Bundle Audit, Risk and Assurance Committee (Open) 21 November 2024

Agenda attachments

ITEM 00 Open Agenda 21 November 2024

0 09:30 - OPENING ITEMS

1 Chair's Welcome, Apols and Quorum

2 Declarations of Interest

ITEM 02 Board Member Register of Interests-Updated 2024-09-30-Published

3 Minutes of the Last Meeting: 12 September 2024

ITEM 03 2024-09-12 Draft ARAC OPEN Minutes

4 Action Log & Matters Arising:

ITEM 04 Action log (Public)

5 Chair's Report on Continuous Committee Effectiveness

5.1 FOR APPROVAL, ASSURANCE AND DISCUSSION

6 09:40 - Audit Wales Reports

Item 6 Audit Wales Update Report
Item 6.1 Review of Cost Savings Arrangements
Item 6.2 Structured Assessment

ITEM 06 WAST Audit Comittee Update 21112024

ITEM 06.1 WAST - 2023 Review of Cost Savings Arrangements

ITEM 06.2 WAST Structured Assessment 2024 Report

7 10:40 - Internal Audit Progress Report and Internal Audit Reports

Item 7 Internal Audit Progress report
Item 7.1 Integrated Quality and Performance Management Framework (Reasonable Assurance)
Item 7.2 Overtime Controls (Reasonable Assurance)
Item 7.3 Data Quality (Reasonable Assurance)
Item 7.4 Resourcing Policy (Limited Assurance)

ITEM 07 WAST_2425_Internal Audit Progress Report_November 24

ITEM 07.1 WAST 2425-5 IQPMF Final Internal Audit Report

ITEM 07.2 WAS-2425-10 Overtime Controls_Final Internal Audit Report

ITEM 07.3 WAS_2425_15_Data Quality_Internal Audit Report (Audit Committee Issue Final)

ITEM 07.4 WAS-2425-16 Resourcing Policy_Final Internal Audit Report

7.1 11:10 - COMFORT BREAK

8 11:25 - Risk Management and Board assurance Framework

8.1 Risk Transformation Programme Update - Presentation

ITEM 08 Executive Summary Risk Management Report ARAC 211124

9 11:45 - Audit Tracker

ITEM 09 SBAR Audit Tracker to Committees - Q2 Reporting - July-September Reporting - ARAC

ITEM 09.1 ARAC Tracker

ITEM 09.2 Audit Wales HIW

ITEM 09.3 Full Tracker

ITEM 09.4 HIW Full Audit Tracker

10 12:00 - Policy Report

Item 10.1 Policy Report
Item 10.2 All Wales Recovery of Overpayments Procedure - Approval

ITEM 10 Executive Summary Policy Report AC 211124

ITEM 10.1 24_10_23 -ES PG All Wales Procedure for the Recovery of Overpayment

ITEM 10.1b Gweithdrefn ar gyfer Adennill Gordaliadau

11 12:10 - Near Miss and Low Harm Intelligence Report

ITEM 11 Executive Summary Low Harm AC 211124

ITEM 11.1 Near Miss and Low Harm Intelligence Report

12 12:25 - Losses and Special Payments

ITEM 12 Executive Summary SBAR Losses and Special Payments

ITEM 12.1 Annex 1 - Losses Special and Payments 2024-25

12.1 CONSENT ITEMS

13 Committee Highlight Report (no alerts from September)

ITEM 13 Audit Committee AAA Report September 2024 (1)

14 Cycle of Business Monitoring Report and Committee Priorities:

ITEM 14 Audit Committee Priorities and Cycle Monitoring Report – November 2024

ITEM 14.1 ARAC CoB Monitoring report

ITEM 14.2 ARAC CoB Monitoring report notes

14.1 12:30 – CLOSING ITEMS

15 Reflections and Summary of Decisions/Actions

16 Any Other Business

17 Date & Time of the Next Meeting: 6 March 2025

Length of Meeting: 03:10 | Agenda Status:

