp Refund	- 400.00	
22RT4GN0019	Wrp Refund	- 300.00	
22RT4GN0021	Wrp Refund	- 250.00	
22RT4GN0015	Wrp Refund	- 600.00	
Totals		**89,145.51**	

AGENDA ITEM No	**12**
OPEN or CLOSED	**Open**
No of ANNEXES	**2**

Board and Committee Induction Programme Update

MEETING	Audit Committee
DATE	14 September 2023
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Trish Mills, Board Secretary Alex Payne, Corporate Governance Manager
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. It is the Committee's agreed priority for the 2023/24 year to ensure that the Board Member induction programme and supporting documents are reviewed, particularly in readiness for the appointment of the Trust's new Vice-Chair.

2. The Corporate Governance Team have updated the Board Induction Programme template, and, taking on learning from Non-Executive Director onboarding in 2022, have developed a Non-Executive Director Set Up Form. Both these documents are attached for review by the Committee.

3. The document at Annex 1 is tailored to the individual Board member being inducted and enables a programme of meetings to be established with key stakeholders in the first three months of them starting in position. It also provides links to key documents. This has been used most recently for the onboarding of the Digital Director, Jonny Sammut.

4. The document in Annex 2 includes the information which is required from the individual in order to set them up on the NHS Wales and Trust's systems. There is also peripheral information to guide Board members on set-up processes, in particular Non-Executive Directors.

5. There are arrangements in place to complete due diligence checks and declarations of interest information for all Board members. These include receipt of the 'Board Member Eligibility Declaration', review of the Disqualified Directors register, the Insolvency and Bankruptcy register and the Charity Commission's disqualified Trustees register.

6. A Committee specific induction programme will be developed in 2023/24 to provide information specific to the particular Board Committee for new Non-Executive Directors joining the Committee, and for those attendees named in the Terms of Reference. This was a particular action that came from the Board effectiveness reviews in early 2023.

RECOMMENDATION

7. **The Committee is asked to receive assurance that the Trust has in place an induction programme for new Board members and note that the next steps are to develop a Committee induction programme for new members and attendees.**

KEY ISSUES/IMPLICATIONS
No issues to raise.

REPORT APPROVAL ROUTE
Not applicable.

REPORT APPENDICES
➢ Annex 1: Board Induction Programme Template (with supporting files/links); ➢ Annex 2: 'Non-Executive Director (NED) Set Up Form'.

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

Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru

Welsh Ambulance Services
NHS Trust

Welsh Ambulance Services NHS Trust

Trust Board and Committee Induction Programme

[name of board member]
Start date: [insert]

1. CONTENTS

Version Control Table

Version	Author	Date	Changes/Comments
1.0	Trish Mills, Board Secretary	1 August 22	Initial induction programme
2.0	Trish Mills, Board Secretary	24 July 2023	General update of information for currency

1. INDUCTION PROGRAMME

This section contains an outline of the induction programme provided to new Board members, including Non-Executive Directors, voting and non-voting Directors – whether substantive or interim - and Trade Union representatives.

1.1. Aim

The induction process provides a timely opportunity to:

- Welcome you to the Trust and the Board and identify where we can support you;
- Ensure you understand how your role contributes to achieving the Trust's purpose, vision, and strategy;
- Emphasise and embed the culture and behaviours of the Trust;
- Inform you about the structure of the Trust, the policies and procedures/practices that are in place; and
- Clarify the requirements, duties, and responsibilities of your role.

1.2. Overview

The Chair of the Trust will ensure that you receive a full, formal, and tailored induction on joining the Board. For Non-Executive Directors, the Chair will also ensure that your skills, knowledge, and familiarity of the Trust are kept updated so that you can fulfil your role and be effective at Board and Board Committee meetings.

The Board Secretary will lead the induction programme supported by the Corporate Governance Manager, and they are your points of contact throughout.

Your induction programme is attached at section 2 so that you understand and are aware of the various meetings and steps we will take you through during the programme. We aim to finalise the programme within three months of your appointment or earlier.

Once you have reviewed the programme, if there are any areas which you feel need to be more fully understood for you to be effective, this may be built into a personal development plan which will form part of the objective setting and appraisal review process with the Chair or Chief Executive as applicable. Any meetings over and above those in section 2 will be arranged by the Personal Assistant to the Chair and Board Secretary.

Your induction will include a balance of information, briefings, site visits and one to one meetings with key staff and members of the Board.

For Non-Executive Directors you will be required to attend the Welsh Government Non-Executive Induction programme within the first six months of your appointment. This will be arranged for you by the Corporate Governance Manager.

You will receive a request to complete a declaration of interests, and an eligibility declaration as part of the induction process and may be asked for documents in support.
You will be required to complete all statutory and mandatory training via the Electronic Staff Record (ESR) as soon as possible.

You will also receive a documentation pack to review, the details of which is set out in Section 6 of the programme. This is kept to essential reading at this point; however, should you wish to review further information please let the Board Secretary know and that will be provided.

1.3. Administration

Your point of contact for the setup of your email address, your IT (laptop and iPad), access to the Electronic Staff Record (ESR) where your statutory and mandatory training takes place, expenses platform 'Assure Expenses' and Ibabs (electronic Board software) access, as well as your WAST badge will be the Corporate Governance Manager for Non-Executive Directors and your Directorate Business Manager for Directors.

2. INDUCTION PROGRAMME

Meetings with Key People
Responsibility: Chair supported by the Board Secretary, Senior Executive Assistant to the Chair and CEO

Lead	Areas for Discussion	Timing
Chair and Chief Executive		
Chair **Colin Dennis** **(voting)** 	• Link to Bio Vision and Trust behaviours • The concept of the unitary Board and expectations of Directors in respect of boardroom behaviours • The role of the Non-Executive Director • Understanding the role of: - Chair - Vice-Chair - Non-Executive Director • Collective and individual objectives of Non-Executive Directors • Non-Executive Director appraisal system • Board support framework, including the role of the Board Secretary • Expectations: - Committee membership - Site visits - Welsh Government Induction Programme - External networking opportunities - Corporate and Mandatory Training	Commence day 1

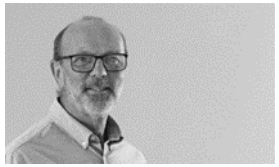
Chief Executive Officer **Jason Killens** **(voting)** 	• Link to bio • Setting the Trust in context, including strategic objectives and priorities for the year • Organisation chart and management structures • Role of the Executive Management Team • Summary of the main events over the last few years including significant transactions, new services, new models of care, etc and future plans • Details of any significant issues, current or potential, against the Trust • System working • Emergency Ambulance Services Committee • Prescribed attendee for the following Committees of Board: - ○ Remuneration Committee	Complete by week 1
Non-Executive Directors		
Vice-Chair (voting)	• Vice Chair • Champion for: ○ Mental health	Within first month

Bethan Evans
 
	• Link to bio
	• Chair of Quality, Patient Experience and Safety Committee
	• Member of the Charity Committee
	• Member of the Finance & Performance Committee
	• Member of the People & Culture Committee
	• Member of the Remuneration Committee
	• Appointed to the Board December 2019
	• Champion for:
	  ○ Infection Prevention & Control
	  ○ Putting Things Right and Patient Safety (non-executive)
	  ○ Welsh language (non-executive)
		Within first month

Paul Hollard
 
	• Link to bio
	• Chair of People and Culture Committee
	• Member of the Academic Partnerships Committee
	• Member of the Audit Committee
	• Member of the Quality, Patient Experience & Safety Committee
	• Member of the Remuneration Committee
	• Appointed to the Board April 2016
	• Champion for:
	  ○ Children and young people
	  ○ Raising concerns
		Within first month

Ceri Jackson
 
	• Link to bio
	• Chair of Charity Committee
	• Member of the Audit Committee
	• Member of the Quality, Patient Experience & Safety Committee
	• Member of the Remuneration Committee
	• Appointed to the Board in April 2021
	• Champion for:
	  ○ Digital and transformation
	  ○ Older persons
		Within first month

Hannah Rowan
 
	• Link to bio
	• Chair of Academic Partnerships Committee
	• Appointed to the Board 1 April 2022
	• Member of the Charity Committee
	• Member of the People & Culture Committee
	• Member of the Remuneration Committee
	• Champion for:
	  ○ Equality, diversity, and inclusion
	  ○ Research
		Within first month

Joga Singh 	• Link to bio • Chair of Finance and Performance Committee • Appointed to the Board December 2019 • Member of the Audit Committee • Member of the People & Culture Committee • Member of the Remuneration Committee	Within first month
Martin Turner 	• Link to bio • Chair of Audit Committee • Chair of All Wales Audit Chairs Group • Appointed to the Board July 2018 • Member of the Academic Partnerships Committee • Member of the Finance & Performance Committee • Member of the Remuneration Committee	Within first month
Executive Directors		

Executive Director of Operations
Lee Brooks
(voting)
 
	• Link to bio
	• Portfolio of the Director:
	  • National Operations and support inclusive of:
	  • EPRR and Special Operations
	  • Volunteering
	  • Integrated Care (111 & CSD)
	  • Emergency Medical Service
	  • Ambulance Care
	  • Resourcing & EMS Coordination
	• Strategic view of portfolio
	• Champion for emergency preparedness
	• Prescribed attendee for the following Committees of the Board: -
	  ○ Audit Committee
	  ○ Charity Committee
		Within first month

	○ Finance & Performance Committee ○ People & Culture Committee ○ Quality, Patient Experience & Safety Committee	

Director of People & Culture
Angela Lewis (non-voting)
 
	• Portfolio of the Director:
	  • Recruitment and Onboarding
	  • Culture & Employee Engagement
	  • Leadership and OD
	  • TU Partnership Working
	  • Equality, Diversity & Inclusion
	  • Education & Development
	  • Occupational Health & Wellbeing
	  • People Services
	  • Workforce Planning, Information & Systems
	• Executive lead for People and Culture Committee
	• Executive lead for Remuneration Committee
	• Prescribed attendee for the following Committees of Board: -
	  ○ Academic Partnerships Committee
	  ○ Audit Committee
	  ○ Charity Committee
	  ○ Finance & Performance Committee
	• Strategic view of portfolio
	• Champion for violence and aggression
	• Champion for equality, diversity, and inclusion
		Within first month

Director of Partnerships & Engagement
Estelle Hitchon (non-voting)
	• Link to bio
	• Portfolio of the Director:
	  • Stakeholder Management
	  • Charity
	  • Public affairs / political engagement
	  • Internal Communications
		Within first month

	• Digital Communications and Regional Partnerships Boards
	• Public Communications
	• Crisis Communications
	• University Trust / Academic Partnerships
	• Wellbeing of Future Generations Act
	• Strategic view of portfolio
	• Executive lead for Academic Partnerships Committee
	• Prescribed attendee for the following Committees of the Board: -
	  ○ Charity Committee
	  ○ People & Culture Committee	

Executive Medical Director
Dr Brendan Lloyd (voting)
 
	• Link to bio
	• Portfolio of the Director:
	  • Medicines Management (statutory responsibilities)
	  • Executive leadership for AMPDS, ECNS and GMC
	  • Responsible Officer for WAST in terms of medical (doctor) employment & governance
	  • Liaising at medical interface with LHBs and Primary Care
	• Strategic view of portfolio
		Within first month

