Bundle Audit Committee (Open) 2 March 2023

Agenda attachments

ITEM 0 Agenda Audit Committee Open March 2023.docx

0 09:30 - OPENING ITEMS

1 Chair's welcome; apologies and confirmation of quorum

2 Minutes of last meeting and Matters Arising

ITEM 2 Audit Committee OPEN Minutes 1 December v3.doc

2.1 ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION

3 09:40 - Internal Audit (IA) reports

3.1. Progress Report
3.2. 2023/2024 Audit Plan
3.3. Immediate Release Requests
3.4. Infection Prevention Control
3.5. Data and Analytics
3.6. Standards of Business Conduct
3.7 IMTP Delivery
3.8 Decarbonisation

ITEM 3.1 WAST_2223_Internal Audit Progress Report_March 23.pdf

ITEM 3.2 WAST_2023-24_Draft Internal Audit Plan_for AC.pdf

ITEM 3.3 WAST_2223-008_Immediate Release Directions_Final Internal Audit Report_Trust issue.pdf

ITEM 3.4 WAST_2223_03_Infection Prevention and Control_Final Internal Audit Report_for Trust issue.pdf

ITEM 3.5 WAST_2223-17_Data Analysis_Final Internal Audit Report.pdf

ITEM 3.6 WAST_2223-018_Standards of Business Conduct - Declarations_Final Internal Audit_Trust Issue.pdf

ITEM 3.7 WAST_2223-14_IMTP delivery_Final Internal Audit Report_ for Trust issue.pdf

ITEM 3.8 Final All-Wales Decarbonisation report (WAST).pdf

4 10:40 - Audit Wales Reports

4.1. Update Report
4.2. 2022 Structured Assessment Report
4.3. 2022 Annual Audit Report
4.4. 2023 Outline Audit Plan

ITEM 4.1 Audit Committee update 032023.pdf

ITEM 4.2 WAST 2022 Structured Assessment Report Final for Issue.pdf

ITEM 4.3 3322A2023_WAST_Annual_Audit_Report_2022.pdf

ITEM 4.4 2023 WAST - Outline Audit Plan - FILE REPLACED.pdf

5 11:10 - Annual Filings Schedule 22/23

ITEM 5 Annual Filings Schedule 2022-23.docx

6 11:20 - Annual Accounts Update 22/23

ITEM 6 SBAR AC - 2022-23 Annual Accounts Update.docx

6.1 11:30 - COMFORT BREAK

7 11:40 - Risk Management and Board Assurance Framework

ITEM 7 Risk Management Report Audit Committee March 2023- FILE REPLACED.docx

8 11:55 - Audit Report

ITEM 8 Executive Summary AC - Internal Audit Report 020323.docx

9 12:00 - Losses and Special Payments

ITEM 9 Executive Summary SBAR Losses and Special Payments.docx

ITEM 9.1 Annex 1 - Losses Special and Payments 2022-23.pdf

9.1 12:15 - 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.

10	Committee Priorities Report - Quarter 4 ITEM 10 Audit Committee Priorities March 23.docx
11	December AAA Highlight Report ITEM 11 Audit Committee Highlight Report December 2022.docx
11.1	12:20 - CLOSING ITEMS
12	Summary of Actions and Decisions and Key messages for Board
13	Any other business
14	Date and time of next meeting: 20 April 2023, 09:30

AGENDA

MEETING OF THE AUDIT COMMITTEE

Held in public on 2 March 2023 from 09:30 to 12:30

Meeting held virtually via Microsoft Teams

No.	Agenda Item	Purpose	Lead	Format	Time
OPENING ITEMS					
1.	Chair's welcome; apologies and confirmation of quorum	Information	Martin Turner	Verbal	10 Mins
2.	Minutes of last meeting and Matters Arising (No open actions)	Approval	Martin Turner	Paper	
ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION					
3.	Internal Audit (IA) reports 3.1. Progress Report 3.2. 2023/2024 Audit Plan 3.3. Immediate release requests 3.4. Infection Prevention Control 3.5. Data and Analytics 3.6. Standards of business conduct 3.7. IMTP Delivery 3.8. Decarbonisation	Assurance	 Osian Lloyd " Osian Lloyd/Felicity Quance " Martyn Lewis Osian Lloyd/Felicity Quance " David Butler	Paper	60 Mins
4.	Audit Wales Reports 4.1. Update Report 4.2. Structured Assessment 4.3. 2022 Annual Audit Report 4.4. 2023 Audit Plan	Assurance	 Fflur Jones/Alison Butler Fflur Jones " Alison Butler	Paper	30 Mins
5.	Annual Filings Schedule 22/23	Approve	Trish Mills	Paper	10 Mins
6.	Annual Accounts Update 22/23	Assurance	Chris Turley	Paper	10 Mins
COMFORT BREAK 10 MINUTES					
7.	Risk Management and Board Assurance Framework	Assurance	Trish Mills	Paper	15 Mins
8.	Audit Report	Assurance	Trish Mills	Paper	5 Mins
9.	Losses and Special Payments	Assurance	Chris Turley	Paper	15 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.**					
10.	Committee priorities report Quarter 4	Information	Trish Mills	Paper	5 Mins
11.	December AAA Highlight Report	Information	Trish Mills	Paper	
CLOSING ITEMS					
12.	Summary of Actions and Decisions and Key messages for Board	Information	Martin Turner	Verbal	10 Mins
13.	Any other business	Discussion	Martin Turner	Verbal	
14.	Date and time of next meeting: 20 April 2023	Information	Martin Turner	Verbal	

Lead Presenters

Name of Lead	Position of Lead
Martin Turner	Non-Executive Director and Committee Chair
Alison Butler	Audit Wales
David Butler	Internal Audit
Fflur Jones	Audit Wales
Martyn Lewis	Internal Audit
Osian Lloyd	Internal Audit
Trish Mills	Board Secretary
Felicity Quance	Internal Audit
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 1 DECEMBER 2022 VIA TEAMS

PRESENT:

Martin Turner	Non-Executive Director and Chair
Paul Hollard	Non-Executive Director & Committee Member
Ceri Jackson	Non-Executive Director & Committee Member
Joga Singh	Non-Executive Director & Committee Member

IN ATTENDANCE:

Julie Boalch	Head of Risk and Deputy Board Secretary
Lee Brooks	Executive Director of Operations
David Butler	Internal Audit
Fflur Jones	Audit Wales
Navin Kalia	Deputy Director of Finance and Corporate Resources
Osian Lloyd	Head of Internal Audit
Trish Mills	Board Secretary
Steve Owen	Corporate Governance Officer
Alex Payne	Corporate Governance Manager
Jessica Price	Deputy Head of Financial Accounting
Felicity Quance	Internal Audit
Duncan Robertson	Interim Assistant Director of Audit, Research and Service Improvement
Paul Seppman	Trade Union Partner
Chris Turley	Executive Director of Finance and Corporate Resources
Jonathan Turnbull-Ross	Assistant Director of Quality Governance
Damon Turner	Trade Union Partner
Mike Whiteley	Audit Wales
Carl Window	Counter Fraud Manager

APOLOGIES:

Brendan Lloyd	Executive Director of Medical and Clinical Services
Angela Lewis	Director of Workforce and Organisational Development
Leanne Smith	Interim Director of Digital Services
Liam Williams	Executive Director of Quality and Nursing

48/22 PROCEDURAL MATTERS

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

2. The Minutes of the open session of the Audit Committee meeting held on 15 September 2022 were confirmed as a correct.

RESOLVED: The Minutes of the meeting held on 15 September 2022 were confirmed as a correct record.

49/22 INTERNAL AUDIT REPORTS

1. Osian Lloyd presented the progress report advising the Committee that good headway had been made on the Internal Audits for the current year. There were no further changes proposed to the Internal Audit (IA) plan of 2022/23. Members noted that the 2023/24 IA plan was due for approval at the 2 March 2023 Audit Committee meeting.

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

Hazardous Area Response Team (HART) – Reasonable Assurance

1. The purpose of the review was to ascertain whether HART was properly trained and equipped to respond to high risk and complex emergency situations.

2. It was a positive report with a reasonable assurance rating. There was one high priority finding which concerned the need to improve the completion and compliance monitoring of training competencies. There were eight medium priority findings which were listed in more detail in the review. Trust management have accepted the findings and IA were content with the management responses.

Comments:

1. Lee Brooks commented there would be similarities between this audit and the recommendations from the Manchester Arena enquiry. He added the audit had given rise to several learning opportunities for the Trust.

2. Members observed a theme across the Trust where managers had missed the opportunity to attend and / or record training. Lee Brooks explained that specifically in respect of HART, there was a broad array of training which had been conducted despite operational pressures. He added this was an opportunity for the Trust to develop both its training opportunities and how such activity is recorded. Members recognised that evidencing this activity under the current reporting method had been challenging.

3. The Committee sought clarity of the lessons learned with partners and how they would be implemented. Lee Brooks explained that any internal actions and recommendations were monitored and shared with partners through a debriefing mechanism.

Attendance Management – Reasonable Assurance

1. Osian Lloyd advised the Committee that the purpose of this review was to assess the effectiveness of the early intervention mechanisms the Trust has implemented to improve staff attendance.

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2. This was a positive report which had been given a reasonable assurance rating. The review had focussed on the three main types of sickness absence reported; mental health, musculoskeletal, and infectious diseases. There were several matters which required management attention of which five were medium priority findings, and one low priority finding.

3. These findings were referenced in more detail within the review. One of the main recommendations was to develop more robust monitoring and recording arrangements around sickness. The findings had been accepted by management and IA were content with the management responses.

Comments:

1. The Committee noted the report had been circulated to the People and Culture Committee for its awareness. Progress against the recommendations from the audit will be discussed and monitored by the People and Culture Committee.

2. In terms of lessening the impact on staff with regards to musculoskeletal issues, particularly with 'lift assist', Lee Brooks explained that the necessary equipment was on vehicles, the relevant training was given to staff and the Trust also had the ability to call upon Fire Service colleagues for assistance, if required.

Electronic Patient Clinical Record (ePCR) system – Reasonable Assurance

1. David Butler presented the audit and explained it was undertaken to review the delivery and management arrangements in place to progress the implementation of the ePCR.

2. The audit considered the following aspects; governance, monitoring and reporting and contractual arrangements, and made eight medium priority recommendations. Central to these recommendations was the need to consider the timing and method of engagement with Health Boards around implementation. Similarly, there was a requirement for early development plans with Digital Health Care Wales.

Comments:

Paul Hollard commented that the positive review had highlighted the many benefits of the ePCR programme; further to this Duncan Robertson advised the Committee that the actions were scheduled to be completed by the end of the current financial year.

RESOLVED: That the IA progress report and IA reviews were received.

50/22 AUDIT WALES REPORTS

Audit Wales (AW) Update Report

1. Fflur Jones, advised the Committee that the report contained details of the AW programme and its progress. It was noted that the structured assessment work was in its final stages and would be presented to the Board in January 2023.

2. The Committee were advised that the review on unscheduled care across Wales

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was underway; the first part of which in relation to patient flow out of hospitals, was progressing well.

Equality Impact Assessment (EIA)

3. Fflur Jones explained this was a national review undertaken on all Welsh public bodies and their compliance with the Equality Act 2010. Overall the review found good areas of practice, however there was scope to make greater use of EIA in terms of their promotion of equality cohesion. There were several recommendations from the report, aimed mainly at Welsh Government.

4. Julie Boalch advised the Committee that a Task and Finish Group had been set up to develop an Integrated Assessment Review Tool which would provide guidance for colleagues regarding the provisions of the Equality Act 2010, as well as other related legislation where assessments for change activities are required. The guidance will include the learning from this Audit Wales report. Once this tool has been developed it will inform future Key Performance Indicators.

National Fraud Initiative

1. Fflur Jones explained that the National Fraud Initiative was a biannual exercise which matched data to help public bodies identify fraud or error in claims and transactions. In 2020/21 this initiative helped Welsh public bodies identify over £6.5m of fraud and overpayments. The report made three recommendations which were contained in the report.

Public sector readiness for Net Zero Carbon by 2030

1. Fflur Jones explained that the report was the first phase of the work which outlined how the public sector was preparing to achieve Welsh Government's (WG) collective ambition for net carbon zero by 2030. The summary report has detailed five actions for organisations to consider.

2. Chris Turley informed the Committee that the Finance and Performance Committee monitored and reviewed progress in this area, and outlined the current work being undertaken by the Trust to achieve the target set by WG.

Comments:

1. In terms of unscheduled care project review, the Committee queried whether the triage system within hospitals would be included. Fflur Jones confirmed this was included in part two of the review.

2. In terms of Equality Diversity and Inclusion (EDI) and the Equality Impact Assessment (EIA), members welcomed this and hoped it had an impact and how EIAs were embedded through the Trust.

RESOLVED: That the Committee received the updates.

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51/22 RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK

1. Julie Boalch gave an outline of the report and the Corporate Risk Register (CRR) and drew the Committee's attention to risks that had been added, increased/decreased in score, and risks that had been closed.

2. Since the last Audit Committee meeting, the following activity has occurred; risk 311 (Inability of the Estate to cope with the increase in Full Time Equivalents (FTE)) had been closed. One new risk has been added, risk 557(potential impact on services as a result of Industrial Action) and had been rated with a score of 16

3. Furthermore, there were two new risks which were in development; risk 538 (possible consequence of a further delay to implementation of the new Integrated Information System (Salus)) and risk 542 (Failure to deliver the WG NHS Decarbonisation Strategic Delivery Plan).

Comments:

Paul Hollard commented that the People and Culture Committee would monitor risk 557 going forward.

RESOLVED: The Committee accepted the status of the risks in the CRR and noted the closure of Risk 311 and the inclusion of the new Risk 557 on the CRR with a risk rating of 16.

52/22 LOSSES AND SPECIAL PAYMENTS – PAYMENTS FOR THE PERIOD 1 APRIL 2022 TO 31 OCTOBER 2022

The Committee were informed by Chris Turley that the total net losses and special payments made during this period amounted to £0.103m. All payments had been made within approved delegated limits.

RESOLVED: That the losses and special payments report for the period 1 April 2022 to 31 October 2022 was noted.

53/22 AUDIT TRACKER

1. Julie Boalch explained that the report provided an update in respect of audit recommendations resulting from Internal Audit and External Audit reviews.
2. There were 10 high priority and 28 medium priority Internal Audit recommendations which were overdue; specifics regarding each and their completion dates were detailed in the report.
3. With regards to the 12 External Audit recommendations generated by the 'Taking Care of the Carers' external review, the Committee noted 8 were overdue, and 4 were not yet due.

Comments:

Members acknowledged the progress and looked forward to receiving updates regarding the older recommendations in due course.

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RESOLVED: The Committee noted the activity and progress since the last Audit Committee meeting in September 2022; specifically that there were 10 high priority and 28 medium priority Internal Audit recommendations overdue.

54/22 CONSENT ITEMS

The following reports were presented for the Committee to note:

1. Committee Priorities Quarter 2;

2. All Wales Audit Committee Chairs Highlight report from the October 2022 meeting.

RESOLVED: The Committee noted the reports.

Date of Next Meeting: 2 March 2023.

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Internal Audit Progress Report

Audit Committee

March 2023

Welsh Ambulance Service NHS Trust

NWSSP Audit and Assurance Services

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6. Key Performance Indicators 4

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Appendix A: Progress against 2022/23 Internal Audit Plan 6

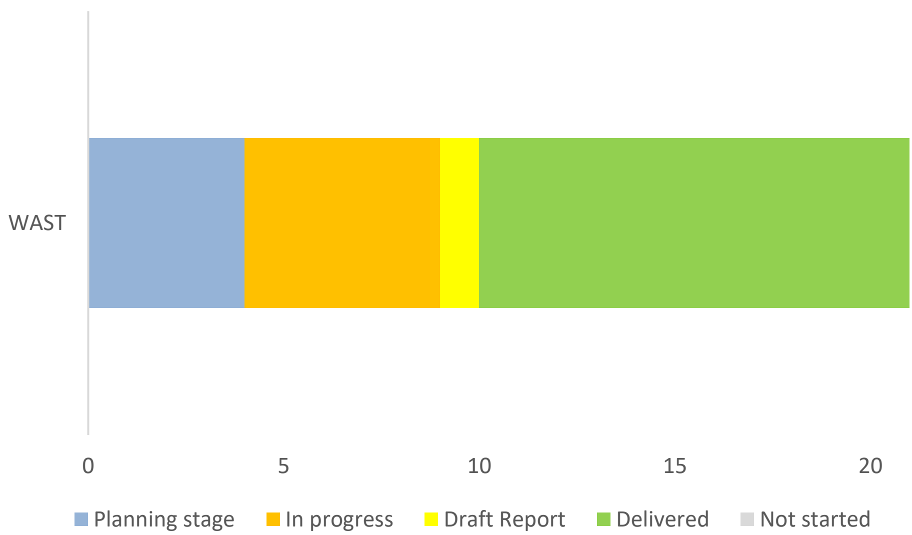
1. Introduction

The purpose of this report is to:

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

2. Progress against the 2022/23 Internal Audit Plan

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



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

3. Proposed changes to approved plan

- Health and Safety – commencement of fieldwork is deferred to quarter 1 of 2023/24 at the request of management, due to operational pressures.
- Clinical handover - is deferred to quarter 1 of the 2023/24 Internal Audit Plan to recognise the operational nature of this review and the impact of the continuing industrial action.
- Strategy development - At the request of management, we are proposing to defer this review to the 2023/24 Internal Audit Plan to allow time for processes to embed. The programme is still at the developmental phase due to the need to pause and re-prioritise key organisational activities to respond to the unprecedented system pressures and continuing industrial action.

4. Planning 2023/24

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

The plan will remain flexible throughout 2023/24 in response to new and emerging risks. We will re-visit the approved plan on a regular basis to allow discussion of priorities.

5. Engagement

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

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

6. Key Performance Indicators

Correct on 31 January 2023

Indicator	**Status**	**Actual**	**Target**
Operational Audit Plan agreed for 2022/23	Green	March	By 30 June
Audits reported over planned	Green	12	15
Work in progress		5	
Report turnaround: time from fieldwork completion to draft reporting [10 days]	Green	8 out of 9	80%
Report turnaround: time taken for management response to draft report [15 days]	Red	4 out of 9	80%
Report turnaround: time from management	Green	9 out of 9	80%

response to issue of final report [10 days]			

Key:

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

7. Recommendation

- The Audit Committee is invited to note the above; and
- Approve the proposed changes at section 3.

Appendix A: Progress against 2022/23 Internal Audit Plan

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

[1] May be subject to change

Review	Status	Rating	Key matters arising	Anticipated Audit Committee[1]
			noted; Arrangements to share plans have been outlined, but we noted instances where action cards required updating; Gaps identified in Commander CPD records.	
Hazardous Area Response Team (HART)	Final report	Reasonable	Training records and materials do not fully capture detail of sub-competencies; Debriefs take place but no mechanisms to capture or monitor associated actions and learning; SOPs require updating to reflect current methods; Activity not currently captured in full and lack of reporting to oversight committee; SLA with Welsh Government in need of updating with opportunities to achieve further alignment with NARU guidance.	December 2022
Immediate Release Directions	Final report	Reasonable	Allocators must review the resource screen prior to directing immediate release of vehicles; Escalation of declined directions to the Operational Delivery Unit; Datix incidents must be completed and reviewed in a timely manner following each declined direction; Review of declined directions to ensure the correct process has been followed; Themes and trends should be captured and lessons learned shared.	March 2023
Trade union release time	Draft report	Limited	Whilst the Facilities Agreement recommends processes to follow, these are not mandated and owing to the caveats included compliance with the process is further reduced; There are inconsistencies in the process of recording and approving facility time; The Trust does not have a complete and accurate record of facility time; There is currently no monitoring and reporting of time spent or cost of facility time. The findings replicate the recommendations raised in the 2018/19 report.	June 2023

Review	Status	Rating	Key matters arising	Anticipated Audit Committee[1]
Attendance management	Final report	Reasonable	Scope to improve analysis of underlying causes of sickness, alternative duties, and their reporting; Standardisation of sickness audits, including criteria and approach; Developing key performance indicators and data for evaluating quality and effectiveness of services; A training register has been established, but there is a need to develop monitoring and reporting arrangements.	December 2022
Clinical handover	Planning			June 2023
Pain management	In progress			June 2023
Strategy development	Planning			June 2023
IMTP delivery	Final report	Reasonable	Lack of documented programme quality management activity; Instance of an absence of a transformation programme level plan; Instances of absence of programme benefit realisation plans.	March 2023
Cyber security	In progress			June 2023
IM&T infrastructure	In progress			June 2023
Data analysis	Final report	Reasonable	The matters requiring management attention include: Replacing legacy reporting software; Fully defining and resourcing the CCC administrator role. Other recommendations include: Absence of report catalogues; Incomplete ERM and metadata for the data warehouse and CAD system; Defining data quality accuracy levels; Data sharing register.	March 2023
Standards of Business Conduct: Declarations	Final report	Limited	Absence of a Declaration of Interest register, and the gifts and hospitality register requires strengthening; Completeness and	March 2023

Review	Status	Rating	Key matters arising	Anticipated Audit Committee[1]
			accuracy of declarations of interest submissions; Non-compliance relating to the completion of gifts and hospitality forms; Lack of due diligence checks on declarations.	
Recommendations tracker	In progress			June 2023
Capital & Estates				
Decarbonisation	Final report	N/A - An action plan of common themes across NHS Wales.	Whilst some progress has been observed with implementation of Decarbonisation Action Plans, this has been restricted by the availability of financial and staff resources. The recommendations made, relating to governance, localised strategy, monitoring and reporting and project delivery, aim to aid management in driving forward the strategies, whilst also highlighting some of the competing pressures / risks.	March 2023
Electronic Patient Clinical Record	Final report	Reasonable	The programme is progressing within budget and target delivery for a highly complex implementation involving multiple health bodies across Wales. Matters arising include: The need to consider the timing and method of engagement of health bodies within lessons learnt; The need for early development plans with DHCW.	December 2022

[1] May be subject to change

Annual Internal Audit Plan: Draft

Internal Audit Charter

February 2023

Welsh Ambulance Services NHS Trust

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Disclaimer notice - please note

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

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

1. Introduction

This document sets out the Internal Audit Plan for 2023/24 (the Plan) detailing the audits to be undertaken and an analysis of the corresponding resources. It also contains the Internal Audit Charter which defines the over-arching purpose, authority and responsibility of Internal Audit and the Key Performance Indicators for the service.

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

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

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

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

Accordingly, this document sets out the risk-based approach and the Plan for 2023/24. The Plan will be delivered in accordance with the Internal Audit Charter and the agreed KPIs which are monitored and reported to you. All internal audit activity will be provided by Audit & Assurance Services, a part of NHS Wales Shared Services Partnership (NWSSP).

1.1 National Assurance Audits

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

2. Developing the Internal Audit Plan

2.1 Link to the Public Sector Internal Audit Standards

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

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

2.2 Risk based internal audit planning approach

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

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

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

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

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

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

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

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

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

3) Follow up: this is follow-up work on previous limited and no/unsatisfactory assurance reports as well as other high priority recommendations. Our work here also links to the organisation's recommendation tracker and considers the impact of their implementation on the systems of governance and control.

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

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

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

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

2.3 Link to the Trust's systems of assurance

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

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

2.4 Audit planning meetings

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

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

3. Audit risk assessment

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

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

4. Planned internal audit coverage

4.1 Internal Audit Plan 2023/24

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

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

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

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

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

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

4.2 Keeping the plan under review

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

Audit & Assurance Services is committed to ensuring its service focuses on priority risk areas, business critical systems, and the provision of assurance to management across the medium term and in the operational year ahead. As in any given year, our Plan will be kept under review and may be subject to change to ensure it remains fit for purpose.

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

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

5. Resource needs assessment

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

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

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

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

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

Under the approach we have adopted for a number of years, the top slice provided to us to undertake the internal audit programme is supplemented by an additional charge for work undertaken over and above the 'top slice' arrangements. To this end the Trust has agreed to pay an additional £38,090 to cover this additional audit work.

Also, under the approach we have adopted since the formation of NWSSP we charge for the specialist Capital & Estates work delivered as a part of the agreed plan. For 2023/24, this additional charge is £20,040.

Therefore, the Trust will be charged an additional amount of £58,130 which is over and above the 'top slice' recharge agreed as part of NWSSP's overall funding for 2023/24.

6. Action required

The Audit Committee is invited to consider the Internal Audit Plan for 2023/24 and:

- approve the Internal Audit Plan for 2023/24;
- approve the Internal Audit Charter; and
- note the associated Internal Audit resource requirements and Key Performance Indicators.

Osian Lloyd

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

Appendix A: Internal Audit Plan 2023/2024

Planned output	Audit Ref	Corporate Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
Annual Governance Statement	N/A	N/A	To provide commentary on key aspects of Board Governance to underpin the completion of the statement.	Chief Executive / Board Secretary	Q4
Risk Management & Assurance	1		To review the extent which the Risk Management Transformation Programme is supporting the Trust in maturing its risk management and assurance framework.	Board Secretary	Q4
Decarbonisation	2	542	To consider progress against the NHS Wales Decarbonisation Strategic Delivery Plan and the Trust's Decarbonisation Action Plan (demonstrating how the Trust will implement the Strategic Delivery Plan initiatives). Following on from the advisory review delivered in 2022/23, the proposed scope will include governance, strategy progress and implementation.	Director of Finance and Corporate Services / Executive Team	Q1/2

Planned output	Audit Ref	Corporate Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
Delivery of Major Change Programmes	3	283	To review and assess the processes and arrangements in place to manage and monitor delivery of major change programmes. To focus on phase 1 of the investment from the Commissioner in respect of the demand and capacity review for EMS.	Director of Planning & Performance & Director of Finance and Corporate Resources	Q3/Q4
111 service commissioning arrangements (advisory)	4	100	To assess the effectiveness of the new commissioning arrangements and structures for the 111 service.	Director of Planning and Performance	Q2
Integrated Quality Performance and Management Framework	5		To review the deployment of the framework and assess the extent it is being embedded across the Trust.	Director of Planning and Performance / Director of Quality & Nursing	Q3/Q4
Strategy Development	6	100	A review of the arrangements in place to support the development of the Trust's strategic ambitions. To include a review of the process in place to manage strategic decision making and how these are communicated throughout the organisation.	Director of Planning and Performance	Q2/3

Planned output	Audit Ref	Corporate Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
Serious Adverse Incidents Joint Investigation Framework	7	224	A review of the Trust's compliance with the Framework.	Director of Quality and Nursing	Q1/Q2
Clinical Handover	8	224	To review the operational deployment of the standardised handover tool being developed and assess compliance.	Director of Paramedicine / Director of Quality and Nursing / Director of Operations	Q3
Senior Paramedic Role	9		To assess the extent Senior Paramedics are achieving their key role objectives. To include a comparison across Wales.	Director of Paramedicine	Q1
Clinical Audit	10		To review the process for clinical audit including how it is used by Committees of the Trust to support assurance.	Director of Paramedicine	Q4
Volunteers Governance	11		To review the design and compliance with the Volunteer Strategy, including the financial management of volunteer activities.	Director of Operations / Board Secretary	Q4

Planned output	Audit Ref	Corporate Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
Seatbelt action plan	12		To review the deployment of the action plan and assess compliance.	Director of Operations	Q2
Records management	13		Review of the arrangements and processes in place to enable the effective management of records.	Interim Director of Digital	Q1
Technical resilience	14	543	Review of the Trust's digital operations to assess whether they have appropriate resilience to minimise the risk of disruption.	Interim Director of Digital	Q2
ICT contract management	15		To assess whether the Trust has appropriate contract management arrangements in place, ensuring achievement of value for money.	Interim Director of Digital	Q3
Retention of staff	16	558	To evaluate and determine the adequacy of the systems and controls in place within the Trust in relation to staff retention.	Director of Workforce & OD	Q2/Q3
Disciplinary case management - Compassionate leadership	17		To assess the adequacy of the arrangements in place for the management of the disciplinary process. To focus on the demonstration of compassionate leadership principles, in addition to	Director of Workforce & OD	Q2/Q3

Planned output	Audit Ref	Corporate Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
			compliance with the Trust's defined disciplinary processes.		
Estates Assurance: Estate Condition	18		Recognising the high profile afforded to the condition of the NHS Estates and the associated risks, focus during 2023/24 will be targeted to the Estate Condition. The areas of review may include for example, Estates Strategy, scale of the issue, risk exposure, records management, delivery of EFAB funding and progress in addressing key risk areas.	Director of Finance and Corporate Services	Q2
Capital Assurance: Vehicle Replacement Programme	19		To evaluate the processes and procedures put in place by the Trust to support the management and control of the procurement of replacement vehicles as part of all allocations of funding from Welsh Government.	Director of Finance and Corporate Services	Q4
Follow Up Action Tracker	20		To review the systems in place to monitor progress with the implementation of actions in response to internal audit reports.	Board Secretary / Executive Team	Q4

Planned output	Audit Ref	Corporate Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
NHS Wales national audit work	N/A	N/A	To collate the assurances derived from the review of NHS Wales bodies that provide services to this organisation and contribute to its overall system of control. This will cover some of our work at Health Education & Improvement Wales, Public Health Wales, NHS Wales Shared Services Partnership, Digital Health and Care Wales and Emergency Ambulance Services Committee.	Board Secretary	Q4

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

Appendix B: Key performance indicators (KPI)

KPI	SLA required	Target 2023/24
Audit plan 2023/24 agreed/in draft by 30 April	✓	To deliver plan
Audit opinion 2022/23 delivered by 31 May	✓	To deliver opinion
Audits reported versus total planned audits, and in line with Audit Committee expectations	✓	varies
% of audit outputs in progress	No	varies
Report turnaround fieldwork to draft reporting [10 working days]	✓	80%
Report turnaround management response to draft report [15 working days maximum]	✓	80%
Report turnaround draft response to final reporting [10 working days]	✓	80%

Appendix C: Internal Audit Charter

1 Introduction

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

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

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

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

2 Purpose and responsibility

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

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

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

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

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

3 Independence and Objectivity

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

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

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

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

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

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

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

4 Authority and Accountability

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

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

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

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

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

private meetings with the Head of Internal Audit.

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

5 Relationships

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

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

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

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

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

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

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

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

6 Standards, Ethics, and Performance

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

6.2 Internal Audit will operate in accordance with the Service Level Agreement (updated 2021) and associated performance standards agreed with the Audit Committee and the Shared Services Partnership Committee. The Service Level Agreement includes a number of Key Performance Indicators, and we will agree with each Audit Committee which of these they want reported to them and how often.

7 Scope

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

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

- ensuring effective co-ordination, as appropriate, with external auditors; and
- reviewing the Annual Governance Statement prepared by senior management.

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

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

8 Approach

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

Figure 1: Audit planning hierarchy

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

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

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

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

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

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

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

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

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

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

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

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

9 Reporting

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

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

9.2 The process for audit reporting is summarised below:

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

managers to confirm understanding and shape the reporting stage;

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

  - Timely.

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

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

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

10 Access and Confidentiality

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

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

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

11 Irregularities, Fraud & Corruption

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

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

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

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

12 Quality Assurance

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

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

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

13 Resolving Concerns

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

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

14 Review of the Internal Audit Charter

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

Simon Cookson
Director of Audit & Assurance
NHS Wales Shared Services Partnership
February 2023

NHS Wales Shared Services Partnership
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Immediate Release Directions
Final Internal Audit Report

January 2023

Welsh Ambulance Services NHS Trust

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Executive Summary

Purpose

A review of the effectiveness of the mechanisms in place to for the immediate release of ambulances outside hospitals to respond to patient needs in the community.

Overview

We have issued reasonable on this area. The significant matters which require management attention include:

- Allocators must review the RES screen prior to directing immediate release of vehicles;
- Escalation of declined directions to the Operational Delivery Unit (ODU);
- Datix incidents must be completed and reviewed in a timely manner following each declined direction;
- Review of declined directions to ensure the correct process has been followed; and
- Themes and trends should be captured and lessons learned shared.

Further matters arising concerning the areas for refinement and further development have also been noted.

Report Classification

		Trend
Reasonable	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	N/A - No previous audit in this area

Assurance summary[1]

	Assurance objectives	Assurance
1	Clear guidance and procedures.	Substantial
2	Alternative options explored.	Reasonable
3	Declined directions investigated and communicated.	Limited
4	Performance monitoring.	Reasonable
5	Appropriate reporting and escalation.	Reasonable

Key matters arising

	Key matters arising	Assurance Objectives	Control Design or Operation	Recommendation Priority
1	Completion of RES screen.	2	Operation	Medium
2	Escalation to Operational Delivery Unit (ODU).	3	Operation	High
3	Completion and timely review of Datix incidents.	3	Operation	High
4	Completeness of Director of Operations briefing paper.	3	Operation	Medium
5	Analysis and feedback of themes, trends and lessons learned.	4	Design	Medium

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

1. Introduction

1.1 Directions to immediately release ambulances outside hospitals should be undertaken for 'Red' and 'Amber 1' incidents, after all other options to identify a suitable resource to meet patient needs in the community have been explored. The decision to release ambulances is made by the nurses in charge at the time and the rationale is relayed to the Chief Operating Officer (COO) at each health board area.

1.2 The '*Patient Safety Highlight Report*' presented to the Quality, Patient Experience & Safety Committee (QUEST) in November 2022, highlights that the number of declined 'Immediate Release Directions' (IRD) remains an ongoing concern, with varying levels of response across health boards. During the quarter ending September 2022, there were a total of 2,883 directions made to health boards. Of these, 1,528 were accepted (53%) and 1,355 were declined (47%).

1.3 The highest scoring risk on the Welsh Ambulance Services NHS Trust's (the 'Trust') Corporate Risk Register relates to: '*The Trust's inability to reach patients in the community causing patient harm and death.*'

1.4 The potential risks considered in this review were:

- Inability and/or a delay in ambulances reaching patients in the community resulting in harm; and
- Failure to achieve the most efficient and effective use of resources.

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	2	2	-	4
Total	**2**	**3**	**-**	**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.

2.3 The 'All Wales Immediate Release Protocol' was approved on 14 July 2022 by the NHS Wales Chief Executive Group, and issued and adopted on 25 July 2022 following agreement at Emergency Ambulance Services Committee (EASC). The protocol details that '*Chairs and Chief Executives across Wales agreed that to manage in real-time the serious risk of harm to patients categorised as immediately life threatened (Red) or Serious (Amber 1) in the community without*

an available emergency ambulance resource assigned that all immediate release directions made by the Trust will be accepted by the receiving emergency department without unnecessary delay enabling a response to be made to the patient awaiting a response in the community'. The protocol also states: '*declining an immediate release direction for Red and Amber 1 patients must not occur.'*

2.4 The IRD report for the period 1 July 2022 to 5 September 2022 is shown in the table below. This highlights a significant volume of immediate release directions being made, which reflects the significant pressures the unscheduled care system is facing, manifesting itself at Emergency Departments (ED) across Wales resulting in extended patient handover times and patients in the community experiencing long waits for ambulance response. 1,900 IRDs were made in total, of which c30% related to Red priority incidents and c70% for Amber 1 patients. Whilst a high percentage of IRDs relating to immediately life-threatening incidents were accepted, it is important to note that only 35.5% of such directions between April 2021 to June 2022 received this decision within the 8-minute response target for red calls. In addition, there remains a high percentage (62%) of declined directions for Amber 1 immediate release directions, despite the new protocol stating that they must not occur. There is also recognition that health boards are not refusing such directions, rather that they have very limited options in a system which is almost overwhelmed.

Red Priority incidents					
Hospital Name	**Accepted**	**Not Accepted**	**Total**	**Percentage accepted**	**Percentage not accepted**
Bronglais General Hospital - Aberystwyth	7	1	**8**	88%	13%
Glan Clwyd Hospital – Bodelwyddan	92	2	**94**	98%	2%
Glangwili General Hospital - Carmarthen	18	2	**20**	90%	10%
Grange University Hospital - Cwmbran	56	16	**72**	78%	22%
Maelor General Hospital - Wrecsam	59	2	**61**	97%	3%
Morriston Hospital - Swansea	68	17	**85**	80%	20%
Prince Charles Hospital – Merthyr Tydfil	21	2	**23**	91%	9%
Prince Philip Hospital - Llanelli	8	2	**10**	80%	20%
Princess of Wales Hospital - Bridgend	12	22	**34**	35%	65%
Royal Glamorgan Hospital - Pontyclun	27	3	**30**	90%	10%
Royal Gwent Hospital - Newport	0	1	**1**	0%	100%
Singleton Hospital - Swansea	1	0	**1**	100%	0%
University Hospital of Wales - Cardiff	56	7	**63**	89%	11%
Withybush Hospital - Haverfordwest	22	0	**22**	100%	0%
Ysbyty Gwynedd Hospital - Bangor	58	5	**63**	92%	8%
Total	**505**	**82**	**587**	**86%**	**14%**

Amber 1 Priority incidents					
Hospital Name	**Accepted**	**Not Accepted**	**Total**	**Percentage accepted**	**Percentage not accepted**
Bronglais General Hospital - Aberystwyth	6	6	**12**	50%	50%
Glan Clwyd Hospital - Bodelwyddan	126	163	**289**	44%	56%
Glangwili General Hospital - Carmarthen	14	51	**65**	22%	78%
Grange University Hospital - Cwmbran	24	24	**48**	50%	50%
Maelor General Hospital - Wrecsam	119	131	**250**	48%	52%
Morriston Hospital - Swansea	14	267	**281**	5%	95%
Prince Charles Hospital – Merthyr Tydfil	17	2	**19**	89%	11%
Prince Philip Hospital - Llanelli	12	9	**21**	57%	43%
Princess of Wales Hospital - Bridgend	8	44	**52**	15%	85%
Royal Glamorgan Hospital - Pontyclun	7	2	**9**	78%	22%
University Hospital of Wales - Cardiff	27	2	**29**	93%	7%
Withybush Hospital - Haverfordwest	20	2	**22**	91%	9%
Ysbyty Gwynedd Hospital - Bangor	107	109	**216**	50%	50%
Total	**501**	**812**	**1313**	**38%**	**62%**

2.5 We have noted variation in relation to declined directions across Wales, with Cardiff and Vale and Aneurin Bevan University Health Boards reporting higher compliance (90% and 77% respectively) during quarter 1 of 2022/23, compared to only 23% at Swansea Bay University Health Board (refer to table under objective 5 below). However, we acknowledge that compliance is higher for red priority incidents and that Swansea Bay University Health Board received significant volumes in comparison, albeit a lot lower than those received by Betsi Cadwaladr University Health Board during the same period.

Audit objective 1: There are clear guidance and procedures in place regarding Immediate Release Directions and expectations have been appropriately communicated.

2.6 The Resource Deployment Standard Operating Procedure (the 'SOP') sets out the procedures the member of staff allocating resources should follow within the Clinical Contact Centre (the CCC). This SOP came into effect on 25 July 2022, following approval by the Senior Operations Team on 21 July 2022. Section 3.2 of the SOP details the Immediate Release Protocol and it is the responsibility of the Allocator to ensure procedures are followed.

2.7 The most recent update to the SOP was to reflect the additional actions associated with immediate release directions, including escalation to the Operational Delivery Unit (ODU) for onward escalation to the health boards, and the inclusion of quality

assurance review of all declined IRD. The SOP also reflected that Red and Amber 1 declines are now considered never events.

2.8 The SOP is available on the Trust's intranet site 'Siren'. Historically, any updates to SOPs are communicated to the CCC staff via staff bulletins. The SOP was shared with all CCC staff managers, supervisors, ODU, the communications team as well as the concerns team in July 2022. This specifically drawing out the language change and the areas of focus.

2.9 As noted above, the 'All Wales Immediate Release Protocol' (the 'Protocol'), was approved by the NHS Wales Chief Executive Group and presented by the Trust to EASC and all health boards in July 2022. It states that Red and Amber 1 immediate release directions shall be honoured in all cases. The protocol was shared internally within the Trust with on call managers and strategic commanders, as well as Heads of Service in Operational areas to cascade to teams.

2.10 The protocol '*outlines the principles and processes for the management of immediate release directions that includes a dynamic escalation process to, as far as possible, minimise patient safety risk for patients awaiting a response in the community when ambulance capacity is reduced when the time for patient handover at emergency departments is extended*'. Additionally, the protocol contains sections setting out step by step procedures for raising an immediate release direction and to escalate a declined direction.

2.11 The protocol was due for review in October 2022. The Director of Operations has written to the Health Board COO's requesting feedback, with the intention to revise by the end November, if necessary.

Conclusion:

2.12 The Trust has a Resource Deployment SOP in place that details the process for allocating resources. A new 'All Wales' protocol has also been agreed recently between the Trust and health boards. The protocol was due to be reviewed in October and feedback has been requested feedback, with the intention to revise by the end November if necessary. Noting this, we have assessed this objective as **substantial** assurance.

Audit objective 2: Immediate release directions are only submitted to health boards after all other options to identify a suitable resource have been explored.

2.13 Immediate release directions must be undertaken for a Red or Amber 1 incident where all actions to identify a suitable resource fail. As noted under audit objective 5 below, at its July 2022 meeting the Trust Board received and discussed a report relating to avoidable harm. The report identified 26 actions, 20 for the Trust and six system stakeholder actions. There is a specific action in place relating to immediate release directions with other actions including: *NHS Wales eradicates all emergency department handover delays in excess of 4 hours; emergency*

department cohorting; and *implement nationwide approach to emergency department 'Fit 2 Sit'.*

2.14 The Trust's Resource Deployment SOP details the actions to be taken and criteria that needs to be met before making an IRD. This includes considering all appropriate options to resource the incident, for example referring to the Resource List (RES) screen to check the status and availability of vehicles, including those outside of the divisional area that they are managing, and issuing messages to resources to identify if they can become clear for response.

2.15 All attempts to identify a suitable resource must be recorded. The Sequence of Events (SoE) screen includes a time stamp to capture actions taken, which in the main involve review of the RES screen which lists the handover status, availability and location and type of vehicle.

2.16 We selected a sample of 30 declined IRDs, 25 of these were before the All Wales Protocol was agreed and five after, to confirm that directions are only submitted to health boards after all other options to identify a suitable resource have been explored. The SoE screen was reviewed to confirm that the RES had been completed prior to the direction being made. Our sample included coverage across all health boards and focussed on Red and Amber 1 incidents. The report we were provided with also included IRDs with 'Amber 2' and 'Green' priority ratings, reflecting that the patient's condition had improved at the point the incident was closed.

2.17 Our testing identified six instances where there was a lack of evidence to demonstrate that the RES screen was reviewed prior to the IRD being made. However, we understand from discussions with CCC managers that where there are multiple incidents of the same priority polling a single call can be made to the appropriate hospital. We were also advised that Allocators would be aware that calls were polling, indicating a lack of available resource to respond prior to making the IRD. See **MA1 in Appendix A**.

Conclusion:

2.18 The Resource Deployment SOP details actions to be taken and criteria that needs to be met before making an IRD, including review of the RES screen to check the status and availability of vehicles. We identified six instances (20%) where completion of this check was not evidenced. Noting this, we have assessed this objective as **reasonable** assurance.

Audit objective 3: Declined directions are appropriately logged and investigated. Outcomes are communicated, both within the Trust and to the health boards.

2.19 All immediate release directions must be recorded in Trust's Computer Aided Dispatch (CAD) system. The following fields can be populated in the Call+ tab screen:

- IRR01: whether IRD has been made;

- IRR02: the IRD decision – accepted, declined or pending. Declined directions must be escalate to the ODU;
- IRR03: the hospital directed;
- IRR04: the name and employee number of health board staff;
- IRR05: whether the declined direction has been escalated to the ODU; and
- IRR06: details the Datix incident reference for the adverse incident report that is required to be submitted for each declined direction.

2.20 Our testing of 30 declined IRDs identified that 22/30 (73%) of the declined directions had not been escalated to the ODU as required. Furthermore, 149 (23%) of the 649 declined directions between 25 July (since the All Wales Protocol was agreed) and 5 September 2022 had not been escalated to the ODU. 27 (18%) and 122 (82%) related to Red and Amber 1 incidents respectively. See **MA2 in Appendix A**.

2.21 Section 3.2.1 of the SOP details that *'ODU interventions and actions must be documented in the Ambulance Daily Occurrence Log (ADOL)'*. The required interventions and actions required of the ODU were not detailed in the SOPs prior to July 2022. Two of our sample of five items selected after the implementation of the most recent SOP had not been escalated to the ODU. Review of the ADOL confirmed that there was upward escalation by the ODU to the health boards for the three incidents that had been escalated.

2.22 Prior to the recent revision of the Trust's Resource Deployment SOP in July 2022, we were informed that raising Datix incidents was only required for declined IRDs in respect of Red category calls. 13 of the sample of 25 declined IRDs selected prior to July 2022 related to immediately life-threatening incidents, a Datix report had not been raised for five of these. See **MA3 in Appendix A**. A Datix report had been raised for all five of the sample of declined directions selected after the implementation of the new SOP and All Wales protocol in July 2022.

2.23 Although we found Datix incidents are raised promptly after the incident date, we found that these were not reviewed and closed in a timely manner, with some taking as long as 10 months to close. Eight of the 13 Datix incidents noted above were recorded as closed. However, the average time taken to closure was 165 days, varying from 15 days to 288 days. The five items that remain open, have been so for 2 months or longer. See **MA3 in Appendix A**. However, we understand that the Trust is reliant on responses and feedback from health boards in order to appropriately close incidents. We also note that, due to the sustained high volumes of declined Amber 1 directions, the Trust may not have the capacity to fully investigate, review and report on these. Input from health boards is also required to facilitate wider learning.

2.24 The Trust's Resource Deployment SOP includes a quality assurance section which requires a daily review of all declined immediate release directions to ensure the correct process has been followed and feedback to dispatch staff where learning has been identified.

2.25 Weekly briefing papers, which detail review of the declined IRD incidents, are required to be produced and shared with the Trust's Director of Operations. These

include detail of the time of the call, the time the IRD was made, the time of first resource at scene and the time of first conveying resource at scene (if different), the age and gender of the patient, the chief complaint, the outcome of the release direction and the outcome for the patient (i.e. were they conveyed to hospital, treated or recognised as life extinct at scene). The narrative should also include any actions taken by the Trust, including if the direction was inappropriately recorded.

2.26 In recognition of the significant volumes of declined directions, particularly relating to Amber 1 incidents, the Trust's Director of Operations revised the requirement so that 10% of Amber 1's declined would be investigated, in addition to all those relating to Red declined. The briefing papers for the weeks commencing 15 August 2022, 22 August 2022, 29 August 2022 and 5 September 2022 were examined, to confirm whether review of declined directions had been undertaken in line with this revised approach. Whilst overall the briefing paper to the Director of Operations typically met the target to investigate 10% of Amber 1 declined directions, we identified two Red declined directions that had been omitted. The See **MA4 in Appendix A**.

2.27 Section 4.11 of the 'All Wales Immediate Release Protocol' details that '*To further aid close monitoring weekly reports will be afforded to Health Board partners detailing immediate release activity and associated outcomes'*.

2.28 Up until the implementation of the new protocol, the Trust's Director of Operations provided updates on declined IRDs for Red incidents to relevant health board Directors. Since the implementation of the new SOP and All Wales protocol, the Director of Operations provides health boards with details of both Red and Amber 1 declined release directions. These updates also detail where action by Trust staff was not in line with internal procedures, demonstrating that the Trust is open and transparent in their updates.

2.29 We also note that the SOP requires the Allocator to record the name of the health board staff member who declined the direction. However, staff names were not obtained for 13 of the declined directions in our sample and we understand that staff at certain hospitals refuse to provide this information, often citing data protection as the reason not to disclose. We have not raised a matter arising for this issue as it is outside the control of the Trust. However, this could prevent or delay the Trust's investigations into declined directions. The Director of Operations has raised this issue in his updates to health board executives.

Conclusion:

2.30 22 (73%) of the 30 declined IRD in our testing sample had not been escalated to the ODU as required, which could result in them not being escalated to the health board in a timely manner. Whilst Datix incidents were raised for all five items in our sample following the agreement of the All Wales Protocol, they had not been raised for 38% of Red incidents prior to this. Where Datix incidents are reported, this is done promptly. However, they are not reviewed and closed in a timely manner. We also note that not all declined directions are reviewed in line with the SOP, which could impact feedback to staff where learning has been identified. The

Director of Operations provides health boards with regular updates on declined release directions. Noting this, we have assessed this objective as **limited** assurance.

Audit objective 4: Performance information relating to Immediate Release Directions is regularly monitored and themes and trends identified.

2.31 As noted above, the Dispatch Teams within the Emergency Medical Service (EMS) Co-ordination Centre produce briefings following each declined IRD and these are used to update the EMS Co-ordination Senior Management Team, including on the actions taken in response.

2.32 The Trust's CEO receives a weekly '*Immediate Release Review Briefing Paper*' from EMS Co-ordination. This provides a colour coded bar chart illustrating the number of declines, showing both the pan-Wales position and analysis by each individual health board. We understand that the report includes incidents with 'Amber2' and 'Green' priority ratings at the point of closure.

2.33 As noted under objective 3 above, the Trust's Director of Operations receives a similar paper, with additional narrative on the circumstances and actions taken following review of all declined Red incidents and 10% of declined Amber 1 incidents, broken down by hospital site. This report is used to inform discussion with Health Board Chief Operating Officer (COO) colleagues.