[OPEN] AUDIT, RISK AND ASSURANCE COMMITTEE - 21 November 2024

Deadline for Papers: 12 November 2024

Time	Mins allotted	Agendum	Title	Format	Item for	Item requested by	Paper prepared by	Item presented by	Colleagues to cc
			OPENING ITEMS						
09:30	00:10	1	Chair's Welcome, Apols and Quorum	Verbal	Information	Standing	n/a	Chair	n/a
		2	Declarations of Interest	Verbal	To State Conflicts	Standing	n/a	Chair	n/a
		3	Minutes of the Last Meeting: 12 September 2024	Paper	Approval	Standing	n/a	Chair	n/a
		4	Action Log & Matters Arising: Action: QPMF - Further information was requested on the three actions in respect of the Trust level work programme that were beyond the Trust's control that were currently paused. (Rachel Marsh)	Paper	Discussion	Standing	n/a	Chair	n/a
		5	Chair's Report on Continuous Committee Effectiveness	Verbal	Information	Standing	n/a	Chair	n/a
			FOR APPROVAL, ASSURANCE AND DISCUSSION						
09:40	01:00	6	Item 6 Audit Wales Update Report Item 6.1 Review of Cost Savings Arrangements Item 6.2 Structured Assessment	Paper	Assurance	CoB	External Audit	Fflur Jones	n/a
10:40	00:30	7	Internal Audit Progress Report and Internal Audit Reports: 7.1 Integrated Quality and Performance Management Framework (Reasonable Assurance) 7.2 Overtime Controls (Reasonable Assurance) 7.3 Data Quality (Reasonable Assurance) 7.4 Resourcing Policy (Limited Assurance)	Paper	Assurance	CoB	Internal Audit	Osian Lloyd	Felicity Quance
11:10	00:15		COMFORT BREAK						
11:25	00:20	8	8.1 Risk Register & Board Assurance Framework 8.2 Risk Transformation Programme Update	Paper Presentation	Assurance	CoB	CorGov	Julie Boalch	n/a
11:45	00:15	9	Audit Tracker	Paper	Assurance	CoB	CorGov	Trish Mills	Alex Payne
12:00	00:10	10	Item 10.1 Policy Report Item 10.2 All Wales Recovery of Overpayments Procedure - Approval	Paper	Assurance	CoB	CorGov	Julie Boalch	Lisa Trounce
12:10	00:15	11	Near Miss Report (Chair of QuEST Committee)	Paper	Assurance	CoB	CorGov	Bethan Evans	Alison Kelly
12:25	00:05	12	Losses and Special Payments	Paper	Assurance	CoB	FinCor	Chris Turley	Edward Roberts
			CONSENT ITEMS						
12:30	00:00	13	Committee Highlight Report (no alerts from September)	Paper	Assurance	CoB	CorGov	Trish Mills	Alex Payne
12:30	00:00	14	Cycle of Business Monitoring Report and Committee Priorities	Paper	Assurance	CoB	CorGov	Trish Mills	Alex Payne
			CLOSING ITEMS						
12:30	00:10	15	Reflections and Summary of Decisions/Actions	Verbal	Discussion	Standing	n/a	Chair	n/a
		16	Any Other Business	Verbal	Discussion	Standing	n/a	Chair	n/a
		17	Date & Time of the Next Meeting: 6 March 2025	Verbal	Information	Standing	n/a	Chair	n/a
12:40	**03:10**		**CLOSE**						

LEAD PRESENTERS

Name	Position
Julie Boalch	Assistant Director of Governance and Risk
Peter Curran	Non-Executive Director and Committee Chair
Bethan Evans	Chair of Quest Committee
Fflur Jones	Audit Wales
Osian Lloyd	Head of Internal Audit
Trish Mills	Director of Corporate Governance/Board Secretary
Rachel Marsh	Executive Director of Strategy, Planning and Performance
Chris Turley	Executive Director of Finance and Corporate Resources