Executive Director of Strategy, Planning and Performance
Rachel Marsh (voting)
 
	• Link to bio
	• Portfolio of the Director:
	  • Strategy & Planning
	  • Commissioning & Performance
	  • Integrated Medium Term Plan (IMTP)
	• Joint executive lead for Finance and Performance Committee
	• Prescribed attendee for the Quality, Patient Experience & Safety Committee
	• Strategic view of portfolio
		Within first month

Director of Digital Services (interim) Dr Leanne Smith (non-voting)
 
	• Link to bio
	• Portfolio of the Director:
	  • Data & Analytics
	  • Emergency Services Mobile Communication Programme
	  • Electronic Patient Care Record (EPCR)
	  • Network & Telecoms
	  • ICT Delivery/ Contracts
	  • Information Governance
	  • Data Protection
	  • Record Services
	  • Service Delivery
	• Strategic view of portfolio
	• Senior Information Risk Officer (SIRO)
	• Prescribed attendee for the following Committees of Board: -
	  ○ Academic Partnerships Committee
	  ○ Finance & Performance Committee
	  ○ Quality, Patient Experience & Safety Committee
		Within first month

Director of Paramedicine Andy Swinburn (non-voting)
 
	• Link to bio
	• Portfolio of the Director:
	  • Professional Standards
	  • Clinical Audit & Effectiveness
	  • Medicines Management
	  • Clinical Equipment & Medical Devices
	  • Research & Innovation
	  • Clinical Service Improvement
	  • EMS and Ambulance Clinical Leadership
	  • ePCR
	  • Palliative Care
		Within first month

	• Advanced and enhanced practice
	• EMC CCC Clinical Oversight
	• Strategic view of portfolio
	• Prescribed attendee for the following Committees of Board: -
	  ○ Academic Partnerships Committee
	  ○ Charity Committee
	  ○ People & Culture Committee
	  ○ Quality, Patient Experience & Safety Committee	

Executive Director of Finance and Corporate Resources
Chris Turley
(voting)
 
	• Link to bio
	• Portfolio of the Director:
	  • Finance
	  • Procurement & Accounts Payable
	  • Counter Fraud
	  • Charitable Funds
	  • Capital
	  • Fleet
	  • Estates
	  • Decarbonisation & Sustainability
	• Strategic view of portfolio
	• Joint executive lead for Finance and Performance Committee
	• Executive lead for Charity Committee
	• Executive lead for Audit Committee
	• Prescribed attendee for the People & Culture Committee
	• Fire safety champion
		Within first month

Executive Director of Quality and Nursing
Liam Williams
(voting)
 
	• Link to bio
	• Portfolio of the Director:
	  • Quality Assurance
	  • Quality Improvement
	  • Patient Safety & Putting Things Right
	  • Infection Prevention and Control (IPC)
	  • Health & Safety
	  • Safeguarding
	  • Mortality Reviews
	  • Caldicott Guardian
	  • Patient Experience & Community Involvement (PECI)
	  • 111Wales (Clinical, Quality, Education and Professional)
	  • Mental Health & Dementia
	  • Children and Young People
	• Champion for:
	  • Children and young people
	  • Putting Things Right and patient safety
	• Strategic view of portfolio
	• Executive lead for Quality, Patient Experience and Safety Committee
	• Prescribed attendee for the following Committees of Board: -
	  ○ Audit Committee
	  ○ Finance & Performance Committee
		Within first month

Board Secretary		

Board Secretary
Trish Mills
 
	• Link to bio
	• Portfolio of Director:
	  • Welsh Language Standards
	  • Governance framework
	  • Risk Management and Board Assurance Framework
	  • Regulation and compliance
	  • Standing Orders
	  • Board of Directors meetings and Board committee governance structure
	  • Board Development
		Within first month

	• Annual Committee effectiveness reviews • Standards of business conduct • Audit • Policy • Strategic view of portfolio • Executive Champion for the Welsh Language • Attends all Committees of the Board	
Trade Union Board Representatives		
Hugh Parry **Trade Union Representative at Board (Unite)**	• Trade Union Representative – Unite • Attendees the following Committees of the Board: - o Charity Committee o Quality, Patient Experience and Safety Committee o Finance and Performance Committee o Remuneration Committee	Within six weeks
Damon Turner **Trade Union Representative at Board (Unison)** 	• Trade Union Representative – Unison • Attendees the following Committees of the Board: - o Audit Committee; o Charity Committee o Finance and Performance Committee o Remuneration Committee	Within six weeks

Key Stakeholders – Depending on your role, the key stakeholders we will arrange for you to meet will be agreed separately, including spending time in the Clinical Contact Centre and the Operational Delivery Unit		
Emergency Ambulance Services Committee (EASC)	Dr Chris Turner (Chair) Stephen Harrhy (Commissioner)	Within first 3 months
Audit Wales	Fflur Jones/Dave Thomas	Within first 3 months
Internal Audit	Osian Lloyd/Simon Cookson	Within first 3 months

3. About WAST

3.1. Areas of Responsibility

The Trust provides health care services for people across the whole of Wales, delivering high quality and patient-led clinical care wherever and whenever needed.

Services include: -

- The blue light emergency ambulance services: including call taking, remote clinical consultation, see and treat and if necessary, conveyance to an appropriate hospital or appropriate treating facility.
- Non-Emergency Patient Transport Service (NEPTS): including call taking, journey planning, service commissioning, taking patients to and from hospital appointments and transferring them between hospitals and treating facilities.
- The 111 service: website and a free-to-call service, acts as a first line gateway to a patients journey within the health and care system providing them with the right advice or referral every time.
- The Trust also supports volunteers: Community First Responders (CFRs), Co-Responders and Uniformed Responders to provide additional response resource to emergency calls and a volunteer car service to aid patient transport to planned appointments.

The Trust is a commissioned service for Emergency Medical Service and NEPTS. The commissioning is undertaken by the Emergency Ambulance Services Committee (EASC), on behalf of Health Boards, who are also supported by the Chief Ambulance Service Commissioner (CASC). The Trust has engaged constructively with EASC and its governance structures, and has received financial support during 2022/23, in particular for the recruitment of an additional 90 FTEs for front line Emergency Medical Service. EASC set out a range of commissioning intentions each year, with good progress made through 2022/23 on delivery.

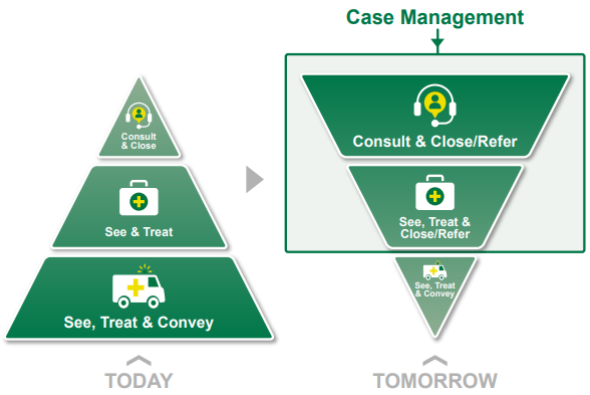
3.2. Our Long Term Strategy

Trust's long term strategic ambitions and goals are contained in our Long Term Strategy Framework 'Delivering Excellence'. It set out an ambition to move from being a traditional ambulance and transport service to being a trusted provider of out-of-hospital high quality care, ensuring that patients receive the 'right advice and care, in the right place, every time', with a greater emphasis on providing care closer to home.

The strategy is not only concerned with service models, but also with how staff and volunteers are supported and enabled to be the best that they can be.

The strategy also commits the Trust to being an organisation that collaborates with its partners, stays at the forefront of innovation and technology, remains focussed on being quality driven and clinically led, and delivers exceptional value.

For our Emergency Medical Services, the clear priority is to reduce avoidable patient harm. We will do this by protecting resources to respond immediately to the most critically ill patients and by continuing our journey to 'invert the triangle', developing more of a personalised case management approach to managing patients' care, growing our remote clinical assessment capacity and capability, transforming our on-scene response models and improving pathways into alternative services.



3.3. Our Purpose

In 2022/23 the Trust has progressed work with colleagues to help frame its organisational 'purpose' which sets out 'why' the organisation exists. This is different from an organisational vision or mission statement which set out 'where' an organisation wants to go and 'how' it will get there. A purpose statement is something that can bind and unite people across the organisation towards a common goal. Our new purpose statement, '**To Support. To Serve. To Save'** will anchor us as we continue to transform and grow.

3.4. Integrated Medium Term Plan

At an organisational level, the Integrated Medium-Term Plan (IMTP) sets out, on a three-year rolling basis, the prioritised actions that the Trust will take to move it towards its strategic objectives. The IMTP considers the national planning guidance issued by Welsh Government, the external environment in which the Trust operates including statutory requirements and commissioning intentions, the risks it is managing, as well as intelligence gathered from patients, staff, and volunteers.

In particular the Trust was required to articulate through the IMTP how it planned to deliver on the priorities set by the Minister for Health and Social Services in Wales and to contribute to the aims of the Six Goals Programme for Urgent and Emergency Care.

The Trust Board approved the IMTP for 2023-26 and submitted it to Welsh Government at the end of March 2023. The Board papers for that meeting are available here. The IMTP for 2023-26 includes the actions to implement the newly refreshed People and Culture Plan for 2023-26 to support our organisational strategic ambitions which will have a focus on our 3Cs: Culture, Capacity and Capability, which provide the basis for the objectives and plans for our people.

4. The WAST Corporate Governance Framework

Governance describes the ways that organisations ensure they run themselves efficiently and effectively. It also describes the ways organisations are open and accountable to the people they serve for the work they do.

All effective public and private sector organisations want to have good governance. For an NHS Wales organisation like WAST, good governance is about creating a framework within which we:

- Provide our patients with good quality healthcare services.
- Are transparent in the ways we are responsible and accountable for our work.
- Ensure we continually improve the ways we work.
- Adhere to principles of good governance and the Nolan Principles.

Good governance is maintained by the structures, systems, and processes we put in place to ensure the proper management of our work, and by the ways we expect our staff to work. It is also about how we scrutinise our performance and deal with poor practice, ensure quality is at the heart of everything we do, and how we identify and manage risks, whether in terms of patient care, to our staff, or to the organisation as a whole.

The Trust's governance framework houses the structures, systems, processes, and behaviours NHS Wales health bodies have for ensuring good governance, and they include but are not limited to:

- Standing Orders, which incorporates the Schedule of Matters Reserved to the Board and Delegated, and the Standing Financial Instructions.
- The requirement for a unitary Board and the Committees that support the Board, together with their terms of reference.
- How line managers operate, including codes of conduct and accountability.
- Annual business planning.
- Procedural guidance for staff.
- Risk registers and assurance framework.
- Internal audit.
- Scrutiny by external assessors including the Welsh Government, HIW, Audit Wales and other stakeholders.

The Trust has agreed Standing Orders for the regulation of proceedings and business. These are designed to translate the statutory requirements set out in the NHS (Wales) Act 2006 and the National Health Service Trusts (Membership and Procedure) Regulations 1990 (SI 1990 No. 2024) as amended, into day-to-day operating practice.