2.34 Assurances on declined immediate release directions are discussed at the 'Daily National Risk Huddle' call between the Trust and health boards. On 1 August 2022, the Immediate Release Direction dashboard went live. This provides metrics on the number and percentage compliance on IRDs for each health board. We also understand that the dashboard is available at Emergency Departments and provides the live position.

2.35 In addition, a summary immediate vehicle release directions report is sent weekly to health board colleagues, via an automated email from WAST Health Informatics. This is a subscribed report targeted at senior managers across the Trust and health boards.

2.36 The Trust also produces 'Patient Safety and Experience Highlight' reports for each health board. This provides an 'at a glance' update on the current patient safety and experience landscape, including declined IRDs. The reports are presented at the quarterly patient safety and experience meetings the Trust holds separately with each health board Nurse Director.

2.37 One of the summary principles set out in the All Wales Protocol is to develop and maintain effective immediate release plans, that support joint working and the reduction of risk across system. We recognise that having an agreed Protocol in place, stating that declining an immediate release direction for Red and Amber 1 patients must not occur, is a step forward and should lead to improvement. However, we note that themes and trends identified following investigation of declined directions, such as the exceptions highlighted within this report, are not

currently being captured, analysed and fed back within the Trust. This is important to enable learning and improve compliance with internal procedures going forward. **See MA5 in Appendix A**.

Conclusion:

2.38 There is regular reporting on performance of IRD internally to the Trust's CEO, Director of Operations and EMS SMT. Performance is also discussed regularly with health boards, including at the daily national risk huddle, quarterly patient safety reports and the live Immediate Release Direction dashboard. However, it is too early to confirm whether the new All Wales Protocol will drive the necessary improvements as there remains a high level of declines for Amber 1 incidents at some health board sites. However, themes and trends identified following investigation of declined directions, such as the exceptions highlighted within this report, are not currently being captured, analysed and fed back within the Trust. Noting this, we have assessed this objective as **reasonable** assurance.

Audit objective 5: There is appropriate reporting and escalation of declined directions, including up to Trust Board and the Emergency Ambulance Services Committee where appropriate.

2.39 Updates on IRDs are provided to the Quality, Patient Experience & Safety Committee (QUEST) via the 'Patient Safety Highlight Report' presented by the Director of Quality and Nursing. The latest report for quarter 2 details that there were a total of 2,883 IRDs made to health boards. Of these, 1,528 were accepted (53%) and 1,355 were declined (47%), as illustrated, by health board, in the table below:

Health Board Quarter 1 2022/23	Number accepted	Number declined	Total	Percentage Accepted	Percentage Declined
Aneurin Bevan University Health Board	138	42	180	77%	23%
Betsi Cadwaladr University Health Board	829	644	1473	56%	44%
Cardiff & Vale University Health Board	135	15	150	90%	10%
Cwm Taf Morgannwg University Health Board	133	117	250	53%	47%
Hywel Dda University Health Board	156	123	279	56%	44%
Swansea Bay University Health Board	117	401	518	23%	77%
Not defined	20	13	33	61%	39%
Total	**1,528**	**1,355**	**2,883**	**53%**	**47%**

2.40 Review of the last three QUEST Patient Safety Highlight Reports show that there has been little movement on the percentage rate of accepted and declined IRDs:

QTR ended	Directions	Accepted	%age accepted	Declined	%age declined
March 2022	1,623	882	54.3%	741	45.7%
July 2022	1,807	953	52.7%	854	47.3%
September 2022	2,883	1,528	53.0%	1,355	47.0%

2.41 The Trust's Board receives updates on IRD performance, including via the QUEST Highlight Report to the Board. At its July 2022 meeting, the Board received and discussed a paper on '*Actions to mitigate realtime avoidable patient harm in the context of extreme and sustained pressure across urgent and emergency care*'. At the 29 September 2022 Board meeting, the Trust's CEO presented a paper providing a progress update on the actions identified. The action in place relating to immediate release directions is rated red - significantly off target, noting that whilst the Trust had completed its actions, compliance remains problematic.

2.42 IRDs were also discussed during three closed Board meetings held on 26th May 2022, 13th June 2022 and 4th July 2022. These discussions covered the steps the Trust has taken to address handover delays and, in particular, actions around IRDs, including discussions with Commissioners and health boards.

2.43 A meeting was held on 1 July 2022, between the CEO, Chair of the Board, the Chairs of the People and Culture Committee (P&C), QUEST, the Finance and Performance Committee (F&P), the Chair of EASC and the Chief Ambulance Services Commissioner (CASC), to escalate concerns around avoidable harm and patient safety due to the Trust's inability to reach patients in the community. There is also intention to escalate regularly at EASC meetings

Conclusion:

2.44 There is regular discussion on IRDs at Board and Committee level. The CEO presented a paper providing a progress update on '*Actions to mitigate realtime avoidable patient harm in the context of extreme and sustained pressure across urgent and emergency care*'. There has been little improvement in the percentage of accepted immediate release directions in the last three quarters of 2022. Concerns have been escalated to the Chair of EASC and CASC, and there is intention to escalate regularly at EASC meetings. Noting this, we have assessed this objective as **reasonable** assurance.

Appendix A: Management Action Plan

Matter arising 1: Completion of RES screen (Operation)	Impact
The Trust's Resource Deployment SOP details the actions to be taken and criteria that needs to be met before making an Immediate Release Directive (IRD). This includes considering all appropriate options to resource the incident, for example referring to the Resource List (RES) screen to check the status and availability of vehicles, including those outside of the divisional area that they are managing, and issuing messages to resources to identify if they can become clear for response. All attempts to identify a suitable resource must be recorded. The Sequence of Events (SoE) screen includes a time stamp to capture actions taken, which in the main involve review of the RES screen which lists the handover status, availability and location and type of vehicle. Our testing identified six instances where there was a lack of evidence to demonstrate that the RES screen was reviewed prior to the IRD being made. However, we understand from discussions with CCC managers that where there are multiple incidents of the same priority polling a single call can be made to the appropriate hospital. We were also advised that Allocators would be aware that calls were polling, indicating a lack of available resource to respond prior to making the IRD.	Potential risk of: • Failure to achieve the most efficient and effective use of resources. • Inability and/or a delay in ambulances reaching patients in the community resulting in harm.

Recommendations		Priority
1.1	Allocators should be reminded of the requirement to complete the RES screen prior to making an immediate release directive.	Medium

Management response		Target Date	Responsible Officer
1.1	The Trust accepts this recommendation and will ensure that communication to allocators on the importance of completing RES prior to making an IRD is actioned.	February 2023	Kate Blackmore, Head of Service EMS Co-ordination

Matter arising 2: Escalation to Operational Delivery Unit (ODU) (Operation)		Impact
The SOP details that Red and Amber 1 declined immediate release directions must be escalated to the Operational Delivery Unit (ODU). Our testing of 30 declined IRDs identified that 22/30 (73%) of the declined directions had not been escalated to the ODU as required. Furthermore, 149 (23%) of the 649 declined directions between 25 July (since the All Wales Protocol was agreed) and 5 September 2022 had not been escalated to the ODU. 27 (18%) and 122 (82%) related to Red and Amber 1 incidents respectively.		Potential risk of: • Inability and/or a delay in ambulances reaching patients in the community resulting in harm.
Recommendations		**Priority**
2.1 Red and Amber 1 declined immediate release directions should be escalated to the ODU to ensure that issues are escalated to the relevant health board site in a timely manner.		High
Management response	**Target Date**	**Responsible Officer**
2.1 The Trust accepts this recommendation and will ensure that communication is issued to emphasise the importance of compliance with the procedure to escalate declined IRDs to the ODU.	February 2023	Kate Blackmore, Head of Service EMS Co-ordination

Matter arising 3: Completion and timely review of Datix incidents (Operation)	Impact
The SOP details that a Datix incident must be raised for all Red and Amber 1 declined immediate release directions. Prior to the recent revision of the Trust's Resource Deployment SOP in July 2022, we were informed that raising Datix incidents was only required for declined IRDs in respect of Red category calls. 13 of the sample of 25 declined IRDs selected prior to July 2022 related to immediately life-threatening incidents, a Datix report had not been raised for five of these. A Datix report had been raised for all five of the sample of declined directions selected after the implementation of the new SOP and All Wales protocol in July 2022. Although we found Datix incidents are raised promptly after the incident date, we found that these were not reviewed and closed in a timely manner, with some taking as long as 10 months to close. Eight of the 13 Datix incidents noted above were recorded as closed. However, the average time taken to closure was 165 days, varying from 15 days to 288 days. The five items that remain open, have been so for 2 months or longer. However, we understand that the Trust is reliant on responses and feedback from health boards in order to appropriately close incidents. We also note that, due to the sustained high volumes of declined Amber 1 directions, the Trust may not have the capacity to fully investigate, review and report on these. Input from health boards is also required to facilitate wider learning.	Potential risk of: • Failure to fully investigate issues and where appropriate learn lessons from incidents.

Recommendations	Priority
3.1 Datix incidents should be reviewed and closed in a timely manner and any lessons learned should be shared with the relevant parties. 3.2 Noting the capacity issues above, the Trust should review the requirement to investigate all Amber 1 declined directions and consider introducing a streamlined mechanism of reporting. The Trust's SOP should then be updated accordingly to reflect the outcome of this review.	High

Management response	Target Date	Responsible Officer
3.1 It remains challenging for the Trust to investigate and subsequently close Datix as refusal to comply with an Immediate Release Direction is a Health Board Decision and so any harm that subsequently occurs, requires the Health Board to lead on a joint investigation, with the same principle being expected by the Trust where harm has not explicitly been identified.	March 2023	Liam Williams, Executive Director of Quality & Nursing

	A new Joint Investigation Process is being piloted under the leadership of the NHS Wales Delivery Unit, which commenced in November and that will run until March 2023. IRD requests that have been declined and where harm has been identified or is considered to have occurred, will form a part of this Pilot and a decision to recommend changes to the process will follow this pilot. Of note the Duty of Candour, that comes into place on 1 April 2023, further regulates the need for openness and transparency with families across the NHS.		
3.2	The Trust will agree a process to record all Amber 1 declined IRDs and report occurrence thematically based on UHB and clinical code sets. Where thematic analysis identifies additional areas of concern, these will be taken forward on a 'task and finish' basis by the Trust with the appropriate UHB and clinical representation.	February 2023	Liam Williams, Executive Director of Quality & Nursing

Matter arising 4: Completeness of Director of Operations briefing paper (Operation)		Impact
Section 3.2.12.1 of the SOP details that '*As part of quality assurance processes a review of all declined immediate release directions must be completed on a daily basis*'. Section 3.2.12.2 further details that '*The day time Duty Control Manager must complete a review of all declined immediate release directions for the previous day to ensure the correct process has been followed and feedback to dispatch staff where learning has been identified*'. In recognition of the significant volumes of declined directions, particularly relating to Amber 1 incidents, the Trust's Director of Operations revised the requirement so that 10% of Amber 1's declined would be investigated, in addition to all those relating to Red declined. The briefing papers for the weeks commencing 15 August 2022, 22 August 2022, 29 August 2022 and 5 September 2022 were examined, to confirm whether review of declined directions had been undertaken in line with this revised approach. Whilst overall the briefing paper to the Director of Operations typically met the target to investigate 10% of Amber 1 declined directions, we identified two Red declined directions that had been omitted.		Potential risk of: • Incomplete briefing.
Recommendations		**Priority**
4.1	The SOP should be updated to reflect the revised approach to investigate 10% of Amber 1 declined directions, and mechanisms put in place to ensure this requirement is adhered to.	Medium

Management response		Target Date	Responsible Officer
4.1	The Trust accepts this recommendation and will update the SOP to reflect the revised approach; Further a mechanism to ensure compliance with the revised approach will be determined.	April 2023	Kate Blackmore, Head of Service EMS Co-ordination

Matter arising 5: Analysis and feedback of themes, trends and lessons learned (Design)		Impact
One of the summary principles set out in the All Wales Protocol is to develop and maintain effective immediate release plans, that support joint working and the reduction of risk across system. We recognise that having an agreed Protocol in place, stating that declining an immediate release direction for Red and Amber 1 patients must not occur, is a step forward and should lead to improvement. However, we note that themes and trends identified following investigation of declined directions, such as the exceptions highlighted within this report (e.g. MA1, MA2 and MA3), are not currently being captured, analysed and fed back within the Trust. This is important to enable learning and improve compliance with internal procedures going forward.		Potential risk of: • Failure to identify trends and deliver improvements.
Recommendations		**Priority**
5.1 Themes and trends identified following review of all declined immediate release directions should be captured and analysed, and lessons learned shared within Trust to improve compliance going forward.		Medium
Management response	**Target Date**	**Responsible Officer**
5.1 The Trust accepts this recommendation and will seek to capture themes and trends and subsequent lessons learnt which will be shared into Senior Operations Team with assurance into Senior Leadership Team.	April 2023	Jon Sweet, Head of Service, Operational Delivery

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:

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

Prioritisation of Recommendations

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

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

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

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Infection Prevention and Control Final Internal Audit Report

January 2023

Welsh Ambulance Services NHS Trust

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Executive sign-off:	Liam Williams, Executive Director of Quality & Nursing
Distribution:	Jonathan Turnbull-Ross, Assistant Director of Quality Governance, Louise Colson, Head of Infection Prevention and Control
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

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Executive Summary

Purpose

To assess adherence to organisational policies and the Standards for Health Services in Wales and consider progress to implement recommendations raised in the 2019/20 'limited' assurance Cleaning Standards report.

Overview

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

- IPC audits are not yet underway with audit tools yet to be finalised.
- Continued issues in operation and membership of the IPC Strategic group.
- Clarity required for ongoing performance monitoring and reporting arrangements.
- Arrangements for formal monitoring of the IPC Action Plan are unclear.
- Inconsistencies identified in roles and responsibilities within draft policies and procedures.

Report Classification

		Trend
Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	⇧ Cleaning Standards 2019/20

Assurance summary[1]

	Assurance objectives	Assurance
1	Policies and procedures	Reasonable
2	Trust structure and responsibilities	Reasonable
3	IPC Programme	Limited
4	Guidance and training	Reasonable
5	Mechanisms for assurance	Limited
6	Performance and oversight	Reasonable

Key matters arising

	Key matters arising	Assurance Objectives	Control Design or Operation	Recommendation Priority
1	IPC Policies and related procedures	1	Design	Medium
2	IPC Strategic Group operation	2	Operation	Medium
3	Roles and responsibilities	1, 2	Design	Medium
4	IPC Work Plan content, monitoring and approval	3	Operation	Medium
5	'Onclick' Resources	4	Operation	Low
6	Trust IPC assurance mechanisms	5	Design	High
7	Performance reporting	4, 6	Operation	Medium

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

1. Introduction

1.1 The Welsh Ambulance Services NHS Trust ('the Trust') is committed to a zero tolerance of preventable healthcare associated infections (HCAI's). The Trust aims to work in partnership with all staff, service users and key stakeholders, to reduce the risk of transfer of community acquired infections in the pre-hospital care environment to secondary care and wider community environments.

1.2 The Infection Prevention and Control Annual Report 2021 – 2022, presented to the Trust's Quality, Patient Experience and Safety (QUEST) Committee in August 2022, outlined that the Infection Prevention and Control (IPC) team has necessarily had a COVID-19 focus in the past two years. The report outlined that the team was now looking to return to a business-as-usual approach, whilst retaining the improvements and IPC related behaviours gained through experience of the pandemic.

1.3 The Annual Report also provided a summary of IPC team priorities to be taken forward in 2022/23, including review of the Trust IPC Policy and a number of standard operating procedures, guidance and standards documents, alongside recommencing IPC audits which were suspended during the pandemic.

1.4 This review will also consider progress made to implement recommendations raised in the 2019/20 '*limited*' assurance Cleaning Standards report.

1.5 The risks considered during the review were as follows:

i. Patient or staff harm where infection prevention and control guidance and practice are not aligned to national standards.
ii. Financial loss or reputational damage to the Trust as a result of poor performance.

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	2	0	3
Operating Effectiveness	0	3	1	4
Total	1	5	1	7

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

Audit objective 1: The Trust has an infection prevention and control policy that provides clear direction, aligns with national standards, and is supported by appropriate operational policies and procedures.

2.3 The Trust has an overarching Infection Prevention and Control policy: '*Infection Prevention & Control Policy: Elimination of Healthcare Associated Infections'* ('the policy'), which was due for review in May 2021. Updates were made in September 2022, by the Head of Infection Prevention and Control (IPC), to align it with the Association of Ambulance Chief Executives (AACE) model national IPC policy. At the time of fieldwork closing the policy was to be submitted to the October 2022 meeting of the Trust Policy Review Group.

2.4 Whilst incorporating content from the AACE national policy, the Trust needs to ensure there remains alignment to the Welsh Government standards (*Code of Practice for the Prevention and Control of Healthcare Associated Infections*). We were also informed that the policy would retain guidance on Personal Protective Equipment provided by the Health and Safety Executive (HSE) that featured in previous revisions.

2.5 Review of the draft policy has identified a number of key revisions and updates. These include revised scope, aim and objectives and, in particular, reference to the previous IPC improvement plan has been replaced with a commitment to the prevention and control of infection and to set the strategic direction for IPC initiatives.

2.6 The draft revised policy expands on roles and responsibilities, including the addition of the Trust Board, Head of IPC and wider IPC team. Roles and responsibilities for managers and staff have also been refreshed and it provides further clarity on the need to ensure all staff and contractors receive sufficient training, information and supervision, with responsibility for developing training content assigned to the IPC team.

2.7 There is also outline of IPC audit arrangements, with audit subjects including vehicles, premises, equipment, clinical waste, sharps, linen and reference to 'local ownership of IPC standards by local management teams.' These are to be undertaken in line with the Trust's IPC audit programme. We discuss IPC audit arrangements in more detail at 2.46.

2.8 The overarching policy is supported by subject specific policies, standard operating procedures (SOPs) and guidance documents, although we note not all of these are owned or maintained by the IPC team. Following the move from Covid-19 response to business as usual in July 2022, there is currently a focus on updating those which have passed their review date, or those previously paused due to the pandemic.

2.9 At the time of fieldwork there were seven documents which were at various stages of draft or pending approval, these included the *Premises and Vehicle Cleanliness Policy*, *Safe Clean Care (IPC Handbook)*, *Key Standards for Environmental*

Cleanliness, and SOPs for hand hygiene, management of linen, mobile device decontamination and invasive procedures.

2.10 The *Premises and Vehicle Cleanliness* policy will be presented to the Trust Policy Review Group in October 2022. It contains detail on cleaning of premises, and outline of staff, management and reporting responsibilities. However, the cleaning instructions will require updating in line with the *Key Standards for Environmental Cleanliness* document which remains in draft, and monitoring arrangements detailed do not mention vehicles currently. We also note the Operations Directorate has issued a *Vehicle Decontamination* SOP, which provides instruction on vehicle cleaning for those which do not have access to regular cleaning at Trust Make Ready Depots (MRD). There is variation in cleaning instructions between these documents, the SOP also lacks detail on audit or other assurance arrangements. **See MA1 & MA3**

2.11 Throughout the pandemic the IPC team has produced a number of updates to Covid-19/PPE guidance documents, to ensure they remained in line with nationally issued guidance. Updates reflected changes in PPE, risk assessments, action cards and isolation/distancing requirements. In line with the movement from transition to business as usual, the team are now developing the next iteration of the IPC handbook: '*Safe Clean Care*'. The handbook combines content from a number of individual SOPs and national guidance, comments provided at the September IPC Strategic group, whilst positive, highlighted the requirement to ensure alignment and consistency. **See MA1**

2.12 There has also been focus on emerging risks with the co-production by IPC Team and Operations Directorate of an *Outbreak Management* SOP. This features trigger action cards for escalation, local management team processes, terms of reference and standard meeting agendas. Additionally, guidance has been issued for PPE and IPC management of Monkeypox.

Conclusion:

2.13 The Trust's IPC Policy has been updated, subject to formal review and approval, and aligns to national practice. A number of policies, SOPs and guidance documents are being reviewed, and the team has continued to address pandemic and other risk areas. However, there are a number of key documents remain in draft with inconsistencies that need to be addressed to ensure alignment. We assign this objective **reasonable** assurance.

Audit objective 2: The Trust has a clear infection prevention and control structure, and Operational and Executive responsibilities are clearly outlined.

2.14 The Trust established a pandemic structure in 2020, which transitioned through response and recovery to a return to business as usual in 2022. The IPC team engaged and contributed to a number of groups within the structure, particularly the Quality, Safety and Wellbeing Advisory and the Business Continuity and Recovery Cells.

2.15 During the pandemic, the IPC Team engaged with the cell structure established across the Trust, including the Quality, Safety and Wellbeing Cell, Health and Safety Advisory Cell, Clinical Advisory Cell, Trade Union Partnership Cell, and Senior Pandemic Team meetings. Example documents were provided supporting IPC team attendance and the sharing of guidance, training compliance, number and locations of positive Covid-19 tests and Covid outbreak team incident reports.

2.16 As the pandemic structure was stood down on 20th July 2022, the Chair of the Business Continuity and Recovery Team (BCRT) produced an SBAR to set out the governance arrangements proposed for those areas which had been included within the remit of the BCRT, and previous Senior Pandemic and Executive Pandemic teams. IPC features within this, with reference to the IPC Strategic Group for development of guidance, and the Clinical Quality Governance Group (CQGG) as the approving forum.

2.17 The IPC Strategic Group met infrequently during the pandemic period, as would be expected with the need to focus on Covid-19 response. The Terms of Reference (ToR) is in the process of being revisited and has been shared with the Executive Management Team (EMT) and the IPC Strategic group for review. The membership of the Group needs to be confirmed before the revised version can be finalised.

2.18 We reviewed agendas, papers and minutes for the three IPC Strategic meetings held in 2022 (January, April and September 2022), and compared these to the contents of the group's ToR and monitoring requirements in line with the updated IPC policy. Acknowledging that only the September meeting would have been held under a business-as-usual heading, the review suggests there are gaps in its operation. All three meetings were quorate.

2.19 The group's ToR includes a requirement '*to provide assurance on performance and the implementation of work programmes*'. However, it has not received the IPC work plan which was developed in 2021. The group is to provide a '*senior cross directorate forum*', but as noted above Senior Operations membership has not been confirmed. There is also a requirement to '*receive and disseminate information pertinent to IPC, monitoring and measuring performance at local, regional and Trust wide levels.*' Whilst the group has met only once since the return to business as usual, our review of meeting agendas does highlight limited performance information being presented. It is important that the Trust take the opportunity to address this for future meetings. **See MA2 & MA7**.

2.20 The IPC Strategic group attendance has included members from Estates, Fleet, and the Make Ready Depot Lead. However, review of agendas indicate that papers and reports are only produced by the IPC team, which suggests there could be more emphasis placed on membership responsibilities and contribution to support the group's operation. **See MA2**

2.21 We also reviewed the group's minutes and action logs, to identify if actions are identified, tracked, and monitored appropriately. Whilst there have been longstanding actions held within the action log, we observed the September meeting and can confirm each action was subject to discussion and review.

However, we do note that the most recent minutes for that meeting did not include specific capture of actions, and so consideration should be given to correct this for future meetings.

2.22 Operating alongside the pandemic cell structure, the CQGG was responsible for non-Covid related business. Review of CQGG minutes identified that it has received the IPC Annual Report 2021/22, circulation of and subsequent approval of Monkeypox guidance at an extraordinary meeting of the group in June 2022. We note the CQGG has also approved updates for a number of SOPs and SBARs, which suggest that there is a clear route for discussion and approval of IPC documents.

2.23 Our recent review of Respiratory Protective Equipment (RPE) included positive reflection of the RPE and Fit Testing SOPs, noting clear outline of both Executive, and operational roles and responsibilities. In particular we noted the IPC team responsibilities for designing policy and process documentation, and as subject experts ensuring these complied with required legislation. This also included consideration of the ability of the Trust to deliver the systems within resources available, while retaining responsibility for implementation through the Operations Directorate. As noted above, the team are progressing and prioritising a number of draft SOPs, and four of these were shared at the September meeting of the IPC Strategic Group for review.

2.24 We compared the outline of roles and responsibilities within those four draft SOPs, and the '*Key Standards for Environmental Cleanliness'* which was also submitted for comment at that meeting. Whilst acknowledging they are still in draft, we note variation in how responsibilities are outlined and so there is opportunity to consider further standardisation in format and terminology to support the good practice identified in our earlier review. **See MA3**

Conclusion:

2.25 There is a clear structure to support IPC within the Trust, with evidence of its use, including across a number of pandemic cells, to discuss and approve SOPs and guidance documents. In the return to business as usual it is important to improve the operation of the IPC Strategic group and its membership. We have also highlighted further opportunities to clarify roles and responsibilities. We assign this objective **reasonable** assurance.

Audit objective 3: A programme is in place to direct and deliver infection prevention and control improvements across the Trust.

2.26 We understand from discussion with the Head of IPC that a post pandemic IPC workplan was requested to support the delivery of the 2021-2024 IMTP, and were informed that this was approved through the Trust Pandemic structure.

2.27 The 2021 IMTP included reference to developing and implementing a sustainable health and safety transformation plan incorporating health and safety and infection prevention and control. The 2022-25 IMTP highlights key areas for

recovery, including how IPC measures continue to apply in a post-pandemic phase, and ensuring the lessons learnt and systems put in place during Covid-19 continue within business as usual.

2.28 The IPC work plan includes that the 2021 IMTP deliverable will be progressed through an IPC action plan, but the document has not been updated to capture the same link to the more recent IMTP.

2.29 The work plan is comprised of 10 IPC team deliverables, each with supporting actions, responsible officer, priority, status, and target implementation dates. There is also a column for progress updates and an outline of specific risks to delivery which are RAG rated.

2.30 In reviewing the priority areas we considered the deliverables listed above, the requirements of the updated IPC policy, and the priorities listed within the IPC Annual Report 2021-22. Overall, we note there is good coverage, although we did identify omissions. For example, the IPC Annual Report includes reference to actions to address audit recommendations, which is not reflected within the IPC work plan. Additionally, we note the plan does not include actions related to the sustainability of Fit Testing, which is currently a risk held by the team and highlighted as a major focus of team capacity. We also note the plan does not include the work to be undertaken in developing training in line with the HEIW national IPC training framework. **See MA4**

2.31 We also reviewed the work plan to consider if it demonstrated consideration of resource requirements, noting that at present it does not with all actions assigned to the Head of IPC. The work plan currently lists two of the ten actions as complete, and whilst a further six have target dates listed for November or December 2022, these include actions yet to be started (Action 10 – Safe Clean Care Campaign), reliant on external support (Action 6 – Audit tools/programme) and progressing of documents out for comment which will likely require approval outside of the group (Action 4 – SOPs, Action 5 IPC Standards). **See MA4**

2.32 Review of the IPC plan confirmed that each action has received at least one status review, with the majority having 2-3 narrative progress updates between June 2021 to September 2022. We have noted that priorities within the work plan have been discussed at the various cells within the pandemic structure, although we note this has been ad-hoc rather than on a regularly scheduled basis.

2.33 The work plan was initially shared at the IPC Strategic group in July 2021, and we are informed the priorities within the plan was also shared within presentations to the Clinical Advisory and Trade Union Partnership Cells. The plan has not returned to the IPC Strategic group or shared at the CQGG, which will have impacted on their ability to review and monitor progress across the priority areas. The QUEST committee terms of reference were revised this year to include '*Review the annual infection prevention and control plan and monitor its implementation*'. However, the IPC work plan has not been shared at that forum.

2.34 We also recognise that the work plan was intended to address post pandemic priorities, but that there has also been a need to tackle other pressing issues,

such as the Fit testing and subsequent quality assurance programme, which has impacted the team's capacity to achieve this.

2.35 Additional resource has been secured for the IPC team, including substantive appointments of a Senior and Assistant IPC Practitioner(s) and shared administrative resource with the Health and Safety team. This has primarily been directed to support the establishment of Fit testers and quality assurance arrangements. The majority of quality assurance assessments were undertaken in November and December 2021 and the Trust is committed to a 12-month review of QA Fit Testers by the accredited IPC team members.

Conclusion:

2.36 The Trust has an established IPC work plan which contains priorities linked to the IMTP and IPC policy. The work plan was shared at the IPC Strategic group but has not returned for further monitoring. It has not been presented to the CQGG, or QUEST committee, and we note there are delays in delivery of identified actions. We have outlined areas that could strengthen the plan content and monitoring. We assign this objective **limited** assurance.

Audit objective 4: There is awareness of infection prevention and control guidance and staff have undertaken appropriate training.

2.37 Outside of the statutory and mandatory IPC training requirements, the Trust has commissioned a supplementary suite of online training materials through the provider '*Onclick*'. The additional modules are available to all staff and volunteers through the Trust Learning Zone site and whilst completion is optional, it is recognised as contributing to Continuous Professional Development (CPD).

2.38 Guidance on the access and use of both statutory and mandatory training and the onclick modules is available through the IPC SharePoint site, under its training and education page.

2.39 Subject areas covered within the online modules include *transmission of infectious diseases*, *evolution of a pandemic*, *day in the life on the frontline*, *PPE Part A, Powered Respiratory Hood Part A*, and *vehicle cleaning, sharps and waste management*.

2.40 We reviewed the *vehicle cleaning, sharps and waste management* module. The module also refers to additional resources such as legislation, policies, and key documents, although we noted instances where the use of links directed the user to incorrect versions and the omission of the *Vehicle Decontamination* SOP. **See MA5**

2.41 Health Education Improvement Wales, at the request of Welsh Government, have developed a national framework for IPC Training. The framework outlines expectation across four levels, ranging from entry level: '*introductory awareness*' to Level 4: '*specialist knowledge understanding and application*'. The IPC team are working with the Trust's Training college to map the levels across staffing groups and specialised roles, and we were provided with an initial training needs

analysis. Further work is being undertaken to develop competency booklets to support these requirements. **See MA5**

2.42 Training compliance rates for statutory and mandatory IPC training and the Onclick modules were included within the IPC Annual Report 2021/22. Whilst this information is not currently reported to the IPC Strategic group, this has been identified as an area to address and capture in reporting going forward. At the time of fieldwork current performance is as below, noting the national target for IPC Level 1 and 2 is 85%:

Training Course	May 2022	October 2022
IPC Level 1	88.23%	75.63%
IPC Level 2	48.51%	45.46%
Onclick – EMS	72.73%	75.50%
Onclick - NEPTS	79.20%	72.34%

2.43 Review of QUEST and People and Culture Committee papers identified that they are provided with an overall combined training compliance figure, rather than a breakdown of performance for each subject area which was previously captured within a Quarterly Assurance Report. We understand that the report is currently under review. **See MA7**

2.44 The IPC team are actively supporting face to face training, and in observing the IPC Strategic group meeting in September it was clear that the team have good working relationships with the Learning and Development team. An action was agreed at that meeting to support the development of 'behavioural IPC champions' and to develop resources to highlight the risks of transmissibility within contact centres.

2.45 There is also awareness raising through the use of Quality & Nursing Directorate notices which are distributed throughout the Trust. We identified a number have been issued this year, including to promote awareness of infectious diseases, cleaning guidance, and fit test expiry dates.

Conclusion:

2.46 The Trust provides additional training and guidance materials to support staff, but links to key documents do require updating. Training compliance figures have been reported to QUEST, but we are unable to identify ongoing monitoring or reporting of these where focus is required to improve IPC Level 2 compliance. The team has undertaken an initial training needs analysis against the national framework, with further actions with the Learning and Development team planned. We assign the objective **reasonable** assurance.

Audit objective 5: Mechanisms in place to ensure compliance with Trust policies and procedures are appropriate.

2.47 Our previous review of Cleaning Standards, which was issued at the beginning of the pandemic in 2020, highlighted the need to develop more effective audit

methods to monitor compliance. The IPC Annual Report 2021/22 outlined that no audits were undertaken for 2021/22 due to the need to focus team resource and capacity on the pandemic response and any emerging variants of concern. The report included that a Trust IPC audit programme would be reintroduced in 2022-23 which would include:

- Corpro mask use, filter and maintenance logs and ESR Records;
- Versaflo usage, filter and maintenance logs;
- Peripheral cannulation and ANTT Compliance;
- On Click and eLearning compliance;
- Premise and Vehicle Cleaning;
- Hand Hygiene and Bare Below the elbow.

2.48 Discussion with the Head of IPC confirmed that at present the audit programme has not commenced, as there was a need to develop appropriate audit tools which utilised current software applications. The team does not have this capability and so both internal and external assistance had been sought. **See MA6**

2.49 The revised IPC policy references a number of additional subject areas which should feature within audit programmes, including staff competency at point of care, storage of medical consumables and equipment, handling and disposal of clinical waste and sharps, management and handling of linen, antimicrobial supply and administration, and local ownership of IPC standards by local management teams. In the previous iteration of the IPC policy some of the above were included but assigned to the Operations and Medical Directorates to undertake. **See MA6**

2.50 For the full benefit of the IPC audit programme, it would also require all subject areas having established criteria to be audited against. At the time of fieldwork, the *Premises and Vehicle Cleanliness* policy, *Key Standards for Environmental Cleaning*, and *Hand Hygiene and bare below the elbows* SOP were at draft stage.

2.51 With IPC audits not in operation, we queried if there were alternative mechanisms for assurance across key areas of premises and vehicles. Since our previous internal audit review of Cleaning Standards in 2019/20, and in response to the pandemic, the Trust has secured cleaning services for all Trust premises. Additionally, we note the health and safety team have undertaken a programme of Covid-19 risk assessments, which include elements of IPC, across Trust premises in 2021.

2.52 Vehicle arrangements have also been strengthened following the opening in 2022 of an additional Make Ready Depot (MRD) in Cardiff. The Trust has an ambition to increase the number of such facilities, to expand this model and approach across Wales. The MRD sites provide dedicated cleaning across three levels, which range from surface clean, a six weekly deep clean, and ad-hoc cleaning where contamination has occurred. As was the case at the time of our previous review of Cleaning Standards, the majority of Trust vehicles are not cleaned at MRD sites,

and so there remains a need to demonstrate and provide assurance for those vehicles.

2.53 Our previous review of cleaning standards identified that Adenosine Triphosphate (ATP) swab testing was being considered as a method for assessing cleaning standard compliance. We are informed that MRDs had used ATP during the pandemic, and was particularly useful as a source of assurance for staff. However, in the return to business as usual the process is currently retained for quality assurance purposes only, with future use to be determined through review of policies and procedures which is currently underway. MRD reporting of activity has continued, but as our previous review identified there is no reporting which captures cleaning status for the entire Trust fleet.

2.54 Included within the IPC Annual Report 21/22 was detailed outline of IPC related datix reporting, which was broken down by theme and health board area. Whilst the report highlighted an increase in needlestick injuries within the Swansea Bay University Health Board area, and we note a consistent number of returns related to IPC policy or procedural issues, these have not resulted in further action. The team has recently introduced a weekly review of datix reports and began to collate responses and actions. The intention will then be to map themes and actions, which can be incorporated into the ongoing highlight and dashboard reporting. **See MA6**

Conclusion:

2.55 The Trust IPC audit programme requirements are outlined within the IPC policy and included within the IPC work plan. Following suspension due to pandemic pressures audits are yet to be restarted. The Trust has some mitigating measures around MRD vehicle cleaning and premise cleaning, however the previous development of ATP swab testing, which provided a method for assessing cleaning standard compliance, has not been implemented fully resulting in an absence of assurance reporting. We assign this objective **limited** assurance.

Audit objective 6: There is regular reporting on Trust performance with clear oversight arrangements to support escalation of risks and issues.

2.56 Prior to the return to business as usual, the route for oversight and reporting remained through the pandemic structure for Covid-19 related activity. Senior Pandemic Team agendas and papers demonstrate the heightened profile of IPC during this period. Covid related incidents, risk assessments and IPC/'on click' training summaries were presented to cells across the structure.

2.57 The IPC Team also provided quarterly highlight reports to both the Assistant Directors Leadership Team, and the Trust's National Health and Safety Committee. These provide a narrative outline of team progress and developments, and a summary of key areas in the alert/advise/assure/inform format. Review of report content, alongside the reporting within the pandemic structure, provides coverage against priorities contained within the IPC work plan,

although only at a high level for some these suggesting therefore more focused monitoring arrangements would be beneficial in the return to business as usual.

2.58 With the pandemic structure now stood down, we considered the arrangements in place to support ongoing monitoring and reporting of risks in the return to business as usual. The IPC Strategic group meets on a quarterly basis and is a subgroup of the CQGG. Its ToR includes that it will provide a highlight report to the CQGG following each meeting. The CQGG holds monthly meetings and in turn provides a 'Quality Highlight Report' summarising its key activities the QUEST Committee, which meets on a quarterly basis.

2.59 We reviewed CQGG papers and minutes for the period January 2022 and August 2022 to identify the frequency and content of reporting in place. In that period the CQGG received and approved a number of IPC SOPs and guidance documents, and the IPC Annual Report 2021-22. The Annual Report provides summary of training compliance, datix incidents, and overview of IPC risks, alongside outline of the team's priorities for 2022/23. We could not identify use of highlight reports from the IPC group to the CQGG, suggesting there is opportunity to enhance future reporting of current performance, or the key activities of the group. **See MA7**

2.60 Review of the Quality Highlight Report from CQGG to QUEST identified that information provided varied. For example, the report provided in May 2022 included outline of the group's purpose, but little on its activity. The second, provided in August 2022, contained further detail including approval of IPC SOP for *High Consequence Infectious Diseases,* and this indicates that the structure for discussion and approval outlined within objective two is in place.

2.61 The Quality Highlight Report did not however contain indicators on performance or detail on progress against the IPC work plan. Our previous review of Cleaning Standards in 2019/20 had identified that the previous Quarterly Quality Assurance Reports, presented at the CQGG predecessor group (the Quality Steering Group), included detail on IPC statutory and mandatory training compliance, datix incidents and cleanliness audits. This, in turn, was reported to the QUEST Committee. Discussion with the Assistant Director of Quality Governance outlined that the reporting requirements from CQGG to QUEST are being considered. The Audit Wales Review of Quality Governance issued in 2022 highlighted that whilst current reporting provides a '*good high-level summary, some of the quality focus and detail in the original Quality Assurance Report has been lost*.'. A highlight report aligned to key indicators is planned for November 2022 onwards. **See MA7**

2.62 The QUEST Committee provides a highlight report to Trust Board following each meeting. This is formatted around an alert (escalation), advise (developments, monitoring, approval), and assure format. We note that receipt of the IPC Annual report at the August QUEST Committee meeting was included within the subsequent report to Board under the assure heading. **See MA7**

2.63 There has been a number of IPC related risks that were included within the Trust's Corporate Risk Register during the pandemic which have been subsequently de-escalated. The IPC Annual Report 2021/22 includes outline of six individual risks

that the team closed during the year, relating to team structure, PPE, and lack of compliance with HSE regulations for Fit testing. The September IPC Strategic group received and discussed a risk opened in May 2022 relating to the sustainability of the Fit testing programme within the Trust, a challenge highlighted within our review of RPE earlier this year. The group agreed that the risk required organisational awareness and that it should be escalated.

Conclusion:

2.64 There is a clear reporting structure from the IPC Strategic Group to the CQGG and onwards to the QUEST Committee and Trust Board. During the pandemic, there has been use of the Trust's cell structure to escalate risks and monitor training levels. We've considered the initial arrangements supporting the return to business as usual, which has identified the need to enhance the flow of reporting, in line with Audit Wales recommendations. We assign this objective **reasonable** assurance.

Appendix A: Management Action Plan

Matter arising 1: IPC Policies and related procedures (Design)	Impact
In returning to business as usual the IPC team are reviewing and updating policies, procedures, and guidance documents. This includes the overarching IPC policy, which has been updated, but is awaiting approval from the Trust Policy Group. A number of supporting policies and procedures were also in development or pending approval at the time of fieldwork. The *Premise and Vehicle Cleanliness* policy is in draft we reviewed its content noting: • The adapting of *Key Standards for Environmental Cleanliness* for use within the Trust is still to be completed and these will need to be incorporated within the above policy once finalised. • Monitoring arrangements within the policy include IPC audits, however under responsibilities Health and Safety Managers are listed as responsible for audit of the policies operation. • Reporting is to be to a Building Cleaning Group yet to be established and there is no mention of the role of the IPC Strategic group. • The document includes cleaning instructions on premise cleaning, but information on vehicle cleaning does not replicate content from the *Vehicle Decontamination SOP* which does provide vehicle cleaning instructions. The SOP contains no outline of audit or other assurance arrangements. Alongside the current policies and SOPs there will shortly be an updated IPC handbook. Discussion at the IPC Strategic group, and our own review of the draft document, notes that handbook duplicates content from a number of other documents and will require ongoing maintenance to ensure content remains current.	Potential risk of: • Policies and procedures do not provide comprehensive coverage of related areas. • Lack of clarity across responsibilities and ownership.

Recommendations	Priority
1.1 Once the overarching IPC policy is formally approved, the supporting policies/procedures/guidance documents should be reviewed and approved in a timely manner. 1.2 The Trust should clarify arrangements within the Premise and Vehicle Cleaning policy to ensure cleaning instructions, responsibilities and monitoring are comprehensive and align with other related documents.	Medium

1.3	The Trust should map IPC and related policies, responsibilities, ownership, monitoring and governance arrangements to support future review and development of policies and guidance.		
1.4	Consideration should be given to modifying the IPC handbook to direct users to relevant content, this could also contain the outcome of mapping recommended above.		
Management response		**Target Date**	**Responsible Officer**
1.1 – 1.3	The recommendations are accepted. A project of work 'IPC 3P' will be undertaken to assess policies, procedures, and other 'powers' (including guidance documents, protocols, and activity-based risk assessments). The aim of the project is to 'map' current provision, monitoring arrangements, undertake a gap analysis, and embed a RACI framework to ensure organisational 'buy-in' and accountability. This work will lead to systematic review of departmental and relevant organisational documents.	March 2023	Louise Colson, Head of IPC
1.4	Consideration will be given to modifying the IPC Handbook following the IPC 3P Project. The aim of this action is to ensure staff are able to navigate to relevant and important content, as and when required.	June 2023	Louise Colson, Head of IPC

Matter arising 2: IPC Strategic Group (Operation)	Impact
Our previous review of Cleaning Standards in 2019/20 identified that the IPC Strategic group was not operating effectively. Since then there has been review of the group's terms of reference, however membership is still to be finalised. The group has met a number of times during the pandemic, transition period, and once during business as usual. Review of group agendas, papers and minutes identified the following gaps against its terms of reference; • '*The purpose of the IPC Strategic Group is to provide strategic expertise, assurance on performance, and implementation of work programmes within the organisation of matters relating to IPC.'* - We note the group has not received, approved, or discussed the IPC work plan which was developed in 2021. • '*The Group will provide a senior cross-directorate forum, in which IPC matters will be considered to ensure successful operationalisation and positive implementation into Trust policies, procedures and practices.'* – There is currently no attendance from senior Operations management and membership from that group is yet to be confirmed. • '*Receive and disseminate information pertinent to IPC, monitoring and measuring performance at local, regional and Trust-wide levels;'* – The group received narrative updates on development of policies/plans and guidance, however currently there are no IPC audits underway and limited input from non-IPC members on their areas of responsibility. • '*Contribute to and influence prudent antimicrobial prescribing into routine practice*.' – We did not identify discussion of this subject area within minutes reviewed. The gaps identified above would also impact the achievement of objectives listed within the updated IPC Policy. Draft minutes circulated following the group's September meeting did not include use of an action column. There would be benefit in a consistent approach and format used to identify and capture actions raised within the meeting.	Potential risk of: • Trust IPC priorities not delivered. • Effectiveness of group operation impacted by gaps in membership and subject coverage.

Recommendations		Priority
2.1	The Terms of Reference for the IPC Strategic group, including membership, should be finalised, and submitted for approval from the CQGG.	**Medium**
2.2	The format and agenda of the IPC Strategic group should be reviewed to align with the IPC Work Plan priorities.	

2.3	In undertaking the above the Trust should consider the information, monitoring, and reporting contributions from each which could contribute to the progressing of the IPC priorities within the work plan.		

Management response		Target Date	Responsible Officer
2.1	The Terms of Reference for the IPC Strategic group, including membership, will be finalised, and submitted for approval from the CQGG. Additionally, a revised Agenda and group work programme will be implemented.	March 2023	J Turnbull-Ross, Asst. Director
2.2 – 2.3	The Terms of Reference, group work programme/agenda will include routine monitoring of performance, and review of documentation in a timely manner. Management response 1.1 will inform the content of the group's monitoring requirements.	March 2023	J Turnbull-Ross, Asst. Director

Matter arising 3: Roles and Responsibilities (Design)	Impact
Our recent review of Respiratory Protective Equipment (RPE) included positive reflection of the RPE and Fit Testing SOPs which contained clear outline roles and responsibilities across both Executive and operational staff and management. We have also noted the alignment within the overarching IPC policy to the content held in the AACE national IPC policy which itself includes outline of roles and responsibilities. We compared the outline of roles and responsibilities within four draft SOPs, and the *Key Standards for Environmental Cleanliness* presented to the IPC Strategic group in September. Whilst acknowledging they are still under development there is variation in frequency and terminology. We noted; • The *Decontamination of Mobile Devices* and *Invasive Procedure* SOPs did not include reference to Executive Director responsibilities. The *Key Standards for Environmental Cleanliness* refer to the Director responsible for IPC rather than the Director of Nursing and Quality. • The *Invasive Procedure, Management of Linen*, and *Decontamination of Mobile Devices* SOPs, and the draft Key Standards do not have clear outline of the responsibilities of the IPC team. • The *Invasive Procedure, Management of Linen*, and the draft *Key Standards for Environmental Cleanliness* do not have managers responsibilities clearly outlined.	Potential risk of: • Inconsistent outline of roles and responsibilities.

	Recommendations	Priority
3.1	The Trust should consider further standardisation of roles and responsibilities outlined across executives, managers and staff which can be included within the development of future SOP, policies, and guidance documents. This could be drawn from the content within the updated IPC policy.	Medium

	Management response	Target Date	Responsible Officer
3.1	We accept the recommendation to standardise documentation formats. This action will be addressed through the IPC 3P Project (management response 1.1)	March 2023	Louise Colson, Head of IPC

Matter arising 4: IPC Work Plan, monitoring and approval (Operation)	Impact
The work plan is comprised of 10 IPC team deliverables each with supporting actions, responsible officer, priority, status, and target implementation date. There is also a column for progress updates and an outline of specific risks to delivery which are RAG rated. Our review noted priorities matched with the requirements of the updated IPC policy and priorities within the IPC Annual Report 2021/22. We noted some small gaps against ongoing delivery including, action to address NWSSP Audit and Assurance reports, inclusion of the Fit testing Quality Assurance programme, and action to address the HEIW national IPC training framework. Review of actions outlined that two of the ten actions are currently complete, with a further six contain target dates of November/December 2022 these include actions yet to be started (Action 10 – Safe Clean Care Campaign), reliant on external support (Action 6 – Audit tools/programme) and progressing of documents out for comment which will likely require approval outside of the group (Action 4 – SOPs, Action 5 IPC Standards). All actions within the IPC work plan are assigned to the Head of IPC. Additional resource secured for the team has been directed towards the establishment of a Fit tester programme, followed by the need to provide ongoing quality assurance. These actions are not included within the plan. The IPC work plan has not been shared at the CQGG or QUEST Committee.	Potential risk of: • IPC performance and delivery of priorities may not be adequately scrutinised.

Recommendations		Priority
4.1	The IPC Work Plan and content should be reviewed to ensure it contains both the Trusts overall IPC priorities but also those areas which have greatest impact on the IPC team capacity and resource. It should then be submitted for approval from the CQGG.	Medium
4.2	Resource requirements and target dates should be reviewed with changes in timescales or actions included at IPC Strategic group and CQGG meetings.	
4.3	The ongoing delivery of the IPC work plan should be regularly monitored at the IPC Strategic group.	

Management response		Target Date	Responsible Officer
4.1	The IPC Work Plan will be reviewed and submitted to CQGG for approval.	March 2023	Louise Colson, Head of IPC

4.2	We accept the recommendation, future workplans will detail requirements.	March 2023	Louise Colson, Head of IPC
4.3	The IPC Strategic Group’s Terms or Reference, group agenda and work programme will include monitoring of deliverables against the IPC Work Programme	March 2023	Louise Colson, Head of IPC

Matter arising 5: 'Onclick' Training resources (Operation)	Impact
Outside of the statutory and mandatory IPC training requirements the Trust has commissioned a supplementary suite of online training materials through the provider 'Onclick'. Subject areas covered within the online modules include *transmission of infectious diseases*, *evolution of a pandemic*, *day in the life on the frontline*, *PPE Part A*, *Powered Respiratory Hood Part A*, and *vehicle cleaning, sharps and waste management*. The modules are also supported by links to additional resources such as legislation, policies, and key documents. Review of the vehicle cleaning, sharps and waste management module The IPC documents linked to within the module were to previous out of date versions; • All things IPC - Version 1.3, current version is 3.0 • A-Z of Common Disease – Version 1.3, current version is 8.2 it did not include the Vehicle Decontamination SOP which provides the Trust's approach to non MRD cleaning instructions.	Potential risk of: • Access and use of out-of-date guidance.