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended	Left Trust
BEESLEE, Jayne	**Non-Executive Director** * Chair of the Finance and Performance Committee * Member of the Remuneration Committee	Employment for interim assignments via Public Sector Resourcing (an agency) regarding the review of major UK government programmes (remunerated net of tax via an Umbrella Company - Danbro Employment Umbrella Ltd)	Financial Interest	01 October 2023		
		Member Representative on the UK Civil Service Pension Board	Non-Financial Personal	01 October 2019		
		Governor on the Finance & General Purposes Committee of Cardiff and Vale Further Education College	Non-Financial Personal	01 February 2024		
		Fellow Chartered Institute of Personnel & Development	Non-Financial Personal	01 April 2006		
BROOKS, Lee	**Executive Director of Operations**	Partner employed by Welsh Ambulance Services NHS Trust	Any Other Interest	July 2019		
		Member of the Order of St John	Any Other Interest	01 March 2023		
		Volunteer – St John's Ambulance Cymru	Any Other Interest	06 April 2023		
		Council Member – St John's Ambulance Cymru Gwent Council	Any Other Interest	06 April 2023		
CURRAN, Peter	**Non-Executive Director** * Chair of the Audit Committee * Member of the Finance and Performance Committee * Member of the Remuneration Committee	Trustee of Action for Children [1097940]	Position in Charity or Voluntary Organisation	01 February 2021		
		Company Director - Action for Children [04764232]	Directorships	01 February 2021		
		Company Director - Action for Children (Wales) Ltd [10011497]	Directorships	05 April 2022		
		Trustee of National Youth Arts Wales [1170643]	Position in Charity or Voluntary Organisation	06 May 2021		
		Company Director - National Youth Arts Wales [10449512]	Directorships	06 May 2021		
		Non-Executive Director for Taff Housing	Position in Charity or Voluntary Organisation	01 May 2022		
		Company Director - Team Police Ltd [12518812]	Directorships	01 January 2022		
		Independent Board Member of the Project Board - National Contemporary Art Gallery for Wales	Any Other Interest	01 January 2024		
		Interim Finance Director for Torfaen Leisure Trust	Directorships	01 September 2023	29 February 2024	
		Interim Independent Member – Kaplan International Colleges UK Ltd [05268303	Directorships	01 March 2024		
		Independent Member - Kaplan Open Learning (inc member of the Audit & Risk Committee)	Directorships	21 March 2024		
DENNIS, Colin	**Chair of Trust Board and Non-Executive Director** * Chair of Remuneration Committee	Chair - Citizen Housing [Charity] (previously WM Housing Group)	Position in Charity or Voluntary Organisation	01 January 2015		
		Company Director - Citizen Treasury PLC (previously WM Housing Treasury Ltd)	Directorships	29 August 2017		
		Company Director - Citizen Treasury Vehicle Ltd	Directorships	04 September 2017		
		Chair - North Devon Homes	Position in Charity or Voluntary Organisation	01 October 2021		
		Company Director - North Devon Homes	Directorships	01 April 2022		
		Chair - Green Square Accord (Housing Association)	Position in Charity or Voluntary Organisation	26 March 2024		
		Company Director - LowCarbonLiving Homes Ltd [04207671]	Directorships	26 March 2024		
		Company Director - Green Square Estates Ltd [8719365]	Directorships	26 March 2024		
EVANS, Bethan	**Non-Executive Director** * Chair of Quality, Patient Experience & Safety Committee * Member of Charity Committee * Member of Finance & Performance Committee * Member of People & Culture Committee * Member of Remuneration Committee	Managing Director (Employed) at My Choice Healthcare Limited.	Any Other Interest	01 June 2019		
		Non-Executive Board Member at RHA (Social Housing Organisation - Community Benefit Society)	Position in Charity or Voluntary Organisation	01 November 2019		
		Company Director - My Choice Healthcare South Wales Limited	Directorships	11 March 2020		
		Company Director - Moorlands Rehabilitation (Staffordshire) Limited.	Directorships	20 December 2019		
		Company Director - Springfield (Bargoed) Limited.	Directorships	12 March 2020		
		Company Director - Homes of Excellence Limited	Directorships	19 March 2021		
		Company Director - Victoria House Care Property Limited	Directorships	05 March 2020		
		Company Director - My Choice Healthcare (Four) Limited	Directorships	27 April 2022		
		Company Director - Luk Ros Property Limited	Directorships	12 March 2020		
		[Previously called Homes of Excellence Healthcare Limited, Company name changed 12.08.2022 - #12513139]	*Directorships*	*12 March 2020*		
		Company Director - Hawthorn Court Property Limited	Directorships	27 April 2022		
		[Previously called My Choice Healthcare (Three) Limited, Company name changed 12.08.2022 - #13371375]	*Directorships*	*27 April 2022*		
		Company Director - Ocean Living Property Limited	Directorships	22 July 2022		
		Company Director - Hawthorn Court Care Limited	Directorships	22 July 2022		
		Company Director - Glyncornel Property Limited	Directorships	01 July 2022		
		Company Director - My Choice Healthcare (Two) Limited	Directorships	01 July 2022		
		Company Director - Carmarthen Care Limited	Directorships	02 January 2024		
		Company Director - Towy Castle Property Limited	Directorships	01 September 2023		
HITCHON, Estelle	**Director of Partnerships and Engagement**	Member of Academi Wales Expert Panel	Position in Charity or Voluntary Organisation	15 July 2024		