The impact of the 2022 amendments to these Regulations on the composition of the Board has been explained in the Directors' Report. Together with the accompanying Scheme of Matters Reserved to the Board, Scheme of Delegation to Officers and Others, and Standing Financial Instructions (all referred to as the 'Standing Orders'), they provide the regulatory framework for the business conduct of the Trust and define its ways of working.

4.1. The Board

The Trust Board meets bi-monthly and is comprised of a Chair, Vice Chair, six Non-Executive Directors, and six Executive Directors. This is the voting membership of the Board.

The Chair has a second and casting vote in the event of a split decision.

The Board includes at its meetings the remaining four Directors that make up the Executive Management Team, but are not voting, as well as the Board Secretary, and two Trade Union Representatives who are also non-voting.

The voting rights of members are primarily relevant to determine if a meeting is quorate, and when a vote is required on a particular issue. In the normal course of Board business however, items included on the agenda are subject to discussion and decisions based on consensus. A vote is therefore not a routine matter and may be regarded as exceptional. The Trust operates a unitary Board with decisions made as a single group, and with responsibility and liability shared in equal measure.

The Chair and Non-Executive Directors are appointed by the Minister for Health and Social Care. The Chief Executive is appointed by the Board through its Remuneration Committee on the recommendation of the Chair to whom the Chief Executive is accountable on a day-to-day basis. Executive Directors are appointed by the Remuneration Committee on the recommendation of the Chief Executive.

The Chair and Non-Executive Directors may serve on the Board for a maximum of 8 years.

Past papers for the Trust Board can be found here and recordings of meetings since can be found on our WAST Facebook page.

The role of the Board is to focus on these key areas:

Strategy: Developing the strategy, vision, and purpose of the Trust. Identifying priorities, establishing goals and objectives, finding resources, and allocating funds to support the decisions that need to be made around strategic planning.

Embedding Ethical Behaviour: The Board shapes the culture of the Trust in several ways, including by the way in which it engages with staff, the public and stakeholders, the way it manages its agenda, by the nature of the debate at the Board and the relative emphasis given to different performance criteria, by the visibility of its members in the organisation, and by where it chooses to invest time and resources. Board members must live up to the highest ethical standards of integrity and probity.

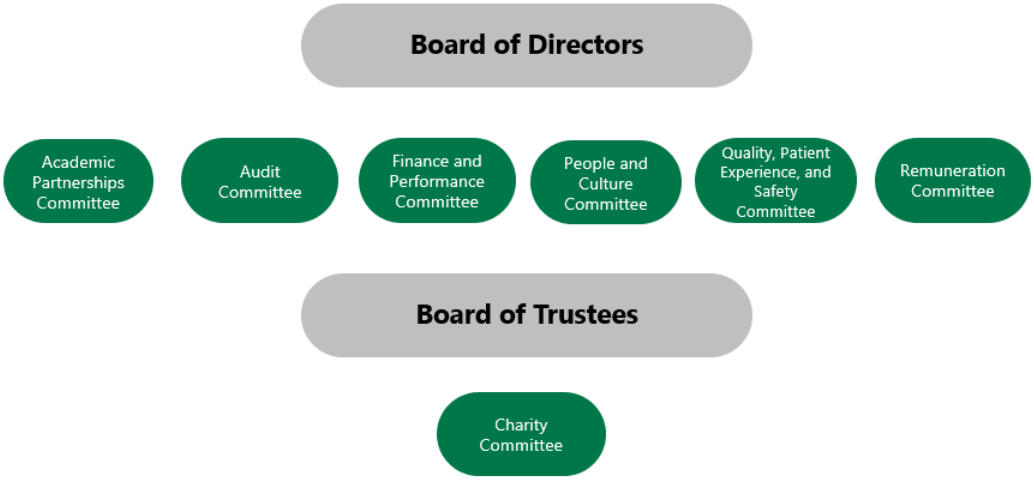
Quality: Set organisation wide expectations and accountability for high performance. Ensure that all staff understand their role in the effective and high-quality provision of care in a governance framework that ensures a balance between trust, constructive debate, and effective challenge in a culture of openness and learning.

Managing Risk: The Board is responsible for managing risk and ensuring there is a robust system of internal controls is in place and that they are sighted on the mitigations in place for the principal risks to the delivery of the strategy.

Gaining Assurance on the Delivery of Strategy and Performance: Holding to account, and being held to account, for the delivery of the strategy in accordance with the strategic and performance frameworks developed by the Board.

4.2. The Board Committees

The Trust Board establishes Committees to advise and assure the Board as to whether effective arrangements are in place to support the Board in their decision making, and in discharging their accountabilities for securing the Trust's objectives. Each Committee comprises voting membership of Non-Executive Directors. The Committees meet quarterly, other than the Finance and Performance Committee which meets bi-monthly. The Board and Committee structure is as follows:



The Board and Committee membership matrix is included in the pack of documents (document f) which provides a snapshot of the spread of Committee business delegated by the Board.

5. Roles and Responsibilities

5.1. Board Member

As a Board member you will be expected to:

- Understand the environment in which the Trust operates;
- Contribute to decision-making and share responsibility for the Board's decisions;
- Maintain eligibility to stand as a Board member;
- Provide scrutiny and challenge;
- Adhere to the Code of Conduct for Board Members of Public Bodies and the Seven Principles of Public Life (Nolan Principles);
- Attend Board meetings on a regular basis and be well prepared by reading relevant papers in advance and, if necessary, seeking further information;
- Attend training and development events and keep up-to-date with subjects relevant to the organisation's work;
- Contribute to the work of any Committees that have been established by the Board;
- Represent the Board at meetings and events when required;
- Attend all meetings well prepared.

Individual roles are set out with more particularly from section 7.2, however the table that follows illustrates that Members have discrete and complementary responsibilities when it comes to formulating strategy, ensuring accountability, shaping culture, providing context and intelligence, engagement, and building capacity and capability.

Table 1

Chair	Chief Executive	Non-Executive Director	Executive Director	Trade Union Representative
Formulate Strategy				
• Ensures Board develops vision, strategies, and clear objectives to deliver organisational purpose.	• Leads the organisation in the delivery of strategy. • Leads strategy development process.	• Brings independence, external perspectives, skills, and challenge to strategy development.	• Takes lead role in developing strategic proposals – drawing on professional and clinical expertise (where relevant).	• Brings a staff perspective to service change and strategic direction
Ensure Accountability				
• Makes sure the Board understands its own accountability for governing the organisation. • Ensures Board committees that support accountability are properly constituted. • Holds Chief Executive to account for delivery of strategy.	• Establishes effective performance management arrangements and controls. • Acts as Accountable Officer.	• Holds the executive to account for the delivery of strategy. • Offers purposeful, constructive scrutiny and challenge. • Chairs or participates as member of key committees that support accountability.	• Leads implementation of strategy within functional areas. • Manages performance within their area and deals effectively with suboptimal outcomes.	• Supports communication of the work of the Board and promotes opportunities for staff to be involved in decision making processes.
Shape Culture				
• Provides visible leadership in developing a healthy culture for the organisation and ensures that this is reflected and modelled in their own and in the Board's behaviour and decision-making. • Leads and supports a constructive dynamic within the Board, enabling grounded debate with	• Provides visible leadership in developing a healthy culture for the organisation and ensures that this is reflected in their own and the executive's behaviour and decision-making.	• Actively supports and promotes a healthy culture for the organisation and reflects this in their own behaviour. • Provides visible leadership in developing a healthy culture so that staff believe Non-Executive Directors provide a safe point of access to the Board for raising concerns.	• Actively supports and promotes a positive culture for the organisation and reflects this in their own behaviour. • Nurtures good leadership at all levels, actively addressing problems impacting staff's ability to do a good job.	• Actively supports and promotes a positive culture for the organisation and reflects this in their own behaviour. • Provides visible leadership in development of a healthy culture and acts as a focal point for all staff, reflecting their needs and aspirations.

Chair	Chief Executive	Non-Executive Director	Executive Director	Trade Union Representative
contributions from all Directors.				
Context				
• Ensures all Board members are well briefed on external context.	• Ensures all Board members are well briefed on internal and external context.	• Mentors less experienced Non-Executive Directors where relevant.	• Ensures all Board members are well briefed on internal and external context.	• Ensures all Board members are well briefed on staff perspectives.
Intelligence				
• Ensures requirements for accurate, timely and clear information to Board / Directors are clear.	• Ensures provision of accurate, timely and clear information to Board / Directors.	• Satisfies themselves of the integrity of financial and quality intelligence including getting out and about, observing and talking to patients and staff.	• Takes principal responsibility for providing accurate, timely and clear information to the Board.	• Brings staff governance issues to the attention of the Board. • Facilitates the interface between the Board and staff.
Engagement				

• Plays key role as an ambassador, and in building strong partnerships with:
  • Patients and public
  • All staff
  • Key partners
  • Regulators
	• Plays key leadership role in effective communication and building strong partnerships with:
	  • Patients and public
	  • All staff
	  • Key partners
	  • Regulators.
		• Ensures Board acts in best interests of patients and the public.
		• Hold various ambassadorial/champion roles
			• Leads on engagement with specific internal or external stakeholder groups.	• Champions partnership working at all levels of the Trust.

Building Capacity and Capability				
• Ensures that the Board sees itself as a team, has the right balance and diversity of skills, knowledge, and perspective, both Non-Executive Directors and Executive Directors, and the confidence to challenge	• Ensures that the executive team has the right balance and diversity of skills, knowledge, and perspectives. • Supports the Chair in ensuring that development	• Participate in Board development and induction, and continually update their skills, knowledge, and familiarity with the organisation.	• Participate in Board development and induction, and continually update their skills, knowledge. • Ensures annual appraisals are undertaken with the Chief	• Participate in Board development and induction, and continually update their skills, knowledge. • Ensures annual appraisals of their Board work are undertaken with the Chair

Chair	Chief Executive	Non-Executive Director	Executive Director	Trade Union Representative
on clinical as well as other intelligence and service plans. • Ensures that Directors have a full induction and continually update their skills, knowledge, and familiarity with the organisation. • Arranges regular evaluation of performance of the Board, and its committees. • Conducts regular performance reviews of the Non-Executive Directors, the Chief Executive and Executive Directors in relation to their Board contribution. • Acts on the results of these evaluations, including supporting personal development planning.	programmes are in place for Board members. • Uses the Board performance evaluations as the basis for determining individual and collective professional development programmes for executive directors relevant to their duties as Board members.	• Ensures annual appraisals are undertaken with the Chair and development areas identified. • Committee Chairs lead the annual evaluation of their Committee	Executive and development areas identified.	and development areas identified.

5.2. Chair

The Chair is committed to fourteen days a month and is accountable for leading the Board and its strategic vision, and for delivering value for money in terms of quality of service and financial balance. They will:

- Provide leadership to the Board, the other non-executives, the Chief Executive, and executive directors; and ensure the effectiveness of the Board in all aspects of its role and agenda; including directing the organisation towards achieving its objectives.;
- Ensure the provision of accurate, timely and clear information to the Board and directors to meet statutory requirements;
- Ensure effective communication with the Board, staff, service users and the public in a changing public service environment;
- Arrange the regular evaluation of the performance of the Board, its committees and individual Non-Executives, Directors, and the Chief Executive;
- Plan and conduct Board meetings, with the Chief Executive. Facilitate the effective contribution of Non-Executive Directors and ensure constructive relations within the organisation and between executive and Non-Executive Directors;
- Share and use relevant expertise of all members of the Board.