Recommendations		Priority
5.1	The Trust should ensure online resources contain up to date links and guidance.	Low

Management response		Target Date	Responsible Officer
5.1	Immediate action will be undertaken on those identified. The IPC 3P Project will systematically review documentation for outdated links/information.	January 2023	Louise Colson, Head of IPC

Matter arising 6: Trust IPC Assurance Mechanisms (Design)	Impact
Our previous review of Cleaning Standards in 2019/20 highlighted that vehicle and premise checks undertaken were 'subjective and therefore provide only limited assurance'. Alternative methods of audit, such as the use of ATP swab testing, which did provide some assurance on the effectiveness of cleaning methods, were being considered at that point but these have not been continued. As outlined within the IPC Annual Report 2021-22 IPC audits were paused as team resource and capacity was directed to support the Trust's pandemic response. The report included intention to reintroduce an audit programme in 2022/23, and we're informed the team has allocated dedicated time to undertake these, however the audit tools to support the programme are yet to be finalised. The previous IPC policy included outline of those responsible for IPC related audits, including those outside of the IPC team itself. Review of IPC Strategic group papers has identified no reporting of any checks made by alternative parties. With the *Key Standards for Environmental Cleanliness* still in draft there will also need to be clear circulation of these once finalised to ensure staff are aware of the criteria being measured against. The IPC team has recently established regular review arrangements for datix incidents to capture related actions and themes, at present this only relates to August and September 2022.	Potential risk of: • Lack of assurance on compliance with policies.

Recommendations		Priority
6.1	Whilst continuing to progress the updating of IPC audit tools the Trust should develop a prioritised schedule of audits which can be delivered by the IPC team for the remainder of 2022/23. This should be alongside finalising and communicating expected criteria and standards.	**High**
6.2	The Trust should consider longer term mechanisms for compliance which incorporate and map responsibilities of the wider IPC Strategic membership and include outline of compliance monitoring and reporting.	
6.3	To support both of the above actions the IPC team should incorporate analysis of datix incidents for 2022/23 so that the targeting of audits is risk based.	

Management response	Target Date	Responsible Officer

6.1	A prioritisation assessment will be undertaken to audit higher risk focus areas.	March 2023	Louise Colson, Head of IPC
6.2	IPC 3P Project will provide a comprehensive assessment of monitoring and audit arrangements. Additionally, responsibilities will be articulated through a RACI framework	June 2023	Louise Colson, Head of IPC
6.3	The recommendation is supported. An analysis of the data will be undertaken to determine priorities for the IPC Work Plan for 2023/24, including auditing.	March 2023	Louise Colson, Head of IPC

Matter arising 7: Performance Reporting (Operation)	Impact
The IPC Annual Report 2021-22 was provided to the Clinical Quality Governance Group (CQGG) in May 2022, Executive Management Team in June 2022, and presented to the QUEST Committee in August 2022. This provided a good summary of training compliance, datix incidents, and overview of IPC risks, alongside outline of the team's priorities for 2022/23. There has been use of the Trust pandemic cell structure to report Covid-19 incidents, IPC training compliance, and use of SBARs for risks across a number of cells and the Senior Pandemic Team. Review of CQGG minutes and papers confirms that the group receives and approves guidance and procedure documents from the IPC Strategic group on a regular basis. In the return to business-as-usual arrangements to support ongoing performance monitoring and escalation is not as clear with no highlight reports from the IPC Strategic group to CQGG identified within the period reviewed. Our previous review of Cleaning Standards identified that whilst there were opportunities to strengthen the monitoring at the IPC Strategic Group, there had been consistent reporting of key indicators such as statutory and mandatory training compliance, datix incidents and audit outcomes featured within the Quarterly Assurance Reports to the QUEST Committee. Audit Wales in their review of Quality Governance highlighted that whilst current reporting provides a '*good high-level summary, some of the quality focus and detail in the original Quality Assurance Report has been lost.'*	Potential risk of: • Gaps in performance reporting.

Recommendations		Priority
7.1	We support the review of key indicators to be reported from CCQG to the QUEST Committee. This review should also determine the key indicators to be reported and monitored at the IPC Strategic Group.	**Medium**

Management response		Target Date	Responsible Officer
7.1	A review of performance indicators will be undertaken for the IPC function. Routinely, these will be reported by exception to CQGG. Further consideration will be undertaken to ensure Board committee oversight of key IPC measures.	March 2023	Louise Colson, Head of IPC

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:

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

Prioritisation of Recommendations

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

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

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

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Data Analysis

Final Internal Audit Report

February 2023

Welsh Ambulance Service NHS Trust

Private and confidential

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Committee:	Audit Committee

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

Acknowledgement
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Executive Summary

Purpose

The overall objective of the audit was to establish and assess data analysis within the Trust and the foundations for it becoming a data-led organisation.

Overview

We have issued reasonable assurance on this area.

WAST is a data-rich organisation and has the people and systems in place to manage and use its data to continuously monitor its performance and forecast future demand.

The matters requiring management attention include:

- Replacing legacy reporting software.
- Fully defining and resourcing the CCC administrator role.

Other recommendations are within the detail of the report, these include:

- Absence of report catalogues
- Incomplete ERM and metadata for the data warehouse and CAD system
- Defining data quality accuracy levels
- Data sharing agreement register

Report Opinion

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

Assurance summary[1]

	Objectives	Assurance
1	Strategy	Substantial
2	Engagement	Substantial
3	Performance metrics	Reasonable
4	Tools and Techniques	Reasonable
5	Data Quality	Reasonable
6	Data Governance	Reasonable

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

Key Matters Arising

	Key Matters Arising	Objective	Control Design or Operation	Recommendation Priority
3.1	Legacy software replacement	3	Operation	High
4.1	CCC System Administrator continuity	4	Design	High

1. Introduction

1.1 The Welsh Ambulance Services NHS Trust ('the Trust') generates significant amounts of data which can be analysed and used to drive improvements in care and service delivery. Intelligent data analysis results in improved patient experience and outcomes, in addition to optimal use of resources.

Data is becoming an increasingly integral resource to the Trust. However, to be beneficial, it needs to be readily available and of high-quality. Quality data plays a role in improving services and decision making, as well as being able to identify trends and patterns, draw comparisons, predict future events and outcomes, and evaluate services.

The overall objective of the audit was to establish and assess data analysis within the Trust and the foundations for it becoming a data-led organisation. The review included consideration of the storage, aggregation, sharing and access of data together with the processes to ensure quality of information.

1.2 The risks considered as part of this audit are:

- ill-defined data analytics objectives may result in failure to meet strategic goals;
- ineffective information security standards and configurations may result in unauthorised access to data, inappropriate modifications of data, and regulatory compliance breaches;
- data quality issues and/or inaccurate reporting may lead to inaccurate management reporting and flawed decision making; and
- lack of appropriate governance arrangements over the analytical function can result in failure to meet strategic goals.

1.3 An audit of WAST Fleet Maintenance (WAST 2223-005) has just been reported with a reasonable audit opinion. It included review of the use of fleet management system data to support the fleets maintenance programme. We have therefore excluded fleet management data from this audit.

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	0	2
Operating Effectiveness	1	0	3	4
Total	2	1	3	6

2.2 All matters arising and the related recommendations and management actions are detailed in Appendix A

Objective 1: Strategy - an appropriate strategy should be in place to enable the organisation to become a data-led organisation

2.3 The Trust's digital strategy, '*WAST Digital Strategy*', was finalised and published in November 2020. It is a key enabler of the Trust's long term strategic framework, '*Delivering Excellence, Our Vision for 2030*'

2.4 It is structured around four digital missions:

- Mission 1 – Empower the digital patient;
- Mission 2 – Build the digital workplace;
- Mission 3 – Intelligence through data; and
- Mission 4 – Digital foundations.

2.5 Each mission has three components: a vision, key objectives, and how success will be measured. Delivery of the missions will be in three phases: stabilise, optimise, and sustain. The aim of the strategy is to create, deliver and embed a Target Operating Model which will be sustainable and deliverable to meet expected future requirements, with flexibility to support the repetition of the three phases to continue to adapt to changing business demands.

2.6 The vision for Mission 3 states '*It is critical that we use our data for maximum value to deliver intelligence and insights, whilst ensuring it is of the best possible quality*.' The Commissioning and Performance Division uses the data for continuous modelling, forecasting and reporting; they clearly demonstrate that they do obtain maximum value from their data. The majority of the reports they use are created by the Health Informatics team in the Digital Directorate, whose work to develop and deliver reports underpin the business intelligence activity. From the work done as part of this audit it is clear that the Trust is engaged in the continuous use of its data to monitor and develop its service provision.

2.7 We note the trust do not specially report on the digital strategy, however the mission 3 progress and work undertaken is reported via the Strategic Transformation Board.

Conclusion:

2.8 The Trust has clearly recognised it is a 'data rich' organisation and has a strategy that sets out that it will be used to modernise and refine its services, all of which are centered on patient safety and outcomes. We consider **substantial** assurance appropriate for this objective.

Objective 2: Engagement - a process should be in place for identifying key stakeholders (internal and external) and their requirements, and translating these into deliverable data products.

External to the Trust

2.9 The Trust provides reports and information including live situational dashboards on its services to its key stakeholders; primarily the Health Boards it provides services to, the Welsh Government and the National Collaboration Commissioning Unit. These include the Ambulance Quality Indicators and relevant Welsh Government targets, and are considered in more detail under objective 3.

2.10 The Trust has a Communications Team that engage with the media and requests for data from external parties. If an interested party requires information, they can contact the Trust's Communications Team to discuss their request.

Internal to the Trust

2.11 Historical performance reporting, i.e., not on live calls and events, and modelling future demand are carried out by the Strategy, Planning and Performance Directorate. This is split into two Assistant Director managed subdivisions:

- Commissioning and Performance; and
- Planning and Transformation.

2.12 These are further split into specialist areas, e.g., resource management. They run a comprehensive suite of data analysis reports, largely developed by the Health Informatics team, on immediate past performance for management reporting purposes, and to supply data for modelling purposes, including future demand over the short, medium, and long-term (see objective 3 below for further detail). Some of this activity is repeated on a daily basis due to continuously changing external factors.

2.13 Reporting on the live position and current demand is provided through dashboards which are available to those that need them, e.g., the Clinical Contact Centres (CCC) that handle all incoming calls have live large screen displays of their current position. There is also a live dashboard that captures where all ambulances are, and how long they have been outside hospital to handover a patient.

Conclusion:

2.14 WAST is a mature organisation and its stakeholders are well known by the digital team. We consider the digital team is engaged with its internal and external delivery partners in making good use of its available data. A facility is in place for stakeholders to request information and for these requests to be appropriately considered. We are happy to report **substantial** assurance appropriate for this objective.

Objective 3 - Performance Metrics - the success criteria of the analytics function should be tracked through agreed-upon performance metrics. These metrics should present a balance of operational and organisational performance. They should also provide management with insight into the cost, level of adoption, availability, and usage of analytics.

2.15 Although the Health Informatics (HI) Team have created over 400 reports there is no catalogue available for users that lists them, including the data fields they contain, nor describes the requirement and rationale for producing the information. Additionally, we were advised that the number of requests for reports are

increasing. Given the volume of report data that is available, and the facilities for stakeholders to customise these and produce their own on Qlik Sense, a catalogue could facilitate a reduction in the demand See **Matter Arising 1.1 in Appendix A**

2.16 In addition to the 400 bespoke reports, we note that the Trust publishes report data on all of its activities via a web-based hub (Qlik Sense, see objective 4). Stakeholders can be granted access to these reports, which includes a drill down facility to individual call level in some cases.

2.17 There are 27 standard reports (Sheets) covering all aspects of non-live 999 emergency calls. 18 sheets on 111 calls, and a Non-Emergency Patient Transport Service (NEPTS) dashboard. There is a facility for users to create their own sheets if required and the data can be exported by users for their own use.

2.18 WAST makes thorough use of data for performance reporting purposes. For example:

- Fortnightly Integrated Quality and Performance Report: A comprehensive report on Emergency Medical Services (EMS) performance and the 111 transformation gateway.
- The WAST Annual Reports and Accounts: An annual public report document on all WAST activity, published on the WAST website.
- Monthly Integrated Quarterly Performance Report: Thorough and comprehensive management report with performance data and supporting analysis. Reports the data, and includes a top indicator dashboard covering 24 key indicators to help the Board focus. The report provides an explanation of performance and detailed analysis of any failure to hit targets.

2.19 Data is also used for forecasting and modelling purposes. Historically, forecasting was done for winter flu seasons. Recent changes and the pandemic meant that forecasting was needed more regularly. This was done, and the process has now developed into a rolling tactical plan. Examples of this include:

- The effect of the pandemic on ambulance demand was modelled, results compared afterwards confirmed the model was accurate.
- Predicted peaks of demand were modelled to staff availability which showed that resources were not available at peak times of demand. This resulted in a large-scale re-rostering exercise to address the issue.

2.20 There is reporting of live events available for the stakeholder groups that need this, primarily the Operations Directorate. This is presented via large screen dashboards allowing call handlers and duty managers to monitor ongoing live performance on all aspects of call performance, e.g., the call queue, response rate/times, call duration etc., and the status of ambulances, including where they are located and how long they have been outside hospital to handover a patient.

2.21 We note that the number of requests for reports is increasing, although there is a process for requesting information we note that there are opportunities to improve this process with increased formality. See **Matter Arising 1.2 in Appendix A**

2.22 We noted there is no feedback information on the data and products provided to the stakeholders. There is management information on report production by reporting services, Qlik sense dashboards and Power BI Report usage. This covers basic use of each report and covers who, what, where and when existing reports are accessed. As it was accepted that there is duplication within the existing reports available, this information could be used to further reduce the overall number of reports. Additionally, there was no management information and analysis on the analytical report creation function, therefore cost and utilisation detail cannot be provided. See **Matter Arising 1.3 in Appendix A**

Conclusion:

2.23 We consider the Trust has excellent analysis and reporting capabilities on its operational activities and provides a high-quality reporting service to its stakeholders. However, the lack of a report catalogue at this time and the likelihood that duplication exists and is potentially increasing, means we provide **Reasonable Assurance** on this objective.

Objective 4: Tools and Technologies – the organisation should identify the most appropriate tools and technologies to fit their current and future needs. These tools should enable the organisation to acquire, process, analyse, and use data from sources that produce increasing amounts of structured and unstructured data.

2.24 The main operational event data (Staff data – Global Rostering System(GRS); EMS data - Cisco; Computer Aided Despatch (CAD); NEPTS data - Cleric; 111 data – Clinical Assessment System (CAS) is recorded on live systems. Periodically, (Daily+) data engineers source the data from the live systems and run a series of data transformation and standardised checks before importing into the WAST Data Warehouse (DW).

2.25 The DW is the main repository of WAST data. Reporting on non-live events is run against the data warehouse, meaning that performance reporting does not impact on the operation of the live system. This is an example of good data management and reporting practice.

2.26 The DW Team's focus in 2020 and 2021 was on delivery, due to the limited support resources available and a significant increase in workload due to COVID. This has now eased and the DW Team has identified a series of tasks to improve performance and DW documentation.

2.27 The DW Team has created a list of objectives that need addressing, though no timescale or priority has been assigned for their completion. Included in this list is documentation, and we have noted an absence of a complete and up to date 'Entity Relationship Diagram' and meta data (description of the data in the tables) for the DW tables. See **Matter Arising 2 in Appendix A**

2.28 There are three tools available for extracting data and developing visualisations and manipulations from the DW: Structured Query Language (SQL) Server Reporting Services (SSRS), Qlik Sense, and Power BI.

2.29 SQL is a domain-specific language used in programming. It is an industry standard reporting language that uses 'queries' to produce reports. These queries can be imported into other reporting packages.

2.30 Qlik Sense is a web-based reporting tool. It is the tool that provides the majority of the hub reports that are provided to stakeholders. It is flexible and can import SQL queries. We noted that the version in use is 2016 and note that it is out of vendor support and not receiving upgrades. See **Matter Arising 3 in Appendix A**

2.31 Power BI is a modern web-based reporting tool and was acquired as part of Microsoft Office 365. It can also upload SQL queries and is being used to produce some reports and dashboards.

2.32 The primary software for managing and monitoring ambulance despatch, activity and location is the Computer Aided Despatch software (CAD). This programme incorporates a reporting module (Radius) which contains a series of dashboard reports which are used to display the live event situation at each of the CCCs. Radius also has bespoke reporting capability supporting user created reports.

2.33 The CAD reports are maintained by the CCC system administrator. Similar to the above, there is an absence of a report catalogue, entity relationship diagrams and meta data. We also note that there are no instructions, procedures or user guides in place to ensure continuity when the Administrator is away on leave.

2.34 Anecdotally, as no data is available to confirm this, the CCC system administrator estimates that producing and supporting CAD reporting takes up 25% of his time. We consider this a potential single point of failure. See **Matter Arising 4 in Appendix A**

2.35 Within WAST there are three options in use for modelling and forecasting; Optima, ORH and Prophet. The Trust currently produces 18 forecasts on a monthly basis. These are reviewed by operational management and feed into planning processes. The process of developing and refining these scripts and their outputs is continuously evolving

2.36 Prophet is Facebook open-source (freely available) time modelling software. The WAST model was developed in house by internal analysts using 'R', which is the preferred computer modelling language used by academia. This means that modelling solutions can be shared and verified by university academics and other peer groups if required.

2.37 Optima is a bespoke modelling software which is maintained on the Trust's behalf by the software provider. It has a high level of accuracy and captures geographical data which is necessary for constantly evolving demand prediction. There are two Optima analysts embedded within the Trust, tasked with predicting demand changes based on key scenario factors.

2.38 ORH is a consultancy service, primarily used to verify forecasts. WAST data is imported into Optima which produces a forecast. That forecast is then supplied to ORH who use their own tools to consider the accuracy of the forecast.

Conclusion:

2.39 WAST has a range of reporting and modelling tools at its disposal. The current ability to develop and produce forecast models in house is an effective way of controlling costs whilst providing vital insight into possible future demand. However, there are some matters that require attention, so we consider **Reasonable** assurance appropriate for this objective.

Objective 5: Data Quality – appropriate data quality management arrangements should be in place, including a policy with clearly defined roles and responsibilities, a framework for data sharing and adequate controls for all systems of data collection.

2.40 The majority of data is recorded automatically by the operational systems. Before data is input into the DW, it is first imported into a development warehouse server for testing and Quality Assessment (QA) (transformation and standardisation checks). The testing is undertaken by analysts, senior stakeholders and data engineers. Only after the data has been approved by all involved in the QA process is it imported into the DW and made available for reporting purposes (NB we have not tested this process as part of this audit).

2.41 There is a quality control function which is responsible for ensuring the accuracy of the datasets used to produce the statutory report for the Welsh Government. This is achieved through use of a suite of standard exception reports run weekly, which are then repeated monthly.

2.42 The quality control function has developed a technical guidance document which defines the meaning of the codes contained within the report. This is supplemented by an 'Official Statistics Incident Correction Guide', which provides guidance to staff members to ensure the data processed is accurate and shows a true reflection. It confirms that the Welsh Government report is designated as part of the 'National Statistics', and should comply with all aspects of the Code of Practice for Official Statistics.

2.43 It is important that the systems used to record calls and incidents are updated regularly to accurately capture the changing circumstances of live events as they develop and evolve. The quality assurance process start can start as soon as the call is closed. Each call is subject to 24 automated data checks, if any of these tests fail then the call is automatically reported as a 'cause for concern'. Part of the CCC Duty Manager role is to monitor, review and address these cases.

2.44 The CCC has 5 days to close these concerns, their access to which is removed after 5 days. Any calls that remain are reported to the CAD System Administrator to clear, noting that this work would not be performed when they are not available (**Matter Arising 4 in Appendix A)**. We were informed by the CAD System Administrator that they considered the level of cause for concern calls to be at an acceptable level, and that the overall quality of the data was good.

2.45 We noted the Health Informatics team leader considered a disproportionate amount of analyst time was spent correcting data errors identified when creating and producing reports, though there is no statistical information to confirm this. In

contrast the Performance and Modelling Lead Analyst considered the data quality suitable for his purposes, though they do caveat that data on live calls can be subject to change. We were informed there is no 'acceptable error rate' for any or all parts of the data stored. See **Matter Arising 5 in Appendix A**

Conclusion:

2.46 Correct levels of data quality are absolutely essential to any organisation looking to be data driven. Although there is some work necessary to establish required data quality levels and their achievement across the entire data range, we are satisfied the Trust devotes resources into achieving an acceptable data quality standard. We consider **reasonable** assurance appropriate for this objective.

Objective 6: Data Governance - the Trust is aware of where its data is and how it is aggregated and shared. Appropriate data governance should be in place to ensure that information remains accurate, consistent, timely and accessible.

2.47 Data protection and information governance requirements mean that access to data needs to be properly controlled. There is an Information Asset Register in place as part of WAST compliance with GDPR requirements which identifies its data assets, although we note that we haven't reviewed the IAR in detail as part of this review

2.48 We also note that as part of the GDPR and national IG compliance requirements, Data Protection Impact Assessments (DPIAs) are undertaken, and these are followed by the creation of Data Sharing Agreements for occasions where information is shared.

2.49 The Trust maintains a register of its DSAs. We reviewed the register and found that it contains the minimum necessary information relating to each agreement. However, it could be improved by capturing more detail on each request, including on the data being shared, how often it is shared, and whether the agreement is to be ongoing or is time limited. See **Matter Arising 6 in Appendix A.** We note that the report catalogue referred to in MA1 will assist in the maintenance of the register of DSAs and vice versa.

2.50 We also noted the register contains signs of recent management review activity, however the comments on some agreements indicate it is not fully up to date. E.G. We reviewed in November 2022, the comment on one agreement was it needed review in June 2022, with no evidence that this happened. See **Matter Arising 6 in Appendix A**

Conclusion:

2.51 Overall, we consider that the Trust aggregates, stores and maintains its data in an appropriate manner. It ensures accurate and timely information on its operations is readily available to internal and external stakeholders that are approved to access it with access managed using NADEX accounts. However, there are areas for improvement so we consider a **Reasonable** opinion appropriate for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Health Informatics Report Catalogue (Design)	Impact
The Health Informatics (HI) team have created over 400 reports. There is no catalogue that lists them available for users, including the data fields they contain, nor describes what they are intended to be reporting on. The report request process is not fully formalised and does not fully link to a report catalogue in order to prevent duplication. We noted there is no feedback information on the data and products provided to the stakeholders. There is management information on report production by reporting services, Qlik sense dashboards and Power BI Report usage. This covers basic use of each report and covers who, what, where and when existing reports are accessed. As it was accepted that there is duplication within the existing reports available this information could be used to further reduce the overall number of reports Additionally, there was no management information and analysis on the analytical report creation function, therefore cost and utilisation detail cannot be provided.	Potential risk of: • Duplication of effort • Wasted resource
Recommendations	**Priority**

1.1	A report (template) catalogue should be created and maintained. It should list all reports available, their purpose, the data fields they contain, and the parameters that can control the actual report production e.g. period, location etc. This can be supported by the MI on report production; if it has not been produced for over 12 months is it still needed, should it be archived?	**Medium**
1.2	The process of requesting a new or modified report should be formalised. It should include reference to the catalogue at 1.1 so that specialised analyst time is not wasted reproducing existing reports.	
1.3	Data on report production and usage should be maintained, and feedback from the requestor obtained. This should be used to maintain and limit the reports available to a manageable number of reports with their usage and priority recorded.	

Agreed Management Action		Target Date	Responsible Officer
1.1	A report catalogue is already in development. We will also set up a small selection of report templates to help speed up development, make self-serve easier for consumers, and streamline this report cataloguing effort.	April 2023	Jon Hopkins, Health Informatics Information Management
1.2	The recommendation is welcomed, and we will look to expand on the existing request process with a formalised (potentially guided self-serve) check of existing functionality, and an ability to decline requests if the content already exists in other places, or if not aligned with organisational priorities.	May 2023	Jon Hopkins, Health Informatics Information Management
1.3	We do already obtain some feedback on service and products, but will look to formalise the collection of this and the embedding of findings within the development cycle process, as well as create management KPIs around these metrics to take through Digital governance routes. However, a dependency here is the management of the HI HelpDesk inbox, and work to converge this with the ICT ServiceDesk inbox.	June 2023	Leanne Smith, Interim Director of Digital Services

<table>
<tr><th colspan="3">Matter Arising 2: Data Warehouse ERM and Meta Data (Operation)</th><th>Impact</th></tr>
<tr><td colspan="3">The Data Warehouse is the main repository of WAST data. The Data Warehouse Team has identified a series of tasks to improve performance, following a significant increase in workload due to COVID. The Team has created a list of objectives that need addressing, though no timescale or priority has been assigned for their completion. This includes to address the absence of a complete and up to date Entity Relationship Diagram and meta data for the data warehouse tables.</td><td>Potential risk of:
Duplication of effort
Wasted resource in report generation</td></tr>
<tr><th colspan="3">Recommendations</th><th>Priority</th></tr>
<tr><td>2.1

2.2</td><td colspan="2">There should be a series of Entity Relationship Models available covering all of the tables in the data warehouse.

All tables should have a completed meta-data table describing their contents.</td><td>Low</td></tr>
<tr><th colspan="2">Agreed Management Action</th><th>Target Date</th><th>Responsible Officer</th></tr>
<tr><td>2.1- 2</td><td>We will develop an ERD library, including meta-data, starting with EMS CAD. We will plan out a roadmap for this exercise to expand into the other systems supporting EMS, Ambulance Care, 111 and Corporate teams around the organisation, to build up a full WAST ERD library and meta-data source.</td><td>March 2023 for EMS CAD

July 2023 for completion of roadmap exercise</td><td>Jon Hopkins, Health Informatics Information Management</td></tr>
</table>

Matter Arising 3: Qlik Sense Legacy Software Replacement (Operation)			Impact
The Qlik Sense software was procured in 2016. It is now out of vendor support and upgrades are not available for this product. Legacy software can present serious cyber security weaknesses requiring costly and continuous remediation. We were advised by HI that replacing this software could cost 6 figures, however it may be possible to replace this functionality with Power BI that is already in use within WAST.			Potential risk of: • Legacy software cyber security risks.
Recommendations			**Priority**
3.1	A programme to replace all of the Qlik reports with Power BI equivalents should be scoped and completed. Qlik should then be decommissioned and removed.		**High**
Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	A risk-assessment will be conducted to understand the exposure to WAST of Qlik Sense being out of vendor support. This platform is not internet facing (i.e. for internal users only, not on a publicly accessible web url), and not believed to present an information security risk, but pending ICT assessment, we will devise a mitigation plan, or an options appraisal for maturity. In the meantime, there is already a programme of work to migrate reports and dashboards to PowerBI. However, this is a lengthy and high-capacity activity, and is not prioritised highly at this current time.	March 2023 for risk assessment March 2024 for PowerBI migration (dependent on inclusion in IMTP)	Aled Williams, Head of ICT

Matter Arising 4: CCC System Administrator Continuity (Design)			Impact
The CAD reports are maintained by the CCC system administrator. There is no catalogue of these reports, nor entity relationship diagrams or meta data for CAD. We note that there are no instructions, procedures or user guides for the reporting role in place to ensure continuity when the Administrator is away on leave. Anecdotally, as no data is available to confirm this, the CCC system administrator estimates that producing and supporting CAD reporting is taking 25% of their time. We consider this a potential single point of failure. The CAD system administrator role in maintaining data quality, by clearing calls generating 'cause for concern', is not carried out when they are not available.			Potential risk of: • Single point of failure.
Recommendations			**Priority**
4.1	The reporting and administration tasks completed by the CCC system administrator should be recorded and used to produce user guides and procedure documents.		High
4.2	Recognising that the CAD system is essential to the Trust's EMT operations, the Trust should establish appropriate cover for the CCC system administrator role to ensure continuity when they are not available, e.g. away on leave.		
Agreed Management Action		**Target Date**	**Responsible Officer**
4.1 - 2	We are in agreement that the CCC System Administrator is a potential single point of failure for the correction of incident data in the CAD ahead of the official statistics submissions. However, some members of ICT are trained in supporting and can perform some CAD actions to mitigate for this data quality issue. We will support the System Administrator in producing guidance documents of the processes followed.	April 2023 (acknowledgement that this activity is important but that it is the single specialist who must action it)	Aled Williams, Health of ICT

<table>
<tr><th colspan="3">Matter Arising 5: Defining Data Quality Accuracy Levels (Operation)</th><th>Impact</th></tr>
<tr><td colspan="3">We noted the Health Informatics team leader considered a disproportionate amount of analyst time is spent correcting data errors identified when creating and producing reports, though there is no statistical information to confirm this.

We were informed there is no ‘acceptable error rate’ / defined data quality levels for any or all parts of the data stored.</td><td>Potential risk of:

Data quality issues threaten the validity of every decision made based on the data.</td></tr>
<tr><th colspan="3">Recommendations</th><th>Priority</th></tr>
<tr><td>5.1

5.2</td><td colspan="2">A defined quality (accuracy) level should be established for all data fields, so that particular focus can be made on those determined as being key, e.g., patient identifiers have to be 100% accurate.

Acceptable error rate(s) should be agreed and processes put in place or improved, so that Trust data reaches the agreed accuracy levels.</td><td>Low</td></tr>
<tr><th colspan="2">Agreed Management Action</th><th>Target Date</th><th>Responsible Officer</th></tr>
<tr><td>5.1 - 2</td><td>It should be noted that we have only 0.4 WTE capacity in this specialist function and so any activities around data quality management improvements will not be able to be completed quickly. However, we will commit to review our Data Quality Policy, adding in detail regarding the minimum level of acceptable accuracy and error rates for key fields where appropriate.</td><td>August 2023</td><td>Leanne Smith, Interim Director of Digital Services</td></tr>
</table>

<table>
<tr><th colspan="3">Matter Arising 6 Data Sharing Agreement Register (Operation)</th><th>Impact</th></tr>
<tr><td colspan="3">The Trust maintains a register of its data sharing agreements. We reviewed the register and found that it contains the minimum necessary information relating to each agreement. However, it could be improved by capturing more detail on each request, including information on the data being shared, how often it is shared, and whether the agreement is to be ongoing or is time limited.

We also noted the register contains signs of recent management review activity, however the comments on some agreements indicate it is not fully up to date.</td><td>Potential risk of:

• Data protection act breaches.</td></tr>
<tr><th colspan="3">Recommendations</th><th>Priority</th></tr>
<tr><td>6.1

6.2</td><td colspan="2">The data sharing agreements register should be enhanced to capture more detail on each request.

The register should be reviewed regularly to ensure it is up to date.</td><td>Low</td></tr>
<tr><th colspan="2">Agreed Management Action</th><th>Target Date</th><th>Responsible Officer</th></tr>
<tr><td>6.1 - 2</td><td>We have a very small Data Protection Compliance function, currently with vacancies. We commit to reviewing the data sharing register and including review dates, but note that this is a lower priority recommendation, and will be contingent on building resilience and capacity within this specialist function in the coming months. This action will therefore be managed by the Information Governance Steering Group (IGSG).</td><td>September 2023 (dependent on filling current vacancies)</td><td>Leanne Smith, Interim Director of Digital Services, via IGSG</td></tr>
</table>

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:

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

Prioritisation of Recommendations

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

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

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

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Standards of Business Conduct: Declarations

Final Internal Audit Report

December 2022

Welsh Ambulance Services NHS Trust

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Executive sign-off:	Trish Mills, Board Secretary
Distribution:	Caroline Jones, Corporate Governance Officer Alex Payne, Corporate Governance Manager Liz Rogers, Deputy Director of Workforce & OD Julie Boalch, Head of Risk / Deputy Board Secretary
Committee:	Audit Committee

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

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Executive Summary

Purpose

To review compliance with the Standards of Business Conduct, including arrangements in place to manage declarations of interest, gifts and hospitality.

Overview

We have issued limited assurance on this area.

The significant matters which require management attention include:

- Absence of a central Declaration of Interest (DOI) register in line with other NHS Wales bodies.
- The gifts and hospitality register requires strengthening.
- Completeness and accuracy of declarations of interest submissions.
- Non-compliance relating to the completion of gifts and hospitality forms; and
- Lack of due diligence checks on declarations.

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

Report Classification

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

Assurance summary[1]

	Assurance objectives	Assurance
1	Policy and procedures	Reasonable
2	Completion of declarations of interest	Reasonable
3	Declarations of interest register and reporting	Limited
4	Declarations of gifts, hospitality and sponsorship	Limited

Key matters arising

	Key matters arising	Assurance Objectives	Control Design or Operation	Recommendation Priority
1	Policy overdue for review	1	Operation	Medium
2	Staff awareness of DOI requirements	2	Design	Medium
3	Due diligence checks	2	Design	Medium
4	Completion of DOI forms	2	Design	Medium
5	DOI register	3	Design	High
6	Completeness of gifts & hospitality register	4	Design	Medium
7	Completion of gifts & hospitality forms	4	Operation	High

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

1. Introduction

1.1 The Welsh Government's Citizen-Centred Governance Principles apply to all public bodies in Wales. These principles integrate all aspects of governance and embody the values and standards of behaviour expected at all levels of public services in Wales.

1.2 All Health Boards and Trusts should have a Standards of Behaviour Framework in place that sets out the arrangements for ensuring that all staff comply with the principles, including recording and declaring potential conflicts of interest and handling of gifts, hospitality, and sponsorship.

1.3 The risks considered during the review were as follows:

i. Personal interests and/or the receipt of gifts and hospitality could consciously or unconsciously affect decisions made within the organisation if not identified and managed effectively;
ii. Breach of mandatory regulations; and
iii. Individuals and the organisation could be exposed to allegations of fraud, bribery or corruption if they are not seen to be transparent in how potential conflicts of interest are handled.

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	4	0	5
Operating Effectiveness	1	1	0	2
Total	2	5	0	7

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

Audit objective 1: The Trust has appropriate and up to date policies and procedures in place, and these are widely available to all relevant parties.

2.3 The Trust has in place a Gifts and Hospitality Policy (the policy), which incorporates DOIs, gifts, hospitality & sponsorship, and is available for all employees and Non-Executive Directors via the Trust's SharePoint site. The policy (approved in 2018) was due for review in September 2021. **See MA1**

2.4 The policy generally is consistent with those in place at other NHS Wales Bodies and it is acknowledged that the Board Secretary is looking to enhance the policy to reflect good practice, including:

- Flowcharts and summary guidance on how to declare interests, gifts, or sponsorships, and the regularity of such.
- Defining certain groups of staff deemed high risk (including Chair, Chief Executive, Non-Executive Directors, Directors and certain members of senior management), who will then be required to complete declarations annually; and
- A do's and don'ts list for accepting gifts.

Conclusion:

2.5 Whilst there is a policy which outlines the Trust's approach to DOIs, Gifts, Hospitality and Sponsorship, it's overdue for review. We acknowledge that plans are in place to update and enhance the policy therefore, we assign **reasonable assurance** to this objective.

Audit objective 2: Arrangements are in place to ensure that specific group of employees and Non-Executive Directors complete a Declaration of Interest Form on initial employment with the Trust, and at periodical intervals thereafter.

2.6 An email is circulated annually to request all Board members to complete their declaration of interest (including nil returns, where applicable). A reminder email is issued by the Corporate Governance Team to those who have not submitted their return in a reasonable timeframe. For all other employees, an annual reminder is issued via the Trust newsletter (Siren), providing a link to the policy. It is acknowledged that there is an intention to include 'decision makers' in the form circulation, however, the members of senior management and staff to be classed as such needs to be defined by the Executive Management Team (EMT) (see **MA1**)

2.7 New Board members are provided with an induction pack, which includes the policy and associated forms to make any declarations of interests. However, we were unable to identify how the policy, and its requirements, are appropriately signposted to all other new employees. **See MA2**

2.8 All DOI forms completed by Board members are submitted, for central retention, to the Corporate Governance Team where they are checked for appropriate completion. We note that the Board Secretary undertakes checks on these declarations, including review of Companies House records, prior to inclusion within the Annual Report. However, evidence of all checks was not retained. **See MA3**

2.9 All other employees are required to submit their forms to their line managers who retain them locally. However, the Corporate Governance Team is reliant on colleagues to ensure this happens. There are currently no practical means by which the Team can confirm that all such required declarations have been made,

nor requirement under the current policy, and therefore identify any missing declarations.

2.10 We note that plans are in place for the DOI forms to be made electronic, which will enable data from 'decision-makers' (see para 2.6) returns to be held centrally. We have observed arrangements in other NHS Wales Bodies where the annual PADR process requires confirmation over DOIs, for all staff, which results in a more comprehensive and complete register. Another example includes the use of the conflicts of interest declarations functionality within ESR. **See MA4**

Conclusion:

2.11 There is an annual reminder for existing Board members to submit DOI returns, and new Board members are required to complete forms during induction. Further work is also required to define other 'key decision makers' in the Trust. For all other staff, upon appointment, improvements for the signposting of such key documents are required. The Corporate Governance team is reliant on colleagues to ensure DOI returns are completed, but we do recognise that the Trust is looking to introduce an electronic version of the form. We also highlight the need to retain evidence of the checks undertaken to ensure the completeness of records. In consideration of these points, we assign **reasonable assurance** for this objective.

Audit objective 3: The Trust has an up-to-date register of interests in place and the content is reported to an appropriate committee at agreed intervals.

2.12 Unlike other NHS Wales Bodies, it was identified that, at the date of fieldwork, the Trust did not maintain a central register of interests (**see MA5**)**.** It is, however, recognised that the Trust has recently developed a register of interests and we were provided with a copy towards the end of fieldwork.

2.13 As per para 2.10, review of the registers held within other NHS Wales Bodies noted that the centrally held registers were not exclusive to Board members (as is currently maintained at the Trust), but expanded to include 'high risk' employees and decision makers. The registers also capture secondary employment and include content on the mitigating actions being undertaken to manage and avoid conflicts arising for ongoing monitoring. We recognise that secondary employment may not be as relevant for Trust staff, but the intention to consider should be addressed and evidenced noting recent Counter Fraud investigations into cases of this nature.

2.14 The policy also states that there is a requirement for senior staff declarations of interest to be reviewed by the Audit Committee and published each year. We are able to confirm that these policy requirements have been met, through inclusion within the Trust's annual report. We note the detail published publicly is limited to Board members, consistent with other NHS Wales bodies.

2.15 We also noted that at the beginning of the Board and committee meetings, members (and those in attendance) will be invited to declare their interests in

relation to any items on the agenda. It is noted that the Board Secretary is looking to improve the effectiveness of this current process.

Conclusion:

2.16 A register of interests has recently been developed but is currently limited to Board members, whereas other NHS Wales Bodies also include decision makers. Until resolved, and embedded into practice, we view this as a high-risk area and therefore **limited assurance** has been assigned for this objective.

Audit objective 4: Processes are in place to ensure that employees and Non-Executive Directors declare any offers of a gift, hospitality or sponsorship, which requires recording.

2.17 We have reviewed the gifts and hospitality registers maintained for 2021/22 and 2022/23. We noted that the format of the register could be enhanced to capture all the information from the Trust's gift and hospitality form (**see MA6**), with the following omissions noted:

- date offered;
- donated by / source of hospitality;
- employee in receipt of gift/hospitality; and
- approving officer for the gift/hospitality.

2.18 The form is expected to be completed for both acceptance and refusal of gifts / hospitality.

2.19 Testing was undertaken on all forms received (nine in total, two of which were refusals), for the same time period, to ensure completeness and appropriate authorisation. A number of issues were noted. **See MA7**

2.20 In common with other NHS Wales Bodies, and consistent with the DOI process (para 2.9), the Corporate Governance Team is reliant on colleagues to ensure all gifts, hospitality and sponsorship forms are completed and submitted as per the policy.

2.21 The policy states that '*the Board Secretary will retain…..a central Register of Gifts and Hospitality which is presented annually to the Audit Committee*'. From review of minutes for the previous 12 months, there was no evidence of such. However, we note that the Audit Committee Cycle of Business now includes a standing agenda item (on an annual basis) for DOIs and gifts and hospitality. On this basis we have not raised a recommendation in our report.

Conclusion:

2.22 Whilst there is a central gifts and hospitality register in place, its format and content does require strengthening. Our testing of forms submissions identified a number of compliance issues. Action has been taken to ensure the register will be presented to the Audit Committee going forward. We consider this to be a significant ongoing risk and therefore assign **limited assurance** for this objective.

Appendix A: Management Action Plan

Matter arising 1: Policy overdue for review (Operation)	Impact
The Trust's Gifts and Hospitality Policy, which incorporates DOIs, gifts, hospitality & sponsorship, has surpassed its review date (scheduled September 2021). The policy generally is consistent with those in place at other NHS Wales Bodies and it is acknowledged that the Board Secretary in looking to enhance the policy to reflect good practice. This will include defining certain groups of staff deemed high risk, who will then be required to complete declarations annually.	Potential risk of: • undeclared conflicts resulting in financial loss. • inaccurate recording of conflicts of interest.

Recommendations		Priority
1.1	The Trust should review and update the Gifts and Hospitality policy for ratification by the Audit Committee.	Medium

Management response		Target Date	Responsible Officer
1.1	A Standards of Business Conduct Policy and accompanying forms, guidance and communication will be developed.	6 June 2023 Audit Committee for endorsement and thereafter approval by Board	Board Secretary

Matter arising 2: Staff awareness of DOI requirements (Design)		Impact
A review of other NHS Wales organisations identified that information / requirements regarding gifts, hospitality and declarations of interest are communicated through the induction process or staff handbooks. Aside from new Board members, who are issued with an induction pack on appointment which provides such information on the Trust's policy and expectations for initial (and ongoing) declarations, there is no guidance for new employees within the Trust.		Potential risk of: • undeclared conflicts resulting in financial loss. • inaccurate recording of conflicts of interest.
Recommendations		**Priority**
2.1 Policies and procedures, including the requirements of the Gifts and Hospitality policy, should be appropriately communicated to all new employees upon appointment, to ensure they are familiar with the requirements.		Medium
Management response	**Target Date**	**Responsible Officer**
2.1 Staff have access to policy information they need via Siren. We will include the policies in the Learner Handbook for Operational staff who train when joining through the Training and Education Team. These are signed to say they have been read and understood. We will add the policies to the local induction list for new starters.	1 June 2023	Deputy Director of Workforce & OD

Matter arising 3: Due diligence checks (Design)	Impact
Prior to inclusion in the Annual Report, completeness of the form received from Board members is verified by the Board Secretary. Evidence provided was in relation to review of Companies House records, but only for two Board members (noting further clarification was sought from them). We understand that other checks are also undertaken, including a review Charity Commission records for disqualified trustees. However, the output of this was not retained.	Potential risk of: • undeclared conflicts resulting in financial loss. • inaccurate recording of conflicts of interest. • conflicts of interest not being appropriately managed.

	Recommendations	Priority
3.1	Evidence to demonstrate the verification process undertaken as part of the annual eligibility checks should be retained centrally.	Medium

	Management response	Target Date	Responsible Officer
3.1	Separate folders have been created in a confidential folder for each Board member. Board member declarations will be checked against Companies House records and the disqualified trustees' reviews at the Charity Commission following their annual declarations.	1 June 2023	Board Secretary

Matter arising 4: Completion of DOI forms (Design)	Impact
Board members are required to complete a declaration of interest form on initial employment with the Trust and at periodic intervals thereafter. In addition, the Trust's standards mandate that all members of staff should declare interests which could impact on the activities of the Trust, regardless of their grade or role. The Board Secretary and the Corporate Governance team is reliant on colleagues to ensure this happens and reminder emails and publications in the Trust newsletter are made to remind them. There is no set process which allows the Corporate Governance Team to be certain that all required declarations have been made, and nor is there an expectation under the current policy for the team to do so. Therefore, it is difficult to identify any missing declarations. We note that plans are in place for the declarations form to be electronic, where the data can be held centrally, and that it is the Trust's intention to introduce for the 'decision-makers' first before rolling out further across all staff. We have observed the arrangements in place at other NHS Wales Bodies where the annual PADR process requires confirmation over declarations of interest, which results in a more comprehensive and complete register. Another example included the use of the conflicts of interest declarations functionality within ESR.	Potential risk of: • undeclared conflicts resulting in financial loss. • inaccurate recording of conflicts of interest. • conflicts of interest not being appropriately managed.

Recommendations	Priority
4.1 Management should determine and implement a solution to ensure the completeness and accuracy of declarations of interest, including nil returns. 4.2 Consideration should also be given to introducing a tracking system and reporting the results, including declarations requested but outstanding, to an appropriate forum e.g., Audit Committee.	Medium

Management response		Target Date	Responsible Officer
4.1	Initially ‘decision makers’ will be targeted for completing of declarations of interest and the register of those decision makers will be held centrally by the Board Secretary.	30 June 2023	Board Secretary
4.2	The ‘decision makers’ will be a finite known cohort and initially their declarations will be captured via Microsoft Forms to allow for tracking and escalation.	30 June 2023	Board Secretary

Matter arising 5: DOI register (Design)	Impact
Review of other NHS Wales Bodies noted that the centrally held registers were not exclusive to Board members, but expanded to include 'high-risk' employees and decision makers and also referenced disclosure for secondary employment where applicable. The Trust currently only lists the interests for only Board members within the detail of the Annual Report. We acknowledge that a formal register for this information was being developed and we were provided with a copy towards the end of fieldwork. It was noted that this register remained limited to Board members and there is an opportunity to enhance and include content on the mitigating actions being undertaken to manage and avoid conflicts arising from declarations for ongoing monitoring. The responsibility sits with the individual and line manager to ensure no conflict arises. We noted that there is an option to disclose secondary employment in this register and, whilst we recognise that this may not be as relevant for Trust staff, the intention to consider should be addressed and evidenced noting recent Counter Fraud investigations into cases of this nature.	Potential risk of: • conflicts of interest not being appropriately managed. • Breach of Trust policy.

Recommendations		Priority
5.1	The Trust should look to implement a centrally maintained register which includes the DOIs of all 'high risk' staff and decision makers, not limiting the register exclusively to Board members.	High
5.2	The Trust should also ensure mitigating actions to manage conflicts of interest arising from declarations are captured and arrangements put in place to monitor their implementation.	

Management response		Target Date	Responsible Officer
5.1	See 4.1 and 4.2 management responses above	30 June 2023	Board Secretary
5.2	Mitigating actions will be captured where that is possible i.e. on declaration of secondary employment. However, it is not always possible, because the declaring of an interest does not of itself make it a conflict. The standards of	6 June 2023	Board Secretary

business conduct policy includes detail on when a conflict arises and how it should be managed. That policy will be completed in line with management response 1.1	Audit Committee for endorsement and thereafter approval by Board

Matter arising 6: Completeness of the gifts & hospitality register (Design)	Impact
The Trust has a gift and hospitality register in place. On review we noted that the format of the register fails to capture the majority of the information from the Trust's gift and hospitality form, including: • date offered; • donated by / source of hospitality; • Trust employee in receipt of gift/hospitality; • details of initial action taken by the individual; and • approving officer of the gift/hospitality.	Potential risk of: • Inaccurate recording of gifts and hospitality received. • Breach of Trust policy.

Recommendations		Priority
6.1	The Trust should enhance the gift and hospitality register to ensure appropriate detail is captured.	Medium

Management response		Target Date	Responsible Officer
6.1	The gifts and hospitality form and the register will be redesigned in line with the new policy.	30 June 2023	Board Secretary

Matter arising 7: Completion of gifts & hospitality forms (Operation)	Impact
Testing was undertaken on the gift and hospitality forms for 2021/22 and 2022/23, 15 forms in total, to confirm they were completed appropriately. The following exceptions were identified: • a discrepancy was identified where donations made for similar items (8 items) were entered as one entry within the register, even though they were donated by separate entities (7 from one organisation, 1 from a different organisation); • two forms were not signed as authorised by a line manager; • one form was authorised by the member of staff declaring the gift; • 12 forms were not signed off by the Board Secretary as required; and • eight forms were not completed in a timely manner – seven were completed 16 months after the gift was received, and one 20 months after receipt.	Potential risk of: • Inaccurate recording of gifts and hospitality. • Gifts and hospitality received are not appropriately managed. • Breach of Trust policy.

Recommendations	Priority
7.1 Management should remind all staff of the requirements of the Gifts and Hospitality policy, and that completed forms should be submitted to Corporate Governance in a timely manner for review. 7.2 Management should return incomplete forms to ensure all required information is captured.	High

Management response	Target Date	Responsible Officer
7.1 Accepted. The standards of business conduct will include a plan of communications on this.	1 August 2023	Board Secretary
7.2 Accepted.	30 June 2023	Board Secretary

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:

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

Prioritisation of Recommendations

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

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

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

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IMTP Delivery

Internal Audit Report

February 2023

Welsh Ambulance Services NHS Trust

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Committee:	Audit Committee

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

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Executive Summary

Purpose

The focus of the review was to examine the governance framework and operations of the Strategic Transformation Board (STB) and its constituent programmes, and to assess their effectiveness in delivering the change programme set out in the Trust's Integrated Medium Term Plan (IMTP)

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- Lack of documented programme quality management activity.
- Instance of an absence of a transformation programme level plan.
- Instances of absence of programme benefit realisation plans.