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended	Left Trust
JACKSON, Ceri	**Non-Executive Director & Vice Chair of the Trust Board** * Chair of Charity Committee * Chair of the People and Culture Committee * Member of Audit Committee * Member of Quality, Patient Experience & Safety Committee * Member of Remuneration Committee	Management Consultant primarily working in third sector	Interest in Companies and Securities	01 May 2019		
		Associate Director of SamKat Consulting Ltd in my capacity as self-employed management consultant	Directorships	01 June 2021		
		Charity Trustee - Stroke Association Trustee, Chair Wales Advisory Group.	Position in Charity or Voluntary Organisation	08 October 2020		
		Charitable Company - Stroke Association - Company Director	Directorships	08 October 2020		
KILLENS, Jason	**Chief Executive**	Honorary Professor - Swansea University	Personal or Departmental Sponsorship	2019		
		Member of the Order of St John	Any Other Interest	2009		
LEWIS, Angela	**Director of Workforce and Organisational Development [12 September 2022]**	Nil Declaration				
MARSH, Rachel	**Executive Director of Strategy, Planning and Performance**	Nil Declaration				
MILLS, Patricia (Trish)	**Director of Corporate Governance/ Board Secretary**	Nil Declaration				
PARRY, Hugh	**Trade Union Partner**	Nil Declaration				
ROWAN, Hannah	**Non-Executive Director** * Chair of Academic Partnership Committee * Member of Charity Committee * Member of People & Culture Committee * Member of Remuneration Committee	Director, St Martin's Associates (Business consulting and coaching)	Directorships	04 April 2022		
		Non -Executive Director Qualifications Wales (regulator for all non degree qualifications in Wales)	Any Other Interest	01 April 2021		
		Trustee MAE Cymru (Christian charity which champions gender equality in church of Wales)	Position in Charity or Voluntary Organisation	13 November 2021	November 2023	
		Elected member, The governing body of the church in Wales (Parliament of church in Wales - voting member)	Any Other Interest	01 April 2021		
		Relative (Parent) is a Non-Executive Director for Social Care Wales	Any Other Interest	01 April 2017		
SAMMUT, Jonathan (Jonny)	**Director of Digital Services [appointed 26.09.2023]**	Fellow of the British Computer Society – FBCS	Any Other Interest	04 March 2024		
		Panel Member of the UK CIO Advisory Panel – Digital Health	Any Other Interest	05 July 2023		
		Federation of Informatics Professionals - Leading Practitioner	Any Other Interest	25 April 2024		
SWINBURN, Andrew (Andy)	**Executive Director of Paramedicine**	Strategic Advisor to College of Paramedics	Any Other Interest	01 January 2020		
TURLEY, Christopher	**Executive Director of Finance and Corporate Resources**	Treasurer of Royal Gwent Hospital League of Friends.	Position in Charity or Voluntary Organisation	01 February 2022		
TURNER, Damon	**Trade Union Partner**	Nil Declaration				
WILLIAMS, Liam	**Executive Director of Quality and Nursing [from 01 August 2022]**	Chair/Director - Thornbury Carnival Community Interest Company Voluntary	Position in Charity or Voluntary Organisation	01 August 2019		
		Member Royal College Nursing	Any Other Interest	01 August 2022		
		Committee member Royal College Nursing, Nurses in Management and Leadership Forum Steering Committee	Position in Charity or Voluntary Organisation	01 August 2022		

WELSH AMBULANCE SERVICES UNIVERSITY NHS TRUST

MINUTES OF THE OPEN MEETING OF THE AUDIT, RISK AND ASSURANCE COMMITTEE OF THE WELSH AMBULANCE SERVICES UNIVERSITY NHS TRUST HELD ON WEDNESDAY 12 SEPTEMBER 2024 IN CARDIFF MRD AND VIA TEAMS

Meeting Commenced at 09:30

PRESENT:

Peter Curran	Non-Executive Director and Committee Chair
Kevin Davies	Non-Executive Director

IN ATTENDANCE:

Julie Boalch	Assistant Director of Corporate Governance and Risk
Judith Bryce	Assistant Director of Operations
Christian Fox	Trade Union Partner
Jill Gill	Interim Assistant Director of Finance
Fflur Jones	Audit Wales
Jason Killens	Chief Executive
Osian Lloyd	Head of Internal Audit, NWSSP
Gareth Lucey	Audit Wales (left meeting after item 43/24)
Rachel Marsh	Executive Director of Strategy, Planning and Performance
Trish Mills	Director of Corporate Governance/Board Secretary
Steve Owen	Corporate Governance Officer
Alex Payne	Corporate Governance Manager
Felicity Quance	Internal Audit
Chris Turley	Executive Director of Finance and Corporate Resources
Damon Turner	Trade Union Partner
Carl Window	Local Counter Fraud Manager

OBSERVERS:

Rusna Begum	Graduate Trainee
Louis Davies	Network 75 Student
Jessica Price	Head of Financial Accounting

APOLOGIES:

Ceri Jackson	Non-Executive Director and Vice Chair of the Trust Board
Angela Lewis	Director of People and Culture
Liam Williams	Executive Director of Quality and Nursing

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40/24 PROCEDURAL MATTERS

The Chair welcomed all to the meeting noting the apologies of Ceri Jackson, Angela Lewis and Liam Williams.