The Chair is appointed by the Minister for Health and Social Services who sets annual objectives for the Chair.

5.3. Chief Executive

As the Accountable Officer, the Chief Executive is responsible for:

- Formulating and proposing strategy for discussion and approval by the Board
- Ensuring the delivery of the agreed strategy and implementation plan
- Managing performance and dealing with suboptimal performance within their team
- Taking responsibility for provision the required information to the Board or its Committees
- Supporting and promoting a positive culture within the organisation and reflecting this in their own behaviour

The Chief Executive's annual objectives are agreed by the Chair.

5.4. Vice-Chair

The Vice-Chair is committed to eight days a month and will deputise for the Chair in their absence for any reason and will do so until either the existing Chair resumes their duties, or a new Chair is appointed.

This is a statutory appointment and is ministerially appointed. Changes in the external environment mean that vice chairs are being called on routinely to participate in collaborative and partnership-based activities on an all-Wales basis.

The Vice-Chair role calls for an increased time commitment.

5.5. Non-Executive Directors

Non-Executive Directors are committed to four days a month and are appointed to bring a particular perspective, skill, or area of expertise to the Board. They are not appointed to directly represent the particular interests of any one group or sector, and all individual members are responsible for contributing across the breadth of the Board's responsibilities.

An effective Non-Executive Director:

- Supports executives in their leadership of the business while monitoring performance.
- Questions intelligently, debates dispassionately and constructively, and challenges rigorously.
- Listens sensitively to the views of others, inside and outside the Board.
- Gains the trust and respect of other Board members.
- Maintains a focus on strategy and performance and is not distracted by detail.

They must:

- Ensure that they understand the role of the organisation and the sector within which it operates.
- Support the Chair in being clear about the information they need in order to discharge their role, including assurance and scrutiny.
- Aside from attending Board and committee meetings, always ensure they have read all papers they are sent and have a good understanding of the work of the organisation.
- Actively participate in all aspects of assurance and scrutiny and not absent themselves from particular discussions.

- Properly declare all areas of potential or perceived conflict of interest.
- Discuss matters they feel uncomfortable with or uncertain about with the chair.
- Go through an annual development appraisal discussion with the chair.
- Undertake their important ambassadorial role for their organisations.

Committee Chairs lead the annual effectiveness reviews of their Committees.

Non-Executive Directors are appointed by the Minister on the recommendation of a Chair led panel but appraised by the Chair annual.

5.6. Executive Directors and Directors

Directors have a dual set of roles and responsibilities. Executive Directors are voting Board members, and Directors are in attendance at Board meetings:

- Firstly, as a result of their management relationship to their Chief Executive, , their accountability is defined by their job description and by the personal objectives and standards of performance they have agreed with their Chief Executive.
- Secondly for Executive Directors, as a result of being a voting Board Member, when they are operating in the Board, they are also accountable to the Chair for the same accountabilities as other Board Members.

Executive Directors and Directors must be able to operate from multiple perspectives and be able to view both their own and the organisation's work as an independent objective observer.

They share collective responsibility for achievement of corporate objectives and do not solely contribute to discussion and decision in the light of their particular executive function.

All Directors have a responsibility to constructively challenge the decisions of the Board and help develop proposals on priorities, risk mitigation, values, standards, and strategy. This enables them to scrutinise all proposals rigorously and objectively, offer dispassionate comments and identify potential improvements to all areas of work, including their own.

The annual objectives for all Directors are agreed by the Chief Executive.

5.7. Trade Union Representatives

Trade Union representatives are non-voting members of the Board and Board Committees. Their role is to ensure that the views of all staff, irrespective of individual membership of a particular Trade Union, are represented fairly and equitably, and to ensure the highest levels of patient care and provision of service.

Trade Union representatives on the Board and Committees will:

- Seek to embed partnership working whilst bringing a staff perspective to strategic discussions;
- Scrutinise proposals, providing constructive challenge and support where appropriate;
- Focus on the creation of a working safely environment being fostered at the Board and Board Committees for the wellbeing and welfare of staff;
- Facilitate interface and communication between the Board/Committees and staff;
- Bring staff governance issues to the attention of the Board and Committees;
- Act as the focal point for all staff, reflecting their needs and aspirations;
- Support communication of the work of the Board and promote opportunities for staff to be involved in the decision-making process.

Trade Union representation attend Board Committees and there is no limitation on information and no exclusions to their attendance, other than where conflicts of interests are declared for items on the agenda. These will be managed in accordance with the Trust's policy and standing orders.

Two Trade Union representatives will attend Board and two deputies will attend in their place where necessary. The deputies will also attend Board Development Sessions.

Trade Union Representatives to the Board and Committees are appointed for a period of 2 years following a vote taken at the Staffside Meeting. The names of the representatives are notified thereafter to the Trust Board Chair and the Board Secretary.

5.8. Board Secretary

The Board Secretary is the independent and principal advisor to the Board. They are non-voting and their primary role is to ensure the establishment and maintenance of, and compliance with, strong governance frameworks and to ensure the Board acts fairly, with integrity and without prejudice or discrimination in all its dealings.

The Board Secretary promotes and helps sustain good governance by:

- Keeping under review legislative, regulatory and governance developments that impact on the Trust's activities and ensuring that the Board is appropriately briefed on them.

- Winning the confidence of the Board – acting as 'wise counsel' providing a confidential sounding Board to the Chair, Chief Executive, and individual Board members on all aspects of Board business including issues of concern.

- Guiding the Board in the responsible and effective conduct of its role, providing, where appropriate, a discreet, challenging, and independent voice in relation to Board deliberations and decision making.

- Ensuring that in all its dealings, the Board acts fairly, with integrity, and without prejudice or discrimination, and within the terms of its establishment order and standing orders.

- Contributing to the development of an organisational culture that embodies NHS values and standards of behaviour.

5.9. Corporate Trustees

The Welsh Ambulance Services NHS Trust Charity (registration number 1050084) is registered as a charity with the Charity Commission for England and Wales.

The Welsh Ambulance Services NHS Trust Charity is a corporate body in its own right. It is led by a Board of Directors with the same composition as the Trust Board. The Trust acts as the Corporate Trustee of the charitable funds held on behalf of the ambulance services in Wales.

The corporate trustee is responsible for the general control, management, and administration of its charity, as well as setting its strategic aims and objectives. Oversight of the Charity is carried out by the Charity Committee, however as a corporate trustee you must:

- understand the purpose and charitable objects of its linked charity which are typically for public benefit relating to the delivery of NHS healthcare services;

- act with integrity and avoid conflicts of interest or misuse of charitable funds or assets;

- ensure that charitable funds and assets are used reasonably and only in furtherance of the charity's objects;

- avoid undertaking activities that might place the charity's funds/assets or reputation at undue risk;

- receive on-going and bespoke training for this role.

Click here for the Charity Annual Report and Accounts for 2020-21.

5.10. Board Champion Roles

Over the last few years, there has been an increasing focus on the designation of Board Champions on Trust Boards and nominated leads designed to engender Board level commitment and focus around key areas of service development or delivery. For the Board's Non-Executive Directors this provides an opportunity to gain a deeper level of insight and knowledge around these key areas with the aim of better equipping them and the whole Board to fulfil its role.

The Welsh Government will continually review the design and designation of these roles so that their purpose within the NHS in Wales is properly focused and supported through the provision of clear guidance.

The current Champion roles for Non-Executive and Executive Directors is set out in the membership matrix.

Whilst a Welsh Government Board Champion Role Description does not yet exist, the role could be described as follows:

The principal responsibility of a Board Champion

- In addition to their responsibilities as a Board Member, the Board Champion will take a lead in an area of responsibility defined by Welsh Government or as set out in any statutory or other guidance and work with the Executive Team and other staff to help develop strategy and policy in that area.

Representing the Board

- To take a lead responsibility in a defined area of the business;
- To be consulted on the development of strategy and policy in relation to the defined area prior to consideration by the Board or Committee of the Board;
- To attend project Groups, working groups or action groups and offer a Board member's perspective to the meetings;
- To contribute to learning events.

Working with Staff

- To support the Executive Director or Lead Officer in the defined area in the preparation of strategy and policy papers;
- To offer advanced level of scrutiny on proposals prior to consideration by the Board or Committee of the Board;
- To ensure that Board members roles and responsibilities do not cross into the operational duties of the staff.

6. Key Documents and Attachments

The following documents are considered as essential reading as part of your induction:

(a) Standing Orders regulate the Trust's proceedings and business. They are designed to translate the statutory requirements set out in the Trust's Establishment Order and the Membership and Procedure Regulations into day-to-day operating practice, and, together with the Scheme of Reservation and Delegation of Powers and Standing Financial Instructions (SFIs), they provide the regulatory framework for business operations.

(b) The Scheme of Reservation and Delegation outlines where activity can be delegated, it is for the Board to decide what it will delegate to others for them to do on its behalf. The Board must assure itself that all matters delegated are effectively carried out. The Board does this in a number of ways, including receiving regular reports and information, speaking to Directors and their staff, and reading information provided as part of news bulletins, staff briefings etc. Because the Board retains responsibility and accountability it is very important for them to receive an accurate picture of what is happening within the organisation, together with information regarding any risks or issue.

(c) The Standing Financial Instructions regulate financial proceedings and business. Designed to achieve probity, accuracy, economy, efficiency, and effectiveness in the conduct of business, they translate statutory and Welsh Government financial requirements for the NHS in Wales into day-to-day operating practice. The Standing Financial Instructions are supported by more detailed Financial Control Procedures. The Audit Committee is responsible for approving Finance related procedures on behalf of the Board. This link will take you to the Standing Orders, Scheme of Reservation and Delegation, and Standing Financial Instructions, as well as the Standing Orders annexures.

(d) This link will take you to the Board Committee terms of reference and papers.

(e) Board and committee schedule of dates (attached).

(f) Board and Committee Membership Matrix (attached).

(g) 2022/23 Annual Report and Annual Accounts

(h) 2021/22 WAST charity annual report and accounts.

(i) Director portfolios (attached).

(j) Key strategic plans can be found on our publications page.

(k) Mandatory training (attached list of core and statutory mandatory training required)

(l) Key Policies (attached). All Trust policies can be viewed on Siren, here.

(m) NHS Wales map (attached).

(n) Independent Member Scrutiny Toolkit (attached).

(o) The Good Governance Guide for NHS Wales Boards. This document contains a wealth of information, designed to support you in your role, it outlines the context for Board members of public organisations in Wales, and also provides more specific detail on the governance, legislation, and policy requirements, emerging good practice and lessons learned in the health service.

(p) Code of Conduct for Board Members of Public Bodies.

(q) Code of Conduct and Accountability for NHS Boards and Managers.

(r) Acronym buster (attached).

(s) Academic Wales - NHS Wales Induction Guide for Independent Board Members.

(t) List of All Wales Peer Groups: Chairs' Group, Vice-Chairs' Group, Quality Committee Chairs' Group, All Wales Audit Committee Chairs' Group, and the Board Secretaries Network.