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

Report Classification

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

Assurance summary[1]

	Assurance objectives	Assurance
1	IMTP priority mapping	Reasonable
2	Delivery programme measures and milestones	Reasonable
3	Escalation of issues and risks	Reasonable
4	Oversight and monitoring	Reasonable

Key matters arising

	Key matters arising	Assurance Objectives	Control Design or Operation	Recommendation Priority
1	Programme quality management	1	Design	Medium
2	Transformation programme level plans	2	Design	Medium
3	Programme benefit realisation plans	2	Design	Medium

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

1. Introduction

1.1 The Integrated Medium Term Plan (IMTP) is a three-year strategic plan which all health boards and trusts are required by Welsh Government to produce. They are expected to be the organisations formal response to the challenges and opportunities facing NHS Wales. Welsh Government expect each organisation's internal mechanisms to provide visible and robust assurance to the Board on delivery and any necessary corrective action.

1.2 In accordance with expectations from Welsh Government, the Trust submitted its 2022/25 IMTP on 31 March 2022 following its approval by the Board on 24 March 2022. This was formally approved by Welsh Government on 13 July 2022. This plan is the vehicle by which the Trust articulates the steps it will be taking over the next 3 years to move towards achieving its long-term strategic ambitions and goals.

1.3 The Trust has underway a range of innovations that, over the course of the IMTP period, will radically change the way in which its services are delivered. These changes are being delivered through a set of transformation programmes, reporting to the Strategic Transformation Board (STB). The STB reports to the Finance and Performance Committee (FPC) to provide detailed assurance around IMTP delivery and then onwards to the Trust Board.

1.4 The IMTP has been subject to internal scrutiny and assurance and the Transformation Programme deliverables it includes and the model which is to be used to deliver them have received internal and external ratification through Welsh Government and commissioner approval.

1.5 The Trust is currently advancing 13 transformation and enabling programmes of work. At the date of fieldwork, seven programmes were fully operational and we selected a sample of three which management advised were the most advanced:

- **EMS Operational Transformation (EMS)** – to deliver improved 999 patient safety and experience, as defined by a range of performance parameters, through a combination of investment, efficiencies and effectiveness;
- **Ambulance Care Transformation (ACT)** – to deliver the NEPTS improvement plan, Transport Solutions Programme and All-Wales Transfer and Discharge Service); and
- **Gateway to Care Transformation (G2C)** – to deliver 111 to be the 'Gateway to Urgent and Emergency Care', working seamlessly with the 999 service supported by a national integrated clinical assessment hub within WAST.

1.6 The overall risk considered in the review was that the achievement of the Trust's strategic ambitions could be impacted by ineffective delivery structures.

2. Detailed Audit Findings

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

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

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

Audit objective 1: The service transformation programmes are appropriately mapped to the IMTP priorities and an appropriate framework is in place to manage their delivery.

2.3 Transformation Programme Boards have been established to plan and implement the associated key programmes of work that underpin the Trust's Long Term Strategic Framework, "Delivering Excellence", and the core deliverables outlined in the IMTPs for 2021/22 – 2023/24 and 2022/23 – 2024/25.

2.4 We noted that IMTP priorities are mapped to programme boards by way of grouping similar themed deliverables e.g., the G2C programme seeks to bring together a range of core workstreams that contribute to achieving the Trust's strategic ambitions as the main gateway and access point to urgent & emergency care across Wales.

2.5 The Trust employs the Managing Successful Programmes (MSP) methodology to manage the development and delivery of the programmes. Each programme is made up of a number of projects / workstreams (see **Appendix B** for details of those associated with the programmes reviewed at this audit); and there is a generic reporting framework in place, which includes:

- Project team / workstream reporting to their specific Programme Board;
- All Programme Boards reporting to the STB; and
- STB reporting to the Finance and Performance Committee.

2.6 For each of the sampled programmes, we reviewed their respective Project Initiation (PID)/ Definition (PDD) documents and noted each covered the following aspects in their project documentation:

- goals and targets of the programme;
- programme benefits (also refer to ***audit objective 2***);
- reporting arrangements (also refer to ***audit objective 3***); and

- programme risk management (also refer to ***audit objective 4***).

2.7 We noted, however, that the documents did not include sections describing programme quality management measures (see **Matter arising 1**).

Conclusion:

2.8 Service transformation programmes have been established as a framework for the delivery of the Trust's IMTP priorities. The programmes are delivered through group / workstreams with similar themed deliverables and a clear project methodology has been established for their development and delivery. Therefore, we have provided **reasonable** assurance for this objective.

Audit objective 2: There is a clear programme of delivery, with defined measures and milestones for each of the service transformation programmes.

2.9 For each of the sampled programmes, we reviewed the expectations within the respective PIDs/PDDs for deliverable planning / scheduling documentation and benefit planning. Our expectation of the programme planning documentation is that it show both a representation of *target* scheduling of milestones and *actual* delivery of these in order that slippage can be visible and addressed. Our review of these areas noted the following:

Programme	Programme level plan in place	Evidence of programme reporting	Benefits described	Benefits quantified	Benefit realisation plan
EMS	✓	✓	✓	✓	X [1]
ACT	✓	✓	✓	X [2]	X [2]
G2C	X [3]	✓	✓	X [3]	X [3]

[1] At the EMS programme, 4 of the 5 workstreams were reported as 'on track' at the date of fieldwork. Whilst programme benefits are described e.g. *'Reduced roster abstractions, in particular, sickness absence'*, the targets are quantified (from current baseline level to new level) in some, but not all cases. Also, we noted there was no clear benefit realisation plan describing the method of assessing benefit achievement, timing of the realisation work or success criteria. See **Matter Arising 3.**

[2] At the ACT programme, 10 of the 17 workstreams were reported as 'on track' at the date of fieldwork. Programme benefits e.g., *'the ability to convey more eligible patients whilst remaining within the resource envelope'* are only described in a narrative form (see **Matter Arising 3**). Some benefits that relate to operational areas of activity are already monitored through processes such as the monthly Integrated Quality & Performance report (MIQPR) and could potentially be proven through this reporting, but the programme, otherwise, has no benefit realisation plan.

[3] At the G2C programme, 13 of the 17 workstreams were reported as 'on track' at the date of fieldwork. However, there is no project plan (monthly / quarterly scheduling of the programmes deliverables in a plan) at programme level (see **Matter Arising 2**). We also noted that whilst programme benefits are described and metrics are identified, there are no targets in place against which achievement can be evaluated (see **Matter Arising 3**).

Conclusion:

2.10 Programmes typically schedule their deliverables, monitor progress against these schedules and regularly report workstream status of delivery. Programme benefits are documented but targets are not always set by which these can subsequently be measured. Benefit realisation plans are also not employed in a consistent manner. Noting this, **reasonable** assurance has been provided for this objective.

Audit objective 3: There are appropriate escalation procedures in place for issues and risks, and agreed action is taken where performance varies from planned delivery.

2.11 From review of the sampled transformation programmes, the following management / documentation procedures for issues and risks were noted:

- Projects / workstreams manage risks and issues as a part of their ongoing project management activity, which includes risks / issues reported within highlight reports which are presented to their 6-weekly respective programme board meetings;
- Programme board meetings include a discussion of such risks / issues, through which programme level risk registers are updated; and
- Risks / issues that require escalation are reported by the programme boards to STB and onward to the Finance & Performance Committee - with updates to the Corporate Risk Register for changes / developments, if applicable. Mitigations will also be determined at this level where appropriate.

2.12 Programme level risk registers are informed by those of the projects / workstreams. Risks that cannot be managed and mitigated at programme level, or have potential impacts on the broader transformation programmes e.g., slippage (see ***audit objective 2***) are escalated in the programmes highlight reports to the STB for consideration. Programme risk registers reviewed included the following:

- EMS: programme wide risks and red risks from programme projects;
- ACT: combined risk register including both programme and project/workstream level risks; and
- G2C: programme level risk register, informed by the project/workstream risk updates.

Conclusion:

2.13 Programme risk registers are appropriately maintained and there is an appropriate escalation procedure in place. Recognising our review was limited to the programme-level risk management document, we have provided a **reasonable** assurance rating for this objective.

Audit objective 4: There is regular oversight and monitoring of the progress of IMTP delivery, including escalation through to the Board.

2.14 We noted the following generic features in the scheduling of deliverables for the transformation programmes reviewed:

- IMTP deliverables are scheduled in the IMTP tracker on a quarterly basis, which correlates with the plan set by the Executives. Actual delivery activity is monitored and reported against this plan;
- Deliverables / products of the programmes are scheduled in various different programme documents which provide a high-level picture of their delivery plan;
- Status of key project milestones / activity dates, through the use of RAG coding or 'on/off track' labelling, is reported in each of the project highlight reports to their respective programme boards (see para 2.18); and in the highlight reports of the programme boards to the STB, and scrutinised accordingly; and
- Programme delivery achievement updates are recorded in programme highlight reports to the STB and in highlight reports from the STB to the Finance & Performance Committee.

2.15 As per audit objective 3, we noted there is regular reporting, to appropriate forums and the Board on the progress of the delivery of the transformation programmes.

2.16 Review of the highlight reports produced for the sampled projects noted the use of standard templates throughout, with only minor variations to these being observed.

2.17 For all programmes, there is an expectation to report regularly to the STB. At the date of fieldwork, eight STB meetings had been held since the beginning of the financial year. Written highlight reports had been prepared by each sample programme for at least three of the meetings, with minutes indicating that verbal progress reports had been provided at other meetings.

2.18 We also reviewed the mechanisms through which oversight groups, at the different levels in the broader programme and corporate structure communicate actions that arise from their review work of the individual programmes:

Programme	Programme level action log	Overdue actions
EMS	✓	✓ (<3 months overdue)
ACT	✓	✓ (>6 months overdue) [1]
G2C	✓	✓[2]

[1] These are actions (4) related to the Grange University project closure report.

[2] These are actions (3) which are open but where there is no target date recorded.

Conclusion:

2.19 We noted no significant issues related to oversight and monitoring. Noting the recommended enhancement for the programme action log, **reasonable** assurance has been provided for this objective.

Appendix A: Management Action Plan

Matter arising 1: Programme quality management (Design)	Impact
Project quality management is a process that considers how a project should proceed to achieve the desired quality for the project's deliverables. It requires project managers to continually measure the quality of the activities and processes involved in the project. In project quality management, standards are set ahead of time to measure deliverables against, and action needs to be taken throughout the project to correct, if necessary. The scope of quality management should cover all aspects of the programme (including its projects and transformation activities) to ensure they are appropriate and fit for purpose. This will enable stakeholders to be assured that the planned benefits have the best chance of being realised. The 'Managing Successful Projects' (MSP) programme methodology, as used by the Trust, provides Project Description Document (PDD) templates which include a Quality Management section. However, we noted two of the three sample transformation programmes did not include in their PDD's a quality management activity.	Potential risk that programme deliverables do not attain the desired quality standards and that this is not identified and rectified.

Recommendations		Priority
1.1	The PDDs of the sample programmes should be enhanced to include a Quality Management element to assure the quality of the programme and its deliverables.	Medium

Management response		Target Date	Responsible Officer
1.1	This recommendation is accepted. We will define the quality standards to be implemented across all projects and programmes as part of the development of the project and programme management framework and will consider how we define quality measures for project deliverables for the delivery of the next iteration of the IMTP. This will commence with a framework workshop by the end of April to determine the actions required to put this in place.	30 April 2023 (NB this is longer than 1 month to account for IA affecting workshop attendees)	Heather Holden, Head of Transformation

Matter arising 2: Transformation programme level plans (Design)			Impact
For one of the three transformation programmes sampled (Gateway to Care programme), it was noted that there is no project plan (monthly / quarterly scheduling of the programmes deliverables in a plan) at programme level. Whilst we appreciate that programme board meetings regularly review project / workstream deliverables status, a programme level deliverables plan combining the deliverables of all projects / workstream could increase the effectiveness of oversight of this aspect, and potentially identify unforeseen impacts of any project level deliverable slippage arising from interdependencies between these.			Potential risk that programme deliverables will fail to meet delivery targets which may have consequences for the success of this or other transformation programmes.
Recommendations			**Priority**
2.1	The G2C programme board should implement a programme level deliverables plan to assure the management of dependencies in the event of individual project / workstream slippage or other development; and that this is universally implemented across the transformation programmes of the Trust.		Medium
Management response		**Target Date**	**Responsible Officer**
2.1	Currently programme level plans are included within the overarching reporting via STB. With specific plans developed at project level. We will therefore develop a detailed G2C Programme Action Plan (Milestone timeline aligned to IMTP deliverables) with project Gantt charts feeding into this timeline.	31 March 2023	Kelsey Rees-Dykes, Planning and Performance Business Partner

Matter arising 3: Programme benefit realisation plans (Design)	Impact
For the three programmes sampled at this review, we noted that the area of programme benefit realisation plans were in place, but to varying degrees. Generally, benefits were identified in programme documentation, were described, and the metrics that would be used to identify them were quantified. However, not in all cases were there targets set that the programme was seeking to achieve. We also noted, in each of the sample programmes, there was no clear benefit realisation plan in place. This plan should define the management actions and reviews needed to ensure that the project's outcomes are achieved and benefits realised.	Potential risk that programme benefits are mis-stated and cannot be achieved.

Recommendations		Priority
3.1	Programme documentation should incorporate a standard benefit realisation plan that includes the methods to assess the identified benefits, the timing of the benefit realisation work and the criteria that will be applied to measure success.	Medium

Management response		Target Date	Responsible Officer
3.1	We would consider there to be a benefits plan in place for EMS Operational Transformation. For other programmes, this has been something that we have intended to do for some time, as we awaited the appointment of a new Head of Transformation. We recognise the need to clearly articulate and plan programme benefits and will review all programmes to determine whether current benefits plans meet the requirement of a benefits realisation plan and will identify dates to hold benefits planning workshops to finalise benefits realisation plans for each programme where this is required.	30 April 2023 (NB this is longer than 1 month to account for IA affecting workshop attendees)	Heather Holden, Head of Transformation & Programme Leads

Appendix B: Transformation Programmes Workstreams

Emergency Medicine Services programme

- Recruitment and training;
- Roster Reviews;
- CHARU – Implementation;
- Rural Model Pilot;
- Fleet – SOP;
- Estate SOP;
- CCC Reconfiguration (CAD Phase 3);
- Leading Change Together & Resource Availability; and
- CCC Clinical review.

Ambulance Care Transformation programme

- NEPTS Operational Improvement;
- Transfer and Discharge;
- NEPTS CAD Upgrade;
- Transport Solutions;
- NEPTS Plurality Model; and
- Demand and Capacity.

Gateway to Care programme

- Work with 111 Programme Team to support the development of a National Strategy for 111 including associated workforce strategy;
- Complete the roll out of 111 First across Wales;
- Work with the programme team to complete the roll out of the 111 service and support the evaluation process;
- Work with Welsh Government to promote the use of 111;
- Continue implementation of recommendations for the CCC Clinical Review;
- Develop with commissioners a remote clinical support strategy;
- Implement 999 Triage system Emergency Communication Nurse System (ECNS);
- Consider options for increasing proportion of 999 callers who have a clinical assessment;
- Develop a case for change for discussion with stakeholders on the integration of clinical teams across 111 & 999;
- Identify opportunities to increase 111 consult & close rates, improving patient experience and outcomes, and increasing the 'value' of the service to the system;
- Develop a clinical specialty educational and career framework for Remote Clinical Decision-making (RCDM);
- Identify small pilot opportunities to test a direct booking system for 111 patients to Health Board services (e.g. Urgent Dental);
- Implement the new 111 system (SALUS);
- Develop a strategic 111 workforce plan;
- Deliver an improved Directory of Services;
- Improve 111.Wales website, and enable better digital self-service, engaging with key partners to identify and agree longer term objectives for the service in support of delivery of the 6 goals for Urgent & Emergency Care; and
- Further enhance and develop WAST internal reporting functions for 111.

Appendix C: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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Decarbonisation Final Report

January 2023

NWSSP Audit and Assurance Services

Welsh Ambulance Services NHS Trust

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Report status:	Final
Draft report issued:	4th November 2022
Management response received:	26th January 2023
Final report issued:	30th January 2023
Auditors:	NWSSP Audit & Assurance: Specialist Services Unit
Committee:	Audit Committee

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

Acknowledgement

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

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1. Context

1.1 The Welsh Government is party to international agreements to reduce carbon emissions and control climate change, most notably those arising from the 2016 Paris Accord.

1.2 The "NHS Wales Decarbonisation Strategic Delivery Plan" was published in March 2021, setting interim targets (from a 2018/19 base) of a 16% reduction by 2025 and a 34% reduction by 2030.

1.3 In October 2021 the Welsh Government set out its second carbon budget, Net Zero Wales, which confirmed:

> "Our ambition is for the public sector to be collectively net zero by 2030".
>
> *Welsh Government, October 2021*

1.4 NHS Wales is also required to comply with the Well-being of Future Generations (Wales) Act 2015. It 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.

2. Background

2.1 In accordance with the "NHS Wales Decarbonisation Strategic Delivery Plan", Health Boards, Trusts and Special Health Authorities were required to develop their own Decarbonisation Action Plans (DAP), demonstrating how NHS Wales organisations would implement the Strategic Delivery Plan initiatives. The DAP's were submitted to Welsh Government in March 2022.

2.2 A peer review of DAP strategies was held on 12 July 2022 led by Welsh Government and attended by all NHS Wales organisations. The general conclusions across all plans were:

- the targets detailed within the plans showed low aspirations;
- there were concerns associated with their successful delivery, primarily due to resource availability (financial and physical); and
- there were a small number of issues associated with their compilation/format.

2.3 Specific feedback was also provided to each organisation by Welsh Government.

2.4 Also in July 2022, Audit Wales issued their review of Public Sector Readiness for Net Zero Carbon by 2030 (fieldwork conducted between November 2021 and January 2022). The review included an assessment of NHS Wales organisations and concluded that:

> "There is clear uncertainty about whether the public sector will meet its 2030 collective ambition. Our work identifies significant, common barriers to progress that public bodies must collectively address to meet the ambition of a net zero public sector by 2030. And while public bodies are demonstrating commitment to carbon reduction, they must now significantly ramp up their activities, increase collaboration and place decarbonisation at the heart of their day-to-day operations and decisions".
>
> *Audit Wales, July 2022*

2.5 In September 2022, Health bodies were required to make two separate submissions to Welsh Government, the first of these being quantitative (i.e., showing progress against the baseline $C0_2$ figures set in 2019) and the second qualitative, being a report detailing progress against the DAP.

3. Approach

3.1 Audits were planned to be undertaken simultaneously across NHS Wales to provide assurance to respective NHS Wales bodies on their arrangements to reduce carbon emissions and control climate change as outlined above. Reviews were not scheduled at Public Health Wales or Health Education and Improvement Wales for 2022/23.

3.2 Risks to be considered included:

- Regulatory/legislative risk through not achieving mandated reductions in carbon emissions;
- Reputational risk by failing to meet emission targets.
- Failing key stakeholders by not reducing carbon emissions which have a detrimental effect on health, and thereby, not meeting the requirements of the Well-being of Future Generations (Wales) Act (2015).

3.3 Having reviewed all DAPs, supporting information for most NHS Wales bodies and fully concluding the fieldwork at five of 11 audits, it was clear that in each instance the implementation plans had not been sufficiently developed to allow meaningful testing and to provide an assurance rating to respective Audit Committees.

3.4 Accordingly, the decision was taken to affirm common themes within this report, to provide an overview of the overarching position across NHS Wales. An action plan of common themes is provided at **Appendix A.**

4. Summary Observations

4.1 While there are variations between the NHS Wales bodies, broadly each is at an early stage of implementation. The following were common themes observed across those reviewed:

Governance

- Governance arrangements at a strategic level were generally good with senior leadership demonstrated.
- Recruiting to additional operational posts has proven difficult – with the limited appointments to date coming from the existing public sector staff pool. These appointments are key to being able to implement the agreed strategies (see **Management Action 1**).

Localised strategy

- All NHS Wales organisations supplied their Decarbonisation Action Plan (DAP) by 31 March 2022 detailing their response to the NHS Wales Decarbonisation Strategic Delivery Plan and the 46 associated initiatives.
- WG provided positive feedback to each organisation on their submissions but concluded overall that there were concerns associated with their successful delivery (primarily due to the availability of financial and physical resource), together with low aspirational targets detailed within the plans.
- Few of the strategies had been costed, and none had associated funding strategies – particularly noting that ring-fenced central funding for 2021/22 was £16m with no provision made in 2022/23 (see **Management Actions 2 & 3**).
- In each instance, the decarbonisation strategies were clearly part of corporate planning and included/reflected within the respective Integrated Medium-Term Plans (IMTPs).

Monitoring & reporting

- Organisations were ISO 14001 accredited ensuring that appropriate Environment Management Systems were in place to manage their environmental performance.
- Each NHS Wales organisation's performance will be assessed against baseline data prepared by the Carbon Trust. Issues have been identified with the baseline data and the disaggregation of the data for reporting purposes. Each organisation should seek assurance on the accuracy of the baseline data (see **Management Action 4**).
- Each NHS Wales organisation should ensure that appropriate engagement is established with NWSSP Procurement Services as a significant contributor to the carbon reductions outlined within respective DAPs and formalise arrangements as appropriate (see **Management Action 5**).

- Each organisation had met its obligations for national reporting to date.
- Internal reporting to date had understandably been limited, with the level of reporting increasing after Welsh Government's review of the DAPs.
- There was therefore a need to fully roll-out the structures to support appropriate monitoring and reporting within the NHS Wales organisations reviewed (see **Management Action 6**).
- It is important that the profile of decarbonisation is increased to reflect the challenge faced, for example general Terms of Reference are reviewed to reflect decarbonisation commitments, and decarbonisation is set as a standard agenda at all appropriate Executive meetings (see **Management Action 7**).
- Potential collaboration should be considered on an All-Wales basis, particularly in relation to consultancy advice and training resource (see **Management Actions 8 & 9**).

Project delivery

- The Welsh Government Estates Funding Advisory Board (EFAB) oversaw the allocation and delivery of the £16m decarbonisation funding for 2021/22 with each NHS Wales organisation successfully securing funding.
- In each instance, adequate records were retained to support the expenditure and the achievement of the original objectives; Post Project Completion Reports were produced and submitted to WG for all funded schemes.
- No ring-fenced WG capital funding was made available for 2022/23. WG offered up to £60k of revenue funding for schemes, however several NHS Wales organisations' bids could not be supported due to them being considered capital bids (see **Management Action 10**).
- NHS Wales Organisations were also self-funding initiatives from their discretionary programme. It is important that the cost benefit of these schemes is also subject to challenge and scrutiny for inclusion within the overall data (see **Management Action 11**).

5. Conclusion

5.1 In conclusion, whilst some progress has been observed, this has been restricted by the availability of financial and staff resource. The recommendations made aim to aid management in driving forward the strategies, whilst also highlighting some of the competing pressures/ risks.

5.2 It is recommended that an audit is scheduled for 2023/24 with the proposed scope to include governance, strategy progress and implementation.

5.3 Additionally, as part of 2023/24 Internal Audit planning update, discussions will be held with management on the appropriateness of other areas within the decarbonisation programme including, for example:

- Procurement and supply chains.
- Application of “Best practice Pharmaceutical waste practice”.
- Transport.
- Fleet and business travel.
- Staff, patient and visitor travel.
- Catering; and
- People and workforce e.g., training, policies, and working arrangements.

Appendix A: Common Management Action Plan

Ref.	Recommendation	Management Comment/ Agreed Action	Responsible Officer/ Deadline
MA 1	Appropriate strategies should be developed to ensure that recruitment and retention issues experienced to date do not impact significantly on the achievement of the DAPs.	Recognising the generic nature of this report, the Trust is happy to report that these issues have not been experienced by WAST. Following some modest investment in the team, based on affordability, the Trust currently has no further recruitment plans in support of the delivery of the DAP but will be mindful of such challenges in future. **Action:** Any future opportunities would be advertised via recognised channels on an open application basis.	Executive Director of Finance & Corporate Resources Ongoing (as and when required)
MA 2	DAPs should be fully costed to fully determine the total funding required.	An initial 10-year capital cost estimate has been provided to WG, along with some initial high level specific estimates of costs of the delivery of the DAP itself. The Trust is committed to exploring the development of a Sustainability and Infrastructure SOP. However it should be noted that some elements cannot yet be accurately costed, specifically those dependent on yet to emerge technology such as mainstreamed EV Emergency Ambulances. In addition,	Executive Director of Finance & Corporate Resources Next planned review - Sept 2023 (9 months post establishment of

Ref.	Recommendation	Management Comment/ Agreed Action	Responsible Officer/ Deadline
		there are wider dependencies such as National Grid infrastructure that WAST will be unable to control. **Action:** potential development of Sustainability and Infrastructure SOP to be explored by Programme Board and consideration of phasing based on known/unknown quantifiable impacts	Decarbonisation Programme Board)
MA 3	DAPs should be supported by funding strategies e.g. differentiating between local/ national funding, revenue or capital funding etc.	Initial 10 year capital estimates have been provided to WG. The Trust continues to prioritise schemes and bid for additional resource against existing funding streams. Further EFAB monies has now been confirmed for 2023/24 and 2024/25. The Trust is committed to exploring the development of a Sustainability and Infrastructure SOP **Action:** potential development of Sustainability and Infrastructure SOP to be explored by Programme Board and consideration of phasing based on known/unknown quantifiable impacts	Executive Director of Finance & Corporate Resources Sept 2023 (9 months post establishment of Decarbonisation Programme Board)

Ref.	Recommendation	Management Comment/ Agreed Action	Responsible Officer/ Deadline
MA 4	NHS Wales Organisation's baselines should be adequately scrutinised and challenged, as errors and overreporting has been identified in a few examples to date.	The 2018 baseline is extant. However, WG reporting requirements have impacted on the ability to make a comparison between current and baseline data. The lack of reporting of REGO energy also impacts on the baseline. Errors and overreporting is a separate issue and is found in the Scope 3 reporting data which is provided by NWSSP (and for which WAST has no control over) as well as homeworking methodology issued by WG. **Action:** continue to engage in the WG reporting process and to provide feedback Agreement that clarity is needed on baselines from which progress is to be measured asap, although this is somewhat outside of WAST's control	Head of Capital Development/ Environment and Sustainability Manager March 2023
MA 5	As a major contributor to the achievement of the targeted reductions appropriate engagement will be established with NWSSP Procurement Services (and formalised as appropriate).	WAST recognises the centrality of NWSSP Procurement support in achieving the targets. In recognising the generic nature of this report, WAST acknowledges the need to work in wider system partnership on common issues and welcomes the	Head of Capital Development Feb 2023

Ref.	Recommendation	Management Comment/ Agreed Action	Responsible Officer/ Deadline
		opportunity to engage in any work being established by NWSSP. **Action:** continue to engage with NWSSP and participate in any newly established engagement forums as they arise from NWSSP**.** Invite NWSSP Procurement Representative to sit on WAST Decarbonisation Programme Board. Ensure that decarbonisation of procurement is added as a regular agenda item on P2P meetings with NWSSP.	
MA 6	Proposed management/accountability structures should be fully implemented as intended within the DAPs.	Agreed. WAST is already working towards establishing a director chaired Decarbonisation Programme Board (first meeting due in January 2023), with supporting Project Initiation Document and Terms of Reference. Routine reporting arrangements have been in place for some time via the Capital Management Board and Finance and Performance Committee, and the Trust will continue to strengthen these. **Action**: establish Programme Board and continue with reporting via EMT, Committee structure and Board	Executive Director of Finance and Corporate Resources Jan 2023 for establishment of Programme Board Ongoing for reporting cycles

Ref.	Recommendation	Management Comment/ Agreed Action	Responsible Officer/ Deadline
MA 7	Where decarbonisation falls within the existing environmental remit of committees/ meetings, it is important that an appropriate profile is set. Terms of Reference and agendas should be reviewed to ensure that sufficient focus is provided.	Agreed **Action:** ToRs and agendas for FPC Committee to be reviewed to re-confirm that decarbonisation is included and is a key priority for the Committee	Head of Capital Development Dec 2022
MA 8	Potential collaboration and common utilisation of decarbonisation resource should be considered on an All-Wales basis, particularly in relation to consultancy advice and training resource.	Agreed and WAST already engages with EPRMG/National Waste Consortium etc. Also engaged with work with WGES. **Action:** engage with WG re the collaborative and common resource opportunities available for future projects via all Wales Decarbonisation Programme Board, Transport and Sustainability Groups and Community of Experts	Head of Capital Development Ongoing
MA 9	In accordance with the NHS Wales Decarbonisation Strategic Delivery Plan, HEIW/ collaborative training should be commissioned on an All-Wales basis to provide both common and tailored decarbonisation training.	Noted **Action:** engage with HEIW re the requirements of a training offer	Head of Capital Development Feb 2023
MA10	Given the scarcity of funding, it is important that bids for funding are appropriately considered prior to submission.	Agreed	Director of Partnership and Engagement (TBC as Chair of

Ref.	Recommendation	Management Comment/ Agreed Action	Responsible Officer/ Deadline
		Action: bids for funding to be managed through the Decarbonisation Programme Board	Decarbonisation Programme Board) Ongoing
MA11	The same rigour and monitoring should be applied to internally commissioned/ funded initiatives to ensure the outcomes are adequately recorded/reported.	Agreed **Action:** bids for funding to be managed through the Decarbonisation Programme Board. Internal Discretionary Capital Business case template includes elements around environmental sustainability and decarbonisation.	Director of Partnership and Engagement (TBC as Chair of Decarbonisation Programme Board) Ongoing

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Audit Committee Update – Welsh Ambulance Service NHS Trust

Date issued: February 2023

Document reference: 3416A2023

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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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	Initial planning work underway.

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
Quality Governance	As an extension to structured assessment, this work considered the structures, information and assurance flows that support quality governance.	Complete Presented to Audit Committee in September 2022
NHS Structured Assessment 2022	A review of the corporate arrangements in place at the Trust in relation to: • Governance and leadership. • Financial management. • Strategic planning • Use of resources (such as digital resources, estates, and other physical assets).	Complete – Presenting to Audit Committee in March 2023
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	Blog and data tool published in 2022 Part One: Draft reporting Anticipated to present to next Audit Committee

Topic	Focus of the work	Current status and Audit Committee consideration
	• Part three: national arrangements and leadership structures	

Exhibit 3 – Planned work not yet started or revised

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

Good Practice events and products

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

5 There have been two Good Practice Exchange (GPX) events since we last reported to the Committee in November 2023: 'Making Equality Impact Assessments more than a tick box exercise' in January 2023 and 'Trans-Atlantic Conversations - Vector Theory of Change with Dave Snowden' in February 2023.

6 The next Good Practice Exchange events will be on the theme of 'Together we can – creating the conditions to empower our communities to thrive' following the publication of our Together we can – community resilience and self-reliance report in January 2023. The events will be held in north Wales on 28 March 2023 and south Wales on 19 April 2023. Further details of future events are available on the GPX website.

NHS-related national studies and related products

7 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.

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

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

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

Title	Publication date
Poverty in Wales data tool	November 2022
Time for Change – Poverty in Wales	November 2022
National Fraud Initiative 2020-21	October 2022
Equality Impact Assessments: More than a Tick Box Exercise?	September 2022

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

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

Title	Indicative publication date
Orthopaedic services	March 2023
Unscheduled care – a whole system view	2023

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Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Structured Assessment 2022 – Welsh Ambulance Services NHS Trust

Audit year: 2022

Date issued: December 2022

Document reference: 3282A2022

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

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Mae’r ddogfen hon hefyd ar gael yn Gymraeg. This document is also available in Welsh.

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Summary report

About this report

1 This report sets out the findings from the Auditor General's 2022 structured assessment work at the Welsh Ambulance Services NHS Trust (the Trust). Our structured assessment work is designed to help discharge the Auditor General's statutory requirement to be satisfied that NHS bodies have made proper arrangements to secure economy, efficiency, and effectiveness in their use of resources under section 61 of the Public Audit (Wales) Act 2004.

2 Our 2022 Structured Assessment work took place at a time when NHS bodies continued to respond to the unprecedented and ongoing challenges presented by the COVID-19 pandemic. Health bodies were not only tackling the immediate challenges presented by the public health emergency but were also seeking to recover and transform services to respond to the significant numbers of people who are waiting for treatment and improve population health. NHS bodies and their Boards need to have sound corporate governance arrangements that can provide assurance to the public and key stakeholders that the necessary action is being taken to deliver high quality, safe and responsive services, and that public money is being spent wisely.

3 The key focus of the work has been on the Trust's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically, with a specific focus on the organisation's governance arrangements; strategic planning arrangements; financial management arrangements; and arrangements for managing the workforce, digital assets, the estate, and other physical assets. The approach we adopted to deliver our work is detailed in summarised in **Appendix 1**.

Key messages

4 Overall, we found that **the Trust has taken positive steps to improve aspects of its corporate governance arrangements, but further work is needed to provide the strong internal challenge and continued external influence required to overcome some of the unprecedented operational challenges it currently faces.**

5 The Board is committed to public transparency, self-reflection, and hearing directly from patients and staff. The Trust has effectively filled key board-level posts in the past year, including a new Chair and the process for recruiting a new vice-Chair is underway. Meetings of the Board and committees are conducted appropriately and are supported by clear Schemes of Delegation. The Trust is continuing to refine its governance arrangements, such as developing cycles of business. However, there is scope to strengthen these arrangements further, particularly around improving the timeliness of publishing Board and committee papers and increasing the public transparency of decisions made in private sessions of the Board.

6 The Trust is strengthening its risk framework. While the Trust regularly reviews its corporate risks, the scores for several significant risks have remained unchanged despite mitigating actions in recent months. This suggests that mitigating action to reduce the risk is not always having the desired effect. The Board receives regular information about the impact of wider system failings on its own performance and related quality concerns for patients. Recognising that many factors are beyond the Trust's direct control, the Trust must continue to seek opportunities to influence its partners to secure improvement as well as focussing on the impact of actions taken locally to address these issues. There is also a need to better respond to concerns and poor experiences captured within the patient experience report.

7 The Trust has a Board-approved long-term vision and clinical strategy, which are rooted in population health and aligned to key national strategies. The Trust recognises that delivery of its longer-term aspirations will depend on the buy-in of partners, therefore external engagement must remain a priority. The Trust has a balanced and approved Integrated Medium-Term Plan for 2022-25, which has clear milestones and good alignment with key plans. The planning approach creates a line-of-sight for the Trust's combined strategic frameworks to be monitored at a high-level quarterly via the Finance and Performance Committee and Board, supplemented by detailed monitoring for key programmes. However, there is a need to improve staff involvement in the planning process.

8 The Trust achieved its financial duty for 2021-22 and has a clear financial plan for 2022-25. While this year's savings plan has an increasing focus on transformational savings, opportunities remain to reduce reliance on vacancy control as a means of achieving short-term non-recurring cost reduction. The well documented whole system issues which are contributing to significant emergency ambulance handover delays also result in significant financial inefficiencies for the Trust. The Trust continues to have good systems of financial control the organisation's financial reports are clear and regularly received by the Finance and Performance Committee and the Board.

9 The Trust has developed a broad programme to support staff well-being which appears to be well-utilised. However, the Trust is not yet evaluating the impact of these services to ensure they are making a real difference. Managing sickness absence is a key area of focus, but rates remain very high particularly amongst Trust staff members in Emergency Medical Services. The Trust's digital strategy is being implemented but there is scope to strengthen and improve oversight of the entirety of its digital programme. The Trust plans to prioritise estate investment but faces challenges because of reducing available capital financing. It must, at the same time, ensure appropriate strategic decisions to support longer-term estates needs and the organisation's decarbonisation agenda.

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Recommendations

10 Recommendations arising from this audit are detailed in **Exhibit 1**. The Trust's management response to these recommendations is summarised in **Appendix 2**.

Exhibit 1: 2022 recommendations

Administrative governance

R1 We have identified opportunities for the Trust to further increase transparency by strengthening administrative governance by:

a) Ensuring the timely publication of committee papers in advance of meetings and minutes following the end of meetings to the Trust website;

b) Enhancing the recording of Chair's actions and decisions taken in private session, for example by identifying the costs and delivery risks relating to decisions made;

c) Providing the declarations of interest, gifts and hospitality as a specific document available to be publicly viewed; and

d) Reconsidering receiving all counter fraud information within the private session of the audit committee.

Patient experience reporting

R2 Improve quarterly patient experience reporting to QuESt by ensuring a balance of both positive and negative feedback and providing information on what is being done to address the negative themes arising in the report.

Staff involvement in the development of future key plans

R3 The Trust should take steps to ensure its key strategic plans, including the IMTP are developed with, and informed by, its staff.

Develop engagement delivery plans

R4 While the Trust has recently refreshed its high-level engagement framework, it should seek to urgently publish and progress detailed plans to support it in providing external in relation to unscheduled care system pressures.

Ensure evaluation of effective staff wellbeing services

R5 While the Trust has introduced a programme of services to support staff wellbeing, it is not currently undertaking sufficient evaluation and review to ensure these are meeting the needs of staff. The Trust should introduce a regular process to evaluate its staff wellbeing services, such as via pulse

surveys or participant questionnaires. This evaluation should inform long-term investment decisions for such services.

Detailed report

Governance arrangements

11 In this section of the report, we provide our views on the Trust's governance arrangements, with a particular focus on:

- Board and committee effectiveness;
- the extent to which organisational design supports good governance; and
- key systems of assurance.

12 We found that **while there have been recent changes in leadership, the Trust continues to be well led. Recognising that governance arrangements are improving, the Trust should also continue to seek opportunities to influence and work together with key partners to help resolve some of the significant performance and quality challenges it faces.**

Board and committee effectiveness

13 We considered the extent to which the Board and its committees conduct their business effectively and support good governance. In examining this, we have looked at whether:

- the Board and its committees demonstrate appropriate levels of public transparency;
- meetings are conducted appropriately supported by clear Schemes of Delegation, Standing Orders, Standing Financial Instructions, and Registers of Interest;
- there is an appropriate and well-functioning committee structure below the Board;
- the Board and its committees receive the right information, including views from staff and service users; and
- there is evidence of sufficient self-review by the Board and its committees.

14 We found that **the Trust is strengthening its governance arrangements; however, there is scope to strengthen the level of scrutiny and challenge provided by Non-Executive Directors.**

15 The Board demonstrates a good commitment to public transparency. The Trust held virtual Board and committee meetings during the pandemic but has reverted to holding in-person Board meetings since summer 2022. The Trust continues to broadcast its Board meetings online via Zoom and Facebook for those unable to attend in person. The Board actively seeks and discusses questions raised by the public. Committee meetings continue to be held virtually, however they are not livestreamed or recorded for public viewing, which increases the importance of timely publication of draft and final minutes.

16 There is an appropriate split of items discussed in public and private sessions of the Board and its new Governance Practice Note clarifies the criteria for agenda

items that should be considered in the private session. However, the arrangements for publicly reporting Chairs actions and the decisions taken by the Board in private session could be strengthened, for example by providing more information on the costs and delivery risks relating to decisions made (see **Recommendation 1**). We also note that the Audit Committee receives its counter fraud update within the committee's private session. Unless it is of the view that the report routinely contains sensitive information, the Trust should reconsider receiving either part or the full update in public session to increase transparency (see **Recommendation 1**).

17 Board and Committee papers are not always made available in advance of meetings in line with the Trust's Standing Orders. We noted instances of delays in publishing some Board and Committee papers on the Trust's website.[1] The Trust does not currently have a process for recording late papers, but is developing Board and Committee Cycles of Business, which should lead to a better shared understanding of which papers are expected by when. Our review of papers also found that some confirmed minutes are not published on the Trust website in a timely way (see **Recommendation 1**).[2]

18 The Audit Committee appropriately oversees the annual review of the Trust's Standing Orders, including the Standing Financial Instructions and Scheme of Reservation and Delegation which is up-to-date and aligns to the organisational structure. No breaches were reported to the Committee during 2021-22. Standing Orders provide clear requirements for recording gifts and hospitality, but the Trust recognises a need to strengthen the process and increase staff compliance. The Trust has actions in place to strengthen its processes for declarations of interest, gifts, hospitality and sponsorship. Once this work is complete, the Trust should also ensure its register of gifts is publicly available on the Trust website (see **Recommendation 1**).

19 The pandemic and limited capacity within the Office of the Board Secretary have significantly affected timely policy review. 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.

20 There has been a significant turnover in Trust Board membership over the last year, with a new Non-Executive Director and three new Directors appointed. A new

[1] Trust Board papers for 28 July 2022 was published on the 25 July 2022. Academic Partnership Committee papers for the 19 July 2022 meeting were published on 1 August 2022.

[2] At the time of fieldwork, we were unable to find three sets of final minutes on the Trust website (Trust Board and Academic Partnership Committee March 2022 confirmed minutes and Finance and Performance April 2022 confirmed minutes)

Chair is now in post and the Trust is seeking to appoint a new Vice-Chair. A new comprehensive Board and Audit Committee induction programme ensures new members are well-informed and supported when they begin their roles. Board members have a good mix of skills to undertake their roles.

21 The Trust held two Board Development Sessions in 2021, facilitated by an external provider. Feedback on the programme indicated that whilst these sessions were helpful, the Board should cover a wider breadth of issues. Since 2021, all Board Development Sessions have been facilitated internally using a formalised annual schedule which alternates between strategic and assurance/learning topics. The Board has self-assessed its effectiveness and did not identify any major learning needs. Following the arrival of the new Chair, the Trust intends to commission an external independent review of board effectiveness and will then consider whether it needs to commission further external Board Development programmes to address any gaps identified.

22 The committee structure is effective and well-functioning. Administration operates properly with declarations in addition to the standing declarations taken at the beginning of each meeting. Each Committee undertook a self-assessment and reviewed their Terms of Reference during 2021-22, clarifying their roles and memberships in the process. The self-assessments and terms of reference for each committee were submitted to the Trust Board in May 2022, and the terms of reference are on the Trust website. Our committee observations found that meetings ran appropriately with agendas covering the most important risks to the Trust while ensuring the length of meetings remain manageable. This has been further enhanced by recent reviews of Committee priorities. The introduction of new Committee assurance reports has also been positive in highlighting key issues and facilitating flows of assurance from Committees to the Board. During the year, each Committee escalated their significant concerns regarding the performance and quality of services in the context of unscheduled care system pressures to the Board. The Trust Board discussed actions to mitigate avoidable patient harm at its meeting in July 2022, setting out actions it and broader partners needed to reduce risk of patient harm. While several actions have been implemented from the Trust's perspective over recent months, they are not able to offset the impact of increasing handover delays.

23 Our observations of the Board and Committees found good collective and cohesive relationships between Directors and Non-Executive Directors. Non-Executive Directors demonstrate a very supportive approach with Senior Officers. While such an approach is positive, there is a risk it could lead to missed opportunities for supporting improvement. Our observations of the Trust Board and its committees found less challenge and scrutiny from Non-Executive Directors, compared with the level of challenge provided by Independent Members in other NHS bodies. While they do not tolerate poor performance, Non-Executive Directors do need to provide stronger challenge to be fully assured that the Trust is taking all necessary actions within its control to address areas of poor quality of service. They also need to ensure that sufficient clarity is provided on what needs to be done to resolve

these issues, recognising of course that solutions are often not within the direct control of the Trust. The Trust's Non-Executive Directors may find it useful to observe Board and committee meetings in other NHS bodies to learn from the different approaches taken elsewhere.

24 Papers presented to the Board and Committees are generally of good quality, but there is scope to reduce their length by increasing the focus on analysis, rather than contextual information. Feedback from Non-Executive Directors suggests they are happy with the quality of papers presented but would like to see better summaries in the cover papers to enable them to focus on the most important issues. The Board Secretary intends to strengthen processes to help ensure papers provide focus and meet the expectations and needs of Non-Executive Directors.

25 The Trust makes good use of patient and staff stories to enable the Board and Committees to understand the experiences of those receiving care and working at the Trust. The Board continues to alternate staff or patient stories at each meeting, which helps focus discussion. Each Quality, Experience and Safety (QuESt) Committee and People and Culture Committee meeting hears patient and staff stories respectively. Senior Officers capture and action any learning arising from these. The QuESt Committee's Quarterly Patient Experience Report outlines the work of the Trust's Patient Experience Team and approach for collecting service user feedback. These reports demonstrate the Trust's commitment to engaging with patients but tend to focus more on the positive responses received. While there are some sobering accounts of poor patient experience, limited narrative is provided by way of response to some of the concerns raised (see **Recommendation 2**).

26 Chief Executive's roadshows, which take place across Wales, and Service Awards provide the Board with regular opportunities to engage directly with, and hear from, staff. Ambulance ride-outs and station visits stopped in response to the COVID-19 pandemic. While some visits have resumed recently, such as the Board's visit to Ysbyty Maelor in July 2022, engagement activity has not yet resumed to pre-pandemic levels, and there is variation in the levels of activity undertaken between Board members. Our report on the Trust's quality governance arrangements, issued in September 2022, recommended the Trust develop a Standard Operating Procedure for such visits to ensure better coverage and capturing of feedback.

Organisational design

27 We considered the extent to which the Trust's organisational structure supports effective governance. In examining this, we have looked at whether:

- the responsibilities of Executive Directors are clear, and that they have balanced and equitable portfolios of work;
- there is clarity on the role of the Board Secretary, and there are adequate resources in place to support the work of the Board and its committees; and

- the organisational structure supports effective governance and facilitates whole-system working.

28 We found that **the organisational design continues to support Trust business, and recent and upcoming changes at leadership level are being managed effectively.**

29 The responsibilities of Executive Directors appear to be clear, and they have balanced and equitable portfolios of work. Three new Directors (Executive Director of Quality and Nursing, Director of Workforce and Organisational Development, Interim Director of Digital Services) have been appointed to the Trust in recent months, along with a new Chair and a new Non-Executive Director. The Trust is also in the process of seeking a new Vice-Chair. These changes, though significant, appear to have been managed well by the Trust that has continued to maintain stability. Changes to Director portfolios during the last 12 months include an increase in the number of Executive Directors on the Trust Board from five to six under new regulations.[3] This saw the addition of the Director of Operations becoming an Executive Director. The Director of Strategic Planning and Performance becoming also became an Executive-level post during the year, in place of the Director of Workforce and Organisational Development. Executive Directors and wider senior management engage in weekly Executive Management Team meetings to oversee operational business and feedback suggests these meetings are working well.

30 There is clarity on the role of the Trust's Board Secretary, who is leading work to strengthen arrangements including developing cycles of business, strengthening recording of gifts and risk management. However, the progress of this programme is reliant on finite capacity within the Board Secretary's Office. Limited capacity is having an impact in some areas by limiting the resilience of the team in ensuring the timely review of policies and risk. Our review of the Trust's quality governance arrangements also raised concerns around the Trust's capacity to support operational risk management. The Trust has recently appointed a Corporate Governance Manager and is seeking to recruit a Risk Officer which may help address these issues.

31 The Trust has a stable organisational structure, with its operational teams' structured to align to each of the seven Health Board areas. We were not made aware during fieldwork of any substantial changes to the operational structures or of any issues with the way the organisation is currently structured.

Systems of assurance

32 We considered the extent to which the Board and its committees oversee, scrutinise, and challenge organisational risks, performance, and quality of services. In examining this, we have looked at whether:

[3] The NHS Trust (Membership and Procedure) (Amendment) (Wales) Regulations 2022

- there is an effective Board Assurance Framework (BAF) in place, which is actively reviewed and owned by the Board;
- the BAF is underpinned by appropriate systems for managing risks and performance; overseeing the quality and safety of services; and handling information in a secure manner; and
- effective action is taken to address audit and review findings and recommendations.

33 We found that **while the Trust is strengthening its systems of assurance with regular reviews of risk, further work is required to understand whether the Trust's mitigating actions are achieving their intended impact on significant and ongoing risks and challenges.**

34 The Trust has strengthened its Board Assurance Framework (BAF) during 2021-22. The new version is more detailed and comprehensive, with much greater articulation of the controls and assurances in place. The BAF currently draws its principal risks from the Corporate Risk Register and maps them to the 2022-25 Integrated Medium-Term Plan deliverables and therefore, by extension, the Trust's strategic risks. It is not yet aligned to the Trust's broader long-term strategy and does not link with wider system controls and assurances. The BAF clearly identifies how the Trust is monitoring risks and the associated mitigating controls, but it currently only provides limited assurance on the impact of the controls in terms of whether they are effectively reducing the risks. While the BAF is a standing agenda item on each Board and Committee agenda, there is a need to better focus discussions on the effectiveness and impact of controls in reducing the strategic risks facing the organisation.

35 The Trust revised its Corporate Risk Framework in 2020 and continues to strengthen it through its risk transformation programme. Risks on the Corporate Risk Register (CRR) have been reviewed using an 'if, then, resulting in' format which provides greater clarity and focus on the potential impact of each risk. Each committee receives and discusses the risks relevant to their remit at every meeting, with any issues escalated in via highlight reports to Board. However, despite regular review, several CRR risks have remained static or deteriorated in recent months, suggesting actions for mitigating risks are not having the intended effect. While this is, in part, due to the risks being impacted by external pressures and partners, the Trust must apply robust challenge to ensure its mitigating actions are achieving their maximum impact. While a recent Internal Audit report on risk management and assurance provided an overall reasonable assurance rating, the work highlighted gaps in oversight and an inconsistent approach to the review of risks at directorate and operational levels. Officers regularly review the corporate risk registers of other NHS bodies in Wales to understand how other bodies are seeking to mitigate broader unscheduled care risks that affect the Trust's performance. The Trust must ensure it gains assurance that the actions taken to address the risks are having the intended impact.