Minutes:
The Minutes of the Audit, Risk and Assurance Committee (ARAC) meeting held on 10 July 2024 were approved.

Action Log:
Action 27/24: Risk Management and Board Assurance Framework. *Following a discussion by the Committee, there will be consideration of a dedicated risk - in relation to risk 424 [Resource availability (revenue, capital and staff capacity) to deliver the organisation's Integrated Medium-Term Plan (IMTP)] in respect of the inclusion of fleet/vehicle, to consider the requirements against the Strategic Outline Plan and the funding requirements.* Consideration was given to an update to the narrative of Risk 424 to reflect this. Alongside this, it was likely that a separate risk will be developed alongside the updated Fleet Procurement Strategy, to capture funding and other fleet risks in the future. This was now in progress, and it was therefore agreed that this action could be closed.

Action 28/24: Audit Tracker - *The Governance Team will consider the development of 'spotlight' communications for colleagues in the Trust regarding the monitoring and management of Audit actions.* This will be considered with the development of Tracker 3.0 (transition to the SharePoint solution) in line with the update provided in the action log. It was agreed that this action could be closed.

Committee Highlight Report:
The Committee highlight report from the 07 June and the 10 July 2024 was received.

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

RESOLVED: The Committee:

(1) Noted the apologies of Ceri Jackson, Angela Lewis and Liam Williams.

(2) Approved the Minutes of 10 July 2024.

(3) Received the combined Committee Highlight report from 07 June and 10 July 2024.

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

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41/24 CHAIR'S REPORT ON CONTINUOUS COMMITTEE EFFECTIVENESS

In terms of this year's Committee effectiveness review, Peter Curran emphasised a continuous approach to addressing areas that did not score well in the previous year's review. He advised that he had met with the ARAC Non-Executive Directors (NEDs) to discuss certain areas and that intends to meet again in November. Trish Mills and Chris Turley will be involved in the meeting scheduled for November.

RESOLVED: The update was noted.

42/24 INTERNAL AUDIT PROGRESS REPORT AND INTERNAL AUDIT REPORTS

Osian Lloyd provided his Internal Audit Progress report update, highlighting the progress against the 2024/25 plan. He mentioned that of the 20 reviews, one draft report was ready, five were in progress, and three were at the planning stage. He also noted that there were no concerns regarding the delivery of the Plan and that it was on track to be delivered by the end of the year. Additionally, Osian Lloyd mentioned there have been no changes to the Plan and no pushbacks or deferral requests, indicating good engagement with the Trust. Trish Mills added that she held monthly meetings with Osian Lloyd to discuss the 2024/25 Plan in detail.

Internal Audit Reports

Volunteers Governance Internal Audit

Felicity Quance provided a detailed overview of the Volunteers Governance Internal Audit Report, which received a reasonable assurance rating. The audit reviewed the adequacy and effectiveness of the Trust's governance and operational management of volunteer activities, covering areas such as recruitment, retention, supervision, support, fundraising, and financial guidance. The audit identified nine medium-priority recommendations and one low-priority recommendation to strengthen existing processes. The review addressed four objectives which were all rated as reasonable:

I. The volunteer strategy aligned with national strategies but could benefit from enhancements like volunteer development plans and a quality assurance framework.
II. Policies and procedures were in place but needed further detail, especially in fundraising and financial guidance.
III. Volunteer recruitment, onboarding, clinical oversight, and fundraising processes were in place but required consistency and better record-keeping.
IV. Oversight and escalation of key issues and risks were regularly reported, but ownership of corporate risk needed to be identified.

Felicity Quance also noted that legal advice on fundraising had been received and was under review to determine the next steps. Trish Mills stated that initial advice on fundraising had been received from a legal firm experienced in advising NHS charities, which would be applied to both to the volunteers and to the charity. Trish noted that she would meet with Judith Bryce and the Volunteer Team to review the advice to support the development of a comprehensive fundraising policy.

Judith Bryce acknowledged the recommendations which reflected the thoroughness of the audit process adding that most of the actions were relatively straightforward to remedy. She added there has been a significant piece of work to get to this point with the Volunteer Team, and there has been a significant focus on the governance arrangements in place in the team.

Kevin Davies emphasised the importance of the fundraising and financial guidance components of the report, noting that irregularities in these areas could bring an organisation into the spotlight of the Charity Commission. He welcomed the recommendations and highlighted the need for centralised accounting to support the distributed model of volunteers.

Carl Window provided assurance to the Committee that from a fraud risk perspective, his team have been continuously engaged in the review process. He noted that he has offered observations, support and guidance, specifically regarding the financial controls, secondary signatories, and account authorisations.