7. Action Required

- Return Personal Details Form;
- Return photo (see below guidance);
- Complete the Board Member Eligibility Form via this MS Link;
- For Non-Executive Directors – please return a copy of your appointment documents and terms of service from WG (for our records and from which we'll build your Register of Interests entry) and;
- For Executive Directors please complete and return to the Corporate Governance Team the Declarations of Interests form which is available on the Governance Directorate page here: Declarations of Interest Form 2023 v2.0.docx.

Photocard guidance: -

- *Facing forward, looking directly at the camera;*
- *Head and Shoulders only;*
- *On a white background;*
- *Free from refection or glare;*
- *Saved to a high resolution;*
  (the use of a good quality mobile phone camera is acceptable)

ANNEX:
Non-Executive Director Set Up Form

- Welcome to the Welsh Ambulance Services NHS Trust (the Trust). In order for the Corporate Governance Team (CGT) to set you up on the necessary systems and finalise your laptop set up we must seek some personal details from you.

- Once the information in this form has been received the Team will progress the set-up of the following system. This information will be held confidentiality and only used for purposes described. The below narrative will hopefully answer any questions you have regarding next steps.

Actions to be completed by you.

Actions to be completed by the Trust.

Return of the Personal Details Form: - ID & Eligibility Checks

1. The information in the below 'Personal Details Form' is required by NHS Recruitment in order to create a new record for you. This process will include the completion of an ID check, a DBS submission and other eligibility checks. Colleagues in the CGT will work closely with NHS Recruitment to progress.

2. It is asked that you respond to any requests for action through the HR system (which is called Trac) as soon as possible, as it is only when these process / checks are completed that you'll gain access to the Trust's systems and other related actions can be taken, e.g., payroll set up.

3. Colleagues in the CGT will populate a Declaration of Interests form on your behalf from the information that you give to the Welsh Government during the appointment process. If you could please provide a copy of the signed Accountability Agreement, appointment letter and conflicts of interest form that would be appreciated.

Trust Email/IT Account Set Up

4. The CGT will use your preferred name in the email / account set up request and your IT account and email address will be created accordingly. This request will be made upon return of the enclosed 'Personal Details Form'.

Laptop / Equipment Procurement

5. The CGT have made a request for a laptop which is in the process of being built by IT colleagues. You will also receive an iPad to support you in your role. If you would like any accessories, such as an audio headset, or other home-working equipment, please include this in the form. This procurement can be made post appointment however, so you can make this request at a later date.

ID Badge Request

6. The CGT will ask colleagues to produce an ID card for you using the photograph that you have returned with this form. If you have a preferred name (compared to your full legal name) the ID card can be produced in this way. It would be very helpful if you could indicate *if you do not wish* to use an alternative name to your full name on your ID card.

Additional actions to be completed by WAST: -

Payroll Set Up

7. Once your ID and eligibility checks have been completed through Trac the CGT will receive a request for you to complete a New Appointment Form (NAF). This form requests other personal details including your bank details to set up your monthly remuneration payments.

A member of the CGT will be in touch to seek these details when this point is reached, as it will need to be completed with you. Please note that Trish Mills, as the Board Secretary, will be recorded on our systems as your authoriser (in lieu of a manager).

Delivery/collection of IT equipment and ID Card

8. Once your laptop has been set up, a member of the CGT will be in touch with you to arrange for collection or delivery of the items. It would be preferable for a member of the Team to meet with you in person to hand over the equipment to ensure that you have everything you need. This will be organised with you directly when the time comes.

9. Electronic Staff Record & Expenses Systems
   Once the ID and eligibility checks / related processes on Trac are completed you will receive (to your Trust email address) instructions on the set up of two other systems which you will need to use. The first is the Electronic Staff Record (ESR) – which is the HR portal for receiving payslips, completing statutory and mandatory training.

   You will also receive instructions on the set up of an expenses account, which will enable you to claim for mileage and subsistence. Information about ESR can be found here, however: ESR Self Service - Statutory and Mandatory Training (sharepoint.com). The Corporate Governance Manager will support you with setting up / beginning to use these systems.

PERSONAL DETAILS FORM

TITLE (Mr/Mrs/Dr etc)	
FULL LEGAL NAME (Including middle names)	
Known as, if different (this will be used for your ID card)	
DATE OF BIRTH	
GENDER	
HOME ADDRESS (Including postcode)	
EMAIL ADDRESS	
HOME NUMBER	
MOBILE NUMBER	
NI NUMBER	
PREFERRED LANGUAGE	
EMERGENCY CONTACT DETAILS	Name: Relationship to you: Contact Number:
PROFESSIONAL REGISTRATION / BODY (if applicable). Please include registration number and registration renewal/expiry date.	

Do you have an in date digital UK/Irish passport, or share code?	
IT accessories or hardware requests should be stated here, if known. You will be provided with a laptop and iPad. If you would like a screen, headphones (or other home-working equipment please state it here.	

PRIVACY NOTICE: - For more information on how your information will be processed, please see the Staff Privacy Notice and NHS Wales Shared Services Partnership's Recruitment Privacy Notice. If you have any questions or concerns, please contact the Corporate Governance Team directly on amb_CorporateGovernance@wales.nhs.uk.

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

Committee Priorities, Cycle Monitoring Report and Committee Membership Update

MEETING	Audit Committee
DATE	14 September 2023
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's attention is drawn to the transfer of oversight of the Quality and Performance Management Framework (QPMF) from the Quality, Patient Experience and Safety Committee (QuEST) to Audit Committee.

3. The Committee is asked to review the proposed change to the prescribed attendance of the Committee with respect to representation from the Operations Directorate, detailed in paragraphs ten and eleven.

RECOMMENDATION: -

4. **The Committee is asked to NOTE the update, and REVIEW and APPROVE the change to the prescribed attendance for the Committee to enable an alternative representative of the Operations Directorate to attend in place of the Executive Director of Operations.**

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, CYCLE MONITORING REPORT & COMMITTEE MEMBERSHIP UPDATE

SITUATION

5. 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

6. During the course of the effectiveness reviews, it was agreed that it is good practice for Committees to set priorities for the forthcoming year. The Committee's priorities, which are set out below, were agreed by the Trust Board in May 2023 and will be tracked quarterly.

7. 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.

8. 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

9. With respect to the Committee membership and prescribed attendance; it has been agreed with the Executive Director of Operations that his deputy - Judith Bryce (Assistant Director of Operations, National Operations & Support) - will attend the Committee as a prescribed attendee, in his place.

10. Subject to this change being agreed by the Committee the Terms of Reference for the Committee will be updated to read 'the Executive Director of Operations (or Deputy/Assistant Director)' within the regular attendees. The Committee is asked to review and approve this change.

11. 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.

12. The Committee is asked to note that the oversight of the development and effectiveness of the QPMF has moved from the QuEST to Audit Committee. The reporting for this business is also under development.

RECOMMENDATION: -

13. **The Committee is asked to NOTE the update, and REVIEW and APPROVE the change to the prescribed attendance for the Committee to enable an alternative representative of the Operations Directorate to attend in place of the Executive Director of Operations.**

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	
Update report	N/A	Quartlery						Audit Wales	Assurance	
Annual Audit Report	EMT and Board	Annually						Audit Wales	Assurance	
Structured Assessment	EMT and Board	Annually						Audit Wales	Assurance	
Losses & Special Payments/Single Tender Waivers										
Quarterly lossess and special payments report	N/A	Quarterly						EDOF	Approval	
Tender update report and single tender waiver request	N/A	Quarterly						EDOF	Assurance	
Counter fraud										
Counter fraud update report	N/A	Quarterly						EDOF	Assurance	
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	
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	
Other										
Near Miss Report	QUEST	Annually						TBC	Assurance	TBC ref this - AP to research.
Policy										
Policy report	EMT	Annually						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	
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	
Governance Practice Notes	EMT	Annually as due						BS	Review/Approve	
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

AGENDA ITEM No	**14**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**1**

TRUST POLICY REPORT

MEETING	Audit Committee
DATE	14th September 2023
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 Policies, a copy of the work plan for the next two years and, for approval, a set of criteria for the extension of review dates on non-critical policies.

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 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. There will be a number of policies that will only require minor changes during the review process as they have already been through robust governance.

3. It is, of course, good practice to review, improve and update our policies in a timely manner and a policy prioritisation exercise has been undertaken to fully assess the Trust's position. This has resulted in a priority programme of work being established to bring the organisation's key policies up to date during 2023/24 with a further work plan agreed for 2024-2025.

4. The work plans include the extension of several review dates for non-critical policies that have already been through a robust review process. A set of proposed criteria is included in this report, for Committee to approve that will provide a framework for Directors and their teams to follow when considering these policies.

5. It should be acknowledged that these work plans are resource intensive and that there needs to be time and resources allocated to undertake the professional reviews to extend policy review dates, to rework policies as SOPs and undertake the priority review of policies within the two year plans.

6. The Trust's policy governance process is being refreshed in partnership with Trade Union colleagues and includes the review of the Policy on Policies. This will be strengthened to include definitions of other written control documents such as Standard Operating Procedures, Frameworks, Guidelines and Procedures for example and the process that will need to be followed to ensure good governance is maintained. It is expected that proposals will be submitted to the Executive Management Team (EMT) for endorsement in early 2024 and a report submitted to Audit Committee and Trust Board in March 2024 for approval.

RECOMMENDATION:

7. **Members are asked to:**
   - **a) Consider the contents of the report and the policy work plans established to mitigate risk and review policies in line with appropriate review dates.**
   - **b) Receive assurance on the prioritisation and progress being made to review Policies.**
   - **c) Approve the criteria to extend the review date on appropriate, non-critical policies following professional review.**
   - **d) Note the policies that have been identified for professional review as potential Standing Operating Procedures.**
   - **e) Note the next steps.**

KEY ISSUES/IMPLICATIONS

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

REPORT APPROVAL ROUTE

9. The report and associated policy tracker were considered by:

- Policy Group – 29th August 2023
- EMT – 6th September 2023
- ADLT – 11th September 2023

REPORT ANNEXES

SBAR Report
Annex 1 – Trust Policy List

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

SITUATION

1. This paper provides an update to the Committee on the status of Trust Policies as of 1st September 2023, a copy of the 2 year policy work plan, and a set of criteria for Members approval which are to be applied when considering the extension of review dates on non-critical policies.

BACKGROUND

2. The Policy Group was set up in 2017 to ensure appropriate governance, process and partnership working was applied to the review of existing policies, the development of new policies and to ensure that all policies were dealt with in agreed timelines.

3. Since the Trust's revised policy process was implemented in 2017 there was a significant improvement in the number of policies within their review date. However, the rate of review fell below reasonable levels during the Covid-19 pandemic as policy work was largely paused and efforts directed to support the response. This means that most policies are now past their review date and are overdue for review.

4. Whilst it is not possible to provide assurance that all Trust policies comply with current legislation, or that they discharge the Trust's statutory duties; the Trust can be assured that professionals across the organisation are proactive in identifying legislation or practice changes and updating policies as and when necessary to reflect any significant changes.