36 Wider system failings and pressures have meant that the Trust currently faces unprecedented performance issues and related quality concerns leading to avoidable harm for patients. In response, the Trust Board needs to do everything within its span of control to improve the way its own services operate, including strongly influencing its partners and stakeholders to collectively address the cause of poor services and outcomes for patients. These challenges include:

- Frequently reaching the highest level (four) of the Trust's Resource Escalation Action Plan (REAP) framework.
- Poorer and deteriorating performance in relation to red and amber calls. The target for reaching 65% of calls categorised as red (immediate life-threatening) has not been met since July 2020. Performance as of October 2022 was 48%. For calls categorised as amber (serious, but not immediately life-threatening), median performance in October 2022 was one hour, 42 minutes with the 95th centile of calls waiting nearly nine hours.
- During 2022, the Trust has routinely seen between 25-35% of its front line 999 response delayed outside of a hospital and unable to respond to calls in the community. 28,937 hours were lost due to handover delays in October 2022.
- There is year-on-year increase in nationally reportable incidents which resulted in an unexpected or avoidable death or severe harm.

37 The Trust recently updated its Performance and Quality Framework and improved the operational performance analysis provided its Integrated Quality and Performance Report. The Trust is also seeking to develop service quality metrics, but it currently is not able to link its systems with Health Board systems. This means that the Trust cannot easily see the outcome for patients after their handover, which is a particular concern if high-risk patients have waited long times for an ambulance. The continuing roll-out of the electronic Patient Clinical Record system aims to resolve this and ultimately improve the breadth of oversight and assurance on the quality of services.

38 Our report on the Trust's quality governance arrangements highlighted the good progress being made in developing quality improvement plans and improving the functioning of the QuESt committee and internal concerns management. However, we identified the need for the Trust to improve its risk management capacity, address the substantial backlog of mortality reviews, and ensure better visibility of clinical audits. During 2022 the Delivery Unit reported on significant weaknesses in the process for incident reporting across organisational boundaries, known as Appendix B reports, which we highlighted that the Trust must work with partners to address to ensure system-wide improvements. The Trust is taking action to address the recommendations of our report.

39 The Trust's audit 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 to date and/or whether actions have a

new proposed completion date. The Audit Committee regularly undertakes a high-level review of the tracker, but there is scope for Committee members to focus more on exploring whether recommendations marked as 'completed' have achieved their intended impact. This could be achieved by inviting the relevant senior leaders to Audit Committee to report on progress.

Strategic planning arrangements

40 In this section of the report, we provide our views on the Trust's strategic planning arrangements, with a particular focus on the organisation's:

- vision and strategic objectives;
- Integrated Medium-term Plan;
- planning arrangements; and
- arrangements for implementing and monitoring the delivery of corporate strategies and plans.

41 We found that **there are good approaches for developing plans, but there needs to be a stronger focus on staff and partner engagement and greater challenge on the impact of plans in supporting improvements to performance.**

Vision and strategic objectives

42 We considered the extent to which there is a clear vision and long-term strategy in place for the organisation. In examining this, we have looked at whether:

- the vision and strategic objectives are future-focussed, and rooted in a detailed and comprehensive analysis of needs, opportunities, challenges, and risks;
- the vision and strategic objectives have been developed and adopted by the Board; and
- the long-term strategy is underpinned by an appropriate long-term clinical strategy.

43 We found that **the Trust has a good long-term strategic vision that is focussed on supporting the population health of Wales and the wider NHS system.**

44 The Trust Board approved its long-term strategic framework (the Framework) titled 'Delivering Excellence, Our Vision for 2030' in March 2019. The Framework has a strong foundation as it draws on detailed predictions about population health. It articulates the Trust's ambition to alter its traditional service model and to manage demand differently, with a focus on increasing telephone consultations and treatments out in the community and reducing ambulance conveyance to hospital. It calls this approach 'inverting the triangle'. The Framework provides sufficient

direction to form the basis of each refresh of the Integrated Medium-Term Plan. Positively, the Trust has recently reviewed its long-term ambitions and, as a result, reframed some specific actions as part of the Integrated Medium-Term Plan development process.

45 The Trust's Clinical Strategy 2020-2025 appropriately supports the long-term Framework by setting out the main drivers of changing service demand, including demography and population-level patterns of illness. The clinical strategy has four clear clinical aims, which are:

- Aim 1: Using excellent clinical leadership;
- Aim 2: Responding to our population's changing care needs;
- Aim 3: Embedding a Value Based Healthcare approach; and
- Aim 4: Improved use of clinical data and information.

46 The Clinical Strategy effectively sets out the required enabling strategies that will support its progress, including the Trust's quality, education and training, and digital strategies.

Integrated Medium Term Plan

47 We considered the extent to which the Trust has been able to produce an approvable Integrated Medium-Term Plan (IMTP) for 2022-2025. In examining this, we have looked at whether:

- the IMTP was submitted within the required timeframes in line with Welsh Government guidance;
- the draft and final versions of the IMTP were discussed, challenged, and agreed by the Board prior to submission; and
- the IMTP received approval from the Minister for Health and Social Services.

48 We found that **the Trust continues to develop approvable and balanced Integrated Medium-Term Plans that meet Welsh Government requirements.**

49 The Trust produced a balanced Integrated Medium-Term Plan (IMTP) 2022-25 which met Welsh Government requirements and secured Ministerial approval. Drafts were provided to various Executive groups and Committees prior to its submission to Welsh Government, including a review by the Trust Board during a development session in February 2022, and endorsement by the Finance and Performance Committee in March 2022. The Board approved and submitted the final version in March 2022 in line with Welsh Government timelines. The Trust's commissioners also approved the IMTP via the Emergency Ambulance Services Committee[4].

[4] The Emergency Ambulance Services Committee is a Joint Committee of all Health Boards in Wales, with responsibility for planning and securing sufficient ambulance services for the population.

50 Welsh Government commented positively on the alignment of the IMTP to the Emergency Ambulance Services Committee's own plan, and a good focus placed on both value-based healthcare and improving workforce efficiencies by reducing sickness absence. Welsh Government also highlighted some areas for improvement, particularly around the need for the Trust to be more ambitious with its performance improvement trajectories, plans for achieving university status, and achieving stronger collaboration with the Fire and Rescue Service.

Planning arrangements

51 We considered the extent to which the Board maintains effective oversight of the process for developing corporate strategies and plans. In examining this, we have looked at whether:

- prudent and value-based healthcare principles are considered and reflected in corporate strategies and plans; and
- corporate strategies and plans have been developed in liaison with relevant internal and external stakeholders;

52 We found that **the Trust has reasonable arrangements for developing key plans, although it recognises that there is scope to increase staff involvement and strengthen partner buy-in.**

53 The Trust continues to have an effective process for developing its IMTP, which it actively seeks to improve on an ongoing basis. The Trust's process for developing the IMTP 2022-25 was comprehensive and included:

- assessing long-term strategic framework achievements;
- reviewing progress against the commitments made in the previous IMTP; and
- considering new and current pressures via the Executive Management Team and board development sessions.

54 While the Trust's approach to IMTP planning has been effective for some time, this year the Trust also recognised the need for its arrangements to more flexible to respond to extreme operational pressures. As a result, the 2022-25 IMTP is now more explicit about its priorities and which actions can be paused if operational pressures place a significant strain on resources. However, since 2019, the Trust has not aligned underpinning directorate level plans to inform the development of the IMTP but intends to rectify this for the 2023-26 plan.

55 In term of wider planning arrangements, there is a mixed state of progress. The revised People and Culture Strategy has been delayed and work on renewing its Public Health Plan 2019-22 is yet to commence. However, the Trust has approved its volunteer strategy in September 2021. This strategy, which was developed with involvement from volunteer working groups, and has been designed to appeal to current and prospective volunteers. However, it was not financially costed when it was approved which makes it difficult to know whether it is affordable. There is also scope to better clarify how it will be delivered and monitored. While the volunteer

strategy is summarised within the IMTP, there is no clear read-across to the IMTP actions for 2022-25.

56 The Trust also recognises that it should do more to engage staff when preparing corporate plans and strategies. It has developed a one-page summary of its IMTP for staff and the public, which is available via its public website. However, the pandemic inevitably led to reduced staff involvement in the IMTP planning process (see **Recommendation 4**).

57 In previous structured assessment reports, we have highlighted that the Trust's partners do not always properly buy into its significant service transformation ambitions and the need to modernise services. This continues to be a risk that the Trust is aware of and is seeking to mitigate. For example, in response to the continuing significant operational pressures, the Trust submitted a 'transitional plan' to its commissioners in December 2021, outlining proposals for improvement based on altering models of service in line with its long-term vision. There were varying appetites from the commissioners for the plan and it was not adopted in that form at that time. While some initiatives have been taken forward with individual Health Boards, the inability to move forward nationally was disappointing for the Trust. The Trust's recently refreshed engagement framework sets out the principles for engagement on its long-term strategic vision. While the document contains high-level principles, detailed plans are due to be published in early 2023. These detailed plans will be vital in providing the helpful direction for the Trust in engaging and maintaining effective dialogue with key partners (see **Recommendation 5**).

58 The Trust is committed to implementing prudent and value-based healthcare principles. It is currently working with the National Collaborative Commissioning Unit and the Finance Delivery Unit to develop a strategy and approach to value-based healthcare which links outcomes, patient experience, and use of resources. The Trust established financial workstreams in September 2022 and set-up a value-based healthcare working group to inform their work. It must demonstrate progress in implementing value-based healthcare during this financial year given it is a key accountability condition set by Welsh Government and features within the priorities set by its commissioners via the EASC commissioning intentions.

Implementation and monitoring arrangements

59 We considered the extent to which the Board oversees, scrutinises, and challenges the implementation and delivery of corporate strategies and plans. In examining this, we have looked at whether:

- corporate strategies and plans contain clear milestones, targets, and outcomes that aid monitoring and reporting; and
- the Board receives regular reports on progress to deliver corporate strategies and plans.

60 We found that **while the Trust has regular and integrated arrangements for monitoring the delivery of key plans, there is a need to develop clear and timely delivery plans to support its strategic documents**

61 The progress of key strategies and plans is monitored on an ongoing basis via the Trust's IMTP monitoring arrangements. This integrated approach is possible due to the strong alignment of the IMTP to key enabling and operational plans as well as the long-term strategic framework. However, our review of quality governance arrangements highlighted that the delay between approving the quality strategy and preparing the subsequent improvement plan have hampered the delivery of some key actions. This is again the case in relation to the clinical strategy. Earlier development of implementation plans would support the delivery of the Trust's strategic aim, and therefore delays should be avoided wherever possible.

62 IMTP deliverable actions are 'SMART'[5] and phased across the three years of the plan. The Strategic Transformation Board monitors the IMTP on a regular basis including reviewing the IMTP delivery tracker for all 2022-23 actions. The Trust's committees monitor specific programmes of IMTP work during their usual business, for example, the Trust's decarbonisation agenda. The Finance and Performance Committee receive detailed IMTP progress update and the Board also tracks progress through a high-level highlights report. This in particular indicates where IMTP progress is on track and where actions need to be paused to free capacity to respond to operational pressures. The Trust currently focusses primarily on actions delivered, rather than the outcome achieved, in terms of IMTP progress. It was positive to see that in November 2022 the Trust stated a new Head of Transformation has been appointed to work with its Performance Team to map benefits realisation back to transformation programmes to establish where possible the programme contribution to those measures.

Managing financial resources

63 In this section of the report, we provide our views on the Trust's arrangements for managing its financial resources, with a particular focus on the organisation's:

- arrangements for meeting key financial objectives;
- financial controls; and
- arrangements for reporting and monitoring financial performance.

64 We found that **the Trust has a good approach to financial planning, management, and reporting, however opportunities exist to reduce the significant inefficiencies caused by external system pressures.**

Financial objectives

[5] SMART - Specific, Measurable, Achievable, Relevant, and Time-Bound

65 We considered the extent to which the Trust has effective arrangements in place to meet its key financial objectives. In examining this, we have looked at whether the Trust:

- met its financial objectives for 2021-22, and is on course to meet its financial duties in 2022-23; and
- has a clear and robust financial plan in place, which includes realistic and sustainable savings and cost improvement plans.

66 We found that **the Trust continues to achieve its financial duties and is increasingly focussed on recurrent and transformational savings, though these are significantly outweighed by costly inefficiencies caused by system pressures**

67 The Trust continues to maintain a good record of meeting its financial duties in 2020-21, and over the rolling three-year period. For 2021-22, it recorded a small surplus, its capital expenditure was fully spent in line with updated plans, and it achieved savings of £2.861 million against a target of £2.800 million. As of Month 7, 2022-23, the Trust is reporting a year-end breakeven position. This is based on assumptions that the Trust will receive Welsh Government funding for all exceptional costs.

68 While financial performance currently remains strong, there are greater financial risks this financial year with increased cost pressures around utilities, fuel, sickness absences, and handover delays. These risks are articulated in the Trust's financial plan as part of its IMTP. The Trust is proactively managing these risks, engaging in regular discussions with Welsh Government and its commissioners around funding assumptions, and providing greater scrutiny on its own savings programme.

69 The Trust continues to receive additional in-year funding directly from Welsh Government. For example, in August 2022, Welsh Government announced £3 million non-recurrent funding for additional paramedics to support winter pressures. However, short-term funding creates challenges in terms of recruitment and the additional resources required to supporting new recruits. The Trust has made plans to mitigate these challenges in discussion with Welsh Government.

70 In order to seek further financial flexibility in addressing current performance issues, the Trust is pursuing access to additional funds available across Wales, such as the Primary Care Fund[6] and funds available through the Six Goal Programme. Access to such funding would enable the Trust to pursue some of the improvement initiatives described in its transition plan to alleviate pressures in unscheduled care and reduce delays in ambulance response. However, the Trust is currently not eligible to apply for such funding.

71 The Trust has a savings programme of £4.3 million focussing on recurrent and transformational savings through efficiencies, collaboration, and outsourcing

[6] Introduced by the Welsh Government in 2015-16, the Primary Care Fund supports implementation of the national primary care plan

opportunities. However, we have previously highlighted risks around the Trust's reliance on non-recurrent savings, particularly through vacancy management. As of Month 7, underspends continued to be driven predominantly by funded vacancies. In July 2022, the Trust established four financial workstreams which are intended to support delivery of a sustainable savings programme rooted in transformation. The four workstreams cover benchmarking value, achieving efficiency, income generation, and best practice. These workstreams should support the Trust to move away from traditional transactional savings and support it to overcome current and future financial challenges.

72 Ambulance handover delays are also a cause of significant inefficiencies. The hourly cost of handover delays, as estimated by the Trust, is around £166 an hour. In September 2022 alone, the loss of around 25,000 hours equated to a total cost impact of around £4 million. If handover delays continue to increase at current rates, the notional cost of lost capacity could equate to as much as £50 million for the full year. Eradicating delayed handovers would not release this cash total given that core staffing levels are always required. However, the extent of inefficiencies mean that far more staff are unproductive and are not able to be positively deployed than would otherwise be needed. Such system-wide inefficiencies are also having to be, in part, propped-up by further investment in additional paramedic staffing to try to offset the performance impact of handover delays.

Financial controls

73 We considered the extent to which the Trust has appropriate and effective arrangements in place for allocating, authorising, recording, and managing the use of its financial resources. In examining this, we have looked at whether:

- there are effective controls in place to ensure compliance with Standing Financial Instructions and Schemes of Delegation;
- the Audit Committee maintains appropriate oversight of arrangements and performance relating to single tender actions, special payments, losses, and counter-fraud;
- there are effective financial management arrangements in place; and
- financial statements were submitted on time, contained no material misstatements, and received a clean audit opinion.

74 We found that **the Trust has appropriate and effective arrangements for financial management and control.**

75 The Board effectively oversees standing financial instructions, last reviewing them in January 2022. The Trust's financial systems and controls have not changed since last year. The Trust's Audit Committee receives information on losses and special payments in its public session and counter-fraud and single tenders in the private session of each meeting (see **Recommendation 1**). No significant issues have been reported to the Audit Committee on these items this year.

76 The Trust submitted good quality draft financial statements for audit on the Welsh Government imposed deadline of 29 April 2022, which were considered by the Audit Committee in early June. Our audit identified one uncorrected misstatement, though this was below material level. Following Board approval, we issued an unqualified audit opinion on 15 June 2022.

Monitoring and reporting arrangements

77 We considered the extent to which the Board oversees, scrutinises, and challenges the organisation's financial performance. In examining this, we have looked at whether:

- reports to the Board provide a clear picture of the organisation's financial position, as well as the key financial challenges, risks, and mitigating actions taken; and
- Board members sufficiently challenge ongoing assessments of the financial position.

78 We found that **the Trust has effective arrangements for reporting and monitoring financial performance and overseeing the delivery of savings programmes.**

79 There are effective arrangements for oversight of financial performance at both executive and Board level. Finance reports and savings and efficiency highlight reports are regularly submitted to the Strategic Transformation Board, the Executive Management Team, and the Finance and Performance Committee. The Board also receives the finance report each quarter.

80 Reports are open and transparent, highlighting the current situation and any key risks that members should be aware of including risks or mitigating actions. Members feel assured by the reports and are sighted on key issues. Challenge observed during meetings demonstrates the Trust's cautious approach to financial management.

Managing the workforce, digital resources, the estate, and other physical assets

81 In this section of the report, we provide our high-level views on the Trust's arrangements for managing its wider resources, with a particular focus on the organisation's arrangements for:

- supporting staff wellbeing (please note we will be undertaking a separate review of the organisation's workforce planning arrangements);
- managing its digital resources; and
- managing its estate and other physical assets.

82 We found that **action is needed to ensure the positive work to support staff well-being is having the desired impact and also to maintain a focus on reducing sickness absence rates. Implementation of the digital strategy would be strengthened by improved oversight of the programme and clarity over funding. Strategic decisions also need to be made in respect of longer term estate needs and decarbonisation.**

Supporting staff well-being

83 We considered the extent to which the Trust has appropriate and effective arrangements in place for supporting staff well-being. In examining this, we have looked at whether:

- mechanisms to seek staff views about their well-being needs are effective, and appropriate action is taken to respond to findings; and
- actions to support and improve staff well-being are actively monitored by the Board, including actions taken in response to our report on how NHS bodies supported staff wellbeing during the COVID-19 pandemic[7].

84 We found that **while the Trust has developed a well-being programme for staff, there is a need to evaluate and understand how well this is supporting staff and reducing sickness absence rates.**

85 The Trust demonstrates a clear appreciation and understanding of the stress staff experience. The Trust has historically had higher sickness absence rates than other NHS bodies in Wales and these were at their highest-ever levels in December 2021, at 12.4%. The Trust continues to work to address short and long-term sickness absence. While sickness rates have decreased to under 9% in September 2022, they remain higher than the Trust's target rate of 8% and continue to be a particular concern for Trust staff in Emergency Medical Services. Progress is monitored through the 'improving attendance' project which reports to

[7] Taking care of the carers? How NHS bodies supported staff wellbeing during the COVID-19 pandemic.

the People and Culture Committee. The project has seven areas of focus including well-being, stress and anxiety and management support.

86 The Trust has a range of well-being services in place for staff, including an employee assistance programme and an in-house Occupational Health Team. The Trust also has arrangements in place to provide information on how this provision can be accessed. Staff well-being activity is reported quarterly to the People and Culture Committee. However, the report does not detail how many staff have engaged in these activities. Furthermore, it does not include any evaluation of impact or assurance that staff needs are being met and that value for money is being delivered (see **Recommendation 6**).

87 Our Taking Care of the Carers report made several recommendations to health bodies around staff well-being. As of December 2022, the Trust is making reasonable progress in implementing these recommendations: ten have been completed to date, however the remaining eight overdue and no reasons were provided for six recommendations. As discussed in **paragraph 86**, despite the well-being improvement activity, sickness absence remains very high for some staff groups and completion of appraisals is lower than target levels.

Managing digital resources

88 We considered the extent to which the Trust has appropriate and effective arrangements in place for managing its digital resources. In examining this, we have looked at whether:

- there is a Board approved digital strategy in place which seeks to harness and exploit digital technology to improve the quality, safety, and efficiency of services, as well as to support new models of care and new ways of working; and
- benefits arising from investments in digital technology are actively monitored by the Board.

89 We found that **while the Trust is closely managing and monitoring key digital and cyber risks, there is scope to strengthen reporting of progress of its digital strategy.**

90 The Trust's Digital Strategy seeks to enable service improvement and modernisation. Following the departure of the Digital Director in July 2022, the interim director is currently reviewing the strategy to understand whether any updates are required since its publication in 2020. The Trust is also developing a digital Strategic Outline Programme to sit alongside the Trust’s Fleet and Estates Strategic Outline Programmes.

91 While it is positive that the Trust’s digital strategy is in place and activity is underway to align it to other key enabling services, further clarity is needed on how the strategy will be funded. The digital strategy is funded via three routes: the Trust’s IMTP process, the national data resource in Digital Health and Care Wales and the Welsh Government Digital Priorities Investment Fund, the strategy was

approved without clarification of how it would be funded in its totality. Staffing arrangements also appear to be a challenge. In addition to its ongoing digital service, the Trust supports delivery of the strategy through a mix of its core team capacity and temporary additional posts on a project-by-project basis. Given the shortage of digital workforce across Wales, the Trust, in common with other NHS bodies, finds permanent as well as short-term recruitment for its digital services a challenge.

92 The implementation of the digital strategy is managed through the Strategic Transformation Board as part of the Trust's process for monitoring progress of the IMTP. The Trust does not report against the digital strategy as a programme, but rather reports against individual elements, such as data analytics which reported to the Strategic Transformation Board in October 2022. The Trust intends to report other elements in coming months. The lack of overall oversight may make it difficult for the Trust to understand the impact of the digital strategy in its totality in supporting the organisation to achieve its strategic ambitions.

93 Both the Finance and Performance Committee and the QuESt Committee have roles in relation to overseeing elements of the Trust's digital activities. While the Finance and Performance Committee oversees most elements relating to digital, data management teams report information security information through the Information Governance Steering Group, currently a sub-group of the QuESt Committee. While this may create a risk of confusion, we did not find evidence that this arrangement was leading to duplication or gaps in oversight. The Trust's current review of the Terms of Reference and reporting lines for the Information Governance Steering Group may help mitigate this risk further. In addition, the Board have shown they have effective oversight of significant risks relating to digital, including the ongoing risk in relation to delivery of a replacement programme for its 111 service.

Managing the estate and other physical assets

94 We considered the extent to which the Trust has appropriate and effective arrangements in place for managing its estate and other physical assets. In examining this, we have looked at whether:

- there are Board-approved strategies and plans in place for managing the organisation's estates and its wider physical assets;
- there are appropriate arrangements in place for the Board to review, scrutinise, challenge, and approve significant capital projects and programmes; and
- there are appropriate arrangements in place for the Board to maintain appropriate oversight of the condition of the estate and other physical assets.

95 We found that **the Trust has effective approaches to estates and decarbonisation, however it must balance strategic opportunities with meeting increasing backlog maintenance costs in the context of limited capital funding.**

96 The Trust has an effective approach to managing its estates in the context of limited available capital funding. In 2021, the Trust refreshed its Estate Strategic Outline Programme. The Trust prioritises its estate based on potential current conditions and potential opportunities, benefits, and collaborative arrangements. From its analysis, the worst (highest) scoring locations have been prioritised for improvement / repair / replacement as appropriate. The Trust's backlog maintenance costs have remained fairly consistent since 2018-19 with a small year on year increase. However, the success of delivering the Estate Strategic Outline Programme is dependent on timely approval of requests for discretionary capital funding and the availability of discretionary capital funding which has reduced by 24%. The shortfall in discretionary capital is leading to a reduced programme and an increasing emphasis on prioritising the highest risk sites.

97 The Trust has in place a decarbonisation action plan to reduce emissions by 34% by 2030. The plan is extensive with over a hundred actions. The Finance and Performance Committee regularly assess progress in relation to the action plan. In November 2022, following a self-assessment, an indicative rating for the plan's progress was rated as red/amber, with remedial actions being put in place. Estates is a significant part of the Trust's decarbonisation process. The Trust has acknowledged that there is a tension and balance between meeting the targets in their decarbonisation plans and delivery estate and asset projects. This is reflected in developing a business case for the new station in Swansea where all options and costing are being discussed.

Appendix 1

Audit approach

Exhibit 2 sets out the approach we adopted for delivering our structured assessment work at the Trust.

Exhibit 2: audit approach

Element of audit approach	Description
Observations	We observed Board meetings as well as meetings of the following Committees: • Board, March 2022 and July 2022; • People and Culture Committee, May 2022 • Quality, Experience and Safety Committee, May 2022 • Finance and Performance Committee, July 2022 • Audit Committee, March 2022 and September 2022

Element of audit approach	Description
Documents	We reviewed a range of documents, including: • Board and Committee Terms of Reference, work programmes, agendas, papers, and minutes; • Key governance documents, including Schemes of Delegation, Standing Orders, Standing Financial Instructions, Registers of Interests, and Registers of Gifts and Hospitality; • Key organisational strategies and plans, including the IMTP; • Key risk management documents, including the Board Assurance Framework and Corporate Risk Register; • Key reports relating to organisational performance and finances; • Annual Report, including the Annual Governance Statement; • Relevant policies and procedures; and • Reports prepared by the Internal Audit Service, Health Inspectorate Wales, Local Counter-Fraud Service, and other relevant external bodies.

Interviews	We interviewed the following Senior Officers and Non-Executive Directors: • Chair of the Trust (as of July 2022) • Chair of Quality, Experience and Safety Committee (QuESt) • Chair of People and Culture Committee • Chief Executive Officer, • Director of Finance • Director of Planning and Performance • Board Secretary • Director of Digital; and • Chief Ambulance Services Commissioner.

Appendix 2

Management response to audit recommendations

98 **Appendix 2** will be completed once the management response has been received.

Exhibit 3: management response

Recommendation	Management response	Completion date	Responsible officer
Administrative governance R1 We have identified opportunities for the Trust to further increase transparency by strengthening administrative governance by: a) Ensuring the timely publication of committee papers in advance of meetings and minutes following	a) Agreed	a) Immediately for timely publication of committee papers and by 1 April 2023 for minutes to allow for repository to be established on website.	a) Board Secretary

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Recommendation	Management response	Completion date	Responsible officer
the end of meetings to the Trust website; b) Enhancing the recording of Chair's actions and decisions taken in private session, for example by identifying the costs and delivery risks relating to decisions made; c) Providing the declarations of interest, gifts and hospitality as a specific document available to be publicly viewed; and d) Reconsidering receiving all counter fraud information within the private session of the audit committee.	b) Agreed. Fuller information on decisions will be provided. c) Agreed d) Due to the fact that the local counter fraud service report routinely contains sensitive information it will remain in private session, however the AAA highlight report from the Audit Committee into the public Trust Board will provide an expanded narrative on the issues discussed including any relevant metrics.	b) Immediately c) 1 April 2023 d) 30 March 2023	b) Board Secretary c) Board Secretary d) Executive Director of Finance and Corporate Resources
Patient experience reporting R2 Improve quarterly patient experience reporting to QuESt by ensuring a balance of both positive and negative feedback and providing information	a) Agreed	September 2023	Executive Director of Quality and Nursing

Recommendation	Management response	Completion date	Responsible officer
on what is being done to address the negative themes arising in the report.			
Staff involvement in the development of future key plans R3 The Trust should take steps to ensure its key strategic plans, including the IMTP are developed with, and informed by, its staff.	Accepted. This has taken place for the development of the 2023-26 IMTP with wide ranging staff and stakeholder engagement	Complete and ongoing	Executive Director of Strategy, Planning and Performance
Develop engagement delivery plans R4 While the Trust has recently refreshed its high-level engagement framework, it should seek to urgently publish and progress detailed plans to support it in providing external in relation to unscheduled care system pressures.	A phased delivery plan is scheduled to be presented to Board at its January 2023 meeting. This document will outline indicative messages/audiences/phasing and approaches over the next 18 months to two years.	January 2023 to Board Timetabled plan to EMT Qtr 1 2023/24	Director of Partnerships and Engagement

Recommendation	Management response	Completion date	Responsible officer
	The granular detail of who, what and where in terms of timetable will be subsequently developed and approved by the Executive Management Team.		
Ensure evaluation of effective staff wellbeing services R5 While the Trust has introduced a programme of services to support staff wellbeing, it is not currently undertaking sufficient evaluation and review to ensure these are meeting the needs of staff. The Trust should introduce a regular process to evaluate its staff wellbeing services, such as via pulse surveys or participant questionnaires. This evaluation should inform long-term investment decisions for such services.	• A wellbeing survey was recently undertaken by WAST in conjunction with Swansea University (SU); the report has now been received and is due to be presented to EMT shortly- this provides valuable insight and qualitative evidence regarding the our current wellbeing offer and identifies areas that need more focus in particular the need to tailor interventions based on a range of factors. • Feedback questionnaires have been implemented from December 2022 to all staff who access our OH and Wellbeing services. The data from these questionnaires will be reviewed monthly within the Workforce and Organisational Development Directorate and will feed into the regular updates provided to People and Culture Committee Mechanisms have also been put in place to receive feedback and evaluation of impact when colleagues are discharged from specific services for example	February 2023 January 2023 onwards	Director of Workforce and Organisational Development (delivered by Catherin Goodwin)

Recommendation	Management response	Completion date	Responsible officer
	Fitback (Physiotherapy Service) and NOSS (Trauma Counselling). – Feb 2023 onwards • Regular meetings are in place with service providers (FitBack, Health Assured, NOSS, Caer Health, Thrive) and monthly data reports are being reviewed regularly in order to understand trends and themes in terms of uptake and gaps (to enable targeted promotion, for example, by role and geographic area). • Fortnightly OH and Wellbeing Team meetings taking place where team members provide qualitative feedback regarding service provision and share feedback from staff who have used the service – ongoing • Specific wellbeing metrics will be developed as part of the people and culture plan evaluation section for 2023-26 – these will include measures such as cost savings associated with reduced sick absences figures , improved	February 2023 onwards Ongoing April 2023 onwards	

Recommendation	Management response	Completion date	Responsible officer
	engagement levels and early intervention to enable colleagues to remain in work • Follow up surveys will be carried out to identify utilisation of wellbeing services, gaps and impact on a twice-yearly basis. • Participation in the Gold Corporate Health Standard will ensure a continued focus on evaluation and assessment of impact of the different interventions offered by WAST.	June 2023 and December 2023 March 2023 – onwards	

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Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Annual Audit Report 2022 – Welsh Ambulance Service NHS Trust

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Summary report

About this report

1. This report summarises the findings from my 2022 audit work at Welsh Ambulance Service NHS Trust (the Trust) undertaken to fulfil my responsibilities under the Public Audit (Wales) Act 2004. That Act requires me to:
   - examine and certify the accounts submitted to me by the Trust, and to lay them before the Senedd;
   - satisfy myself that expenditure and income have been applied to the purposes intended and are in accordance with authorities; and
   - satisfy myself that the Trust has made proper arrangements for securing economy, efficiency, and effectiveness in its use of resources.
2. I report my overall findings under the following headings:
   - Audit of accounts
   - Arrangements for securing economy, efficiency, and effectiveness in the use of resources
3. This year's audit work took place at a time when NHS bodies continued to respond to the unprecedented and ongoing challenges presented by the COVID-19 pandemic. Health bodies were not only tackling the immediate challenges presented by the public health emergency but were also seeking to recover and transform services to respond to the significant numbers of people who are waiting for treatment and improve population health. My work programme, therefore, was designed to best assure the people of Wales that public funds are well managed. I have considered the impact of the current crisis on both resilience and the future shape of public services.
4. I aimed to ensure my work did not hamper public bodies in tackling the crisis, whilst ensuring it continued to support both scrutiny and learning. We largely continued to work and engage remotely where possible, through the use of technology, but some on-site audit work resumed where it was safe and appropriate to do so. This inevitably had an impact on how we deliver audit work but has also helped to embed positive changes in our ways of working.
5. As was the case in the previous two years, the delivery of my audit of accounts work has continued mostly remotely. The success in delivering it reflects a great collective effort by both my staff and the Trust's officers.
6. I have adjusted the focus and approach of my performance audit work to ensure its relevance in the context of the crisis and to enable remote working. I have commented on how NHS Wales is tackling the backlog of patients waiting for planned care. My local audit teams have commented on how governance arrangements have adapted to respond to the pandemic, and the impact the crisis has had on service delivery.

7 This report is a summary of the issues presented in more detailed reports to the Trust this year (see **Appendix 1)**. I also include a summary of the status of work still underway, but not yet completed.

8 **Appendix 2** presents the latest estimate of the audit fee that I will need to charge to cover the costs of undertaking my work, compared to the original fee set out in the 2022 Audit Plan.

9 **Appendix 3** sets out the audit of accounts risks set out in my 2022 Audit Plan and how they were addressed through the audit.

10 The Chief Executive and the Director of Finance have agreed the factual accuracy of this report. We will present it to the Audit Committee on 2 March 2023. The Board will receive the report at a later Board meeting and every member will receive a copy. We strongly encourage the Trust to arrange its wider publication. We will make the report available to the public on the Audit Wales website after the Board have considered it.

11 I would like to thank the Trust's staff and members for their help and co-operation throughout my audit.

Key messages

Audit of accounts

12 I concluded that the Trust's accounts were properly prepared and materially accurate and issued an unqualified audit opinion on them. My work did not identify any material weaknesses in the Trust's internal controls (as relevant to my audit).

13 I brought several issues to the attention of officers and the Audit Committee, which I will review and monitor as part of my audit of the 2022-23 accounts.

14 I identified no material financial transactions within the Trust's 2021-22 accounts that were not in accordance with authorities or not used for the purpose intended, and so I have issued an unqualified opinion on the regularity of the financial transactions within the Trust's 2021-22 accounts.

15 The Trust achieved financial balance for the three-year period ending 31 March 2022, reporting a cumulative surplus of £190,000. The Trust has an approved three-year plan in place.

16 I did not place a substantive report on the accounts alongside my opinion this year as there were no issues to report.

Arrangements for securing efficiency, effectiveness, and economy in the use of resources

17 My programme of Performance Audit work has led me to draw the following conclusions:

- whilst many facets of the Trust's quality governance arrangements are working well, improvements are required in a number of key areas to ensure the Trust is fully informed on issues relating to the quality and safety of its services. The Trust also needs to play its part in the improvements that are required for responding to serious incident reporting where incidents occur across organisational boundaries.
- my structured assessment work found:
  - that whilst there have been recent changes in leadership, the Trust continues to be well led. Recognising that governance arrangements are improving, the Trust should also continue to seek opportunities to enhance its influence and joint working with key partners to help resolve some of the significant performance and quality challenges it faces.
  - there are good approaches for developing plans, but there needs to be a stronger focus on staff and partner engagement and greater challenge on the impact of plans in supporting improvements to performance.
  - the Trust has a good approach to financial planning, management, and reporting, however, opportunities exist to reduce the significant inefficiencies caused by external system pressures.
  - action is needed to ensure the positive work to support staff well-being is having the desired impact and also to maintain a focus on reducing sickness absence rates. Implementation of the digital strategy would be strengthened by improved oversight of the programme and clarity over funding. Strategic decisions also need to be made in respect of longer-term estate needs and decarbonisation.

18 These findings are considered further in the following sections.

Detailed report

Audit of accounts

19 Preparing annual accounts is an essential part of demonstrating the stewardship of public money. The accounts show the organisation's financial performance and set out its net assets, net operating costs, gains and losses, and cash flows. My annual audit of those accounts provides an opinion on both their accuracy and the proper use ('regularity') of public monies.

20 My 2022 Audit Plan set out the key risks for audit of the accounts for 2021-22 and these are detailed along with how they were addressed in **Exhibit 4** in **Appendix 3**.

21 My responsibilities in auditing the accounts are described in my Statement of Responsibilities publications, which are available on the Audit Wales website.

Accuracy and preparation of the 2021-22 accounts

22 I concluded that the Trust's accounts were properly prepared and materially accurate and issued an unqualified audit opinion on them. My work did not identify any material weaknesses in internal controls (as relevant to my audit), however, I brought some issues to the attention of officers and the Audit Committee for improvement.

23 The Trust submitted its unaudited financial statements by the deadline issued by the Welsh Government. The working papers provided were comprehensive and of good quality, and officers promptly responded to audit queries and requests for further information.

24 I must report issues arising from my work to those charged with governance (the Audit Committee) for consideration before I issue my audit opinion on the accounts. My Financial Audit Engagement Lead reported these issues on 13 June 2022. **Exhibit 1** summarises the key issues set out in that report.

Exhibit 1: issues reported to the Audit Committee

Issue	Auditors' comments
Uncorrected misstatements	There were two uncorrected misstatements identified within the accounts: • Indexation: The Trust followed Welsh Government guidance not to apply the increase in indexation notified in late March 2022. This resulted in asset values being understated by £328,000.

Issue	Auditors' comments
	• Finance lease: The Trust's Airwave finance lease contract extension was found to end in December 2022 and not November 2022, as indicated by the original financial models provided to the Trust at the time of the contract negotiation. This resulted in both the asset value and finance lease liability being understated by £166,000.
Corrected misstatements	There were initially misstatements in the accounts that were corrected by management.
Other significant issues	• Potential liability resulting from the ministerial direction to the Welsh Government to fund pensions tax liabilities above the pension savings annual allowance: we recommended the Trust should continue to engage with the Welsh Government to resolve the issue in 2022-23, so the contingent liability disclosure can be removed, or if a liability has arisen, a provision included in the accounts. • Property, Plant and Equipment and Intangible Assets: we recommended the Trust should complete an annual review of its assets to identify those which are no longer in use or have been disposed of and ensure these are removed from the asset register. • Defibrillators: we reported the need for the Trust to implement the planned RFID tagging system to be able to easily identify the existence and location of all defibrillators held on the fixed asset register.

25 I also undertook a review of the Whole of Government Accounts return. I concluded that the counterparty consolidation information was consistent with the Trust's financial position on 31 March 2022 and the return was prepared in accordance with the Treasury's instructions.

26 My separate audit of the charitable funds accounts is ongoing, to be completed by the Charities Commission deadline of 31 January 2023.

Regularity of financial transactions

27 The Trust's financial transactions must be in accordance with the authorities that govern them. It must have the powers to receive the income and incur the expenditure. Our work reviews these powers and tests that there are no material elements of income or expenditure which the Trust does not have the powers to receive or incur.

28 I identified no material financial transactions within the Trust's 2021-22 accounts that were not in accordance with authorities or not used for the purpose intended, and so I have issued an unqualified opinion on the regularity of the financial transactions within the Trust's 2021-22 accounts.

29 I did not place a substantive report on the accounts alongside my opinion this year as there were no issues to report.

30 I have the power to place a substantive report on the Trust's accounts alongside my opinions where I want to highlight issues. Where the Trust fails one of its financial duties – to break even over a three-year period and to have an approved three-year plan in place – or my opinion is qualified, I will issue a substantive report.

31 The Trust met both of its financial duties, achieving an in-year surplus of £75,000 and a three-year cumulative surplus of £190,000, and my opinions were unqualified, so I did not issue a such a report.

Arrangements for securing efficiency, effectiveness, and economy in the use of resources

32 I have a statutory requirement to satisfy myself that the Trust has proper arrangements in place to secure efficiency, effectiveness, and economy in the use of resources. My performance audit work at the Trust over the last 12 months has supported me to discharge that responsibility. This work has involved:

- reviewing the effectiveness of the Trust's quality governance arrangements.
- undertaking a structured assessment of the Trust's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically.

33 My conclusions based on this work are set out below.

Quality governance arrangements

34 My review examined whether the organisation's governance arrangements support delivery of high quality, safe and effective services. The review focused on both the operational and corporate approach to quality governance, organisational culture

and behaviours, strategy, structures and processes, information flows and reporting.

35 My work found that that **whilst many facets of the Trust's quality governance arrangements are working well, improvements are required in a number of key areas to ensure the Trust is fully informed on issues relating to the quality and safety of its services. The Trust also needs to play its part in the improvements that are required to serious incident reporting across organisational boundaries.**

36 The Trust has renewed its Quality Strategy, is strengthening its risk management arrangements and has invested in quality improvement processes. Lines of accountability for quality governance are clear, and there are good arrangements to listen to and act upon the experiences of patients and staff. Although more focus is needed to address concerns around incident reporting, appraisal rates and to ensure adequate responses to any incidents of bullying and harassment.

37 The role of Quality Patient Experience and Safety (QuESt) Committee is clearly defined, and its work is supported by a good suite of performance information. However, clinical audit needs to become a more recognised and visible source of assurance within the Trust's quality governance framework.

38 A key area for improvement is the need to address the significant backlog of mortality reviews, and to keep the QuESt Committee adequately sighted of progress in this area. There is also a need to better triangulate information from different sources to ensure there is a full understanding of patient outcomes and avoidable harms associated with long waits for an emergency ambulance.

39 Whilst the Trust's internal system for managing concerns and serious incidents is sound, the joint escalation framework for managing serious incidents across organisational boundaries is no longer effective, and the Trust must work with its commissioners and health board partners to improve this.

Structured assessment

40 My 2022 structured assessment work took place at a time when NHS bodies were not only continuing to tackle the challenges presented by COVID-19, but were also seeking to recover and transform services to respond to the significant numbers of people who are waiting for treatment and improve population health.

41 My team focussed on the Trust's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically, with a specific focus on the organisation's governance arrangements; strategic planning arrangements; financial management arrangements; and arrangements for managing the workforce, digital assets, the estate, and other physical assets. Auditors also paid attention to progress made to address previous recommendations.

42 Overall, we found that **the Trust has taken positive steps to improve aspects of its corporate governance arrangements, but further work is needed to provide the strong internal challenge and continued external influence**

required to overcome some of the unprecedented operational challenges it currently faces.

Governance arrangements

43 My work considered the Trust's governance arrangements, with a particular focus on:

- Board and committee effectiveness;
- the extent to which organisational design supports good governance; and
- key systems of assurance.

44 My work found that **while there have been recent changes in leadership, the Trust continues to be well led. Recognising that governance arrangements are improving, the Trust should also continue to seek opportunities to influence and work together with key partners to help resolve some of the significant performance and quality challenges it faces.**

45 The Board is committed to public transparency, self-reflection, and hearing directly from patients and staff. The Trust has effectively filled key board-level posts in the past year, including a new Chair and the process for recruiting a new vice-Chair is underway. Meetings of the Board and committees are conducted appropriately and are supported by clear Schemes of Delegation. However, there is scope to strengthen governance arrangements particularly around improving the timeliness of publishing Board and committee papers and increasing the public transparency of decisions made in private sessions of the Board.

46 The Trust is strengthening its risk framework, however, several significant risks have remained unchanged despite mitigating actions in recent months. This suggests that mitigating action to reduce the risk is not always having the desired effect. The Board receives regular information about the impact of wider system failings on its own performance and related quality concerns for patients. Recognising that many factors are beyond the Trust's direct control, the Trust must continue to seek opportunities to influence its partners to secure improvement as well as focussing on the impact of actions taken locally to address these issues.

Strategic planning arrangements

47 My work considered the Trust's strategic planning arrangements, with a particular focus on the organisation's:

- vision and strategic objectives;
- Integrated Medium Term Plan;
- planning arrangements; and
- arrangements for implementing and monitoring the delivery of corporate strategies and plans.

48 My work found that **there are good approaches for developing plans, but there needs to be a stronger focus on staff and partner engagement and greater challenge on the impact of plans in supporting improvements to performance.**

49 The Trust has a Board-approved long-term vision and clinical strategy, which are rooted in population health and aligned to key national strategies. The Trust recognises that delivery of its longer-term aspirations will depend on the buy-in of partners, therefore external engagement must remain a priority. The Trust has a balanced and approved Integrated Medium Term Plan for 2022-2025, which has clear milestones and good alignment with key plans. The Trust's combined strategic frameworks are monitored quarterly by the Finance and Performance Committee and Board, supplemented by detailed monitoring for key programmes. However, there is a need to develop clear and timely delivery plans to support its strategic documents and improve staff involvement in the planning process.

Managing financial resources

50 My work considered the Trust's arrangements for managing its financial resources, with a particular focus on the organisation's:

- arrangements for meeting key financial objectives;
- financial controls; and
- arrangements for reporting and monitoring financial performance.

51 My work found that **the Trust has a good approach to financial planning, management, and reporting, however, opportunities exist to reduce the significant inefficiencies caused by external system pressures.**

52 The Trust achieved its financial duty for 2021-22 and has a clear financial plan for 2022-2025. While this year's savings plan has an increasing focus on transformational savings, opportunities remain to reduce reliance on vacancy control as a means of achieving short-term non-recurring cost reduction. The well-documented whole-system issues which are contributing to significant emergency ambulance handover delays also result in significant financial inefficiencies for the Trust. The Trust continues to have good systems of financial control and is taking steps to reduce the number of single tender waivers used. The organisation's financial reports are clear and regularly received by the Finance and Performance Committee and the Board.

Managing the workforce, digital resources, the estate, and other physical assets

53 My work considered the Trust's arrangements for managing its wider resources, with a particular focus on the organisation's:

- arrangements for supporting staff wellbeing;
- arrangements for managing its digital resources; and

- arrangements for managing its estate and other physical assets.

54 My work found that **action is needed to ensure the positive work to support staff wellbeing is having the desired impact and also to maintain a focus on reducing sickness absence rates. Implementation of the digital strategy would be strengthened by improved oversight of the programme and clarity over funding. Strategic decisions also need to be made in respect of longer-term estate needs and decarbonisation.**

55 The Trust has developed a broad programme to support staff wellbeing which appears to be well utilised. However, the Trust is not yet evaluating the impact of these services to ensure they are making a real difference. Managing sickness absence remains a key area of focus, but absence rates are very high, particularly amongst Trust staff in emergency medical services.

56 The Trust's digital strategy is being implemented but there is scope to strengthen and improve oversight of the entirety of its digital programme. The Trust is also developing a digital Strategic Outline Programme to sit alongside the Trust's Fleet and Estates Strategic Outline Programmes. While some aspects of the digital programme are funded, the strategy was approved without clarification of how it would be funded in its totality.

57 The Trust plans to prioritise estate investment but faces challenges because of reducing available discretionary capital financing. It must, at the same time, ensure appropriate strategic decisions to support longer-term estates needs and the organisation's decarbonisation agenda.

Appendix 1

Reports issued since my last annual audit report

Exhibit 2: reports issued since my last annual audit report

The following table lists the reports issued to the Trust in 2022.

Report	Date
Financial audit reports	
Audit of Financial Statements Report	June 2022
Opinion on the Financial Statements	June 2022
Performance audit reports	
Review of Quality Governance Arrangements	August 2022
Structured Assessment 2022	December 2022
Other	
2022 Trust Audit Plan	April 2022
2022 Charity Audit Plan	December 2022

My wider programme of national value for money studies in 2022 included reviews that focused on the NHS and pan-public-sector topics. These studies are typically funded through the Welsh Consolidated Fund and are presented to the Public Accounts Committee to support its scrutiny of public expenditure. Reports are available on the Audit Wales website.

Exhibit 3: performance audit work still underway

There are performance audits that are still underway at the Trust. These are shown in the following table, with the estimated dates for completion of the work.

Report	Estimated completion date
Unscheduled care – access to unscheduled care services	July 2023
Workforce planning	June 2023

Appendix 2

Audit fee

The 2022 Audit Plan set out the proposed audit fee of £159,752 (excluding VAT). My latest estimate of the actual fee, on the basis that some work remains in progress, is in keeping with the fee set out in the plan.

A full audit of the Charity's accounts was requested by the Trustees this year, which is not included in the fee detailed above. The 2022 Charity Audit Plan set out the proposed fee for this work of £12,000 (excluding VAT).

Appendix 3

Audit of accounts risks

Exhibit 4: audit of accounts risks

My 2022 Audit Plan set out the risks for the audit of the Trust's 2021-22 accounts. The table below lists these risks and sets out how they were addressed as part of the audit.

Audit risk	Proposed audit response	Work done and outcome
Significant risks		
The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.31-33].	We will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for biases; and • evaluate the rationale for any significant transactions outside the normal course of business.	On a sample basis, my team tested both journal entries and accounting estimates and found no evidence of the management override of controls. My team were satisfied that the accounts were free from material error.
The implementation of the 'scheme pays' initiative in respect of the NHS pension tax arrangements for clinical staff is ongoing. Last year, we included an Emphasis of Matter paragraph in the audit opinion drawing attention to your disclosure of the contingent liability. Applications to the scheme will close on 31 March 2022, and if any expenditure is made in-year, we would consider it to be irregular, as it contravenes the requirements of Managing Welsh Public Money.	We will review the evidence one year on around the take-up of the scheme and the need for a provision, and the consequential impact on the regularity opinion.	Officers reviewed the terms of eligibility for the scheme and information from received from the Welsh Government and concluded that no provision for future liabilities was required within the accounts. However, as the Welsh Government is yet to finalise the allocation of cases, the Trust appropriately included a contingent liability disclosure within the financial statements for this issue. My team agreed with the Trust's accounting treatment of this issue.