Disciplinary Case Management Compassionate Practices Internal Audit
Felicity Quance presented the Disciplinary Case Management (Compassionate Practices) Internal Audit Report which received a reasonable assurance rating, and highlighted the following key points for the Committee's attention:

1. The review aimed to assess the adequacy of the disciplinary process and the integration of compassionate leadership principles;
2. The report included six matters arising, with 12 recommendations (three high, seven medium, and two low priority);
3. The Trust has adopted the All Wales Disciplinary Policy, with substantial assurance given for the alignment of strategic and operational actions with compassionate practices;
4. Limited assurance was assigned due to delays in embedding compassionate practices and the need for broader training coverage among those involved in case management;
5. The audit found general compliance with the All Wales policy in the sampled case files, indicating appropriate management of disciplinary cases. However, there were issues with compliance in fast-track investigations, documentation completeness and appeals not being heard within the 28 day target;

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6. Regular reporting of disciplinary cases to the People and Culture Committee (PCC) was noted, with recent introductions of six monthly trend and theme reports.

The Trust Management have accepted the findings and have provided detailed responses to address the recommendations within the audit report Trish Mills advised the Committee that the report was reviewed at the PCC meeting on 30 August 2024, where it was linked to discussions on cultural themes and trends.

It was acknowledged there has been an increase in disciplinary cases, which was anticipated due to the "speaking up safely" programme encouraging more people to come forward. In terms of training, 228 people have been trained in compassionate practices, 70 have attended investigating officer training, and there were now three full-time investigation officers in post.

Kevin Davies expressed his surprise at the limited assurance for compassionate practices element, given the organisational changes and efforts made. He asked for more information regarding the underlying reasons for the limited assurance rating on this element, to better understand the situation. It was agreed that this action would be passed to Angela Lewis, for response.

Damon Turner asked whether the audit was conducted across all Directorates or if it was focused mainly on operations. He noted there were varying standards of compassionate practices across different Directorates, with some areas showing good practices and others that require improvement.

Felicity Quance stated that the sample for the audit was taken from across all directorates, not just the Operations Directorate. It was a random sample of cases that had been closed during the year. She acknowledged that while the narrative might seem more operations focused, it covered the entire Trust.

Risk Management Internal Audit

Felicity Quance provided an overview of the risk management internal audit, which received a reasonable assurance rating. The purpose of this audit was to assess the effectiveness of the risk management and assurance arrangements in place within the Directorates. Management accepted the findings and provided clear responses to address the issues raised. The key points from the report included:

1. The audit aimed to assess the effectiveness of risk management assurance arrangements at both corporate and directorate levels, specifically within the Operations and Clinical directorates;

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2. Five medium priority matters were raised. The audit noted continued development and delivery of the Trust's Risk Transformation Programme, with processes in place for recording and monitoring risks. However, there were inconsistencies in the application of guidelines and issues with the completeness of the audit trail for local and directorate risks;
3. A Risk Management Policy and guidelines were in place and published; however, an additional corporate governance notice to inform staff had not been published at the time of the audit;
4. Inconsistencies were found in the completion of risk assessment forms and the recording and scoring of risks on Datix;
5. Active management of risks at the corporate level was noted, but there were issues with updating Datix to reflect reviews at the Directorate level;
6. Risks and mitigating actions were sometimes overdue for review, and some local risks were recorded outside of Datix, which could hinder effective oversight.

Julie Boalch acknowledged the issues around the Datix platform and noted that the 'Once for Wales' solution, which would address many of the issues highlighted in the report was experiencing delays with the provider. She emphasised the importance of ensuring clear audit trails in risk management and noted that whilst the Trust managed and reported risk well, not all local and Directorate risks were currently held centrally through a digital platform. Julie noted the upcoming recruitment of a band 7 Risk Manager, which will help with the delivery and support of risk management at this level across the Trust.

Trish Mills added that the Trust has effective risk management practices but acknowledged that there is room for improvement. She emphasised the importance of audit in the wider organisational approach to risk, and the delivery of the Risk Transformation Programme. Trish thanked Internal Audit colleagues for the partnership approach taken during this audit, specifically.

RESOLVED: The Internal Audit Progress report and the Volunteers Governance, Disciplinary Case Management Compassionate Practices and Risk Management Internal Audit Reports were received.

43/24 AUDIT WALES REPORTS

Financial Audit

Gareth Lucey provided an update from the financial perspective. He confirmed that the 2023-2024 Annual Report and Accounts for the Trust were certified and forwarded to Welsh Government in mid-July, meeting the set target. He noted that the focus was now on the independent examination of the Trust's charity accounts, with a deadline at the end of January 2025, and the planning for the 2024-2025 Trust financial statements. Gareth Lucey also noted that a meeting has been scheduled to begin the work associated with these audits.