ASSESSMENT

5. The Corporate Governance Team has maintained a policy tracker contained at Annex 1. This has been specifically designed to facilitate dynamic reporting dependent on the areas which are of most interest to users, for example reports can be produced by Directorate, type of policy, review date or Policy Lead.

6. The tracker describes the status of all policies and lists those which have been identified as a priority for review to date by working with Directors and their teams as well as reviewing Committee Terms of Reference and cycles of business.

7. In terms of a breakdown of the numbers; the Trust holds 96 polices and, for the reasons set out in this paper, only 15 of those are within their review date – this equates to 16% overall.

8. Additionally, there are 22 all Wales NHS Policies that the Trust has adopted from the NHS Employers Unit and only 4 of these are within their review date - equating to 18% overall. These figures and policy reviews are out of the Trust's control as the

programme of policy review work sits with NHS Wales. The Trust has received a review schedule from the NHS Employers Unit and whilst 6 policies are under review, all NHS Wales employment policies remain extant. These are described in the table below.

All Wales Policies

Policy Title	Issue Date	Review Date	Comments
NHS Wales Apprenticeship Policy	New	New	New Policy to be developed
NHS Wales Disclosure and Barring Service	New	New	New Policy to be developed
NHS Wales Pay Progression Policy	01/06/22	01/06/25	Remains extant
NHS Wales Respect and Resolution Policy	01/04/21	01/04/24	Remains extant - Under review
NHS Wales Patient Safety Incident Reporting and Management	01/06/23	31/03/24	Remains extant
NHS Wales Menopause Policy	10/01/19	10/12/21	Remains extant
NHS Wales Managing Attendance at Work	16/10/18	16/10/21	Remains extant - Under review
NMC Revalidation and Registration	04/09/18	04/09/21	All Wales Policy - to be reviewed
NHS Wales ANTT Policy	25/02/20	25/07/21	NHS Wales Policy - to be reviewed
NHS Wales Capability Policy	27/06/18	27/06/21	Remains extant - Under review
NHS Wales Email Use Policy	04/10/19	26/06/20	Remains extant
NHS Wales Disciplinary Policy	27/07/17	01/03/20	Remains extant
NHS Wales Recruitment & Retention Payment Protocol	27/07/17	01/03/20	Remains extant
NHS Wales Organisational Change Policy	10/01/19	01/03/20	Remains extant - Under review
NHS Wales Speaking up Safely Policy	01/09/23	01/09/26	Remains extant
NHS Wales Special Leave Policy	13/03/18	01/01/20	Remains extant
NHS Wales Reserve Forces Training and Mobilisation Policy	07/03/16	01/09/19	Remains extant
NHS Wales Secondment Policy	07/03/16	01/09/19	Remains extant
NHS Wales Employment Break Scheme Policy	27/07/17	01/03/19	Remains extant
NHS Wales Internet Use Policy	24/05/16	01/01/18	Remains extant
NHS Wales Social Media Use Policy	24/05/16	01/01/18	Remains extant
NHS Wales Equality Impact Assessment Guidelines Policy	01/10/10	01/09/13	Remains extant

9. There are 11 new policies which have been identified for development as described in the table below. This brings the total number of policies on the policy tracker to 118.

New Policies Identified for Development

Policy Title	Priority Number 1 High 10 Low	Directorate	Policy Lead	Comments
Equality Policy	1	People Services	Paula Spiteri	
Risk Management Policy	1	Corporate Governance	Julie Boalch	In development for approval March 24
Staff Immunisation Policy	1	People Services	TBC	
People Development Policy	2	People Services	Lynda Bugonovic	
Colleague Experience / Wellbeing Policy	3	People Services	Lynda Bugonovic	
Mental Capacity Policy	3	QS&PE	Mark Jones / Nikki Harvey	
Information Sharing Policy	6	Digital	Kelly Holding	
Bank Worker Policy	7	People Services	Michelle Morse	
Forensic / Digital Evidence Policy	7	Digital	Aled Williams / James Rowlands	
Patient Clinical Record Policy	7	Medical & Clinical	Kevin Webb	
Overpayments Policy	N/A	Finance & Corporate Resources	NWSSP / Jill Gill	All Wales Review Group established

Policy Work Plan

10. Colleagues have reviewed their directorate lists within the tracker to support the development of a priority workplan for 2023/24 and schedule for 2024/25. The Policy Group proposed a final work programme which has been agreed by the EMT. It is important to note the need to be flexible given the priority and needs of the service particularly over the winter period. Key Policies identified for priority review in 2023/24 are described in the table below.

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Workplan 2023/24

Policy Title	Priority Number 1 High 10 Low	Directorate	Policy Lead
Counter Fraud, Corruption and Bribery Policy	1	Finance & Corporate Resources	Carl Window
Education Programme Policy (RTW)	1	People Services	Martin Mulholland
Environmental, Estates and Facilities Policy	1	Finance & Corporate Resources	Susan Woodham
Flexible Working Policy	1	People Services	Karen Jones
Professional Regulation Policy	1	Medical & Clinical	Greg Lloyd
Retirement Policy	1	People Services	Sara Williams / Hilary Caffrey
Violence & Aggression Policy	1	QS&PE	Nicola White

11. The work plan for 2024/25 is described in the table below. The EMT approved both the 2023/24 and 2024/25 workplans at its meeting on the 6th September 2023.

Workplan 2024/25

Policy Title	Priority Number 1 High 10 Low	Directorate	Policy Lead
CCTV Policy	2	Digital	Kelly Holding
Data Quality Policy	2	Digital	Jon Hopkins / Sue Brown
Management of Allegations Policy: When an allegation or concern is raised about an Employee or Volunteer	2	QS&PE	Nikki Harvey
Non-Medical Prescribing Policy	2	Medical & Clinical	Kerry Robertshaw
Occupational Health Policy	2	People Services	Ceri Bryant
Alternatives to Conveyance Policy	3	Medical & Clinical	Bryn Thomas
Consent to Examination and Treatment Policy	3	Medical & Clinical	Bryn Thomas
Lone Worker Policy	3	QS&PE	Nicola White
Maternity and Adoption Policy	3	People Services	Sophie James
Paternity Policy	3	People Services	Sophie James
Safer Handling Policy	3	QS&PE	Graham Stockford
Shared Parental Leave Policy	3	People Services	Sophie James

12. It is worthy of note that several policies are already at various stages of the review and development process for 2023/24, as described in the list below, and have been or are included on the Policy Group Agenda in recent months.

Policies Currently Under Review

Policy Title	Priority Number 1 High 10 Low	Directorate	Policy Lead	Comments
Clinical Supervision Policy (New)	1	Medical & Clinical	Jonathan Chippendale	Under review – approval stage
Data Protection Policy	1	Digital	Aled Williams (DPO)	Under review
Driving at Work Policy	1	People Services	Andrew Morgan	Under review (Within review date)
Health and Safety Policy	1	QS&PE	Nicola White	Under review
Home Working Policy	1	People Services	Karen Jones	Under review
Infection Prevention & Control Policy	1	QS&PE	Louise Colson	Under review – approval phase
Information Security Policy	1	Digital	James Rowlands	Under review - approval phase
Management of Controlled Drugs Policy	1	Medical & Clinical	Chris Moore	Under review (Within review date)
Medicines Management Policy	1	Medical & Clinical	Chris Moore	Under review
Management of High Intensity Service Users (Previous Frequent Caller) Policy	1	Medical & Clinical	Sarah Woods	Under review – TFG established
Management of Medical Devices Policy	1	Medical & Clinical	Jon Wilson	Under review – consultation phase
Policy for the Development, Review and Approval of Policies	1	Corporate Governance	Julie Boalch	Under review For approval Mar 24
Waste Management Policy (New)	1	Finance & Corporate Resources	Nicola Stephens	In development – consultation phase
Charitable Funds Investment Policy	N/A	Finance & Corporate Resources	Jill Gill	Approved July 2023
Command Policy	N/A	Operations	Clare Langshaw	Approved April 2023
Standards of Business Conduct Policy	N/A	Corporate Governance	Trish Mills	Approved July 2023

13. Once these policies have navigated the policy process and been approved this will bring the number of policies within their review date to 26 equating to 27% by 31st March 2024.

14. The EMT agreed proposals to consider extending the current review dates for several non-critical policies that have already been through a robust review process. An

extension could be between 6-12 months, from September 2023, to support a manageable and staggered work plan over the next 3 years. The extension could be applied to policies that fell due just before, during and just after the pandemic period.

15. Work has been undertaken to assess which policies this extension could be applied to facilitate a manageable work plan. These are described in the table below.

Policies for Extended Review Dates

Policy Title	Priority Number 1 High 10 Low	Directorate	Policy Lead
Dispatch Cross Reference (DCR) Table Policy	4	Medical & Clinical	Grayham McLean
Fire Safety Policy	4	Finance & Corporate Resources	Susan Woodham
Domestic Abuse, Gender Based Violence and Sexual Violence "Ask and Act" Policy	5	QS&PE	Rhiannon Thomas
Safeguarding Children and Adults at Risk of Harm Policy. This policy has merged with the Protection of Vulnerable Adults Policy	5	QS&PE	Nikki Harvey
Working Time Regulations Policy	5	People Services	Sara Williams / Emma Morgan
Information Governance Policy	6	Digital	Kelly Holding
Management of Compensation Claims Policy	6	QS&PE	Trish Gaskell
Access to Personal Information Policy	7	Digital	Judith Birkett
Redeployment Policy	7	People Services	Emma Morgan
Access Control Policy	8	Digital	Kelly Holding
Records Management Policy	8	Digital	Judith Birkett
Vehicle Disposal Policy	8	Finance & Corporate Resources	Gavin Lane
Information Classification Policy	9	Digital	Aled Williams
Managing Families and Relatives Working Together Policy	9	People Services	Amanda Jones
Mobile Computing Policy	9	Digital	Aled Williams / James Rowlands
Bursary Scheme Policy	10	People Services	Sarah Davies
Confidentiality and Code of Conduct	10	Digital	Kelly Holding
Information Risk Policy	10	Digital	Kelly Holding
Organisational Learning and Promoting Improvements in Patient Safety Policy and Procedure	TBC	QS&PE	TBC
Intellectual Rights Policy	TBC	Medical & Clinical	Nigel Rees

Business Continuity Management Policy	TBC	Operations	TBC
Children in Special Circumstances Policy & Procedure	TBC	Medical & Clinical	Ed O'Brien
High Risk Record Policy	TBC	Operations	Katie Blackmore
MPDS QA Policy	TBC	Operations	TBC
Quality Assurance Framework for the Clinical Desk	TBC	Operations	TBC
Resourcing Policy	TBC	Operations	TBC
Transfer Policy	TBC	Operations	TBC

Policy Review Date Extension Criteria

16. Committee are asked to consider and approve the list of criteria described below. This forms a checklist for professionals and policy Leads to utilise when determining whether non-critical policies within their remit could be extended following professional review. It is intended that a return will be provided from the Director and professional lead to the Policy Group and the EMT for noting.

    a) Is the policy still fit for current purpose, describing current industry practices accurately and therefore extant.
    b) Have there been any legislative changes, governmental regulations or change in clinical practice that would prompt a review.
    c) Are the Executive Leads, Policy leads, contact information, job titles, hyperlinks etc correct and current.
    d) Does the policy contradict older policies or align to relevant policies within the suite.
    e) Have new systems and technology with the Trust been included that support current practice.
    f) Has there been any repeat incidents that would prompt a review of training - did the policy have the intended effect - was the policy explicit – were there any gaps in training which meant the policy wasn't followed properly.