Audit risk	Proposed audit response	Work done and outcome
Significant risks		
NHS Trusts have a financial duty to break even over a three-year rolling period. Although the Trust is forecasting a break-even position, this duty increases the risk that management judgements and estimates included in the financial statements could be biased in helping achieve this financial duty. Where the Trust fails this financial duty, I will place a substantive report on the financial statements highlighting the failure.	We will focus our testing on areas of the financial statements which could contain reporting bias.	My team undertook a range of audit work to provide assurance over the risk of bias to ensure that the actual year-end position was true and fair. This included: • detailed sample testing of transactions either side of the year-end to ensure that they were recorded in the correct accounting period. This was focussed on the areas of greatest risk. • ensuring that accounting estimates were prepared on a reasonable basis and were supported by appropriate accounting judgements. My team were satisfied that the accounts were free from material error.
Introduction of IFRS 16 Leases has been deferred until 1 April 2022. There may be considerable work required to identify leases and the COVID-19 national emergency may pose additional implementation risks. The 2021-22 accounts will need to disclose the potential impact of implementing the standard.	We will review the completeness and accuracy of the disclosures.	My team satisfied themselves that the disclosures were materially complete and accurate.

Audit risk	Proposed audit response	Work done and outcome
Significant risks		
We audit some of the disclosures in the Remuneration Report, such as the remuneration of senior officers and independent members, to a lower level of materiality. The disclosures are therefore inherently more prone to material misstatement. A number of changes have taken place to the senior management team and non-executive directors during the financial year. There is a risk that these changes are not correctly disclosed within the Trust's Remuneration Report.	We will review all entries in the Remuneration Report to verify that the Trust has reflected all known changes to senior positions, and that the disclosures are complete and accurate.	The work was carried out as proposed. Some amendments were agreed with the Trust to ensure the final remuneration report was accurate and disclosures complied with the requirements of the NHS Manual for Accounts.
There continues to be increased funding streams and expenditure in 2021-22 to deal with the COVID-19 pandemic. These could have an impact on the risks of misstatement and the shape and approach to our audit. Examples of issues include fraud, error and regularity risks of additional spending; valuation (including obsolescence) of year-end inventory, including PPE; and estimation of annual leave balances.	We will identify the key issues and associated risks and plan our work to obtain the assurance needed for our audit.	My team completed audit testing around COVID-19-related funding and expenditure, and also on year-end balances. No issues were identified from the work completed.

Audit risk	Proposed audit response	Work done and outcome
Significant risks		
Although COVID-19 restrictions have now been removed, there have been ongoing pressures on staff resources and of remote working that may impact on the preparation, audit and publication of accounts. There is a risk that the quality of the accounts and supporting working papers may be compromised leading to an increased incidence of errors. Quality monitoring arrangements may be compromised due to timing issues and/or resource availability.	We will discuss your closedown process and quality monitoring arrangements with the accounts preparation team and make arrangements to monitor the accounts preparation process. We will help to identify areas where there may be gaps in arrangements.	The work was carried out as proposed. My team found that the Trust has robust arrangements in place and did not identify any issues in this respect.

Audit Wales

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Website: www.audit.wales

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

Welsh Ambulance Services NHS Trust

Outline Audit Plan 2023

Audit year: 2022-2023

Date issued: February 2023

This document has been prepared as part of work performed in accordance with statutory functions. Further information can be found in our Statement of Responsibilities.

Audit Wales is the non-statutory collective name for the Auditor General for Wales and the Wales Audit Office, which are separate legal entities each with their own legal functions. Audit Wales is not a legal entity and itself does not have any functions.

No responsibility is taken by the Auditor General, the staff of the Wales Audit Office or, where applicable, the appointed auditor in relation to any member, director, officer or other employee in their individual capacity, or to any third party.

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000. The section 45 Code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales, the Wales Audit Office and, where applicable, the appointed auditor are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to the Wales Audit Office at infoofficer@audit.wales.

We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

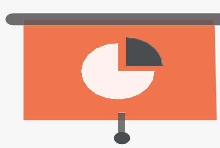
About Audit Wales

Our aims:

Assure

the people of Wales that public money is well managed

Explain

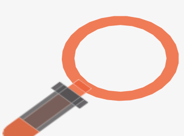


how public money is being used to meet people's needs

Inspire

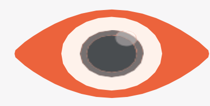
and empower the Welsh public sector to improve

Our ambitions:



Fully exploit our unique perspective, expertise and depth of insight

Strengthen our position as an authoritative, trusted and independent voice



Increase our visibility, influence and relevance

Be a model organisation for the public sector in Wales and beyond

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Introduction

This Outline Audit Plan specifies my statutory responsibilities as your external auditor and to fulfil my obligations under the Code of Audit Practice. It also sets out details of my audit team and key dates for delivering my audit team's activities and planned outputs. I intend sharing a Detailed Audit Plan later in the year following the completion of my planning work. It will set out my estimated audit fee and the work my team intends undertaking to address the audit risks identified and other key areas of audit focus during 2023.

Adrian Crompton

Auditor General for Wales

My audit responsibilities

Audit of financial statements

I am required to issue a report on your financial statements which includes an opinion on their 'truth and fairness' and the regularity of income and expenditure. and the proper preparation of key elements of your Remuneration and Staff Report. I lay them before the Senedd together with any report that I make on them. I will also report by exception on a number of matters which are set out in more detail in our Statement of Responsibilities.

I do not seek to obtain absolute assurance on the truth and fairness of the financial statements and related notes but adopt a concept of materiality. My aim is to identify material misstatements, that is, those that might result in a reader of the accounts being misled. The levels at which I judge such misstatements to be material will be reported to you in my Detailed Audit Plan.

I am also required to certify a return to the Welsh Government which provides information about the Trust to support preparation of the Whole of Government Accounts.

Performance audit work

I must satisfy myself that the Trust has made proper arrangements for securing economy, efficiency, and effectiveness in its use of resources. I do this by undertaking an appropriate programme of performance audit work each year.

My work programme is informed by specific issues and risks facing the Trust and the wider NHS in Wales. I have also taken account of the work that is being undertaken or planned by other external review bodies and by internal audit.

Fees and audit team

In January 2023 I published the fee scheme for the year, approved by the Senedd Finance Committee. This sets out my fee rates and also highlights the impact of the revised auditing standard ISA 315 on my financial audit approach. More details of the revised auditing standard and what it means for the audit I undertake is set out in **Appendix 1**.

I will provide an estimate of your fee in my Detailed Audit Plan in May 2023, following completion of my detailed risk assessment.

Your engagement team:

Dave Thomas	**Engagement Director & Audit Director (Performance Audit)**
Gareth Lucey	**Audit Director (Financial Audit)**
Alison Butler	**Audit Manager (Financial Audit)**
Andrew Doughton	**Audit Manager (Performance Audit)**
Erin Pollard	**Audit Lead (Financial Audit)**
Fflur Jones	**Audit Lead (Performance Audit)**

We confirm that our audit team members are all independent of the Trust and your officers. There is one potential issue to bring to your attention. The Accounts Audit Manager's husband is the Director of Finance and Corporate Services at NHS Wales Shared Services Partnership. We have put arrangements in place to ensure any actual or perceived conflicts of interest are addressed.

Audit timeline

We set out below key dates for delivery of our audit work and planned outputs.

Planned output	Work undertaken	Report finalised
2023 Outline Audit Plan	February 2023	February 2023
2023 Detailed Audit Plan	February – April 2023 Audit Wales and Trust officers are currently discussing timescales for completing key areas of audit work in this period.	May 2023
Audit of financial statements work: • Audit of Financial Statements Report • Opinion on the Financial Statements.	May - July 2023	July 2023
Performance audit work: • Structured Assessment, incorporating a deep dive into a specific thematic area which will be confirmed in the detailed plan in May 2023. • Local project work (to be confirmed in detailed plan in May 2023)	Timescales for individual projects will be discussed with you and detailed within the specific project briefings produced for each study.	

Audit quality

My commitment to audit quality in Audit Wales is absolute.

I believe that audit quality is about getting things right first-time.

We use a three lines of assurance model to demonstrate how we achieve this.

We have established an Audit Quality Committee to co-ordinate and oversee those arrangements. We subject our work to independent scrutiny by QAD[1] and our Chair acts as a link to our Board on audit quality. For more information see our Audit Quality Report 2022.

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Our People

The first line of assurance is formed by our staff and management who are individually and collectively responsible for achieving the standards of audit quality to which we aspire.

- Selection of right team
- Use of specialists
- Supervisions and review

Arrangements for achieving audit quality

The second line of assurance is formed by the policies, tools, learning & development, guidance, and leadership we provide to our staff to support them in achieving those standards of audit quality.

- Audit platform
- Ethics
- Guidance
- Culture
- Learning and development
- Leadership
- Technical support

Independent assurance

The third line of assurance is formed by those activities that provide independent assurance over the effectiveness of the first two lines of assurance.

- EQCRs
- Themed reviews
- Cold reviews
- Root cause analysis
- Peer review
- Audit Quality Committee
- External monitoring

[1] QAD is the Quality Assurance Department of ICAEW

Appendix 1 – the key changes to ISA315 and the potential impact on your organisation

Key change	Potential impact on your organisation
More detailed and extensive risk identification and assessment procedures	Your finance team and others in your organisation may receive a greater number of enquiries from our audit teams at the planning stage of the audit. Requests for information may include: • information on your organisation's business model and how it integrates the use of information technology (IT); • information about your organisation's risk assessment process and how your organisation monitors the system of internal control; • more detailed information on how transactions are initiated, recorded, processed, and reported. This may include access to supporting documentation such as policy and procedure manuals; and • more detailed discussions with your organisation to support the audit team's assessment of inherent risk.
Obtaining an enhanced understanding of your organisation's environment,	Your organisation may receive more enquiries to assist the audit team in understanding the IT environment. This may include information on: • IT applications relevant to financial reporting; • the supporting IT infrastructure (e.g. the network, databases); • IT processes (e.g. managing program changes, IT operations); and

Key change	Potential impact on your organisation
particularly in relation to IT	• the IT personnel involved in the IT processes. Audit teams may need to test the general IT controls and this may require obtaining more detailed audit evidence on the operation of IT controls within your organisation. On some audits, our audit teams may involve IT audit specialists to assist with their work. Our IT auditors may need to engage with members of your IT team who have not previously been involved in the audit process.
Enhanced requirements relating to exercising professional scepticism	Our audit teams may make additional inquiries if they identify information which appears to contradict what they have already learned in the audit.
Risk assessments are scalable depending on the nature and complexity of the audited body	The audit team's expectations regarding the formality of your organisation's policies, procedures, processes, and systems will depend on the complexity of your organisation.
Audit teams may make greater use of technology in the performance of their audit	Our audit teams may make use of automated tools and techniques such as data analytics when performing their audit. Our teams may request different information or information in a different format from previous audits so that they can perform their audit procedures.

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

ANNUAL FILINGS SCHEDULE 2022-23

MEETING	Audit Committee
DATE	2nd March 2023
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Trish Mills, Board Secretary Alex Payne, Corporate Governance Manager
CONTACT	Email: Trish.Mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. The Annual Filings Task and Finish Group (the "Group") was re-established in November 2022 to ensure that the Trust meets the Annual Report & Accounts 2022-23 disclosure and reporting requirements as set out in the Manual for Accounts (MfA) published by Welsh Government (WG).

2. A timetable for the Annual Filings has been developed and is set out in Annex 1. A supplementary (fuller) schedule is in place for contributions to the various sections of the Annual Report which will be managed by the Group.

3. The timetable has been drafted based on the draft MfA, and the schedule is subject to change based on the final dates confirmed by the WG. The schedule for the external audit is yet to be agreed, therefore the full schedule and submission deadlines are not yet confirmed by WG. Additional context has been included in section 7 of the paper.

RECOMMENDATION

4. The Audit Committee is asked to approve:

4.1 The Annual Filings 2022-23 schedule, acknowledging that there will likely be changes to the dates presented due to the submission deadlines not yet having been confirmed by Welsh Government;

4.2 Circulation of the reports set out at paragraph 7.2 by email for review.

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

REPORT APPROVAL ROUTE
13th February 2023: ADLT – Review of Annual Filings Timetable 15th February 2023: EMT – Review of Annual Filings Timetable

REPORT APPENDICES
1. Annex 1 – SBAR

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

ANNEX 1

SITUATION

1. The Annual Filings Task and Finish Group ("Group") was re-established in November 2022 to take a structured approach to the 2022-23 Annual Filings requirements as set out in the Manual for Accounts published by Welsh Government (WG).

BACKGROUND

2. The WG Manual for Accounts 2022-23 requires the Trust to submit as a single PDF document, a three-part Annual Report and Accounts. The Annual Report includes the Performance Report and Accountability Report.

ASSESSMENT

3. The Annual Report requires contributions from several individuals including performance and planning, partnerships and engagement, corporate governance, finance, workforce and organisational development and others.

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

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

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

DRAFT 2022/23 ANNUAL FILINGS TIMETABLE

HIGH LEVEL DEADLINES	ACTION	DETAIL	EXECUTIVE LEAD
28/04/2023	Submission Deadline	Draft Unaudited Accounts	Chris Turley
05/05/2023	Submission Deadline	Draft Annual Report	Trish Mills
14/06/2023	Submission Deadline	Final Annual Report & Accounts to Audit Wales	Chris/Trish

	DEADLINE/MILESTONE	ACTION	DETAIL	
1	08/02/2023	Submission Deadline	22/23 Annual Filings Schedule to EMT	Trish Mills
2	15/02/2023	Meeting of EMT	22/23 Annual Filings Schedule received at EMT	Trish Mills
3	22/02/2023	Submission Deadline	22/23 Annual Filings Schedule to Audit Committee	Trish Mills
4	02/03/2023	Meeting of Audit Committee	22/23 Annual Filings Schedule approved by Audit Committee	Trish Mills
5	05/04/2023	Submission Deadline	22/23 Draft Annual Report to EMT [Exc. RemReport]	Trish Mills
6	12/04/2023	Meeting of EMT	22/23 Draft Annual Report received at EMT [Exc. RemReport]	Trish Mills
7	27/04/2023 - TBC	Email Circulation	EMT to Review Draft Remuneration Report	Trish Mills
8	28/04/2023 - TBC	Email Circulation	Circulate of Remuneration Report to RemCom by email	Trish Mills
9	28/04/2023 - TBC	Email Circulation	Circulate draft Annual Report to Audit Committee	Trish Mills
10	TBC	Email Circulation	Circulate draft Annual Report to Trust Board - For Info	Trish Mills
11	28/04/2023 - TBC	Submission Deadline	Draft Unaudited Accounts to WG/Audit Wales	Chris Turley
12	05/05/2023 - TBC	Submission Deadline	Draft Annual Report to WG/Audit Wales	Trish Mills
13	TBC	*Audit Commencement*	*Waiting on final Manual for Accounts guidance*	Chris Turley
14	TBC	*Audit Closure Meeting*	*Waiting on final Manual for Accounts guidance*	Chris Turley
15	30/05/2023 - TBC	Submission Deadline	Final 22/23 ARA submitted for Audit Committee	Chris/Trish
16	06/06/2023 - TBC	Meeting of Audit Committee	Audit Committee to scrutinise/endorse final 22/23 ARA	Chris/Trish
17	07/06/2023 - TBC	Submission Deadline	Final ARA Submitted for Trust Board	Chris/Trish
18	13/06/2023 - TBC	Meeting of Trust Board	Trust Board - Approval/sign-off of audited ARA	Chris/Trish
19	14/06/2023 - TBC	Submission Deadline	AUDIT WALES TO SUBMIT FINAL AUDITED ARA	Chris/Trish
20	10/07/2023 - TBC	Submission Deadline	Submission of papers for AGM	Estelle Hitchon
21	27/07/2023 - TBC	Annual General Meeting	Presentation of the 22/23 ARA	Estelle Hitchon

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

   7.1 A supplementary timetable will be developed by the Group to manage contributions to the various sections of the Annual Report, its layout and Welsh translation;

   7.2 Due to the scheduling of Trust Board and Committee meetings and timelines for the production of the financial content, it is proposed that some draft documents are provided by email, namely those referenced in points 7-10.

   7.3 The timetable has been drafted based on the draft Manual for Accounts, and the schedule is subject to change based on the final dates confirmed by WG. The schedule for the external audit is yet to be agreed, therefore the full schedule and submission deadlines are not yet confirmed by WG.

   7.4 The dates in the timetable will therefore change, however we will keep ADLT apprised of those changes and the Group will adjust work plans accordingly. The Corporate Governance Team will work closely with colleagues in Finance to align the respective workplans and reporting schedules.

RECOMMENDATION

8. **The Audit Committee is asked to approve:**

   8.1 **The Annual Filings 2022-23 schedule, acknowledging that there will likely be changes to the dates presented due to the submission deadlines not yet having been confirmed by Welsh Government;**

   8.2 **The circulation of the reports set out at paragraph 7.2 by email for review.**

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

2022/23 Annual Accounts Update

MEETING	AUDIT COMMITTEE
DATE	2 March 2023
EXECUTIVE	Chris Turley, Executive Director of Finance and Corporate Resources
AUTHOR	Jessica Price – Deputy Head of Financial Accounting
CONTACT	Chris Turley, 01633 626201, Chris.Turley2@wales.nhs.uk

EXECUTIVE SUMMARY

This report provides to the Committee an update on planning undertaken, progress made and any issues arising with both the preparation and external audit of the 2022/23 Annual Accounts.

KEY ISSUES/IMPLICATIONS

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

- An update has been provided on the 'Scheme Pays' arrangements for NHS Pensions and the potential qualification implications for Trust's accounts in 2022/23.
- Audit Wales (AW) have requested an extension to the NHS Wales audit timetable to 31st July 2023. We are working closely with the AW team on what this would mean to the Trust audit.
- Due to ongoing discussions between Welsh Government (WG) and AW around the extension to the audit timetable, at the time of writing WG are yet to provide the final year-end timetable.
- AW will not be commencing their Interim Audit until late March at the earliest, due to this the Audit Plan and *'Audit Enquiries to those charged with governance and management'* could not be provided to this meeting (as is usually the case) and will need to be circulated at a later date.

REPORT APPROVAL ROUTE

- Audit Committee – 2nd March 2023

REPORT APPENDICIES
N/A

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

WELSH AMBULANCE SERVICES NHS TRUST

AUDIT COMMITTEE

2022/23 Annual Accounts Update

SITUATION

1. In preparation for year-end, an interim audit is expected to take place virtually by the AW team from late March and will be concluded in early May 2023.

2. The purpose of this paper is to make Audit Committee aware of where we are at present with regards to working through the detailed timetable for the 2022/23 year-end and any emerging issues.

BACKGROUND/ASSESSMENT

Scheme Pays – NHS Pension Scheme

3. Committee members may recall that following a Government Ministerial Direction issued on 18 December 2019, a scheme was arranged which allowed NHS Clinicians who are members of the NHS Pension Scheme to apply for the 'Scheme Pays' facility to settle annual allowance tax charges arising from their 2019/20 NHS Pension savings (i.e. settling the charge by way of reduced annual pension, rather than by making an immediate one-off payment), then their NHS employer would meet the impact of those tax charges on their pension when they retire.

4. The Ministerial Direction was required because this solution could be viewed by HMRC to constitute tax planning, hence making the expenditure irregular. Managing Welsh Public Money specifically states that 'public sector organisations should not engage in tax evasion, tax avoidance or tax planning'. A Ministerial Direction does not make regular what would otherwise be irregular, but it does move the accountability for such decisions from the Accounting Officer to the Minister issuing the direction.

5. The 'Scheme Pays' solution applies only to annual allowance tax charges arising from an increase in the benefits accrued in the NHS Pension Scheme during the tax year ended 5th April 2020.

6. The Trust has not previously recognised any potential costs in relation to 'Scheme Pays' due to insufficient information being available to do so. However, the Trust has recently received confirmation from NHS Pensions of the acceptance of a 2019/20 'Scheme Pays' application for one individual who was employed by the Trust during 2019/20.

7. Audit Wales consider any transactions included in the Trust's accounts to recognise this liability as irregular and material by nature due to the payments being contrary to Managing Welsh Public Money and it constituting a form of tax planning.

8. If the Trust is required to recognise a provision in relation to the liability arising from the accepted application, this will result in an audit opinion of the 2022/23 accounts being one of a technical qualification. This is however in line with that

which all health boards and most of the NHS organisations in Wales were subject to in 2021/22.

9. The Finance team are working closely with WG to gain further clarification as to whether the accepted application meets the criteria of the scheme as the individual was not a practicing clinician. At present, it is unclear whether it is correct that this application has been accepted. Clarification has also been sought as to whether the liability would lie with the Trust or with the individuals' current employer, as the individual has since left WAST employment.

10. The Finance team have also made Audit Wales aware of the potential liability to be recognised within the 2022/23 accounts.

Year End Timetable & Audit

11. At the time of writing, WG are yet to provide details of the final year-end submission dates in order for us to complete our detailed year-end timetable.

12. This is due to ongoing discussions between WG and AW around the requested extension of the audit timetable to 31st July 2023.

13. The Trust is anticipating an update on this situation imminently and once confirmed, will work to produce the detailed year-end timetable and circulate for information.

14. AW have advised, the interim audit will focus on the implementation of the new auditing standard (ISA 315) in which AW will undertake a more robust risk assessment. This will entail conversations with Finance team and assessments of the systems and procedures in place to identify the level of risk of material misstatement to areas of the accounts.

RECOMMENDED:

15. The Committee note the contents of this report.

AGENDA ITEM No	7
OPEN or CLOSED	Open
No of ANNEXES ATTACHED	4

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

MEETING	Audit Committee
DATE	2 March 2023
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Trish Mills, Board Secretary
CONTACT	trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. At the Board meeting on 26 January 2023 the Chair of the Audit Committee sought further clarity on the roles and responsibilities for risk management within the existing framework, in particular the role of the Executives, the Committees and the Board with respect to the higher rated risks. This report provides assurances in respect of the management of the Trust's principal risks, an overview of the current risk management framework with particular focus on assurance to Committees and the Board, and detail of the risk programme for the Integrated Medium Term Plan (IMTP) 2023-26.

2. The IMTP 2023-26 includes the elements that comprise the Risk Framework, including the Risk Policy, Procedures and Guidance, as well as training and education. The IMTP 2023-26 includes the development of a BAF that reflects more closely the Trust's strategic objectives against its long term strategy – Delivering Excellence: Vision 2030.

3. However, in the meantime there are some measures that are proposed in this paper to further strengthen risk management including the way the risk report is presented at Board meetings, development of guidance on interpretation of the BAF, and risks escalated via Alert, Advise, Assure reports from Committees being presented to the Audit Committee.

4. This report also includes the principal risks in Annexes 1 and 2 which were presented to the Trust Board on 26 January 2023 and are updated as at 17 January 2023. The risk review schedule and governance routes agreed by the Audit Committee have been delayed due to current operational pressures including industrial action, as well as absence in the team. All endeavours will be made to formally review the risks prior to the March 2023 Board

RECOMMENDED

5. **Members are asked to consider and discuss the contents of the report and the proposed measures to strengthen the risk management framework.**

KEY ISSUES/IMPLICATIONS
The key issues and implications are set out in the Executive Summary above.
REPORT APPROVAL ROUTE
The report has been circulated to the EMT as the scheduled meeting on 22 February was cancelled due to industrial action taking place. Each of the Corporate Risks were considered by the following Committees, as relevant to their remit, during the reporting period: a) **Quality, Safety & Patient Experience** (9 February 2023) b) **Finance & Performance Committee** (16 January 2023)

REPORT ANNEXES
• SBAR report. • Annex 1 - Summary table describing the Trust's Corporate Risks. • Annex 2 – Scoring Matrix • Annex 3 – Frequency of Risk review • Annex 4 - 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)	Y
Health Improvement	NA	Socio Economic Duty	NA
Health and Safety	NA	TU Partner Consultation	NA

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

SITUATION

6. The purpose of the report is to provide assurance in respect of the management of the Trust's principal risks, an overview of the current risk management framework with particular focus on assurance to Committees and the Board, and detail of the risk programme for the IMTP 2023-26.

7. A summary of the Trust's 17 principal risks on the corporate risk register as of 17 January 2023 is detailed in Annex 1.

BACKGROUND

8. As a result of discussion at the Board meeting on 28 July 2022 regarding its engagement on the higher rated risks the executive summary of the Board risk management report was adjusted for the 29 September 2022 Board meeting.

9. That report highlighted the focus that is maintained on management of the higher rated risks, not only as a result of risk discussions in various forums including Assistant Directors Leadership Team (ADLT) and Executive Management Team (EMT) and the Committees, but as a result of broader attention to planned mitigations. The report draws together those broader discussions and signposts the Board accordingly. The Board noted at its September 2022 meeting that this better defined the process and the format has therefore continued to date.

10. At the Board meeting on 26 January 2023 the Chair of the Audit Committee sought further clarity on the roles and responsibilities for risk management within the existing framework, in particular the role of the Executives, the Committees and the Board with respect to the higher rated risks.

ASSESSMENT

11. The principal risks set out at Annex 1 and Annex 2 were presented to the Trust Board on 26 January 2023 and are updated as at 17 January 2023. The risk review schedule and governance routes agreed by the Audit Committee have been delayed due to current operational pressures including industrial action, as well as absence in the team. All endeavours will be made to formally review the risks prior to the March 2023 Board.

Risk Management Framework

12. The Trust's principal risks are set out in its corporate risk register. The Trust also operates directorate and local registers where risks are managed locally.

13. In July 2022 those principal risks were first presented to the Board and Committees in the format of a Board Assurance Framework (BAF). As noted in the 2022 Audit Wales Structured Assessment *"The new version* [of the BAF] *is more detailed and comprehensive, with much greater articulation of the controls*

and assurances in place. The BAF currently draws its principal risks from the Corporate Risk Register and maps them to the 2022-25 Integrated Medium-Term Plan deliverables and therefore, by extension, the Trust's strategic risks. It is not yet aligned to the Trust's broader long-term strategy and does not link with wider system controls and assurances[1]". Until such time as the Trust transitions to a more mature and strategic BAF during 2023/24 as part of the risk transformational programme, these principal risks will continue to be drawn directly from the corporate risk register.

14. The IMTP 2022-25 had an ambition to develop and deliver a strategic risk management framework as a key enabler of our business strategy and decision making. A significant amount of progress was made in developing the current BAF template and to rearticulate all principal risks into an 'if, then, resulting in' format to better understand the risks and therefore controls and mitigations. Development of a risk management framework (including policy, procedures, training, all Wales Datix, and risk appetite statements) was planned to replace the outdated risk management strategy 2018-2021. With the delay in appointment of the Trust Board Chair to October 2022 and reduced resourcing in the risk team it was felt that the dates for the framework should be recalibrated. The risk management policy has been drafted however its progress through the policy process has been slowed due to current pressures. It is due for approval by the Audit Committee at the July 2023 meeting. The Once For Wales Datix implementation is off target and is entirely out of the Trust's control. The Trust continues to utilise the extant Datix system as a central repository for all risks.

15. A focus throughout 2022 on the principal risks in the new BAF format with the scheduled confirm and challenge meetings, and rhythm of review by ADLT and EMT has strengthened the commitment to risk management by senior levels of management. This level of risk maturity, along with the clarity in the BAF of controls, gaps and assigned actions owned by individual Executives, provides a good springboard upon which to move to the next stage of maturity in developing a more traditional BAF.

16. The IMTP 2023-26 includes the development of a BAF that reflects more closely the Trust's strategic objectives against its long term strategy – Delivering Excellence: Vision 2030. The BAF brings together in one place all of the relevant information on the risks relating to the Trust's strategic objectives. These are usually identified 'top down' by the Board as opposed to more operational (or corporate) risks that arise from day to day activities and are usually identified bottom up. The BAF is one element of a suite of mechanisms which the Board uses to assure itself that it is delivering against its strategic objectives including but not limited to the Monthly Integrated Performance and Quality Report (MIQPR), the outcomes of Board visits, 'Alert, Advise and Assure' reports (AAA reports) from Committees, deep dives into specific areas of the business of the Trust, and third lines of defence such as Internal Audit and Audit Wales reviews.

17. Risks scored as high (15-25) are reviewed monthly, medium risks (8-12) are reviewed quarterly, and low risks (1-6) are reviewed every 6 months. These

[1] Paragraph 34 Structured Assessment 2022 – date issued January 2023

reviews take place with the risk owners supported by the risk team. The BAF is formally updated quarterly and reviewed by the ADLT and EMT as the senior internal risk forums before reporting to the Committees and Trust Board. Any additional actions on the high rated risks in between the cycles are reported verbally or in the cover report where appropriate.

18. Principal risks are assigned to an Executive Director for ownership and to a Committee for oversight and assurance. A risk owner is the individual best placed, through their authority and influence, to take responsibility for mitigating the risk and is responsible for:

- Ensuring the risk is managed appropriately, controls are in place to mitigate the risk and an action plan is identified to address gaps in control measures;
- Reviewing the risk register at appropriate intervals and that progress is being made at sufficient pace to reduce the risk score to the target risk level;
- Liaising with action owners to ensure they are aware of their responsibilities for delivering actions (action owners have responsibility for activities to address gaps); and
- Reporting on the overall status of the risk.

19. Principal risks are presented to each Committee meeting in line with the agreed review cycles and are presented by the responsible Executive Director. The discussion and any escalations from the Committee are set out in a dedicated section of the AAA report to the Board. An important step to ensuring the Committee agenda is driven by the highest rated risks is the agenda setting meeting for each Committee. This takes place with the Chair, Executive lead and Board Secretary and the agenda is compiled with reference to the cycle of business, forward planner and the highest rated risks.

20. Recent effectiveness surveys for Committees sought feedback on the Committee's review of risk. The question on whether management fully briefs the Committee on key risks, safety issues and any gaps in control was in on the whole in agreement that they did – particularly those Committees that are assigned principal risks for oversight. The question on whether key risks are discussed at each meeting, including controls in place, assurances against controls and actions to address the gaps received a mixed response, but on the whole there was agreement that this was the case. In addition, the Audit Wales Structured Assessment[2] noted "*Our committee observations found that meetings ran appropriately with agendas covering the most important risks to the Trust and the introduction of new Committee assurance reports has also been positive in highlighting key issues and facilitating flows of assurance from Committees to the Board*".

21. The Audit Committee receives the BAF at each meeting as well as more detailed information on the risk transformation programme and ambition for risk at the Trust. It has oversight of the risk management framework and the adequacy and effectiveness of the risk and control related disclosure statements (particularly the Annual Governance Statement), prior to endorsement by the Board. It has oversight of the effectiveness of the systems and processes for the management of risks and the BAF.

[2] Para number 22 Structured Assessment 2022 – date issued January 2023

22. As noted above, the Board agreed to a form of reporting in September 2022 that ensured it saw all principal risks, but that the higher rated risks and assurances were drawn out more particularly in the executive summary. This is a standalone report to each meeting and enables the Board to further scrutinise over and above that which takes place at Committees. The Board also receives the AAA reports from Committees drawing out the risk discussions and escalations. More recently, from July to date, the report which shows progress against actions to mitigate avoidable harm deals in large part with the actions underway to mitigate risks 223 and 224 and is an area of focus for discussion at Board. Similar to the Committees, the Board agenda is set with the Trust Board Chair, Chief Executive and the Board Secretary with the highest rated risks cross-checked to ensure they drive the agenda's focus.

Further Measures Proposed to the Risk Management Framework

23. The Risk Management Policy that is in development will set out the various roles and responsibilities in more detail, and the framework will include a BAF standard operating procedure, training and guidance. However, there are some measures that are proposed in the interim to further strengthen risk management which are as follows:

- Presentation of risk at Board: It is proposed to retain the standalone risk paper at the Board which demonstrates in the executive summary where focus is maintained on management and mitigation of the principal risks rated 25 and 20, drawing together those broader discussions and signposting the Board accordingly. In addition, the risk owners will have an opportunity to add to that narrative and that which is contained in the full BAF document, with Committee Chairs providing further assurance or escalations as appropriate, drawing from their AAA reports. This will afford the Board as a whole an opportunity to scrutinise further to ensure mitigating actions are achieving their maximum impact. **This can commence from the March Board meeting.**

- Guidance on interpretation of the BAF: Audit Wales in their Structured Assessment noted that:

  - *"While the Trust regularly reviews its corporate risks, the scores for several significant risks have remained unchanged despite mitigating actions in recent months. This suggests that mitigating action to reduce the risk is not always having the desired effect"*[3]*;* and

  - *"We found that while the Trust is strengthening its systems of assurance with regular reviews of risk, further work is required to understand whether the Trust's mitigating actions are achieving their intended impact on significant and ongoing risks and challenges*"[4]; and

  - *"While the BAF is a standing agenda item on each Board and Committee agenda, there is a need to better focus discussions on the effectiveness*

[3] Paragraph 6 Structured Assessment 2022 – date issued January 2023
[4] Paragraph 33 Structured Assessment 2022 – date issued January 2023

and impact of controls in reducing the strategic risks facing the organisation"[5]; and

- *"Our observations of the Trust Board and its committees found less challenge and scrutiny from Non-Executive Directors, compared with the level of challenge provided by Independent Members in other NHS bodies. While they do not tolerate poor performance, Non-Executive Directors do need to provide stronger challenge to be fully assured that the Trust is taking all necessary actions within its control to address areas of poor quality of service. They also need to ensure that sufficient clarity is provided on what needs to be done to resolve these issues, recognising of course that solutions are often not within the direct control of the Trust.[6]"*

A simple guidance note will be developed to assist Board and Committee members to interpret the BAF, address some of the issues raised in the Structured Assessment and provide proportionate challenge on actions to mitigate the risks and their intended impact. This will focus on:

- Review date: has it followed the agreed review and if not why not?
- Risk articulation: is the cause and effect of the risk clear?
- Scoring: a guide on how likelihood and consequence scores are arrived at to gauge if the score is appropriate.
- Controls and assurances: what are they and how robust are they to mitigate the risk?
- Gaps: are they comprehensive with what we currently know?
- Actions: is there an action for each gap?; are the actions on track?; will they reduce the risk when completed and they move to controls?

This guidance will be developed by 1 April.

- Any escalations made by Committees to the Board in their AAA report are to be separately provided to the next Audit Committee meeting. **This will commence immediately.**

24. Internal Audit are due to commence their review of risk management and assurance in March/April 2023.

RECOMMENDED

25. **Members are asked to consider and discuss the contents of the report and the proposed measures to strengthen the risk management framework.**

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[5] Paragraph 34 Structured Assessment 2022 – date issued January 2023
[6] Paragraph 23 Structured Assessment 2022 – date issued January 2023

Annex 1 – Corporate Risk Register Summary

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
223 QuEST	The Trust's inability to reach patients in the community causing patient harm and death	**IF** significant internal and external system pressures continue **THEN** there is a risk of an inability and/or a delay in ambulances reaching patients in the community **RESULTING IN** patient harm and death	Director of Operations	**25 (5x5)** ➡
224 QuEST	Significant handover delays outside A&E departments impacts on access to definitive care being delayed and affects the trust's ability to provide a safe and effective service	**IF** patients are significantly delayed in ambulances outside A&E departments **THEN** there is a risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised **RESULTING IN** patients potentially coming to harm and a poor patient experience	Director of Quality & Nursing	**25 (5x5)** ➡
160 PCC	High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service	**IF** there are high levels of absence **THEN** there is a risk that there is a reduced resource capacity **RESULTING IN** an inability to deliver services which adversely impacts on quality, safety and patient/staff experience	Director of Workforce & Organisational Development	**20 (5x4)** ➡
201 PCC	Damage to Trust reputation following a loss of stakeholder confidence	**IF** the stability of the Trust deteriorates to a level where service delivery fails to meet patient safety, national standards and contractual obligations **THEN** there is a risk of a loss of stakeholder confidence in the Trust **RESULTING IN** damage to reputation and increased external scrutiny	Director of Partnerships & Engagement	**20 (4x5)** ➡

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
139 FPC	Failure to Deliver our Statutory Financial Duties in accordance with legislation	**IF** the Trust does: • not achieve financial breakeven and/or • does not meet the planning framework requirements and/or • does not work within the EFL and/or • fails to meet the 95% PSPP target and/or • does not receive an agreement with commissioners on funding (linked to 458) **THEN** there is a risk that the Trust will fail to achieve all its statutory financial obligations and the requirements as set out within the Standing Financial Instructions (SFIs) **RESULTING IN** potential interventions by the regulators, qualified accounts and impact on delivery of services and reputational damage	Director of Finance & Corporate Resources	**16 (4x4)** ➡
244 FPC **CLOSED**	Estates accommodation capacity limitations impacting on EMS Clinical Contact Centre's (CCC) ability to provide a safe and effective service	**IF** the Trust is unable to increase accommodation capacity **THEN** there is a risk that EMS CCC will not be able to accommodate all roles during periods of escalation and surge management or expand operations to support new initiatives **RESULTING IN** EMS CCC being unable to deliver services effectively which adversely impacts on quality, safety and patient/staff experience	Director of Operations	**16 (4x4)** ➡

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
245 FPC	Failure to have sufficient capacity at an alternative site for EMS Clinical Contact Centres (CCCs) which could cause a breach of Statutory Business Continuity regulations	**IF** CCCs are unable to accommodate additional core functions and do not have alternative site arrangements in place in the event of a business continuity incident **THEN** there is a risk that EMS CCCs cannot utilise other CCC's space, accommodation and facilities **RESULTING IN** potential patient harm and a breach of the requirements of the Civil Contingencies Act (2004) and Contingency Planning Regulations (2005)	Director of Operations	**16 (4x4)** ➡
458 FPC	A confirmed commitment from EASC and/or Welsh Government is required in relation to funding for recurrent costs of commissioning	**IF** sufficient recurrent funding is not forthcoming there is a risk that the Trust will be committed to additional expenditure through delivery of the IMTP and in year developments which are only recognised by commissioners on a cost recovery basis **THEN** there is a risk that the Trust may not be able to deliver services and there will be a lack of funding certainty when making recurrent cost commitments. Any potential 'exit strategies' from developed services could be challenging and harmful to patients. **RESULTING IN** patients not receiving services, the Trust not achieving financial balance and a potential failure to meet statutory obligations causing reputational damage	Director of Finance & Corporate Resources	**16 (4x4)** ➡

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
557 PCC	Potential impact on services as a result of Industrial Action	**IF** trade unions take industrial action in response to the national pay award **THEN** this is likely to disrupt our ability to provide a safe, efficient and good quality service in the 6 core areas the business **RESULTING IN** potential harm to patients, adverse effect to patient outcomes, increase in SAIs/concerns/coroners cases, negative media reports, and impact on the Trust's corporate reputation	Director of Workforce & Organisational Development	**16 (4x4)**
199 PCC	Failure to embed an interdependent and mature health and safety culture which could cause harm and a breach in compliance with Health & Safety statutory legislation	**IF** there is a failure to embed an interdependent and mature health and safety culture, effective arrangements and associated governance **THEN** there is a risk of a potential breach in compliance with the requirements of the Health & Safety at Work etc. Act 1974 and associated regulations and other statutory instruments **RESULTING IN** death or serious injury, and punitive actions from multiple enforcement agencies including penalties and adverse publicity leading to damage to reputation	Director of Quality & Nursing	**15 (3x5)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
260 FPC	A significant and sustained cyber-attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems	**IF** there is a large-scale cyber-attack on WAST, NHS Wales and interdependent networks which shuts down the IT network and there are insufficient information security arrangements in place **THEN** there is a risk of a significant information security incident **RESULTING IN** a partial or total interruption in WAST's ability to deliver essential services, loss or theft of personal/patient data and patient harm or loss of life	Director of Digital Services	**15 (3x5)** ➡
543 FPC	Major disruptive incident resulting in a loss of critical IT systems	**IF** there is an unexpected or uncontrolled event e.g. flood, fire, security incident, power failure, network failure in WAST, NHS Wales or interdependent systems **THEN** there is a risk of a loss of critical IT systems **RESULTING IN** a partial or total interruption in WAST's effective ability to deliver essential services	Director of Digital Services	**15 (3x5)** ➡
558 PCC	Deterioration of staff health and wellbeing in as a consequence of both internal and external system pressures	**IF** significant internal and external system pressures continue **THEN** there is a risk of a significant deterioration in staff health and wellbeing within WAST **RESULTING IN** increased sickness levels, staff burnout, poor staff and patient experience and patient harm	Director of Workforce & Organisational Development	**15 (3x5)** ➡

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
100 FPC	Failure to persuade EASC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience	**IF** WAST fails to persuade EASC/Health Boards about WAST ambitions **THEN** there is a risk of a delay or failure to receive funding and support **RESULTING IN** a catastrophic impact on services to patients and staff and key outcomes within the IMTP not being delivered	Director of Strategy Planning & Performance	**12 (3x4)** ➡
163 PCC	Maintaining Effective & Strong Trade Union Partnerships	**IF** the response to tensions and challenges in the relationships with Trade Union partners is not effectively and swiftly addressed and trust and (early) engagement is not maintained **THEN** there is a risk that Trade Union partnership relationships increase in fragility and the ability to effectively deliver change is compromised **RESULTING IN** a negative impact on colleague experience and/or services to patients.	Director of Workforce & Organisational Development	**12 (3x4)** ➡
283 FPC	Failure to implement the EMS Operational Transformation Programme	**IF** there are issues and delays in the planning and organisation of the EMS Demand & Capacity Review Implementation Programme **THEN** there is a risk that WAST will fail to implement the EMS Operational Transformation Programme to the agreed performance parameters **RESULTING IN** potential patient harm, deterioration in staff wellbeing and reputational damage	Director of Strategy Planning & Performance	**12 (3x4)** ➡

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
424 FPC	Prioritisation or Availability of Resources to Deliver the Trust's IMTP	**IF** resources are not forthcoming within the funding envelope available to WAST (link to risk 139) **THEN** there is a risk that there is insufficient capacity to deliver the IMTP **RESULTING IN** delay or non-delivery of IMTP deliverables which will adversely impact on the Trust's ability to deliver its strategic objectives and improvement in patient safety and staff wellbeing	Director of Strategy Planning and Performance	**12 (3x4)** ➡

Annex 2 - 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. Jnsafe staffing level (>1 day)/competence. Low staff morale. Poor staff attendance for mandatory/key professional training.	Uncertain delivery of key objective/ service due to lack/loss of staff. Insafe staffing level (>5 days)/competence. Very low staff morale. Significant numbers of staff not attending mandatory/key professional training.	Non-delivery of key objective/service due to loss of several key staff. Ongoing unsafe staffing levels or competence/skill mix. No staff attending mandatory/professional training.
Statutory Duty, Regulation, Mandatory Requirements	No or minimal impact or breach of guidance/statutory duty.	Breach of statutory legislation. Reduced performance levels if unresolved.	Single breach in statutory duty. Challenging external recommendations/improvement notice.	Enforcement action. Multiple breaches in statutory duty. Improvement notices. Low achievement of performance/ delivery requirements. Critical report.	Multiple breaches in statutory duty. Zero performance rating. Prosecution. Severely critical report. Total system change needed.
Adverse Publicity or Reputation	Rumours. Low level negative social media. Potential for public concern.	ical 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:	13/01/2023	TREND	25 (5x5)
			Date of Next Review:	13/02/2023	➡	
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

CONTROLS	**ASSURANCES**
1. Patient Flow Co-Ordination based in the Grange University Hospital	**Internal** **Management (1st Line of Assurance)** 1. Patient Flow Coordinators (PFCs) are a commissioned service by the Health Board (x2 in ABUHB specifically for GUH) with a bespoke job description, these link directly with the National Delivery Managers in ODU
2. Regional Escalation Protocol	2. Daily conference calls to agree RE levels in conjunction with Health Boards
3. Immediate release protocol	3. The Immediate Release Protocol is a Nationally agreed NHS Wales protocol. Refusals by Health Boards are Datixed by WAST and compliance report shared weekly with the Health Board Chief Operating Officers (COOs)
4. Resource Escalation Action Plan (REAP)	4. Weekly review by Senior Operations team with assessment of action compliance. The Senior Leadership Team convenes every Tuesday as the Weekly Performance Meeting to review performance and demand data, and review/assign REAP Levels as appropriate. Dynamic escalation via Strategic Command structure.
5. 24/7 Operational Delivery Unit (ODU)	5. Shift reports from ODU & ODU Dashboard received by Exec, SOT and On-Call Team at start/end. Provides operational oversight with dynamic CSP review and system escalation as required.
6. Gold/Strategic, Silver/Tactical and Bronze/Operational 24 hour/ 7 day per week system to manage escalation plans	6. Same as 5 - Shift reports from ODU & ODU Dashboard received by Exec, SOT and On-Call Team at start/end. Provides operational oversight with dynamic CSP review and system escalation as required.
7. Limited Alternative Care Pathways in place	7. Limited Assurance - Health Informatics reports, APP dashboard monitors, reports on app use by Consultant Connect, APP development and expansion, and bids for additional prescribing APPs.
8. Consult and Close (previously Hear and Treat)	8. Monitoring CSD rates through AQIs. Consult and Close volumes form part of EMS CCC weekly reports to SLT. Regular reporting of incident volumes to Operational Review Groups. Summary level information about Consult and Close volumes, targets, trends and recontact rates reported to TB and sub-committees. Metrics relating to Ambulance Quality Indicators (AQI) published on a quarterly basis by EASC. Bi-monthly EASC Provider reports. Consult and Close performance reported in Joint Executive Team meeting every 6 months with Welsh Government. NWSSP Information Management Internal Audit report February 2022 (External Assurance)
9. Advanced Paramedic Practitioner (APP) deployment model / APP Navigation	9. Qlik sense APP dashboard monitors performance and provides assurance that APPs are flowing patients into alternatives to emergency department. Qlik sense is a national report and can drill down into regional, local and individual performance as required. APP Navigation – Test of Change Framework (Swansea Bay & Hywel Dda). Review of despatch criteria for APPs.
10. Clinical Safety Plan	10. Clinical agreement – agreeing escalation to higher levels, ODU dashboard, AACE paper through National Director of Operations group
11. Recruitment and deployment of CFRs	11. Volunteers are another resource for response, Volunteer
12. ETA scripting	12. The ETA Dashboard is a tactic that was signed off by EMT – there is a dashboard that supports scripting analysed by comparing with real time data
13. Clinical Contact Centre (CCC) emergency rule	13. CCC Emergency Rule is policy that has been signed off by Execs.
14. National Risk Huddle	14. This is a tactic contained in REAP ratified through SPT and EPT. Daily risk huddles are recorded, and documented actions are shared with stakeholders and progress monitored via the ODU.
15. Handover Improvement Plans agreed between Health Boards and WAST	15. Improvement plans are reviewed by EAST
16. Summer/Winter initiatives	16. Monitoring through SLT and STB
17. CHARU implementation	17. Monitored via the EMS project Board
18. National Transfer & Discharge Model	18. Task and Finish Group established

Risk ID 223	The Trust’s inability to reach patients in the community causing patient harm and death	Date of Review:	13/01/2023	TREND	25 (5x5)
		Date of Next Review:	13/02/2023	➡	

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

19. Conveyance Reduction	19. This is part of the weekly performance review and aligned to Care Closer to Home Programme
20. Access to Same Day Emergency Care (SDEC) for paramedic referrals	20. This forms part of the handover improvement plans in place with Health Boards
21. Mental Health Practitioners in cars	21. Part of the Care Closer to Home workstream
22. Roll out of ECNS	22. Reported through QuEST
23. Clinical Model and clinical review of code sets	23. Reported through QuEST
24. Remote Clinical Support Strategy	24. Strategic Transformation Board – IMTP deliverable
25. Trust Board paper (28/07/22) detailing actions being taken to mitigate the risks (see actions section for details of specific work streams being progressed to mitigate this risk)	25. Formally documented action plan – actions captured are contained within and monitored via the Performance Improvement Plan (PIP)
26. Information sharing	26. Information Sharing: Patient Safety Reports, Chief Operating Officer (COO) Data Pack, Immediate Release Declined (IRD) Reports.