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Audit Wales will be completing an independent examination of the charity accounts for 2023/24 as opposed to a full financial audit, as agreed by the Charity Committee and Corporate Trustee. It was noted that the charity Annual Report and Accounts for 2023/24 will be prepared and issued to the Charity Committee for endorsement, prior to their submission to the Corporate Trustee in January 2025, for approval. The deadline for submission of the charity's annual return with the annual report and accounts to the Charity Commission is the 31 January 2025.

Performance Report

Fflur Jones advised the Committee that two reports have been issued in draft to the Trust recently: the financial efficiencies report, and the quality governance follow up report. These reports were currently going through clearance and will be presented at the November ARAC meeting. Additionally, two more reports were anticipated for the November meeting: the 2024 Structured Assessment report and the unscheduled care part two report for the Trust. Fflur Jones added that her team were in the stages of scoping the digital deep dive review, which will accompany this year's Structured Assessment.

Kevin Davies asked for clarification from Audit Wales on the digital deep dive review and asked whether this was the first time such a review was being conducted, and whether it would consider the systems that interact across Wales. He expressed concern that external factors beyond the Trust's control might negatively impact the review's findings.

Fflur Jones explained that the digital deep dive review was part of the 2024 Structured Assessment and that different areas were chosen each year for these deep dives. She advised that the current focus was on digital plans and strategies; specifically, how bodies were using these plans to guide their investments. She acknowledged Kevin's concern about national systems and assured him that his comments would were noted.

RESOLVED: The Committee noted the updates from Audit Wales.

44/24 RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK

Risk Management Transformation Programme

The purpose of this report was to provide a detailed update on the Risk Transformation Programme, assurance, a high level synopsis of the 2023/24 Risk Management Internal Audit, and assurance in respect of the management of the Trust's principal risks. Julie Boalch shared a presentation on the Risk Management Transformation Programme and drew the Committee's attention to the following areas:

BDO Report: The Trust commissioned BDO to support the Risk Management Transformation Programme advising on best practices. The programme is in its third and

final year as far as the Integrated Medium Term Plan (IMTP) is concerned; however, the programme is expected to span another two to three years to fully achieve its goals.

The BDO report focused on three main areas:

- Providing best practice guidance on the design and build of a strategic Board Assurance Framework (BAF).
- Providing expert advice on developing risk appetite statements.
- Repositioning of the Trust's highest scoring risks.

The next steps for the programme will see the development of a strategic Board Assurance Framework (BAF) which is a high level tool that provides the Board with assurance that the key risks to the Trust's strategic objectives are being managed effectively. It consolidates all relevant information on these risks and serves as a methodology for the Board to oversee these risks. The programme aims to enhance the BAF to reflect the Trust's future strategic ambitions by aligning it to risks in achieving the organisational strategy.

Trish Mills commented that the Trust was in a good position due to the work done over the past couple of years in embedding effective risk management practices. The Board was now familiar with the top five risks and the governance flow, which sets a solid foundation for the next steps.

Julie Boalch explained that the next tranche of work involves exploring and developing the Trust's risk appetite against the six strategic objectives. This will be done in conjunction with Rachel Marsh and colleagues in the Strategy, Planning and Performance Team. The goal was to use risk appetite to aid decision making and allow clearer downward delegation.

Kevin Davies acknowledged that the Risk Management Transformation Programme showed a maturity journey and ambition. He expressed concern regarding the resource required to apply the necessary intellectual effort to this initiative and was interested in seeing how the realignment of risks 223 and 224 will develop. Kevin added that this work may help the Trust more clearly articulate its ambitions externally, including to Commissioners and other stakeholders in the political arena.
Julie Boalch confirmed that a workshop with Lee Brooks, Liam Williams, and their senior teams had been conducted to discuss the repositioning of these risks. Judith Bryce clarified that the reframing of these risks did not indicate an acceptance of the situation but instead, helped to categorise what can be influenced by the Trust and what can only be monitored. She found the recent workshop on repositioning these risks very helpful in starting the journey towards better categorisation and management.

Osian Lloyd expressed support for the direction of travel and the proposals to move forward with the Risk Management Transformation Programme. He noted that the Trust has consistently reached reasonable assurance on risk management in recent years. He further mentioned that he has regular meetings with Trish Mills and Julie Boalch to stay informed about the developments.

Osian Lloyd also indicated that reviews on risk management assurance were consistent in the programme. and can be tailored to look at the right areas. He pointed out that the timing was appropriate as the Trust was evolving its clinical model, which aligned with the Trust's strategic objectives.