Policies identified as potential Standing Operating Procedures

17. Several policies could be considered as Standing Operating Procedures (SOPs) due to their nature and content. These are described in the table below and are a suggested list only. A piece of work is underway to review these in more detail as to whether they would be better suited as SOPS rather than policy. The intention is that a final list will be included in the paper for Committee in March 2024. Additionally, a governance process will need to be applied including the development of a central, online repository. This will form part of the Policy on Policy review as described in the next steps section of the paper at paragraph 19 and 20.

Potential Standing Operating Procedures

Policy Title	Priority Number 1 High 10 Low	Directorate	Policy Lead
Exit Interview Policy	1	People Services	Emma Morgan
HR Starting Salary Policy	1	People Services	Hilary Caffrey / Anna Stein
Recruitment and Selection Policy	1	People Services	Dee Udeze-Chibuzor / Charlie Bosher
Assessment, Failure Referral and Appeals Policy	2	People Services	Martin Mulholland
Infection Prevention & Control: Sharps Policy	2	QS&PE	Louise Coulson
Premises and Vehicle Cleanliness Policy	2	QS&PE	Louise Coulson
Relocation Expenses Policy	2	People Services	Jan Cross
Study Leave Policy	4	People Services	Sara Williams / Emma Morgan
Adverse Weather Conditions Policy	8	People Services	Bethan Davies
Work Experience Policy	8	People Services	Sara Minahan
Fuel Card Policy	9	Finance & Corporate Resources	Gavin Lane
Trust Mobile Phone Policy	9	Digital	Aled Williams / Tony Raine
Tyres and Wheels Policy	10	Finance & Corporate Resources	Gavin Lane
Transfer Policy	TBC	Operations	TBC

18. It should be acknowledged; however, that these work plans are resource intensive and that there needs to be time and resources allocated to undertake the professional reviews to extend policy review dates, rework policies as SOPs and undertake the priority review of policies within the two year plans.

Next Steps

19. The Trust's policy governance process is being refreshed in partnership with Trade Union colleagues and includes the review of the Policy on Policies. This will be strengthened to include definitions of other written control documents such as Standard Operating Procedures, Frameworks, Guidelines and Procedures for example and the process that will need to be followed to ensure good governance is maintained. It is expected that proposals will be submitted to the Executive Management Team (EMT) for endorsement in early 2024 and a report submitted to Audit Committee and Trust Board in March 2024 for approval.

20. This will include consideration of a policy management software solution, for example using Sharepoint, including automatic reminders and collaboration online during the consultation process.

RECOMMENDED

21. **Members are asked to:**
    a) **Consider the contents of the report and the policy work plans established to mitigate risk and review policies in line with appropriate review dates.**
    b) **Receive assurance on the prioritisation and progress being made to review Policies.**
    c) **Approve the criteria to extend the review date on appropriate, non-critical policies following professional review.**
    d) **Note the policies that have been identified for professional review as potential Standing Operating Procedures.**
    e) **Note the next steps.**

Policy Title	Priority Number 1 High 10 Low	Directorate	Policy Lead	Policy Type	Issue Date	Review Date	Date Review due to Commence (within 3 months)	Comments
Clinical Supervision Policy	1	MEDICAL & CLINICAL	Jonathan Chippendale	Corporate	New	New	#VALUE!	
Counter Fraud, Corruption and Bribery Policy	1	FINANCE & CORPORATE RESOURCES	Carl Window	Corporate	24/05/18	24/05/21	24/02/21	scheduled within 2023 work plan
Data Protection Policy	1	DIGITAL	Aled Williams (DPO)	Corporate	15/12/16	15/12/19	15/09/19	Under review
Driving at Work Policy	1	PEOPLE SERVICES	Andrew Morgan	Employment	07/09/21	06/09/24	07/05/24	Under review
Education Programme Policy (RTW)	1	PEOPLE SERVICES	Martin Mulholland	Employment	19/12/12	02/05/18	19/01/18	
Environmental, Estates and Facilities Policy	1	FINANCE & CORPORATE RESOURCES	Susan Woodham	Corporate	16/07/14	16/02/17	16/11/16	
Equality Policy	1	PEOPLE SERVICES	Paula Spiteri	Employment	New	New	#VALUE!	How does this fit with NHS Wales Policy?
Exit Interview Policy	1	PEOPLE SERVICES	Emma Morgan	Employment	01/06/04	01/06/07	01/03/07	Under review
Flexible Working Policy	1	PEOPLE SERVICES	Karen Jones	Employment	10/05/18	10/09/20	10/06/20	
Health and Safety Policy	1	QS&PE	Nicola White	Corporate	28/11/17	28/11/20	28/08/20	Under review
Home Working Policy	1	PEOPLE SERVICES	Karen Jones	Employment	26/03/20	26/03/21	26/12/20	Under review
HR Starting Salary Policy	1	PEOPLE SERVICES	Hilary Caffrey / Anna Stein	Employment	01/10/09	01/10/10	01/07/10	Under review
Infection Prevention & Control Policy	1	QS&PE	Louise Coulson	Clinical	08/09/20	22/05/21	08/02/21	Under review - this will be an overarching Policy for Premises & Vehicle Cleaning Policy and Decontaminatino of Medical Devices Policy which will be SOPs/Protocols
Information Security Policy	1	DIGITAL	James Rowlands	Corporate	25/04/19	25/04/22	25/01/22	Under review
Management of Controlled Drugs Policy	1	MEDICAL & CLINICAL	Chris Moore	Clinical	27/07/21	27/07/24	27/04/24	In process now
Management of ~~Frequent Callers~~ High Intensity Users Policy	1	MEDICAL & CLINICAL	Sarah Woods	Clinical	04/09/18	04/09/21	04/06/21	Under Review T&F group reviewing changes and then back to PG
Management of Medical Devices Policy	1	MEDICAL & CLINICAL	Jon Wilson	Corporate	22/05/18	22/07/18	22/04/18	Under review - Out to consultation. Back at PG 26 Sept, QuEST 9 Nov
Medicines Management Policy	1	MEDICAL & CLINICAL	Chris Moore	Clinical	25/02/20	25/02/23	25/11/22	Under review
Policy for the Development, Review and Approval of Policies	1	CORPORATE GOVERNANCE	Julie Boalch	Corporate	28/03/19	28/03/21	28/12/20	Under review
Professional Regulation Policy	1	MEDICAL & CLINICAL	Greg Lloyd	Employment	10/01/19	10/01/21	10/10/20	
Recruitment and Selection Policy	1	PEOPLE SERVICES	Dee Udeze-Chibuzor/Charlie Bosher	Employment	25/10/18	25/04/20	25/01/20	Under review
Retirement Policy	1	PEOPLE SERVICES	Sara Williams / Hilary Caffrey	Employment	01/08/14	01/08/15	01/05/15	Changes in legislation, UK, National and Partnership Forum
Risk Management Policy	1	CORPORATE GOVERNANCE	Julie Boalch	Corporate	New	New	#VALUE!	Under development
Staff Immunisation Policy	1	PEOPLE SERVICES	Ceri Bryant	Employment	New	New	#VALUE!	
Violence & Aggression Policy	1	QS&PE	Nicola White	Employment	04/02/21	04/02/24	04/11/23	Will be undertake once Health & Safety Policy agreed.
Waste Management Policy`	1	FINANCE & CORPORATE RESOURCES	Nicola Stephens	Corporate	New	New	#VALUE!	In development - consultation phase
Assessment, Failure Referral and Appeals Policy	2	PEOPLE SERVICES	Martin Mulholland	Employment	01/02/16	01/02/18	01/11/17	
CCTV Policy	2	DIGITAL	Kelly Holding	Corporate	25/04/19	25/04/21	25/01/21	
Data Quality Policy	2	DIGITAL	Jon Hopkins / Sue Brown	Corporate	16/07/19	16/07/22	16/04/22	Likely to be a recommendation from the 2023 internal audit for data analysis
Decontamination of Medical Devices Policy (SOP)	2	QS&PE	Louise Coulson	Clinical	New	New	New	IPC owned SOP, not Clinical Directorate policy
Infection Prevention & Control: Sharps Policy	2	QS&PE	Louise Coulson	Clinical	01/12/20	01/12/23	01/09/23	Dealing with principles of IPC to sit under IPC Policy with health and safety elements to sit under Health & Safety Policy (SOP)
Management of Allegations Policy: When an allegation or concern is raised about an Employee or Volunteer	2	QS&PE	Nikki Harvey	Corporate	27/02/18	27/02/21	27/11/20	Robust process - All Wales Policy. Will be changes to allegations process within the Wales Safeguarding Procedures so may need to update this Policy.
Non Medical Prescribing Policy	2	MEDICAL & CLINICAL	Kerry Robertshaw	Clinical	25/02/20	25/02/23	25/11/22	
Occupational Health Policy	2	PEOPLE SERVICES	Ceri Bryant	Employment	01/01/14	01/01/14	01/10/13	