GAPS IN CONTROLS	GAPS IN ASSURANCE
1. Acknowledgement and acceptance of risk by Health Boards and balancing the risks across the whole system	None immediately identified but subject to continual review
2. Blockages in system e.g. internal capacity within Health Boards which affect patient flow	
3. Covid capacity streaming	
4. Transition Plan/Inverted Triangle – bid for transition plan has been put in and is now subject to funding	
5. Local delivery units mirroring WAST ODU	
6. Handover delays link to risk 224	
7. Tolerance in Health Boards has become the norm. As delays have increased, there appears to be no visible appetite to address these issues	
8. There is an ambition that no handover should exceed 4 hours and for lost hours to handover to be reduced by 25% but given the track record over last 6 months there is a low confidence in attaining this.	
9. Outputs from the NHS System Reset – it is a closer collaboration to address some of the system blockages and reduce system pressures. This is the aspiration	
Please note that the gaps listed are not WAST’s and are therefore outside of the control of WAST	

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Exploring Rural model options (Paused during Pandemic Response) – subject to funding through IMTP. Now refreshed to wider rural model opportunities to include recruitment of CFRs. Additional funding has been sourced to increase posts within the volunteer function.	Assistant Director of Operations EMS / Assistant Director of Operations – National Operations & Support	31.12.22	Rural model options are being explored. Discussions have been opened up with one workshop held another scheduled for 28th October 2022 with the aim of producing a set of recommendations for consideration by SLT and EMT.
2. Leading Change Together (forum to progress workforce related work streams jointly with TUPs)	ADLT Sub-Group	30.09.22 - Paused	
3. EMS Demand & Capacity i.e. review and implementation of new EMS rosters	Assistant Director of Operations EMS	Extended from 30.09.22 to 31.12.22	On schedule to implement all EA and UCS rosters by the end of November 2022. CHARU rosters may drift into December 2022 due to recruitment and training.
4. Transition arrangements post pandemic	Executive Pandemic Team / Assistant Director of Strategic Planning (BCRT Chair)	Complete 30/08/22	Transition complete
5. Recruit and train more Advanced Paramedic Practitioners – Value Based Healthcare Fund bid for up to 50 WTE (I)	TBA	TBA	

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	13/01/2023	TREND	25 (5x5)
		Date of Next Review:	13/02/2023	→	

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

[Source: Action Plan presented to Trust Board 28/07/22]			
6. Maximise the opportunity from Consult and Close – stretch to 15% and beyond (I) [Source: Action Plan presented to Trust Board 28/07/22]	Assistant Director of Operations, Integrated Care	31.12.22	Work undertaken to map influences and progress towards each. Trajectory cast until December 2022 - 15% to be achieved through efficiencies.
7. 24/7 operational oversight by ODU with dynamic CSP review and system escalation as required (I) [Source: Action Plan presented to Trust Board 28/07/22]	Assistant Director of Operations, National Operations & Support	Complete	System in place and ongoing.
8. Weekly REAP review by senior Operations Directorate team with assessment of action compliance (I) Source: Action Plan presented to Trust Board 28/07/22]	Director of Operations / Operations Senior Leadership Team	Complete	In place and ongoing - Weekly Performance Meetings occur every Tuesday lunchtime to review performance, etc. and determine REAP level.
9. Recruitment and deployment of new CFRs (I) [Source: Action Plan presented to Trust Board 28/07/22]	Assistant Director of Operations, National Operations & Support / National Volunteer Manager	Ongoing	Additional CFR Trainers and Operations Assistants appointed to support recruitment and training of new CFRs. Volunteer Management Team, supported by the Volunteer Steering Group, now embarking on volunteer recruitment programme and increasing public engagement to raise awareness about volunteering opportunities available within WAST.
10. Transition Plan (I) [Source: Action Plan presented to Trust Board 28/07/22]			
11. Overnight Falls Service extension (I) [Source: Action Plan presented to Trust Board 28/07/22]	Assistant Director of Quality & Governance / Head of Quality Improvement	TBA	Level 2 Falls Service implemented as a pilot. Awaiting evaluation of the pilot and assessment of outcomes and potential longevity of this initiative.
12. External Controls detailed within the Action Plan presented to Trust Board on 28/07/22: a. Audit Wales's investigation of Urgent and Emergency Care System. Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time? (E) b. Consideration of additional WAST schemes to support risk mitigation through winter (I) c. NHS Wales educes emergency department handover lost hours by 25% (E) d. NHS Wales eradicates all emergency department handover delays in excess of 4 hours (E) e. Alterative capacity equivalent to 1000 beds (E) f. Implement nationwide approach to emergency department 'Fit 2 Sit' (E) g. Implementation of Same Day Emergency Care services in each Health Board (E) h. National Six Goals programme for Urgent and Emergency Car (E)			

Risk ID 224	Significant Handover of Care Delays Outside Accident and Emergency Departments Impacts on Access to Definitive Care Being Delayed and Affects the Trust's Ability to Provide a Safe & Effective Service for Patients	Date of Review:	09/01/2023	TREND	25 (5x5)
		Date of Next Review:	09/02/2023	→	

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

CONTROLS	**ASSURANCES**
	Internal **Management (1st Line of Assurance)**
1. WAST Serious Clinical Incident Forum (SCIF) is in place to discuss patient safety incidents, learning and improvement actions to prevent future harm, working in collaboration with Health Boards / NHS Wales Delivery Unit under the Joint Investigation Framework which is currently in pilot phase and an evaluation is to be undertaken in quarter 4 2023.	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 – the pilot has commenced, and the next meeting is due to be held on 25.01.2023.To date the pilot is working well with good engagement from health board colleagues.
3. WAST and system compliance with National Standards - 15-minute handover (NHS Wales Hospital Handover Guidance v2 (May 2016)	3. Monthly Integrated Quality and Performance Report, Health Informatics reports, APP dashboard monitors, reports on app use by Consultant Connect and shared at local and corporate meetings regarding patient safety and handover of care position across NHS Wales and NHS England.
4. WAST Clinical Notice in place - Escalating a clinical concern with a deteriorating patient outside the Emergency Department (11.02.2021). National Early Warning Score (NEWS) trigger of 5 or above for escalation to hospital clinicians. NEWS data available via EPCR (electronic patient care record).	4. NEWS data now available via ePCR and escalation system in place. Learning from incident reporting processes.
5. Workstreams put in place to meet requirements of *Right care, right place, first time Six Goals for Urgent and Emergency Care A policy handbook 2021–2026.* Goal 4 incorporates the reduction of handover of care delays through collective system partnership. WAST membership at system workshops supported by Commissioners looking at handover of care delays which includes the implementation of the Fit2Sit programme and handover of care checklist pan NHS Wales. Learning from NWAS shared that indicates up to 20% of ambulance arrivals may be suitable for Fit 2 Sit Additionally, the Emergency Ambulance Services Committee (EASC) have stated that no delay should exceed 4 hours.	5. Monthly Integrated Quality and Performance Report
6. Hospital Ambulance Liaison Officer (HALO) (Some health Boards).	6. Patient Flow Coordinators (PFCs) are a commissioned service by the Health Board (x2 in ABUHB specifically for GUH) with a bespoke job description, these link directly with the National Delivery Managers in ODU.
7. Regional Escalation Protocol and Resource Escalation Action Plan (REAP).	7. The Senior Leadership Team convenes every Tuesday as the Weekly Performance Meeting to review performance and demand data, and review/assign REAP Levels as appropriate. Dynamic escalation via Strategic Command structure.
8. Staff from WAST, Health Boards and third sector organisations assisting to meet patient's Fundamentals of Care as best they can in the circumstances.	8. Confirmed through Healthcare Inspectorate Wales (HIW) workshops and Health & Care Standards self-assessment process
9. 24/7 Operational Delivery Unit (ODU) escalating handover delays / patient condition to Health Board colleagues.	9. Shift reports from ODU & ODU Dashboard received by 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. Integrated Quality and Performance Report (November 2022 overall 85% mandatory training target met)
13. Clinical audit programme in place.	13. Clinical audit programme with oversight from the Clinical Quality Governance Group and QuEST.

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:	09/01/2023	TREND	25 (5x5)
		Date of Next Review:	09/02/2023	➡	

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

14. Workshop set up by the Deputy Chief Ambulance Commissioner to respond to the findings in the Health Care Inspectorate Wales (HIW) Report *Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover* (undertaken 2021). WAST has senior representation at this meeting. – assurance is that HIW approve and sign off WAST elements and Health Board elements of recommendations.	14. Workshop set up by the Deputy Chief Ambulance Commissioner to respond to the findings in the Health Care Inspectorate Wales (HIW) Report Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover (undertaken 2021). WAST has senior representation at this meeting. A collective response from WAST and Health Boards is being overseen by EASC.
15. Escalation of patient safety concerns by Trust Board: featured in provider reports to the Emergency Ambulance Committee (EASC); been the subject of Accountable Officer correspondence to the NHS Wales Chief Executive; numerous escalations to professional peer groups initiated by WAST Directors; and coverage at Joint Executive Meetings with Welsh Government. Evidence submission to Senedd Health and Social Care Committee. Written evidence submitted during Q4 21/22 to the committee to assist their inquiry into Hospital Discharge and its impact on patient flow through hospitals Report published in June 2022 containing 25 recommendations with recommendation six specifically WAST related stating "The Welsh Government should explain how the targets outlined in the Minister for Health and Social Service's statement of 19 May 2022 on urgent and emergency care and the Six Goals Programme to eradicate ambulance patient handover delays of more than four hours and reduce the average ambulance time lost per arrival by 25 per cent (from the October 2021 level) have been set. It should also confirm the target dates for the achievement of these targets."	15. Monthly Integrated Quality and Performance Report, CEO Reports to Trust Board (including 'Actions to Mitigate Avoidable Patient Harm Report') and Board sub-committee oversight and escalation.
	External Sources of Assurance **Management (1st Line of Assurance)**
	1. Monitoring and oversight of the Ambulance Quality Indicators (AQIs) including handover of care timeliness and Commissioning Framework by the Chief Ambulance Services Commissioner (CASC) and Joint Executive Team meeting Welsh Government (I&E).
	2. Healthcare Inspectorate Wales (HIW) 'Review of Patient Safety, Privacy, Dignity and Experience whilst waiting in Ambulances during Delayed Handover' Report and system wide improvement plan with working group in place with WAST senior representation. Oversight by HIW and CASC
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Patient safety reporting and escalation through the Serious Clinical Incident Panel (SCIF), Patient Safety Highlight Reports, Health Board specific reports in place with escalation through WAST governance framework.	1. Strengthen and triangulate patient safety metrics and look back data at ED, service and corporate level for baseline data for improvement projects and WAST reports.
2. Inconsistent review of potentially serious / catastrophic patient safety incidents in line with the Framework for the Investigation of Patient Safety Serious Incidents (SIs) V2.2, dated July 2019 (frequently referenced as 'Appendix B' Reports) by Health Boards pan NHS Wales and lack of ownership of system risks. Lack of whole system approach to handling patient safety incidents resulting from system pressures*.	2. Implementation of revised process, engagement and outcome and improvement measures at system level – early work commenced with the pilot in progress of the Joint Investigation Framework.
3. Lack of implementation and holding to account regarding the NHS Wales of the Handover Guidance v2 and recognition of the patient safety risks pan NHS Wales*.	3. 15-minute handover target is not being achieved pan-Wales consistently and has led to a substantial growth in emergency ambulance handover lost hours from c6000 hours per month at the end of 2018 to in excess of 28,038 hours in October 2022. This scale of lost emergency ambulance capacity has peaked at 30% per month of the entire emergency ambulance fleet in October 2022.
4. Variation in responsiveness at Emergency Departments to the escalating concerns regarding patients' NEWS*.	4. Strengthening of patient safety reports and audit processes as system embeds.
5. (a) Variation in appetite across the Health Boards to implement Fit2Sit, citing overcrowded emergency department waiting rooms as the reason. Limited confidence in system engagement to address Goal 4 and achieve reduction in handover delays*. 5. (b) Protracted timescales in the Right care, right place, first time Six Goals for Urgent and Emergency Care - A policy handbook 2021–2026. Goal 4 'Improving ambulance patient handover, ensuring no one arriving by ambulance at an Emergency Department waits more than 60 minutes from arrival to handover to a clinician – by the end of April 2025. The number of people waiting over this period for ambulance patient handover will reduce on an annual basis until that point'. No detail on incremental improvements required at emergency department level or oversight mechanisms. EASC have stated that no delay should exceed 4 hours although WAST is yet to see any demonstrable plans to support this*.	5. 15-minute handover target is not being achieved pan-Wales consistently.

Risk ID 224	Significant Handover of Care Delays Outside Accident and Emergency Departments Impacts on Access to Definitive Care Being Delayed and Affects the Trust's Ability to Provide a Safe & Effective Service for Patients	Date of Review:	09/01/2023	TREND	25 (5x5)
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IF patients continue to be significantly delayed in ambulances outside Accident and Emergency Departments	THEN there is a continued risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised	RESULTING IN patients coming to significant harm and a poor patient experience

	Likelihood	Consequence	Score
Inherent	5	5	25
Current	5	5	25
Target	3	2	6

6. Variation pan Wales / England as position not implemented across all emergency departments*.	6.
7.	7.
8. Variation pan Wales / England as position not implemented across all emergency departments*.	8. Health & Care Standards self – assessment in progress.
9. Variable response pan Wales / England. WAST have minimal control on this at patient level*.	9.
10.	10.
11. Variable response pan Wales / England. WAST have minimal control on this at patient level*.	11.
12.	12.
13. Transition to ePCR impacting on data temporarily	13.
14. National steer required to confirm the accountability arrangements regarding patients in ambulances outside of the emergency departments. The seven Local Health Boards (LHBs) in Wales are responsible for planning and securing delivery of primary, community, secondary care services, and also the specialist services for their areas*.	14. HIW approve and sign off WAST elements of recommendations.
15.	15.
	External Gaps in Assurance 1. Lack of escalation and response to AQIs by the wider urgent care system and regulators
	2. Lack of collective system response to HIW 'Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover' Report. Meetings cancelled x 2 in May 2022. WAST has representation on the working group*

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Right care, right place, first time Six Goals for Urgent and Emergency Care A policy handbook 2021–2026 – Goal 4: Rapid response in physical or mental health crisis.	CEO	• Checkpoint Q4 2022/23	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 the Director of Paramedicine (not yet established though or invite not received). • The Trust is also working with the National Collaborative Commissioning Unit to develop integrated commissioning action plans in each Health Board which will support the ambitions within the Six Goals programme, particularly, goal 4 "Rapid response in a physical or mental health crisis". The Trust has also mapped the interactions nationally and locally into the Six Goals Programme, with updates brought via the Integrated Strategic Planning Group to Strategic Transformation Board to consider impact for WAST strategic planning.
2. Handover checklist implementation – Nationally WAST Quality Improvement (QI) Project	WAST QI Team (QSPE)	• Checkpoint Q4 2022/23	Timeframes awaited via Emergency Department Quality & Delivery Framework (EDQDF)
3. Implement nationwide approach to emergency department 'Fit 2 Sit'	CMO/CNO	• Checkpoint Q4 2022/23	Acceptance at meeting of Chairs and CEOs led by JP

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				Inherent	5	5	25
				Current	5	5	25
				Target	3	2	6

			on 8/6/2022 that a national approach to Fit 2 Sit should be adopted. Learning from NWAS shared that indicates up to 20% of ambulance arrivals may be suitable for Fit 2 Sit. Meetings brokered by National Collaborative Commissioning Unit. Attendance at meetings often in excess of 50 attendees. WAST proposed clinician guidance document circulated to all health boards. Challenges around universal patient criteria. Challenges around rapid handover with patient booking self in. Challenges within some hospitals in infrastructure to host monitored area of fit2sit patients. Fit to Sit SBAR (6 September 2022) sent to the Trust from the NCCU. To be discussed at the next IQPD meeting to focus on the variation in practice being seen. More data identified as a key area for development before an evaluation can take place. Commitment to no >4 hour waits and a reduction in 25% overall. These have not yet had any impact in most areas.
4. Implement patient safety dashboards (live and look back data) triangulating quality metrics / KPIs and performance data sourcing health informatics resource.	Assistant Director of Quality & Nursing	• Checkpoint Q4 2022/23	Incremental improvements to quality and safety data and information to enable triangulation. Access to ePCR data (NEWS) now available.
5. Continued Health Board interactions – my next patient, patient safety team dialogue – proactive conversations with Health Board Directors of Quality & Nursing.	Executive Director of Quality & Nursing	• Monthly • Checkpoint Q4 2022/23	Monthly meetings continue to be held and the content of the health board reports are currently under review.
6. HIW Improvement Plan / Workshop– WAST inputs / influencing improvements Response and improvement actions to Healthcare Inspectorate Wales Inspection report (2021) 'Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover' which links to Fundamentals of Care.	Assistant Director of Quality & Nursing	• August 2022 in progress • Checkpoint Q4 2022/23	
7. 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	• Checkpoint post pilot Q4 2022/23	Revised joint investigation approach agreed which is to be piloted from November 2022.
8. Recruit additional frontline capacity – additional £3m non recurrent 22/23 allocation	Director of Workforce & Organisational Development	• Q4 2022/23	Good progress with pilot of payment of the C1 license proved a positive move. Over 370 new starters recruited this year. 60 of the 100 will be operational on 23.0123 with 30 more operational at the end of Feb. 99.5% of the establishment of 1761 will be in post at the end of March. Higher attrition that forecast was experienced at the end of 2022.
9. Recruit and train more Advanced Paramedic Practitioners – Value Based Healthcare Fund bid for up to 50 WTE	Director of Paramedicine	• Checkpoint Q4 2023/24	Bid not successful. Feedback received from Welsh Government that will be incorporated into future bids. However, Trust decision to proceed with 18 MSC places. 10 started in September (North) with the balance (eight) on target for March 2023 start.

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:	09/01/2023	TREND	25 (5x5)
		Date of Next Review:	09/02/2023	➡	

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

			• RAG status reframed around the new timelines / programme
10. Senior system influencing	Trust Chair Chief Executive Officer	• Checkpoint Q4 2022/23	CEO and Directors have ensured that system safety and avoidable harm remain a live topic of discussion in all relevant fora e.g. recent paper provided by EDQNs to CEOs on pressures and risk. Continue to seize opportunities as they emerge that can contribute to mitigating avoidable harm, with potential CEO summit to be arranged following recent meeting with Minister.
11. Emergency Department cohorting	Director of Operations	• Closed	Evaluation of cohorting has been completed and as a result, there has been an agreement to terminate these arrangements in Morriston and GUH.
12. Transition Plan	Chief Executive Officer	• Checkpoint Q4 2022/23	Formally submitted to Commissioners in December 2021. As above +100 FTEs secured although nonrecurring at this point in time. Also, funding for additional APPs not secured via Value Based Healthcare fund; however, decision of Trust to proceed with take up of 18 MSC places anyway. Further discussions with funders as part of IMTP 2023-2026 required and also possible rebasing of EMS Demand & Capacity Review with increased system pressures built in, during 2023. This is now a required action with terms of reference to be developed.
13. Overnight falls service extension	Executive Director of Quality & Nursing	• Scheme extension agreed to 31 March 2023 • Checkpoint Q4 2022/23	A Falls Utilisation Task and Finish Group has been set up. Aim to achieve 60% utilisation of Falls Assistant resources, by December 2022 and achieve consistent utilisation of 60% + through January-March 2023. Utilisation was 58% in August and September 2022 and 65% in October 2022, demonstrating an increase of 7% in utilisation. Current utilisation for the night vehicles for November (up to 13th) is 64%. 117 incidents were attended in September compared to 158 incidents in October 2022. Additional 'ideal code set' identified though Utilisation Task & Finish group and approved by CPAS, which went live 08 November 2022. Anticipated to support sustained improved utilisation. The Trust now has 6 ideal code sets. Falls level 1 and 2 impact evaluation report well underway, anticipated to be available for end of November 2022.

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:	09/01/2023	TREND	25 (5x5)
		Date of Next Review:	09/02/2023	→	

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

Action	Owner	Checkpoint	Progress
14. Audit Wales investigation of Urgent and Emergency Care System: Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time?	Chief Executive Officer	• Checkpoint Q142023/2024	Conducted in three phases over the next 6 to 9 months Audit Wales will independently investigate and report on patient flow out of hospital; access to unscheduled care services and national arrangements (structure, governance and support) WAST will proactively support this work and offer best practice examples from other jurisdictions that can support benchmarking and improvement activities Audit Wales updated the Audit Committee on the Review of Unscheduled Care work they are undertaking at its meeting on 15 September 2022.
15. Consideration of additional WAST schemes to support overall risk mitigation through winter	Director of Operations	• Checkpoint Q4 2022/23	Winter modelling complete and being reported to Welsh Government via Joint Executive Team meeting (16 November 2022). Winter schemes identified and funded e.g. additional UCS, additional overtime etc. Performance Improvement Plan (the Trust's rolling tactical seasonal plan up to date). Good progress on Performance Improvement Plan (and associated schemes). Winter event undertaken 16 November 2022. Specific seasonal structures (business continuity) approved and currently being enacted.
16. National 111 awareness campaign	Director of Partnerships and Engagement Director of Digital	• Checkpoint Q4 2022/23	National public awareness campaign funded by Welsh Government to promote appropriate use of services (111 as an alternative to 999/ED where appropriate) Upgrade to 111 website and symptom checkers also underway
17. 24/7 Operational oversight by ODU with dynamic review and system escalation as required	Director of Operations	• Checkpoint Q4 2022/23	Realtime management and escalation of risks and harm with system partners Triggering and escalation levels within Clinical Safety Plan 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.
18. Implementation of Same Day Emergency Care (SDEC) services in each Health Board	NHS Wales Health Boards	• Checkpoint Q4 2022/23	Welsh Government funding provided to each Health Board to implement SDEC WAST has nationally agreed referral rights to these services enabling us to avoid the emergency department with suitable patients SDEC Implementation: four sites live in Hywel Dda and one in Betsi Cadwaldr. Expectation is at least one per health board, 12 hours a day seven days a week. Ongoing discussions with other Health Board to agree implementation plan.

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:	09/01/2023	TREND	25 (5x5)
		Date of Next Review:	09/02/2023	➡	

				Likelihood	Consequence	Score
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	Inherent	5	5	25
			Current	5	5	25
			Target	3	2	6

			Welsh Government has asked the Trust to forecast the level of patient flow into the existing and proposed SDECs, which may be lower than anticipated. Also, the Forecasting & Modelling Group is planning to model the impact of SDECs, which again may be lower than anticipated.

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:	12/01/2023	TREND	20 (5x4)
				Date of Next Review:	12/02/2023	➡	

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 Workforce & Organisational Development	ASSURANCE COMMITTEE	People and Culture Committee

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. Managing Attendance at Work Policy/Procedures in place	1. (a) Policy reviews to ensure policies and procedures are fit for purpose (b) Audits by People Services on sickness
2. Respect and Resolution Policy	2. Policy reviews to ensure policies and procedures are fit for purpose
3. Raising Concerns Policy	3. Policy reviews to ensure policies and procedures are fit for purpose
4. Health and Wellbeing Strategy	4.
5. Operational Workforce Recruitment Plans	5.
6. Roster Review & Implementation	6.
7. Return to Work interviews are undertaken	7.
8. Training	8.
9. Directors receives monthly email with setting out ESR sickness data	9.
10. Operational managers receive daily sickness absence data via GRS	10.
11. People Services & Occupational Health & Wellbeing support/Employee Assistance Programme	11.
12. WAST Keep Talking (mental health portal)	12.
13. Suicide first aiders	13.
14. TRiM	14.
15. Peer Support network	15.
16. Coaching and mentoring framework	16.
17. Staff surveys	17.
18. Stress risk assessments	18.
19. Sickness statistics are reported to SLT, SOT, People & Culture Committee, Trust Board and the CASC	19. Sickness forms part of Workforce Scorecard to People & Culture Committee
20. External agency support e.g. St John Ambulance, Fire and Rescue	20.
21. Strategic Equality Objectives	21. Policy reviews to ensure policies and procedures are fit for purpose
22. Volunteers	22.
23. Monthly reviews of colleagues on Alternative duties	23. Action plans arising from meetings with colleagues implemented through monthly diarised meetings
24. Manager guidance on managing Alternative duties	24.
25. Fortnightly report on absence to EMT and report to every meeting of People & Culture Committee	25. Minuted meetings and action logs for EMT & People & Culture Committee
	External Management (2nd Line of Assurance)
	1a. All Wales review of All Wales Attendance at Work Policy
	Independent Assurance (3rd Line of Assurance)
	1b. Internal Audits scheduled through Shared Services Partnership (controls 1 - 24)
	2. Audit Wales – Taking Care of the Carers report in October 2021 (controls 1 - 24)

Risk ID 160	High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service	Date of Review:	12/01/2023	TREND	20 (5x4)
		Date of Next Review:	12/02/2023	➡	

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

GAPS IN CONTROLS	GAPS IN ASSURANCE
1. (a) Consistency and Application in Managing Attendance at Work Policy (b) Education and communication with managers about resources available and how to implement it e.g. stress risk assessments	1. There are other factors that impact on sickness which can't be controlled
4a. Wellbeing policy currently being produced	8. Reporting on training compliance
9 and 10 It is not known what is undertaken with respect to the data covered in assurances 9 and 10 once it is received	9, 10 and 19 Absence data is not updated in a timely manner into ESR by managers
1 – 22 Education and communication with managers about resources available and how to implement it e.g. stress risk assessments	
	External Gaps in Assurance None identified at the present moment

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Implementation of Improving Attendance project	Deputy Director of Workforce & OD	31.09.23	Underway and ongoing. Downward trajectory 8.77% for November 2022.
2. Implementation of Behaviours Refresh Plan	Assistant Director – Inclusion, Culture and Wellbeing	31.10.22	Underway and ongoing
3. Long term sickness absence deep dive	Deputy Director of Workforce & OD	31.07.23	Underway and ongoing. Downward trajectory in levels of long term absence
4 . Develop guidance for line managers to support addressing challenging conversations and change	Deputy Director of Workforce & OD	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	Extended from 31.07.22 to 31.03.23	Pushed out date in terms of project plans and impact of Industrial Action
6. Strengthen Freedom to Speak Up Arrangements policy and advice	Deputy Director of Workforce and OD	31.05.23	Ongoing
7. Create a Manager and Staff training plan for Freedom to Speak Up Arrangements	Deputy Director of Workforce and OD	31.05.23	Ongoing
8. Accountability meetings with senior ops managers	Deputy Director of Workforce & OD	30.09.22	Underway, conversations re sickness absence well established and continuing
9. Attendance Management training for managers	Deputy Director of Workforce & OD	31.12.22 Complete and BAU	Underway and ongoing – now BAU 1.11.22
10.PADR review including wellness questions	Assistant Director – Inclusion, Culture and Wellbeing	Complete	Complete. New PADR distributed October 22.
11.Restart the Health and Wellbeing Steering Group	Assistant Director – Inclusion, Culture and Wellbeing	Complete	Complete – group started 17.10.22 and will meet quarterly.
12. Roll out of meta data compliance policy solution	Senior ICT Security Specialist	31.12.22	

Risk ID 201	Damage to Trust reputation following a loss of stakeholder confidence	Date of Review:	06/01/2023	TREND	20 (4x5)
		Date of Next Review:	06/02/2023	➡	

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

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1. Regular engagement with senior stakeholders e.g. Ministers, senior Welsh Government officials, commissioners, elected politicians and NHS Wales organisational system leaders	1. Agendas, minutes and documents of engagement events
2. Challenging of media reports to ensure accuracy	2. Programme of daily media engagement
3. Media liaison to ensure relationships developed with key media stakeholders	3. Programme of daily media engagement
4. Engagement Framework approved by the Board July 2022	4. Issues of reputation monitored at EMT via weekly Forward Look item – minuted meetings and action logs.
5. Engagement Framework Delivery Plan	6. Due to be considered by Board 26/01/23
7. 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
8. Escalation procedure for issues to the Board	7. Minuted meetings, action logs and Board papers

GAPS IN CONTROLS	GAPS IN ASSURANCE
1. Inability to control external environment	1.
2. Dependency on Commissioners' decisions	2.
3. Unpredictable external environment affecting the way the Trust operates	3.
4.	4.
5. Engagement Framework Delivery Plan in development and due to be considered by the Board in January 2023	5. Engagement Framework Delivery Plan in development and due to be considered by Board in November 2022
6. Lack of resilience in the function – team is very small so any absences would have an impact on ability to respond	6.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Submit refreshed Board Engagement Framework to Trust Board for approval	Director of Partnerships & Engagement	26.05.22 Complete	Approved July 2022
2. Report progress on Engagement Framework Delivery Plan to the People and Culture Committee	Director of Partnerships & Engagement	30.12.22 extended to 23.01.23	Will be considered by January 2023 Trust Board
3. Monitoring internal Quality and Performance of Trust	Executive Management Team Finance and Performance Committee Quality, Safety and Patient Experience Committee People and Culture Committee Audit Committee	31.03.23 Checkpoint Date	
4. Engaging with internal and external stakeholders to develop confidence	CEO & Director of Partnerships & Engagement	31.03.23 Checkpoint Date	
5. Monitoring external factors that may affect the Trust	CEO & Director of Partnerships & Engagement	31.03.23 Checkpoint date	

Risk ID 139	Failure to deliver our Statutory Financial Duties in accordance with Legislation	Date of Review:	12/01/2023	TREND	16 (4x4)
		Date of Next Review:	12/02/2023	→	

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

Risk ID 139	Failure to deliver our Statutory Financial Duties in accordance with Legislation	Date of Review:	12/01/2023	TREND	16 (4x4)
		Date of Next Review:	12/02/2023	➡	

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

	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

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Continuing negotiations with Commissioners	Director of Finance and Corporate Resources/ Director of Strategy Planning and Performance	31/03/23 – Checkpoint Date	
2. Embed a transformative savings plan and ensure organisational buy in	ADLT and Savings subgroup	31/03/23 – Checkpoint Date	
3. Embed value-based healthcare working through the organisation	Executive Management Team and Value Based Healthcare Group	31/03/23 – Checkpoint Date	
4. WIIN support for procurement, savings and efficiencies	WAST Improvement and Innovation Network group	31/03/23 – Checkpoint Date	
5. Foundational economy, Decommissioning and procurement to mitigate social and economic wellbeing of Wales	Estates, Capital and Fleet Groups, NHS Wales Shared Services Partnership	31/03/23 – Checkpoint Date	

Risk ID 244	Estates accommodation capacity limitations impacting on EMS Clinical Contact Centre's (CCC) ability to provide a safe and effective service	Date of Review:	15/11/2022 (SLT)	TREND	12 (3x4)
		Date of Next Review:	N/A	⬇	

IF the Trust is unable to increase accommodation capacity	THEN there is a risk that EMS CCC will not be able to accommodate all roles during periods of escalation and surge management or expand operations to support new initiatives	RESULTING IN EMS CCC being unable to deliver services effectively which adversely impacts on quality, safety and patient/staff experience

	Likelihood	Consequence	Score
Inherent	5	4	20
Current	3	4	12
Target	3	4	12

IMTP Deliverable Numbers: 1,5,9, 10,18, 28, 30, 34

EXECUTIVE OWNER	Director of Finance & Corporate Resources	ASSURANCE COMMITTEE	Finance and Performance Committee

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1. Temporary call handling provision in Carmarthen - Llangunner	1. Monitoring of Performance standards for call handling (daily) and dispatch (weekly) to identify impacts on service with further investigation on a monthly basis
2. Maximum use of space at the Bryn Tyrion site	2. All desks have been realigned to 2m physical distancing as part of covid preparations
3. Maximum use of space at the Vantage Point House (VPH) site	3. Review of VPH undertaken – November 2021 Staffing levels are managed according to maximum desk space on each centre. In VPH, because of agile working there is capacity for non-dispatch functions.
4. Prioritisation of space utilisation for each shift by CCC management team and alignment to priorities associated with safe service delivery	4. Business continuity tracker for staffing levels updated daily
5. Estates SOP amended and TFG established	5. Estates SOP amended and TFG established
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. No gaps in controls	1. Carmarthen solution for call handling is temporary
	2. Reconfiguration work reviewed by architects during pandemic preparation and earlier have yet to be delivered.
	3. Agile working solution would be compromised in an ICT outage and paper-based approach would be used

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Review current estate to identify moderate workplans to maximise available capacity within existing estate.	Assistant Director of Operations – Resourcing & EMS Coordination	30.09.22 Complete	Review took place to maximise capacity, some additional desks and roster planning supported. Site specific updates are as follows: Capacity within Central & West CCC (Carmarthen) which has been extended to provide extra accommodation for additional EMDs required to comply with Covid regulations. South East CCC (VPH) is currently undergoing renovation, but there are plans to provide additional capacity for EMS CCC when it is completed in January 2023 – this is to be achieved by the Ambulance Care Team (NEPTS CCC) moving upstairs to create some additional space. In terms of the North CCC, a plan has been submitted for consideration at the Estates SOP. In addition, the ADO Integrated Care has been part of a broader discussion as part of a T&F group. There are longer term plans to potentially move to more suitable and spacious accommodation in the North but there are technology requirements to enable the move away from the current

Risk ID 244	**Estates accommodation capacity limitations impacting on EMS Clinical Contact Centre's (CCC) ability to provide a safe and effective service**	Date of Review:	15/11/2022 (SLT)	TREND	12 (3x4)
		Date of Next Review:	N/A	⬇	

IF the Trust is unable to increase accommodation capacity	**THEN** there is a risk that EMS CCC will not be able to accommodate all roles during periods of escalation and surge management or expand operations to support new initiatives	**RESULTING IN** EMS CCC being unable to deliver services effectively which adversely impacts on quality, safety and patient/staff experience

	Likelihood	Consequence	Score
Inherent	5	4	20
Current	3	4	12
Target	3	4	12

			Airwave equipment, which is projected to be affected at the end of 2023.
2. Develop digital solutions for remote supervision and clinical support to maximise virtual network of CCC reducing capacity required in existing sites.	EMS CCC Area Manager	12.07.22 Complete	Remote supervision implemented 12.07.22. Action Complete.
3. Option appraisal required to review options for increasing CCC capacity. This should be aligned to the HIW review recommendation for the North CCC estates strategy and expanding this to support the pan-Wales estates position.	Assistant Director – Capital & Estates	31.12.22 – Checkpoint Date	Task and Finish group appointed into Estates to complete this work. Checkpoint later in Q3 2022-23.
4. Based on modelling data under D&C review explore any efficiencies that can be gained in CCC estates through revised dispatch models maximising use of digital technology	CCC SE Manager	30.06.22 Checkpoint Date	Checkpoint review complete. Project change is being developed and revised action/date to be added.

Risk ID 245	Failure to have sufficient capacity at an alternative site for EMS Clinical Contact Centres (CCCs) which could cause a breach of Statutory Business Continuity regulations	Date of Review:	14/11/2022	TREND	16 (4x4)
		Date of Next Review:	14/12/2022	➡	

IF CCCs are unable to accommodate additional core functions and do not have alternative site arrangements in place in the event of a business continuity incident	**THEN** there is a risk that EMS CCCs cannot utilise other CCC's space, accommodation and facilities	**RESULTING IN** potential patient harm and a breach of the requirements of the Civil Contingencies Act (2004) and Contingency Planning Regulations (2005)

	Likelihood	Consequence	Score
Inherent	3	5	15
Current	4	4	16
Target	2	4	8

IMTP Deliverable Numbers: 1, 5, 9

EXECUTIVE OWNER	Executive Director of Finance & Corporate Resources	ASSURANCE COMMITTEE	Finance and Performance Committee

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1. Trust Business Continuity Procedure and Incident Response Plan	1. Debrief from significant business continuity incidents which are put into organisational learning spreadsheet. Governance with respect to this goes through SOTs. Full review of Incident Response plan every 3 years and partial review annually unless there is a major learning point. This is currently undergoing a partial review. BCPs and BIAs should be reviewed annually by their owners. Annual schedule of testing
2. National EMS CCC Business Continuity Plan (reviewed in March 2021)	2. Business Continuity Plan is up to date and has been reviewed and is currently waiting sign off. Business continuity exercise undertaken on 9.03.22.
3. Clinical remote working arrangements	3. SOP in place with respect to Clinical Remote Working – this is being reviewed at present moment
4. Single instance CAD allowing virtualisation which enables staff to work anywhere	4. CAD alerts if there are systems issues
5. ITK (Interoperability Toolkit) technology in place which provides connectivity with other UK ambulance Trusts. This is used on a daily basis	5. Monitoring undertaken locally at least weekly
	External Not applicable
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
• If CAD is not functional then any impact of current controls would be negated by need to move physical staff	• Business continuity plan requires increased duties for existing staff as a result of lack of physical accommodation (link to risk 244)

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
TBC			

<table>
<tr><td>Risk ID 458</td><td colspan="3">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</td><td>Date of Review:
Date of Next Review:</td><td>12/01/2023
12/02/2023</td><td>TREND
→</td><td>16 (4x4)</td></tr>
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<table>
<tr><td rowspan="4">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.</td><td rowspan="4">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.</td><td rowspan="4">RESULTING IN patients not receiving services, the Trust not achieving financial balance and a potential failure to meet statutory obligations causing reputational damage</td><td></td><td>Likelihood</td><td>Consequence</td><td>Score</td></tr>
<tr><td>Inherent</td><td>3</td><td>4</td><td>12</td></tr>
<tr><td>Current</td><td>4</td><td>4</td><td>16</td></tr>
<tr><td>Target</td><td>2</td><td>4</td><td>8</td></tr>
</table>

IMTP Deliverable Numbers: 2, 12, 16, 18, 23, 24, 25, 26, 28,30, 34, 37, 38

EXECUTIVE OWNER	Director of Finance and Corporate Resources	ASSURANCE COMMITTEE	Finance and Performance Committee

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1. Financial governance and reporting structures in place	1. Risk is reviewed quarterly at F&P and a report is submitted bimonthly to Trust Board
2. Financial policies and procedures in place	2.
3. Setting and agreement of recurrent resources	3.
4. Budget management meetings	4. Diarised dates for budget management meetings. If an area is in financial deficit, the meeting would be at least once a month. If the area is in balance or surplus, the meeting would be quarterly.
5. Budget holder training	5. Diarised dates for budget holder training
6. Annual Financial Plan	6. Submission to Trust Board in March annually
7. Regular financial reporting to EFG & FPC in place	7. Diarised dates for EFG and FPC with full financial reports
8. Regular engagement with commissioners of Trust’s services	**External** **Management (1st Line of Assurance)** 1. Accountability Officer letter to Welsh Government e.g. November 2021 3 and 8 EASC management meetings. Monthly meetings with EASC and DAG meetings for NEPTS. Meetings are diarised 9. Monthly monitoring returns
9. Welsh Government reporting on a monthly basis	**Independent Assurance (3rd Line of Assurance)** 2. Internal Audit reviews of financial policies & procedures as part of their audit plan
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
• Lack of clarity regarding EASC/Welsh Government commitments with respect to recurrent funding	1. Dialogue with EASC and DAG does not always result in recurrent arrangements (outside of WAST control)

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. A formal approach to service change to be developed providing secure recurrent funding with commissioners.	Deputy Director of Finance	31.12.22	
1. Develop a Value Based Healthcare system approach with commissioners. This would mean that funding would flow more seamlessly between organisations and would go some way to mitigating the risk of not receiving recurrent funding.	Deputy Director of Finance	31.12.22	

Risk ID 557	Potential impact on services as a result of Industrial Action		Date of Review:	12/01/2023	TREND	16 (4x4)
			Date of Next Review:	12/02/2023	NEW	

IF trade unions take industrial action in response to the national pay award	**THEN** this is likely to disrupt our ability to provide a safe, efficient and good quality service in the 6 core areas the business	**RESULTING IN** potential harm to patients, adverse effect to patient outcomes, increase in SAIs/concerns/coroners cases, negative media reports, and impact on the Trust's corporate reputation

	Likelihood	Consequence	Score
Inherent	3	4	12
Current	4	4	16
Target	2	4	8

IMTP Deliverable Numbers:

EXECUTIVE OWNER	Director of Workforce & Organisational Development	ASSURANCE COMMITTEE	People and Culture Committee

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1. Detailed planning process in place	1. Industrial action plan agreed and published
2. Significant preparation for industrial action prior to events	2. Documented processes and actions
3. Negotiations with TU officers on derogations	3. Communications and engagement across the organisation
4. Communications with organisation on IA – regular WAST Live Q&As, briefings and updates	
5. IA issues discussed and recorded at EMT and ADLT	
6. ADLT and Managers co-ordinated on picket sites during IA days	
7. Strategic Command arrangements and HR cover for whole of strike period	
8. Lessons learned exercise after each strike day	
9. Engagement with wider network to maximise system preparedness and support	**External** **Independent Assurance (3rd Line of Assurance)**

GAPS IN CONTROLS	GAPS IN ASSURANCE
1. Need to determine life and limb cover to meet our legal requirements under the Industrial Action Regulations	1. Awaiting outcome of UNISON ballot (Feb 2023)
2. No control or mitigation on TU decisions on derogations	2.
3.	4.
4.	5.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Maximum engagement with TU colleagues	Director of WOD	Ongoing	Daily meetings with relevant TUPs
2. Negotiate the best derogations possible to protect patient safety	Director of WOD	Ongoing	Derogations negotiated for each IA day
3. Consider options for external support if necessary	Director of WOD / CEO	Ongoing	Watching brief
4.			
5.			
6.			

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:	23/12/2022	TREND	15 (3x5)
		Date of Next Review:	23/01/2023	⬇	

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.
2. Health & Safety Governance and reporting arrangements – National Health, Safety and Welfare Committee. Reporting into People and Culture Committee. (PCC)	10. Trusts Legislative Compliance Register in place. Assessments to be reviewed in ADLT in January 2023. 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, PCC. • Reports published on H&S webpage. • H&S climate cultural survey developed to determine perception of Trust position against Bradley Curve.
3. 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'.	11. The Working Safely team ceased on 31.09.22. The approval of the transformation of the H&S function business case allowed for significant increase into the function which commenced on 03.10.22. This allowed for the new structure to be implemented.
4. Health & Safety Policy and Corporate level Procedures.	12. H&S Policy approved in 2018. Following landing of business case, Policy review underway Q4 2022. 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 awaiting approval at ADLT in Jan 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 approval during Q1 2023. Lone worker Procedure ongoing- expectation of second draft Q1 2023. Trust wide Hazard register framework in place. Expectation of being presented at ADLT in Q4 2023.
5. Mandatory Health and Safety training for all staff on ESR. Induction training in place for all new operational staff.	13. Quarterly statistics provided by ESR support team and incorporated into Health and Safety' quarterly and annual Performance reports. Induction training compliance held on ESR
6. 2 year rolling programme of scheduled H&S premise audits.	14. Inspections are being undertaken in line with schedule.
7. Risk assessments (including local risk assessments - Covid 19, workplace risk assessments, risk assessments covering EMS and NEPTs activities, operations risk assessments).	15. 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.
8. 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.	16. 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.
9. Rolling programme of IOSH Managing Safely- for Managers- scheduled training programme in place.	17. Attendance and competency figures provided in a quarterly report to ADLT, National Health, Safety and Welfare Committee and People and Culture Committee.
10. IOSH Leading Safely for Directors and Senior Managers training in place.	18. Attendance and figures provided in monthly report to ADLT. Personal safety commitments are being monitored on a quarterly basis

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:	23/12/2022	TREND	15 (3x5)
		Date of Next Review:	23/01/2023	⬇	

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

11. Board development Day covering Health & Safety Management and Culture Awareness training undertaken in April 2022.	19. Diarised meeting.
12. Health and Safety Management System recognised document approval routes for health and safety documentation.	20. Approved and minuted at ADLT meeting in 2022.
13. IOSH Leading Safely training delivered to majority of Board and Executive Team on 26 July 2022.	21. Compliance metrics held on H&S team database.
14. IOSH Leading Safely additional sessions for new Board /EMT members and ADLT to be scheduled for 2023.	22.
15. Leading Safely, Safety Positive conversations training to be delivered to Board and EMT in March 2023.	23.
16.	24. Internal Audit to be undertaken in Q4 22/23 (controls 1– 10) **(External Independent Assurance (3rd Line of Assurance)**

GAPS IN CONTROLS	GAPS IN ASSURANCE
1.	**1.** Baseline audit for HSMS not to be commenced till Q1 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 Q4 2023 (***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 is due at end of Q4 2022 (***being addressed in Action 4)*** (b) Workforce Transformational change will influence 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, 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 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)***
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	Q1 2023	

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:	23/12/2022	TREND	15 (3x5)
		Date of Next Review:	23/01/2023	⬇	

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

Action	Action Owner	When /Milestone	Progress Notes
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	Q4 2022	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.
3. Assessment to be undertaken in Q4 of political pressure to determine viability of conducting culture survey	Head of Health and Safety	Q4 2022	
4. H&S Policy Group meeting to be established and draft policy to be created	Head of Health and Safety	Q4 2022/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.
5. Quarterly report on training compliance to be presented to ADLT for actioning within respective Directorates	Head of Health and Safety	Q3 2022	Report is a standard section of quarterly H&S performance report to ADLT
6. 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.
7. 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 2023	
8. 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	Q4 2022	Priority actions for 2023-24 identified as Culture, Manual Handling, Violence and Aggression, Incident investigation training.
9. Review of number of line managers within the Trust to put in place a suitable schedule to roll out training.	Deputy Head of Health and Safety	Q2 2023	Interim schedule in place to address known line managers.
Completed Actions	**Action Owner**	**When /Milestone**	**Progress Notes:**
1. Delivery of the Working Safely Action Plan (WSAP) (Priority top 25)	Head of Health & Safety	31.09.22 Partially completed.	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. Further sessions to be scheduled for Q4 2022/2- Q1 2022/23 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	Scheduled for BDD - February 2023.
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.
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 Q2 2022.
7. An initial assessment will provide assurance on how we are complying with the legislation.	Deputy Head of H&S	Partially completed Assurance - 0.06.22 Rolling programme of assessments – 31.12.22 (Checkpoint date)	Assessments undertaken. Some outstanding estates assessments scheduled January 2023.