People Development Policy	2	PEOPLE SERVICES	Lynda Bugonovic	Employment	New	New	#VALUE!	
Premises and Vehicle Cleanliness Policy	2	QS&PE	Louise Coulson	Clinical	26/11/19	26/11/21	26/08/21	Query SOP under Health & Safety Policy
Relocation Expenses Policy	2	PEOPLE SERVICES	Jan Cross	Employment	10/01/19	10/01/21	10/10/20	
Alternatives to Conveyance Policy	3	MEDICAL & CLINICAL	Bryn Thomas	Clinical	01/11/10	01/11/11	01/08/11	
Colleague Experience / Wellbeing Policy	3	PEOPLE SERVICES	Lynda Bugonovic	Employment	New	New	#VALUE!	
Consent to Examination and Treatment Policy	3	MEDICAL & CLINICAL	Bryn Thomas	Clinical	25/02/20	25/02/21	25/11/20	
Lone Worker Policy	3	QS&PE	Nicola White	Employment	No dates	No dates		Feed into Health & Safety Committee to progress
Maternity and Adoption Policy	3	PEOPLE SERVICES	Sophie James	Employment	10/05/18	10/05/21	10/02/21	
Mental Capacity Policy	3	QS&PE	Mark Jones / Nikki Harvey	Employment	New	New	New	Policy to be written by Mental Health Team & Safeguarding Team. ?National Policy
Paternity Policy	3	PEOPLE SERVICES	Sophie James	Employment	10/05/18	10/05/21	10/02/21	
Safer Handling Policy	3	QS&PE	Graham Stockford	Employment	01/12/20	01/12/23	01/09/23	To Health & Safety Committee as a planned extension. Additional work to be undertaken once Health & Safety Policy agreed.
Shared Parental Leave Policy	3	PEOPLE SERVICES	Sophie James	Employment	10/05/18	10/05/21	10/02/21	
Dispatch Cross Reference (DCR) Table Policy	4	MEDICAL & CLINICAL	Grayham McLean	Corporate	23/02/21	23/02/24	23/11/23	
Fire Safety Policy	4	FINANCE & CORPORATE RESOURCES	Susan Woodham	Corporate	17/03/22	17/03/25	17/12/24	A fire safety policy exists and is reviewed, however recent changes to ther team does mean elements of the policy need to be updated.
Study Leave Policy	4	PEOPLE SERVICES	Sara Williams / Emma Morgan	Employment	01/06/15	01/06/16	01/03/16	September 2023 review possibly
Domestic Abuse, Gender Based Violence and Sexual Violence “Ask and Act” Policy	5	QS&PE	Rhiannon Thomas	Clinical	26/11/19	26/11/21	26/08/21	Integrate into single Safeguarding Policy, further discussion needed with QSPE
Safeguarding Children and Adults at Risk of Harm Policy This policy has merged with the Protection of Vulnerable Adults Policy	5	QS&PE	Nikki Harvey	Corporate	28/11/17	27/11/20	28/07/20	Integrate into single Safeguarding Policy, further discussion needed with QSPE
Working Time Regulations Policy	5	PEOPLE SERVICES	Sara Williams / Emma Morgan	Employment	01/07/04	01/07/07	01/04/07	
Information Governance Policy	6	DIGITAL	Kelly Holding	Corporate	25/10/18	25/10/21	25/07/21	
Information Sharing Policy	6	DIGITAL	Kelly Holding	Corporate	New	New	New	
Management of Compensation Claims Policy	6	QS&PE	Trish Gaskell	Corporate	26/02/19	26/02/21	26/11/20	Timeframe realistically would be early Quarter 4 so extension to March 2024 would be helpful so the review is meaningful.
Access to Personal Information Policy	7	DIGITAL	Judith Birkett	Corporate	25/04/19	25/04/21	25/01/21	
Bank Worker Policy	7	PEOPLE SERVICES	Michelle Morse	Employment	New	New	#VALUE!	
Forensic / Digital Evidence Policy	7	DIGITAL	Aled Williams / James Rowlands	Corporate	New	New	New	Not yet written - no systems in place yet for forensics
Patient Clinical Record Policy	7	MEDICAL & CLINICAL	Kevin Webb	Clinical	New	New	New	
Redeployment Policy	7	PEOPLE SERVICES	Emma Morgan	Employment	25/02/20	25/02/23	25/11/22	
Access Control Policy	8	DIGITAL	Kelly Holding	Corporate	25/10/18	25/04/20	25/01/20	
Adverse Weather Conditions Policy	8	PEOPLE SERVICES	Bethan Davies	Employment	05/07/18	05/07/21	05/04/21	
Records Management Policy	8	DIGITAL	Judith Birkett	Corporate	25/10/18	25/10/21	25/07/21	Needs updating to latest GDPR references
Vehicle Disposal Policy	8	FINANCE & CORPORATE RESOURCES	Gavin Lane	Corporate	11/03/21	11/03/24	11/12/23	
Work Experience Policy	8	PEOPLE SERVICES	Sara Minahan	Employment	No dates	No dates	#VALUE!	
Fuel Card Policy	9	FINANCE & CORPORATE RESOURCES	Gavin Lane	Corporate	25/04/19	25/04/21	25/01/21	
Information Classification Policy	9	DIGITAL	Aled Williams	Corporate	No dates	No dates		
Managing Families and Relatives Working Together Policy	9	PEOPLE SERVICES	Amanda Jones	Employment	10/03/20	10/03/23	10/12/22	
Mobile Computing Policy	9	DIGITAL	Aled Williams / James Rowlands	Corporate	No dates	No dates		Drafted - but most remote working aspects now covered under Info Security Policy
Trust Mobile Phone Policy	9	DIGITAL	Aled Williams / Tony Raine	Corporate	01/11/09	01/11/12	01/08/12	Possibly obsolete
Bursary Scheme Policy	10	PEOPLE SERVICES	Sarah Davies	Employment	01/08/16	NRS	#VALUE!	

Confidentiality and Code of Conduct	10	DIGITAL	Kelly Holding	Corporate	23/02/21	23/02/24	23/11/23	
Information Risk Policy	10	DIGITAL	Kelly Holding	Corporate	23/02/21	23/02/24	23/11/23	
Purchase Card Policy	10	FINANCE & CORPORATE RESOURCES	Jill Gill	Corporate	New	New	New	Purchase card process in place on a trial basis which will help to inform the final purchase card policy which has been to the policy group for review previously
Tyres and Wheels Policy	10	FINANCE & CORPORATE RESOURCES	Gavin Lane	Corporate	16/07/19	16/07/20	16/04/20	
Adverse Incident/Hazard Reporting Policy	N/A	QS&PE	Jane Palin	Clinical	25/04/23	25/04/26	25/01/26	In review date
Charitable Funds Investment Policy	N/A	FINANCE & CORPORATE RESOURCES	Jill Gill	Corporate	05/07/23	05/07/26	05/04/26	Approved
Command Policy	N/A	OPERATIONS	Clare Langshaw	Corporate	25/04/23	25/04/26	25/01/26	Approved
NHS Wales ANTT Policy	N/A	QS&PE	Louise Coulson	Employment - All Wales	25/02/20	25/07/21	25/04/21	NHS Wales Policy - to be reviewed.
NHS Wales Apprenticeship Policy	N/A	PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	New	New	#VALUE!	
NHS Wales Capability Policy	N/A	PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	27/06/18	27/06/21	27/03/21	Remains extant - Under review
NHS Wales Disciplinary Policy	N/A	PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	27/07/17	01/03/20	27/11/19	Remains extant
NHS Wales Disclosure and Barring Service	N/A	PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	New	New	#VALUE!	
NHS Wales Do Not Attempt CPR for Adults in Wales	N/A	MEDICAL & CLINICAL	Dr Paul Buss	Clinical	30/10/18	NRS	Value	
NHS Wales Email Use Policy	N/A	PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	04/10/19	26/06/20	04/03/20	Remains extant
NHS Wales Employment Break Scheme Policy	N/A	PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	27/07/17	01/03/19	27/11/18	Remains extant
NHS Wales Equality Impact Assessment Guidelines Policy	N/A	PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	01/10/10	01/09/13	01/06/13	Remains extant
NHS Wales Internet Use Policy	N/A	PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	24/05/16	01/01/18	24/09/17	Remains extant
NHS Wales Lease Car Policy	N/A	FINANCE & CORPORATE RESOURCES	Angie Evans	Corporate	30/09/20	30/09/23	30/06/23	New All-Wales policy only recently provided and approved by AC in Nov 22 - would assume no review required for another 3 years or until Shared services advise
NHS Wales Managing Attendance at Work	N/A	PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	16/10/18	16/10/21	16/07/21	Remains extant - Under review
NHS Wales Menopause Policy	N/A	PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	10/01/19	10/12/21	10/09/21	Remains extant
NHS Wales No PO No Pay (No Purchase Order No Payment) Policy	N/A	FINANCE & CORPORATE RESOURCES	NHS Employers Unit	Corporate	No dates	No dates	Value	All Wales Policy - T&F group set up across Wales to review start of Sept 23
NHS Wales Organisational Change Policy	N/A	PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	10/01/19	01/03/20	10/11/19	Remains extant - Under review
NHS Wales Patient Safety Incident Reporting and Management	N/A	PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	01/06/23	31/03/24	01/12/23	Remains extant
NHS Wales Pay Progression Policy	N/A	PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	01/06/22	01/06/25	01/03/25	Remains extant
NHS Wales Raising Concerns Policy - Whistleblowing	N/A	PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	13/03/18	01/01/20	13/09/19	Remains extant - Under review
NHS Wales Recruitment & Retention Payment Protocol	N/A	PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	27/07/17	01/03/20	27/11/19	Remains extant
NHS Wales Research and Development Policy NHS Wales	N/A	MEDICAL & CLINICAL	Nigel Rees	Corporate	10/05/18	10/05/21	10/02/21	
NHS Wales Reserve Forces Training and Mobilisation Policy	N/A	PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	07/03/16	01/09/19	07/05/19	Remains extant
NHS Wales Respect and Resolution Policy	N/A	PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	01/04/21	01/04/24	01/01/24	Remains extant - Under review
NHS Wales Secondment Policy	N/A	PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	07/03/16	01/09/19	07/05/19	Remains extant
NHS Wales Social Media Use Policy	N/A	PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	24/05/16	01/01/18	24/09/17	Remains extant
NHS Wales Speaking Up Safely Policy	N/A	PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	01/09/23	01/09/26	01/06/26	Remains extant
NHS Wales Special Leave Policy	N/A	PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	13/03/18	01/01/20	13/09/19	Remains extant
NMC Revalidation and Registration	N/A	QS&PE	Deborah Armstrong	Employment - All Wales	04/09/18	04/09/21	04/06/21	National Policy adopted which needs updating
Overpayments Policy	N/A	FINANCE & CORPORATE RESOURCES	NWSSP / Jill Gill	Corporate	New	New	New	All Wales Overpayments Policy review group has been set up with a second meeeting taking place on 28/6 - draft all-Wales policy being compared across bodies with comments being provided back to review group
Pubic Sector Payment Policy - WG	N/A	FINANCE & CORPORATE RESOURCES	TBC	Corporate	01/01/21	NRS	Value	All Wales Policy - Shared Services Procurement team asked to provide any review dates

Putting Things Right Policy	N/A	QS&PE	Jane Palin	Corporate	25/04/23	25/04/26	25/01/26	In review date
Standards of Business Conduct Policy	N/A	CORPORATE GOVERNANCE	Trish Mills	Corporate	27/07/23	27/07/25	27/04/25	Approved
Vehicle Telematics Policy	N/A	FINANCE & CORPORATE RESOURCES	Gavin Lane	Corporate	10/05/18	10/05/21	10/02/21	
Organisational Learning and Promoting Improvements in Patient Safety Policy and Procedure	TBC	QS&PE	TBC	Clinical	01/11/13	01/11/14	01/08/14	TBC as Jonathan would like to discuss with Senior Team
Intellectual Rights Policy	x	MEDICAL & CLINICAL	Nigel Rees	Clinical	01/01/17	01/11/18	01/08/18	Will be superseded by all Wales Policy
Business Continuity Management Policy		OPERATIONS	TBC	Corporate	24/10/19	24/10/22	24/07/22	
Children in Special Circumstances Policy & Procedure		MEDICAL & CLINICAL	Ed O'Brien	Clinical	28/11/17	28/11/20	28/08/20	
High Risk Record Policy		OPERATIONS	Katie Blackmore	Corporate	16/07/20	16/07/23	16/04/23	
MPDS QA Policy		OPERATIONS	TBC	Clinical	10/01/19	10/01/21	10/10/20	
Quality Assurance Framework for the Clinical Desk		OPERATIONS	TBC	Clinical	01/06/15	NRS		
Resourcing Policy *		OPERATIONS	TBC	Employment	01/03/14	01/06/14	01/03/14	
Transfer Policy *		OPERATIONS	TBC	Employment	10/03/20	10/03/23	10/12/22	

Key
Year 1 (Sept - Mar 2024)
Year 2 (Apr - Mar 2025)
Extend for 18 months with professional review
Review as SOPS with professional review
Yet to be prioritised