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:**	**06/12/2022**	**TREND**	**15 (3x5)**
		Date of Next Review:	**06/01/2023**	➡	

				Likelihood	Consequence	Score
IF there is a large-scale cyber-attack on WAST, NHS Wales and interdependent networks which shuts down the IT network and there are insufficient information security arrangements in place	**THEN** there is a risk of a significant information security incident	**RESULTING IN** a partial or total interruption in WAST's ability to deliver essential services, loss or theft of personal/patient data and patient harm or loss of life	**Inherent**	4	5	20
			Current	3	5	15
			Target	2	5	10

IMTP Deliverable Numbers: 7,8,9,10,12, 16,18,21,23, 24,25, 26, 38

EXECUTIVE OWNER	Director of Digital Services	**ASSURANCE COMMITTEE**	Finance and Performance Committee

CONTROLS	**ASSURANCES**
	Internal **Management (1st Line of Assurance)**
1. Appropriate policy and procedures in place for Information/Cyber Security	1. Information Security Policy reviewed every 3 years (currently due for renewal). Incident Policy and Procedure put in place in February 2022 – renewed annually.
2. Trust Business Continuity Procedure and Incident Response Plan	2. Debrief from significant business continuity incidents captured within organisational learning spreadsheet. Governance with respect to this goes through SOTs. Full review of Incident Response plan every 3 years - currently undergoing a partial review. BCPs and BIAs should be reviewed annually by their owners. Annual schedule of testing
3. IT Disaster Recovery Plan	3. Organisation-wide tabletop exercise undertaken in March 2022 with all BC leads and Digital teams.
4. Relevant expertise in Trust with respect to information security	4. Staff undertake relevant training courses e.g. CISSP to increase knowledge and expertise
5. Data Protection Officer in post	5. In job description of Head of ICT
6. Cyber and information security training and awareness	6. Training statistics are available on ESR and from Phish threat module
7. Mandatory Information Governance training which includes GDPR	7. Training statistics reported on by Information Governance department
8. ICT tests and monitoring on networks & servers	8. Any issues would be identified and flagged and actioned
9. Information Governance framework	9. WAST self-assesses its Information Governance Framework against the Welsh Information Governance toolkit.
10. Internal and NHS Wales governance reporting structures in place	10. Internal WAST Information Governance Steering Group & All Wales Information Governance Management Advisory Group (IGMAG) meets quarterly, National Ambulance Information Governance Group (NIAG) meets every 2 weeks, Operational Security and Service Management Board (OSSMB) (national) – daily/weekly meetings and minuted meetings every 2 months. Minutes and actions logs available for meetings.
11. Checks undertaken on inactive user accounts	11. Software in place to run check on inactive accounts as and when
12. Business Continuity exercises	12. Annual schedule of testing
13. Operational ICT controls e.g. penetration testing, firewalls, patching	13. Monthly scans on infrastructure. Penetration testing has occurred for different systems. 2 physical firewalls on networks to monitor traffic. Monthly patching occurs or as and when.
14. Security alerts	14. Daily alerts are received. Anti-virus alerts received as and when threat discovered
	External **Independent Assurance** NHS Wales Cyber Response Unit independent view of Network and Information Systems (NIS) Directive compliance within last 4 – 5 months (covering controls 1 -,3 – 11, 13 – 14
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Not all information security procedures are documented	1. No regular Cyber/Info Security KPIs are reported to senior management committees

Risk ID 260	Significant and Sustained Cyber Attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems	Date of Review:	06/12/2022	TREND	15 (3x5)
		Date of Next Review:	06/01/2023	➡	

IF there is a large-scale cyber-attack on WAST, NHS Wales and interdependent networks which shuts down the IT network and there are insufficient information security arrangements in place	**THEN** there is a risk of a significant information security incident	**RESULTING IN** a partial or total interruption in WAST's ability to deliver essential services, loss or theft of personal/patient data and patient harm or loss of life

	Likelihood	Consequence	Score
Inherent	4	5	20
Current	3	5	15
Target	2	5	10

2. Lack of understanding and compliance with policy and procedures by all staff members	2. Cyber awareness campaigns could be undertaken more regularly e.g. bi-monthly
3. No organisational information security management system in place	
4. IT Disaster Recovery Plan does not include a cyber response	
5. Departments do not communicate in a timely manner with Digital Services around putting in new processes, new projects and procurement and this has a cyber security, information governance and resource impact	

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1.Establish Cyber and Information Security KPIs	Director of Digital Services	31.12.22	Draft KPIs have been agreed and produced for quarterly reporting. Q1 and Q2 are currently being reviewed within ICT prior to wider circulation.
2.Discuss how cyber risk is reviewed and frequency of review	Director of Digital Services	28/10/22 Close – now Business as Usual	a. The ongoing cyber threat to the organisation is continually monitored using daily comms feeds and automated alerts from various external sources. b. The corporate cyber risk assessment will be reviewed monthly at the Digital Leadership Group informed by the threat and intelligence monitoring and national strategic trends.
3. Suite of business continuity exercises that departments can undertake to test their plans to be provided.	North Resilience Manager	28/10/22 Complete	The Trust has run two exercise Joshua & Joshua 2 to test departments readiness
4.Exercise template report which shows recommendations to be created	North Resilience Manager	31.12.22 - Ongoing	Exercise reports being drafted
5.Formalise Cyber Incident Response Plan	Head of ICT	31.12.22 – Checkpoint Date	Ongoing
6.Implement Meta Compliance Policy Solution	Senior ICT Security Specialist	31.12.22 – Checkpoint Date	Ongoing

Risk ID 543	Major disruptive incident resulting in a loss of critical IT systems		Date of Review:	06/01/2022	TREND	15 (3x5)
			Date of Next Review:	06/01/2023	➡	

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

IMTP Deliverable Numbers:

EXECUTIVE OWNER	Director of Digital Services	**ASSURANCE COMMITTEE**	Finance and Performance Committee

CONTROLS	**ASSURANCES**
	Internal **Management (1st Line of Assurance)**
1. Trust Incident Response Plan and Department Business Continuity Plans	1. Full review of Incident Response plan every 3 years and partial review annually unless there is a major learning point. Annual schedule of testing of BCPs.
2. IT Disaster Recovery Plan	2. Recent ICT tabletop exercise undertaken
3. Recovery/contingency plans for critical systems	3. Reports from tabletop exercises
4. Service management processes in place	4. Documented and approved service management processes in place
5. Incident Management Policy, Procedure and Process	5. Incident Policy and Procedure put in place in February 2022. This would be required annually and if there is a system change, the review would be earlier
6. Regular data back ups	6. Daily report on status of backup and fully automated process. Log kept of where restores are undertaken
7. Resilient and high availability ICT infrastructure in place	7.
8. Robust security architecture and protocols	8.
9. Diverse IT network (both data and voice) delivery at key operational sites	9.
10. Regular routine maintenance and patching	10.
11. Environmental controls	11.
12. Intelligence gathered from suppliers with respect to future tool sets and enhancements	12. Via email and webinars
	External **Independent Assurance** • 2021_16 Internal Audit review of IM&T Control Assessment – baseline exercise • 2021_19 Internal Audit review of ICT Disaster Recovery – Limited Assurance • NIS Directive internal audit report 2022 – Reasonable Assurance (covering controls 1-12)
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
Non identified	Undertaking Cyber Essentials assessment

Actions to reduce risk score or address gaps in controls and assurances	**Action Owner**	**By When/Milestone**	**Progress Notes:**
1. Suite of business continuity exercises that departments can undertake to test their plans to be provided.	North Resilience Manager	31.12.22 Checkpoint date	
2. Exercise template report which shows recommendations to be created	North Resilience Manager	31.12.22 Checkpoint date	
3. Cyber Essentials assessment to be completed	Head of ICT	31.12.22 Checkpoint date	

Risk ID 558	Deterioration of staff health and wellbeing in the face of continued system pressures as a consequence of workplace experiences	Date of Review:	13/01/2023	TREND	15 (3x5)
		Date of Next Review:	13/02/2023	➡	

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:

EXECUTIVE OWNER	Director of Workforce & OD	ASSURANCE COMMITTEE	People & Culture Committee

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1. Health and wellbeing strategy in place and shared across the Trust.	1. Review undertaken of the Health and Wellbeing Strategy by Assistant Director annually.
2. People Services & Occupational Health & Wellbeing support/Employee Assistance Programme	2. Regular review meetings with all external providers to ensure they meet requirements of the SLA contracts. Regular management information received so that trends can be monitored.
3. Self-referrals or managerial referrals to Occupational Health	3. Regular reports submitted by Occupational Health team to WOD Business Meetings for monitoring.
4. Wellbeing support and training for line managers	4. Diarised meetings, webinars and workshops in place through a rolling programme.
5. Development of range of wellbeing resources for staff and line manager	5. Tools are available on WAST intranet. Occupational Health and Wellbeing teams visit stations, A&E , CCCs and other locations regularly where operational staff are based to promote the occupational health and wellbeing offer.
6. Peer support network forum	6. Agendas and minutes of meetings produced for each meeting.
7. WAST Keep Talking (mental health portal)	7. Available on intranet for staff to access easily.
8. TRiM	8. TRiM Coordinator has regular dialogue with TRiM managers and practitioners. Project plan and training schedule in place. Information in TRim Teams folder.
9. Coaching and mentoring framework	9. Information on intranet on Learning launch pad available to all staff.
10. Acting on results of staff surveys relating to staff experience	10. Each Directorate has developed their own action plan to address staff surveys.
11. HSE stress risk assessments	11. Undertaken by managers and advice is provided on how to use them by Occupational Health team.
12. KPIs are reported monthly to WOD regarding Occupational Health and Wellbeing activity	12. Received at WOD Business Meetings monthly.
13. Wellbeing drop-in sessions for CCC and 111 staff	13. Diarised sessions in place as part of the programme.
14. Fast track physiotherapy	14. Regular review meetings with physiotherapy provider and monthly monitoring information received at WOD Business meetings.
15. Specialist trauma counselling service	15. Same as 15.
16. Regular psycho-educational sessions with managers and staff	16. Diarised sessions
17. Compassionate leadership training sessions	17. Same as 17 in place as part of the programme.
18. Chaplaincy programme	18. Training plan and minutes of meetings produced quarterly for the Wellbeing Team – to be reviewed.
19. Occupational Health team inclusion in sickness and absence meetings	19. Diarised meetings in place.
	External **Independent Assurance** Audit Wales – Taking Care of the Carers report in October 2021
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
	4. Reporting on wellbeing training take up
11. Need to increase the education and communication with managers about stress risk assessments	• Lack of awareness about staff wellbeing services
	• Effects of REAP 4 affecting the ability of staff to engage with staff health and wellbeing services

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:

Risk ID 558	Deterioration of staff health and wellbeing in the face of continued system pressures as a consequence of workplace experiences		Date of Review:	13/01/2023		TREND	15 (3x5)
			Date of Next Review:	13/02/2023		➡	
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**	
1. Restart the Health and Wellbeing Steering Group (link to risk 160)		Assistant Director – Inclusion, Culture and Wellbeing	Completed	First meeting was on 17/10/2022. This however does not yet bring down the score of the risk as the Steering Group meeting was to re-establish a way forward. Next meeting to be scheduled within 2 months.			
2. Increase the education and communication with managers about stress risk assessments		Head of Health & Safety	Completed	This is part of the IOSH Managing Safety Training BAU. OH to undertake workshops with CCC managers – dates to be confirmed this week.			

Risk ID 100	Failure to persuade EASC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience	Date of Review:	12/01/2023	TREND	12 (3x4)
		Date of Next Review:	10/03/2023	➡	

IF	THEN	RESULTING IN
IF WAST fails to persuade EASC/Health Boards about WAST ambitions	**THEN** there is a risk of a delay or failure to receive funding and support	**RESULTING IN** a catastrophic impact on services to patients & staff and key outcomes in the IMTP not being delivered

	Likelihood	Consequence	Score
Inherent	4	4	16
Current	3	4	12
Target	2	4	8

IMTP Deliverable Numbers: 2, 3, 4, 6, 11, 14, 29, 34

EXECUTIVE OWNER	Director of Strategy Planning & Performance	ASSURANCE COMMITTEE	Finance and Performance Committee

CONTROLS	ASSURANCES
	Internal & External **Management (1st Line of Assurance)**
1. EASC/WAST Forward Plan for EMS and NEPTS in place and monitored at EASC meetings	1. Minutes of meetings and a standard agenda item
2. EASC and its 2 sub-committees established as a forum to discuss WAST's strategy	2. Minutes of meetings and a standard agenda item
3. Weekly catch up between CASC/CEO	3. Meetings are diarised every week
4. Collaboration between EASC and WAST on specific projects e.g. Amber Review, EMS Operational Transformation Programme, Ambulance Care Programme	4. Representatives are co-opted onto meetings and frequency is between 3–6 weeks. Set agendas with NCCU reps co-opted.
5. Monthly CASC Quality and Delivery Meeting established	5. Formal meeting with agendas, minutes and action logs available.
6. Patient Safety information e.g. Appendix B incidents, weekly/monthly patient safety reports produced	6. These reports supplied to Director of Quality and Nursing in Health Boards and other senior stakeholders fortnightly
7. Programme structure has been established for 'inverting the triangles' including EASC	7. It exists and has had its first meeting
	External **Management (1st Line of Assurance)** 1. Plans go to every bi-monthly meeting 2. Meet bi-monthly and agendas, minutes and action logs available

GAPS IN CONTROLS	GAPS IN ASSURANCE
1. EASC meetings focus largely on EMS and cursory note of NEPTS	1. Health Boards are not sending Patient Safety Incidents that are National Reportable Incidents to the Delivery Unit (identified within a Delivery Unit audit)
2. Governance coordination between NCCU and WAST to be improved.	2. Identified need for a governance meeting between NCCU and WAST to manage the overall commissioner/provider interface
3.	7. This is a new structure that has been established and is yet to be embedded and tested for assurance
Xx WAST's ability to influence hospital handover delays (this is outside of the Trust's control and a Health Board responsibility)	
Xx Funding does not flow in a manner to balance demand with capacity (this is outside of WAST's control)	

	Action Owner	By When/Milestone	Progress Notes:
1. Agree and influence EASC/Health Boards that sufficient funding to be provided to WAST	CEO WAST	31.12.22 – Checkpoint Date	30.09.22 Additional £3m provided for +100 FTEs into Response by 23/01/23. 12/01/23 Recurrent funding for the +100 not secure.
2. Agree and influence EASC/Health Board of the need for significant reduction in hospital handover hours	CEO WAST	31.12.22 – Checkpoint Date	30.09.22 4 hour handover backstop agreed and -25% reduction in handover from October 2021 baseline. 12/01/23 There has been a significant worsening picture
3. Increased understanding of NEPTS by EASC	Director of Strategy Planning and Performance	31.12.22 – Checkpoint Date	30.09.22 "Focus on" session at May 2022 EASC and NCCU represented on Ambulance Care Programme Board. 12/01/23 F&P Deep Dive made available to NCCU.
4. Governance meeting between NCCU and WAST to manage the commissioner provider interface	Assistant Director Commissioning & Performance	31.12.22 – Checkpoint Date	30.09.22 Meeting in place and meeting regularly. 12/01/23 Meetings continue.
5. Utilising the engagement framework to engage with the stakeholders	Director of Partnerships & Engagement AD Planning & Transformation	31.12.22 Checkpoint date	30.09.22 Significant engagement through roster review briefings.

Risk ID 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:	12/01/2023	TREND	12 (3x4)
		Date of Next Review:	10/03/2023	➡	

IF WAST fails to persuade EASC/Health Boards about WAST ambitions	THEN there is a risk of a delay or failure to receive funding and support	RESULTING IN a catastrophic impact on services to patients & staff and key outcomes in the IMTP not being delivered

	Likelihood	Consequence	Score
Inherent	4	4	16
Current	3	4	12
Target	2	4	8

			12/01/23 Engagement on roster review largely concluded, with some political interest continuing in a few areas.

Risk ID 163	Maintaining Effective & Strong Trade Union Partnerships	Date of Review:	12/01/2023	TREND	12 (4x3)
		Date of Next Review:	12/03/2023	➡	

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	3	12
Target	4	3	12

IMTP Deliverable Numbers: 2, 4, 6, 11, 20, 34

EXECUTIVE OWNER	Director of Workforce and Organisational Development	ASSURANCE COMMITTEE	People & Culture Committee

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1. Agreed (Refreshed) TU Facilities Agreement developed in partnership	1. Agreed document which states governance arrangements and the criteria for time off for TU activity etc.
2. Go Together Go Far (GTGF) statement and CEO/TU Partners statement	2. Both parties refer to the documents and are signed up/committed to it
3. IPA Workshops	3. Meetings completed with participation from TUs and senior managers. Attendance lists are available
4. Trade Union representation at Trust Board, Committees	4. Committee or Board ask TU representative for feedback or whether they have been consulted. Big issues items progress as planned as a result of TU partner buy in
5. Monthly Informal Lead TU representatives and Chief Executive meetings	5. Diarised meetings
6. Staff representative management in Task & Finish Groups	6. Good attendance and commitment is observed at the meetings. TU partners listed as members in terms of reference
7. 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
	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 Workforce & Organisational Development	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 Workforce & Organisational Development	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 Workforce & Organisational Development	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

Risk ID 163	Maintaining Effective & Strong Trade Union Partnerships			Date of Review:	12/01/2023	TREND	12 (4x3)
				Date of Next Review:	12/03/2023	➡	

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	3	12
			Target	4	3	12

			meeting. Actions from the ACAS recommendations will be added on receipt. Report received in October. Action plan developed and shared with TUs. Implementation underway
4. Minutes of formal Partnership Forum should be reported to PCC or Board in future (return to BAU).	Deputy Director of Workforce & Organisational Development	Completed 12/01/23	WASPT feeding into PCC

Risk ID 283	Failure to implement the EMS Operational Transformation Programme		Date of Review:	12/01/2023	TREND	12 (3x4)
			Date of Next Review:	10/03/2023	➡	

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

IMTP Deliverable Numbers: 3, 7, 17, 18, 19, 20, 27

EXECUTIVE OWNER	Director of Strategy Planning & Performance	ASSURANCE COMMITTEE	Finance and Performance Committee

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1. Implementation Programme Board in place – meetings held every 3 weeks with the DASC and TU reps on the membership	1. Minutes and papers of Implementation Programme Board
2. Executive sponsor and Senior Responsible Owner (SRO) for programme in place	2. Project Initiation Document (PID) detailing structure and minutes of Implementation Programme Board
3. Programme Manager and Programme support office in place (for delivery of the programme)	3. Same as 2
4. Programme risk register	4. Highlight reports showing key risks reported to STB every 6 weeks
5. Assurance meetings held with Strategic Transformation Board (STB) every 6 weeks and with CEO every 3 weeks	5. Highlight reports presented to STB every 6 weeks
6. Programme budget in place (including additional £3m funding for 22/23)	6. Programme budget monitoring report is provided to the Implementation Programme Board – every 6 weeks and letter received from CASC on £3m funding for 22/23
7. Programme documentation and reporting is in place to Programme Board every 3 weeks and STB receives highlight report	7. PID and Programme Plan Summary kept up to date. PID is presented to the STB if there is a significant change in the programme deliverables. Programme Plan Summary reported to the Implementation Programme Board every 3 weeks.
8. Regular engagement with the Commissioner and Trade Unions and representation	8. Commissioner and TU participation at the Implementation Programme Board
9. Management of external stakeholder and political concerns	9. Communications and Engagement Plan sets out WAST's arrangements for engagement with stakeholders
10. Secured specialist consultancy to support decision making	10. Reports and contractual compliance
11.	**External** **Management (1st Line of Assurance)**
	a. Deputy Ambulance Services Commissioner sits on the Implementation Programme Board
	b. Emergency Ambulance Service Committee Management Group receives a highlight report every two months
	c. EASC receives an update every 2 months on the programme as part of the WAST Provider Report

GAPS IN CONTROLS	GAPS IN ASSURANCE
1. Current controls on workforce buy in are not sufficient due to changes in working practices	1. Project Initiation Document (PID) needs to be updated to reflect 22/23 budget position
2. System pressures – patient handover delays at hospitals (link to risks 223 & 224)	2. No prompts from STB for programme PID or risk register updates

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Increase in engagement on the specifics of change through facilitation mechanisms	Assistant Director – Commissioning & Performance	31.12.22 – Checkpoint Date	30.09.22 Significant engagement through roster review project. 12/01/23 Largely complete.
2. More capacity requested (transition plan)	Assistant Director of Planning & Transformation	31.12.22 – Checkpoint Date	30.09.22 Transition plan not funded, but +100 FTE agreed. 12/01/23 Recurrent funding not secure.
3. Engage with key stakeholders to reduce handover delays	CASC	31.12.22 – Checkpoint Date	30.09.22 Reduction commitments agreed, but trend is still upwards. 12/01/23 Extreme and upward trend.

Risk ID 283	Failure to implement the EMS Operational Transformation Programme			Date of Review:	12/01/2023	TREND	12 (3x4)
				Date of Next Review:	10/03/2023	➡	
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

Action	Owner	Date	Update
4. Reduce abstractions in particular sickness absence	Deputy Director of Workforce & OD	31.12.22 – Checkpoint Date	30.09.22 Sickness absence reducing, but abstractions high linked to sickness, but also training abstraction linked to the +100. 12/01/23 Abstractions have reduced, but still very high. Sickness is reducing and on trend to achieving the 8% Mar-23 target. High abstractions linked to internal movements caused by internal recruitment.
5. Engage with Assistant Director of Planning and Transformation on process for PID updates	Assistant Director – Commissioning & Performance	31.12.22 Checkpoint Date	30.09.22 HoT recruited and now started. Initial contact made with HoT. PID is up to date. 12/01/23 PID has been further updated but requires sign off by the SRO and STB.

<table>
<tr><td>Risk ID 424</td><td colspan="3">Resource availability (capital) to deliver the organisation's Integrated Medium-Term Plan (IMTP)</td><td>Date of Review:
Date of Next Review:</td><td>13/01/2023
01/04/2023</td><td>TREND
➡</td><td>12 (3x4)</td></tr>
<tr><td colspan="2">IF resources are not forthcoming within the funding envelope available to WAST (link to risk 139)</td><td>THEN there is a risk that there is insufficient capacity to deliver the IMTP</td><td>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</td><td colspan="4">
<table>
<tr><th></th><th>Likelihood</th><th>Consequence</th><th>Score</th></tr>
<tr><td>Inherent</td><td>4</td><td>4</td><td>16</td></tr>
<tr><td>Current</td><td>3</td><td>4</td><td>12</td></tr>
<tr><td>Target</td><td>1</td><td>4</td><td>4</td></tr>
</table></td></tr>
<tr><td colspan="8">IMTP Deliverable Numbers: 5,9,10, 17, 28</td></tr>
<tr><td colspan="2">EXECUTIVE OWNER</td><td>Director of Strategy Planning & Performance</td><td>ASSURANCE COMMITTEE</td><td colspan="4">Strategic Transformation Board and Finance and Performance Committee</td></tr>
<tr><td colspan="3">CONTROLS</td><td colspan="5">ASSURANCES</td></tr>
<tr><td colspan="3"></td><td colspan="5">Internal
Management (1st Line of Assurance)</td></tr>
<tr><td colspan="3">1. Prioritisation of IMTP deliverables</td><td colspan="5">1. Prioritisation detailed in IMTP and reviewed and agreed at Strategic Transformation Board</td></tr>
<tr><td colspan="3">2. Financial policy and procedures</td><td colspan="5">2.</td></tr>
<tr><td colspan="3">3. Governance and reporting structures e.g. Strategic Transformation Board (STB)</td><td colspan="5">3. IMTP sets out delivery structures and meeting minutes are available</td></tr>
<tr><td colspan="3">4. Assurance meetings with Welsh Government and Commissioners</td><td colspan="5">4. Agendas, minutes and slide decks available</td></tr>
<tr><td colspan="3">5. Transformation Support Office (TSO) which supports the major delivery programmes</td><td colspan="5">5. Paper on TSO to Strategic Transformation Board</td></tr>
<tr><td colspan="3">6. Project and programme management framework</td><td colspan="5">6. PowerPoint pack detailing PPM</td></tr>
<tr><td colspan="3">7. Regular engagement with key stakeholders</td><td colspan="5">7. Stakeholder Engagement Framework</td></tr>
<tr><td colspan="3"></td><td colspan="5">Independent Assurance (3rd Line of Assurance)
2. Subject to Internal Audit</td></tr>
<tr><td colspan="3">GAPS IN CONTROLS</td><td colspan="5">GAPS IN ASSURANCE</td></tr>
<tr><td colspan="3">1. Project and programme management (PPM) framework to be reviewed</td><td colspan="5">1. PPM needs to be reviewed and approved through STB</td></tr>
<tr><td colspan="3">2. Head of Transformation vacancy</td><td colspan="5">2. Benefits have not been fully linked to benefits realisation</td></tr>
<tr><td colspan="3">3. Lack of a commercial contractual relationship with Commissioners (link to risk 458)</td><td colspan="5"></td></tr>
<tr><td colspan="3">Actions to reduce risk score or address gaps in controls and assurances</td><td>Action Owner</td><td>By When/Milestone</td><td colspan="3">Progress Notes:</td></tr>
<tr><td colspan="3">1. Recruit a Head of Transformation</td><td>Assistant Director of Planning</td><td>30.09.22 complete</td><td colspan="3">Recruited 02.08.22 in post on 01.11.22</td></tr>
<tr><td colspan="3">2. Review the PPM</td><td>Head of Transformation</td><td>Extended from 31.03.23 – To 31.03.23 Checkpoint Date</td><td colspan="3">Currently (January 2023) working through delivery structures for 2023-26 which will inform the PPM review – changed checkpoint date to 31.06.23</td></tr>
<tr><td colspan="3">2. Develop Benefits Realisation plans in line with Quality and Performance Management framework</td><td>Assistant Director of Planning/Assistant Director, Commissioning & Performance</td><td>Extended from 30.09.22 – To 31.03.23</td><td colspan="3">Reviewed action and extended checkpoint date further as approach being developed for next iteration of IMTP. Work ongoing.</td></tr>
</table>

Risk ID 424	Resource availability (capital) to deliver the organisation's Integrated Medium-Term Plan (IMTP)	Date of Review:	13/01/2023	TREND	12 (3x4)
		Date of Next Review:	01/04/2023	➡	

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	3	4	12
			Target	1	4	4

		Checkpoint Date – T0 31.06.23 checkpoint date	
3. A formal approach to service change to be developed providing secure recurrent funding with commissioners (link to risk 458)	Deputy Director of Finance	31.12.22 – checkpoint date 31.03.23	Extend checkpoint date to 31.03.2023 on basis of new financial allocations for 2023 to be worked through with Commissioner

IMTP Deliverable Key

No.	IMTP Deliverable
1	We will recover our systems of working and implement new ways of working developed during the pandemic as we learn to live with COVID-19
2	We will engage with a range of stakeholders, developing genuine Pan-Wales representation on partnership structures and delivering strong political and media relationships across the spectrum
3	We will develop and deliver a collaborative programme of work to design and implement new models within EMS (Inverting the Triangles)
4	We will work with partners to promote and expand use of 111 across Wales
5	We will increase the capacity and capability of the clinical teams for 111 and 999 callers, increasing clinical information available to them and we will create one integrated national team
6	We will work with partners to increase the number of seamless 24/7 pathways from the 111 clinical team to appropriate face to face consultations
7	We will take steps to continuously improve the safety and quality of the service and provide an improved patient experience
8	We will increase accessibility, content and user experience of the 111 Digital front end, which can offer increasingly personalised advice
9	We will increase and balance response capacity and capability across urban and rural area of Wales
10	We will increase skill levels and resources (information, equipment and technology) available to clinicians on scene to allow them to most effectively assess and treat patients
11	We will work with partners to increase number of seamless 24/7 referral pathways as alternatives to ED conveyance and improve hospital handover
12	We will take steps to continuously improve the safety and quality of the service and provide an improved patient experience
13	We will develop and deliver an improvement plan for NEPTS and increase capacity where required to meet demand
14	We will develop and implement with partners an-All Wales transfer and discharge service
15	We will continue to deliver against our Transport Solutions Programme to embed as a business-as-usual approach to service delivery
16	We will take steps to continuously improve the safety and quality of the service and provide an improved patient experience
17	We will improve resource availability, tackling absence and recruitment challenges to deliver improved performance
18	We will effectively manage risk, governance and compliance to promote and protect colleague and patient safety, and ensure a safe, productive and fair work environment
19	We will purposefully shape our future People and Culture Strategy to equip our people to thrive in a changing environment
20	We will foster a culture of belonging and wellbeing where our people can engage, feel supported and represented
21	We will improve access to, and availability of services via the 111 Wales website and other digital channels (NHS Wales app)
22	Improved signposting to the most appropriate service
23	Improved digital tools and services to empower our teams to do their best
24	We will use modern technology to reduce repeat tasks and improve processes
25	Standardised information architecture and common approach to data and analytics across the organisation
26	We will deliver greater insights to WAST and NHS Wales, through improved data sharing, analytics and visualisation
27	Improved resilience, flexibility and interoperability for the 999-call platform
28	We will provide an improved financial plan to support our ambitions
29	Finalise our organisational position on achieving University Trust Status (UTS) in collaboration with WG, embracing a culture of learning, research and innovation
30	We will deliver the Estates Strategic Outline Plan
31	We will implement the Environmental and Sustainability Strategy
32	Deliver the Fleet SOP
33	We will secure and implement Quality Management and control systems
No.	**IMTP Deliverable**
34	We will transform the way we work and engage with people
35	We will revisit and implement the Public Health Plan
36	We will implement the Clinical Strategy to support developments across our service ambitions
37	We will deliver a values-based approach
38	We will deliver strong risk management processes and embed a Trust-wide risk culture that embeds the principles of good governance

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

AUDIT REPORT

MEETING	Audit Committee
DATE	2 March 2023
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Trish Mills, Board Secretary
CONTACT	trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. The audit recommendation tracker is in place for the purpose of tracking progress across the Trust to ensure that recommendations contained in internal and external audit review reports are actioned in a timely manner.

2. A number of the management actions were due in Q3 and Q4 and requests have been made by action owners to move those dates by a few months. This will primarily be due to availability of teams to focus on these areas due to winter and industrial action pressures. In addition, the Corporate Governance Team has experienced resource challenges that has precluded it from conducting confirm and challenge meetings with action owners and Executives to enable it to assure the Audit Committee on the appropriateness of revised dates. For the same reason the team have been unable to review evidence of closure of actions.

3. The audit tracker will be updated for the next regular meeting of the Audit Committee. In addition, Internal Audit will shortly conduct their annual review of the tracker.

4. **The Audit Committee is requested to note the update.**

KEY ISSUES/IMPLICATIONS

As set out above.

REPORT APPROVAL ROUTE

Not applicable.

REPORT APPENDICIES
Not applicable.

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

AGENDA ITEM No	9
OPEN or CLOSED	Open
No of ANNEXES ATTACHED	1

LOSSES AND SPECIAL PAYMENTS - PAYMENTS FOR THE PERIOD FROM 1ST APRIL 2022 TO 31st JANUARY 2023

MEETING	Audit Committee
DATE	2nd March 2023
EXECUTIVE	Chris Turley, Executive Director of Finance and Corporate Resources
AUTHOR	Jessica Price – Deputy Head of Financial Accounting
CONTACT	Chris Turley Chris.Turley2@wales.nhs.uk

EXECUTIVE SUMMARY

In accordance with SFI's this report presents to the Committee details of Losses and Special Payments made during the ten months from 1st April 2022 to 31st January 2023 (**Annex 1**).

KEY ISSUES/IMPLICATIONS

Total net Losses and Special Payments made were as follows:-

- period 1st April 2022 to 31st January 2023 -£0.920m

REPORT APPROVAL ROUTE
Audit Committee 2nd March 2023 – no action required for information under SFI's only

REPORT APPENDICES
Annex 1 – Summary and details of payments made for the ten months to 31st January 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 JANUARY 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 ten months from 1st April 2022 to 31st January 2023 (**Annex 1**).

ASSESSMENT

3. Total net Losses and Special Payments made during the period 1st April 2022 to 31st January 2023 amounted to -£0.920 million.

4. This relates to actual payments made less reimbursements received from the Welsh Risk Pool and does not relate to any adjustments made to the provision. During the ten months to 31st January 2023 reimbursements received exceeded payments made by -£0.920m.

5. During December you will note the Welsh Risk Pool reimbursements amounted to £1.184m. The majority of which relates to the reimbursement of 2 finalised medical negligence cases against the Trust. £0.603m relates to the reimbursement received for a medical negligence case against the Trust for incorrect advice given by a paramedic over the telephone, resulting in the patient later requiring critical care. £0.548m relates to a medical negligence case against the Trust due to patients recovery being effected by delays to ambulance arrival.

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 ten months to 31st January 2023:

	£
April 2022	£109,893.12
May 2022	£141,037.72
June 2022	-£121,785.57
July 2022	£104,081.28
August 2022	-£242,461.55
September 2022	£31,524.41
October 2022	£80,621.95
November 2022	£97,829.14
December 2022	-£1,170,608.84
January 2023	£49,830.39
February 2023	£0.00
March 2023	£0.00
	-£920,037.95

Losses and Special Payments Breakdown:

Payment Type	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
	£	£	£	£	£	£	£	£	£	£	£	£	
Claimants Solicitor Costs	40,455.00	40,731.00	83,866.00	23,200.00	233,182.00	5,000.00	38,656.00	23,100.00	0.00	5,328.96	0	0	£493,518.96
Counsel fees	10,825.00	5,339.00	2,827.50	17,195.63	9,050.00	1,150.00	6,077.08	9,912.50	3,656.26	5,675.00	0	0	£71,707.97
CRU	0	29,816.83	3,686.00	1,312.00	0	3,791.00	33,858.00	-27,374.38	688.00	0.00	0	0	£45,777.45
Damages	12,875.00	23,200.00	42,374.31	21,095.87	17,600.00	0	39,000.00	0.00	-950.00	5,000.00	0	0	£160,195.18
Defence Costs	4,061.02	2,318.90	2,368.87	4,012.20	221.79	4,510.46	532.10	4,295.61	464.08	3,516.50	0	0	£26,301.53
Expert Witness	15,024.00	10,140.75	6,587.50	7,740.00	2,400.00	2,856.25	1,350.00	5,880.00	2,900.00	4,680.03	0	0	£59,558.53
Vehicle Repairs	12,155.60	29,491.24	5,156.51	29,525.58	6,786.46	14,216.70	36,038.77	12,015.41	6,663.66	14,849.90	0	0	£166,899.83
WRP Refund	0.00	0 -	268,652.26	0 -	518,151.70	0	-74,890.00	70,000.00	-1,184,030.84	10,780.00	0	0	-£1,964,944.80
Property Repairs	14,497.50	0	0	0	6,449.90	0	0	0	0	0	0	0	£20,947.40
Court Refund	0.00	0	0	0	0	0	0	0	0	0	0	0	£0.00
Total	**£109,893.12**	**£141,037.72**	**-£121,785.57**	**£104,081.28**	**-£242,461.55**	**£31,524.41**	**£80,621.95**	**£97,829.14**	**-£1,170,608.84**	**£49,830.39**	**£0.00**	**£0.00**	**-£920,037.95**

Welsh Ambulance Services NHS Trust

Losses and Special Payments

Summary of payments for the ten months to 31st January 2023:

Key

MN Medical Negligence
PI Personal Injury
DP Damage To Property

	£	
PI cases < £1,000	2,659.30	6 CASES
DP cases < £1,000	19,540.04	45 CASES
23RT4MN0014	8.61	
22RT4MN0018	20.09	
23RT4MN0006	39.42	
23RT4MN0001	80.36	
23RT4MN0009	130.58	
22RT4MN0013	206.64	
23RT4MN0005	455.69	
21RT4MN0013	1,000.00	
21RT4PI0035	1,000.00	
22RT4MN0011	1,050.00	
22RT4MN0001	1,067.72	
22RT4PI0016	1,100.00	
22RT4DP0097	1,113.36	
22RT4EG0005	1,200.00	
22RT4DP0091	1,213.84	
23RT4MN0008	1,275.00	
18RT4MN0023	1,287.00	
23RT4DP0042	1,352.44	
22RT4DP0042	1,382.04	
23RT4DP0010	1,449.49	
23RT4GN0016	1,500.00	
22RT4DP0099	1,500.40	
22RT4DP0102	1,520.13	
21RT4GN0014	1,600.00	
23RT4DP0002	1,651.41	
23RT4DP0003	1,659.37	
23RT4PI0001	1,732.50	
23RT4DP0037	1,794.00	
23RT4DP0007	1,827.40	
23RT4DP0015	1,907.45	
23RT4DP0011	1,948.86	
23RT4DP0049	1,962.74	
23RT4MN0012	1,980.00	
22RT4PI0040	2,000.00	
22RT4GN0011	2,020.00	
23RT4DP0008	2,053.80	
23RT4DP0043	2,073.64	
23RT4DP0001	2,157.23	
19RT4PI0037	2,300.00	
23RT4DP0016	2,310.44	
23RT4DP0020	2,315.47	
22RT4DP0094	2,320.14	
22RT4DP0085	2,369.84	
23RT4DP0017	2,376.89	
22RT4DP0075	2,434.68	
23RT4MN0011	2,450.00	
23RT4PI0006	2,510.00	
23RT4DP0055	2,634.13	
23RT4DP0058	2,690.69	
23RT4DP0019	2,700.43	
23RT4DP0060	2,919.01	
19RT4PI0061	2,930.00	
22RT4DP0013	2,955.20	
19RT4MN0008	3,021.00	
23RT4DP0051	3,032.28	
22RT4DP0086	3,053.20	
22RT4DP0090	3,108.94	
22RT4GN0014	3,400.00	
23RT4DP0005	3,437.50	
22RT4DP0057	3,522.90	
22RT4PI0036	3,560.00	
22RT4GN0004	3,670.00	
23RT4DP0024	3,921.48	
22RT4DP0101	4,421.27	
23RT4DP0050	4,496.15	
23RT4DP0039	4,665.00	
23RT4DP0056	5,020.79	
22RT4PI0018	5,328.96	
23RT4DP0018	5,440.85	
16RT4MN0009	5,500.00	
20RT4PI0008	5,542.96	
21RT4GN0011	5,750.00	
20RT4PI0028	5,942.00	
18RT4MN0012	6,140.00	
20RT4PI0035	6,645.00	
23RT4DP0038	6,665.13	
18RT4MN0016	6,673.75	
23RT4DP0012	6,865.40	
21RT4MN0009	7,022.50	
23RT4DP0014	7,049.48	
22RT4PI0026	7,151.00	
22RT4PI0008	7,207.00	
22RT4MN0002	7,534.48	
19RT4DP0079	7,964.82	
23RT4DP0032	8,083.42	
23RT4DP0013	8,612.22	
21RT4PI0009	9,132.00	
21RT4DP0086	10,387.33	
22RT4MN0012	10,776.50	
22RT4PI0038	11,239.29	
19RT4PI0049	12,325.00	
23RT4DP0033	12,659.74	
21RT4PI0022	12,991.00	
19RT4PI0060	13,376.00	
20RT4PI0042	14,865.00	
20RT4MN0011	17,025.78	
20RT4PI0007	19,825.33	
22RT4DP0080	20,947.40	
18RT4MN0001	25,035.00	
20RT4PI0025	26,508.45	
20RT4MN0010	48,985.20	
21RT4PI0001	38,820.25	
20RT4MN0019	65,753.00	
17RT4MN0007	70,510.00	
21RT4PI0017	72,967.00	
19RT4PI0008	123,871.63	
18RT4MN0005	117,719.00	
22RT4GN0017	- 350.00	WRP REFUND
22RT4GN0008	- 500.00	WRP REFUND
22RT4GN0011	- 500.00	WRP REFUND
21RT4GN0016	- 1,250.00	WRP REFUND
22RT4GN0007	- 1,750.00	WRP REFUND
22RT4GN0004	- 1,750.00	WRP REFUND
22RT4GN0014	- 1,800.00	WRP REFUND
18RT4MN0001	- 1,830.00	WRP REFUND
21RT4GN0014	- 2,560.00	WRP REFUND
21RT4GN0008	- 5,000.00	WRP REFUND
20RT4MN0006	- 7,682.00	WRP REFUND
20RT4PI0025	- 28,380.83	WRP REFUND
19RT4PI0053	- 56,834.01	WRP REFUND
18RT4PI0060	- 202,886.25	WRP REFUND
18RT4MN0023	- 221,366.50	WRP REFUND
20RT4MN0010	- 289,685.20	WRP REFUND
18RT4MN0005	- 536,929.00	WRP REFUND
17RT4MN0007	- 603,891.01	WRP REFUND
Total	**- 920,037.95**	

Nov-22

Case Reference	Details	Amount (£)
18RT4MN0005	CRU	- 10,780.00
18RT4MN0016	Counsel fees	- 375.00
18RT4MN0016	Counsel fees	1,250.00
18RT4MN0016	Expert witness	2,100.00
18RT4PI0060	WRP Refund	70,000.00
19RT4PI0037	Counsel fees	550.00
19RT4PI0037	Counsel fees	1,750.00
19RT4PI0061	Counsel fees	1,705.00
20RT4MN0011	Defence Costs	108.00
20RT4MN0011	Expert witness	750.00
20RT4MN0011	Counsel fees	1,025.00
20RT4MN0011	Expert witness	1,050.00
20RT4MN0019	Claimants Solicitor Costs	23,100.00
20RT4PI0004	Defence Costs	159.50
20RT4PI0008	Counsel fees	170.00
20RT4PI0008	Counsel fees	500.00
20RT4PI0008	Counsel fees	2,250.00
20RT4PI0025	CRU	- 18,152.38
20RT4PI0025	Defence Costs	1,680.00
21RT4EG0003	CRU	725.00
21RT4GN0007	CRU	833.00
21RT4PI0001	Defence Costs	1,152.25
22RT4DP0013	Counsel fees	775.00
22RT4DP0028	Vehicle Repairs	- 40.00
22RT4DP0075	Vehicle Repairs	1,834.68
22RT4DP0086	Defence Costs	195.00
22RT4DP0086	Vehicle Repairs	961.20
22RT4MN0012	Counsel fees	312.50
23RT4DP0032	Vehicle Repairs	4,705.80
23RT4DP0038	Vehicle Repairs	4,553.73
23RT4DP0047	Vehicle Repairs	- 1,296.03
23RT4DP0047	Vehicle Repairs	1,296.03
23RT4EG0011	Defence Costs	30.50
23RT4EG0011	Defence Costs	495.00
23RT4EG0012	Defence Costs	100.45
23RT4MN0012	Expert witness	1,980.00
23RT4MN0014	Defence Costs	8.61
23RT4PI0001	Defence Costs	366.30
Totals		**97,829.14**

Dec-22

Case Reference	Details	Amount (£)
17RT4MN0007	WRP Refund	- 603,244.01
18RT4MN0005	WRP Refund	- 547,709.00
18RT4MN0016	Counsel fees	550.00
18RT4MN0023	WRP Refund	- 647.00
19RT4PI0009	Defence Costs	625.00
20RT4MN0011	Expert witness	450.00
20RT4PI0004	Defence Costs	- 160.92
20RT4PI0007	CRU	688.00
20RT4PI0025	WRP Refund	- 28,380.83
21RT4GN0011	Damages	- 1,200.00
21RT4PI0023	Counsel fees	825.00
22RT4DP0085	Vehicle Repairs	503.24
22RT4GN0004	WRP Refund	- 1,750.00
22RT4GN0011	WRP Refund	- 500.00
22RT4GN0014	WRP Refund	- 1,800.00
22RT4MN0001	Counsel fees	379.17
22RT4MN0001	Counsel fees	72.92
22RT4MN0001	Counsel fees	150.00
22RT4MN0012	Counsel fees	262.50
23RT4DP0046	Vehicle Repairs	217.08
23RT4DP0049	Vehicle Repairs	1,962.74
23RT4DP0052	Vehicle Repairs	817.84
23RT4DP0052	Vehicle Repairs	39.32
23RT4DP0053	Vehicle Repairs	489.31
23RT4DP0055	Vehicle Repairs	2,634.13
23RT4EG0001	Counsel fees	450.00
23RT4EG0010	Damages	250.00
23RT4EG0013	Counsel fees	666.67
23RT4EG0014	Counsel fees	300.00
23RT4MN0011	Expert witness	2,450.00
Totals		**- 1,170,608.84**

Jan-23

Case Reference	Details	Amount (£)
18RT4MN0005	WRP Refund	10,780.00
20RT4MN0011	Counsel fees	2,850.00
20RT4MN0011	Expert witness	213.33
20RT4MN0011	Expert witness	106.70
20RT4PI0004	Defence Costs	43.5
20RT4PI0008	Counsel fees	1,500.00
21RT4DP0046	Vehicle Repairs	94.58
22RT4DP0013	Expert witness	160.00
22RT4DP0086	Vehicle Repairs	- 480.60
22RT4MN0012	Expert witness	1,400.00
22RT4MN0012	Counsel fees	1,325.00
22RT4MN0012	Expert witness	2,800.00
22RT4PI0018	Claimants Solicitor Costs	5,328.96
22RT4PI0038	Damages	5,000.00
23RT4DP0012	Vehicle Repairs	200.00
23RT4DP0050	Vehicle Repairs	4,496.15
23RT4DP0051	Vehicle Repairs	3,032.28
23RT4DP0054	Defence Costs	3,473.00
23RT4DP0054	Vehicle Repairs	144.00
23RT4DP0054	Vehicle Repairs	467.67
23RT4DP0054	Vehicle Repairs	- 4,084.67
23RT4DP0056	Vehicle Repairs	5,020.79
23RT4DP0057	Vehicle Repairs	350.00
23RT4DP0058	Vehicle Repairs	2,690.69
23RT4DP0059	Vehicle Repairs	250.00
23RT4DP0059	Vehicle Repairs	- 250.00
23RT4DP0060	Vehicle Repairs	2,569.01
23RT4DP0060	Vehicle Repairs	350.00
23RT4EG0015	Vehicle Repairs	1,874.89
23RT4EG0015	Vehicle Repairs	230.66
23RT4EG0015	Vehicle Repairs	- 2,105.55
Totals		**49,830.39**

AGENDA ITEM No	10
OPEN or CLOSED	Open
No of APPENDIX ATTACHED	0

Committee Priorities 2022/23

MEETING	Audit Committee
DATE	2 March 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 2022/23.

2. The Committee received a progress report in March 2023 which indicated slippage on the risk policy and development of the BAF. These will be incorporated into the IMTP 2023-26 and will align with review of the strategic objectives in the long term strategy.

RECOMMENDATION

1. The Committee is asked to note the update.

KEY ISSUES/IMPLICATIONS

No issues to raise.

REPORT APPROVAL ROUTE

Not applicable.

REPORT APPENDICES

None.

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

COMMITTEE PRIORITIES FOR 2022/23

SITUATION

2. This report updates the Committee on progress against the priorities it set for 2022/23.

BACKGROUND

3. During the course of the 2021/22 effectiveness reviews, it was agreed that it is good practice for Committees to set priorities for the forthcoming year.

4. The Committee's priorities, which are set out below, were agreed by the Trust Board in May 2022 and will be tracked quarterly.

ASSESSMENT

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

Priority	Progress
1. Develop an induction programme for new Audit Committee Members	• The overarching new Board member induction programme is complete other than the roles and responsibilities for trade union representatives. This should be completed by mid-September. • The induction programme is in use for new Board members and includes a scrutiny toolkit, however in collaboration with Audit Wales we are looking to produce Audit Committee specific induction material and checklists. • In addition, a bespoke WAST finance induction for new members is also being developed with the Finance Team. • An addition to the induction programme is in development for Board members specifically around ESR, expenses, digital and payroll and will be complete by 31 December 2022.
2. The transformation of risk management and the Board Assurance Framework (BAF).	• The Committee received a progress report in March 2023 which indicated slippage on the risk policy and development of the BAF. These will be incorporated into the IMTP 2023-26 and will align with review of the strategic objectives in the long term strategy. • The Committee received a progress report on the risk management programme in June 2022. • The programme is part of the IMTP with oversight of the IMTP in Finance and Performance Committee. • The programme includes maturity of risk management and the BAF through 2022/23 and

	into 2024, and improvements are noted by the Audit Committee with the regular risk management reports. • The risk management policy and procedure will come to this committee for approval as part of that programme.

RECOMMENDATION

6. The Committee is asked to note the update.

AUDIT COMMITTEE
HIGHLIGHT REPORT TO BOARD

This report provides the Board with key escalation and discussion points at the last Committee meeting. A full list of items discussed appears at the end of the report to enable members to raise any questions to the Chair which have not been drawn out in the report.

Trust Board Meeting Date	26 January 2023
Committee Meeting Date	1 December 2022
Chair	Martin Turner

KEY ESCALATION AND DISCUSSION POINTS

ALERT
(Alert the Board to areas of attention)

There were no alerts generated from this meeting.

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

1. There is good progress against the **2022/23 Internal Audit Plan**, and the Internal Auditors have met with Directors to develop the 2023/24 internal audit plan which will be presented in March 2023 for Audit Committee approval.

2. The **Audit Wales** Structured Assessment was not presented to this meeting but will be on the agenda for the January Board meeting. The audit of the 2021/22 charitable funds financial statements is in progress.

3. Audit Wales updated the Committee on the **Review of Unscheduled Care** work they are undertaking. This work will examine various aspects of the unscheduled care system and will include analysis of national data sets to present a high-level picture of how the unscheduled care system is currently working. The first phase which focuses on the flow out of hospital is progressing well across Wales with completion due in Spring 2023.

4. The Committee reviewed a number of national Audit Wales reports including:

    - The Equality Impact Assessments: more than a tick box exercise? report. The new integrated assessment tool which will replace the WAST equality impact assessment has taken the findings and recommendations of this report into account.

    - The National Fraud Initiative in Wales 2020-21 report makes three recommendations relevant to WAST and which have been considered in the work of the Local Counter Fraud Service.

    - Public Sector Readiness for Net Zero Carbon by 2030: Evidence Report will be considered as part of the decarbonisation and sustainability work of the Trust. The Committee recognised the need for a more coordinated approach to this very important topic at national level.

5. The Audit Wales '**Cyber Resilience** Follow Up' report was taken in private session due to its sensitivities. The Interim Digital Director provided an update on the mitigations in place and further actions planned in response to this report, and generally, as part of cyber resilience improvements. The Finance and Performance Committee will review the WAST response more fully at a future meeting.

ASSURE

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

6. Three **Internal Audits** reviews were completed during the quarter and reviewed by the Committee. They were Attendance Management (reasonable assurance), Hazardous Area Response Team (HART) (reasonable assurance), and Electronic Patient Clinical Records (ePCR) (reasonable assurance). The reviews will also be presented to the People and Culture and the Finance and Performance Committees at their next meetings for assurance.
7. The overarching **tracker for internal and external audit** was reviewed. Board Committees have reviewed recommendations relevant to their remit, and overdue recommendations were in hand and with agreed revised dates.
8. The **losses and special payments** made during the period 1 April to 31 October 2022 amounted to £0.103m.
9. In **private *session*** the committee received the counter fraud update 1 September to 30 November 2022, as well as the report on tenders and single tender waiver requests.
10. The **2022/23 Committee Priorities** were reviewed, with good progress being made.

RISK MANAGEMENT

Risks Discussed: The corporate risks and board assurance framework (BAF) were reviewed. There are currently 18 risks on the register. Reporting on these risks also appears on the agenda for the January Trust Board meeting.

The Committee noted that risks **223** and **224** remain at a rating of 25 and now include the actions set out in the July Board paper on avoidable harm and subsequent updates provided on progress to the Board. The health and safety risk number **199** has reduced in score from 20 to 15 as a result of a number of initiatives being completed to mitigate the risk.

Risk **311** – inability of the estate to cope with the increase in FTEs was closed largely due to estate interim plan within the EMS Operations Transformation Programme.

New Risks Identified: A new risk **557** related to the potential impact on services as a result of industrial action was added to the register at a rating of 16 (4x4). Risks related to the further delay of the integrated information system (**538**) and to the failure to deliver the Welsh Government Decarbonisation Strategic Delivery Plan (**542**) are developing for entry on the register.

In the closed session, the local counter fraud service also advised that fraud-specific risks are also being developed.

COMMITTEE AGENDA FOR MEETING		
Internal Audit updates and reports on HART, ePCR and Attendance Management	Audit Wales update and reports on Equality Impact Assessment, National Fraud Initiative in Wales, and Public Sector Readiness for Net Zero Carbon by 2030	Risk management and Board Assurance Framework
Losses and special payments	Audit tracker	Committee priorities report Q3
All Wales Audit Committee Chairs highlight report		

COMMITTEE ATTENDANCE					
Name	**7 June 2022**	**15 Sep 2022**	**1 Dec 2022**	**2 March 2023**	**[insert date]**
Martin Turner					
Paul Hollard					
Joga Singh					
Ceri Jackson					
Chris Turley					
Lee Brooks					
Wendy Herbert	J Turnbull-Ross				
Liam Williams		First meeting	J Turnbull-Ross		
Catherine Goodwin					
Angie Lewis		First meeting	From 11.10		
Osian Lloyd (IA rep)					
Audit Wales representative	Mike Whitley	Fflur Jones			
Paul Seppman					
Damon Turner					
Trish Mills					
Carl Window					

	Attended
	Deputy attended
	Apologies received
	No longer member