Members acknowledged the limitations with the existing digital system which supported the management of risk – Datix – and noted that it is not supportive of the direction of travel and ambition of the programme. The Committee discussed in detail the need for a new digital system to support risk management, the ongoing evaluation of options, and the importance of securing the necessary resources and external support to achieve this.

Peter Curran asked what could be expected to be received in November by way of advancement and preparation for the February ARAC meeting. Julie Boalch confirmed that a new strategic BAF template and a progress update would be brought to the next meeting and that a session on the development of risk appetite statements is scheduled for the February 2025 Board Development session.

Board Assurance Framework

Julie Boalch provided an update on the principal risk activity and general risk updates:

1. The Trust's highest rated risks: **Risk 223** (*the Trust's inability to reach patients in the community causing patient harm and death*) and **Risk 224** (*Significant handover of care delays outside accident and emergency departments impacts on access to definitive care being delayed and affects the Trust's ability to provide a safe & effective service for patients*), remain at the highest score of 25. These scores reflected individual cases of avoidable harm, highlighting ongoing challenges in the unscheduled care system due to the levels of handover delays.

2. Risk 424 (*Resource availability (revenue, capital and staff capacity) to deliver the organisation's Integrated Medium-Term Plan (IMTP)):* The score has been reduced from 12 to 8 and will be removed from the corporate register but managed at the directorate level, closely linked to Risk 139 (financial risk)

3. Risk 619: This risk, related to the replacement of the CAS system, has been fully mitigated and will be closed.

Julie Boalch assured the Committee that the risks were reviewed in line with their risk ratings and given the appropriate governance and scrutiny. The Executive Leadership Team approved these updates for the last quarter.

Peter Curran noted that Ceri Jackson, member of the Committee, had given her apologies but provided comments for the record. Ceri welcomed the assurance provided in the

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papers and supported the direction of travel following the BDO work. She emphasised the importance of clear strategic objectives with tangible success measures and risk appetite, acknowledging the challenges in their operating environment. These comments were noted.

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

(1) Supported the direction of travel for the next stage of the Risk Management Transformation Programme: specifically,

a. the development of a new Strategic Board Assurance Framework template based on the private healthcare example.
b. the intention to commission external resources to develop the risk appetite statements.

(2) Noted the plans to reposition Risks 223 and 224.

(3) Received assurance on the 2023/24 Internal Audit Risk Management Review.

(4) Noted the reduction in score for Risk 424 from 12 (3x4) to 8 (2x4). The risk will be de-escalated to the Directorate Risk Registers for ongoing management.

(5) Noted the closure of Risk 619 from all registers having been fully mitigated.

(6) Received assurance on the review and attention to the principal risks, including their review at ADLT, ELT and at relevant Committees.

(7) Noted the ratings and mitigating actions for each principal risk.

45/24 AUDIT TRACKER

Trish Mills updated the with the current position with respect to management actions for audits within the purview of the Committee, in addition to the wider progress in Quarter. There has been good engagement with Directorates on the revised Tracker 2.0 for quarter one, with the result that of the total of 144 internal audit actions on the Tracker, 36 have been closed in quarter. This was a closure figure of 25% of all internal audit actions.

Of the total internal audit actions, 45 of the 144 actions have been given proposed revised dates in Quarter (31% of the total) and there were five actions on their third revised date (3%). This latter figure included one action, reference 567, which was on its third revised date and was yet to be completed.

Of the six internal audit actions where the ARAC is the owning Committee, none of the actions have been closed in quarter. Of these, four have been given revised dates in quarter; none were on a third revised date.

In terms of the total external audit actions eight of the 22 have been closed in quarter (36%); seven (31%) have been given a proposed date in quarter, and one action was on its third revised date (reference 106a). There has been positive engagement from Directorates on the progression of actions, as was demonstrated by the closure position., with focused reviews and drop-in sessions helping to manage and close actions.

Trish Mills advised the Committee that it was intended that the new SharePoint Tracker 3.0 is still in development and would begin to be used for the 2024-2025 audits, onwards. This decision was made to avoid the huge workload and potential data loss associated with transitioning all the data from the current large Excel sheet. The intention was for the Excel Tracker 2.0 to be run down as the actions are closed. The new tracker will provide better reporting for the Committee, with Power BI helping to extract data. Full implementation was expected early next year.

Judith Bryce explained that action 567 related to the Hazardous Area Response Team (HART) internal audit, which was part of the 2022-2023 audit programme. She advised that the required self-assessment had been completed however it had been asked that a peer review of the self-assessment be completed before the action is closed. This peer review was yet to be completed but would be completed by the end of October 2024.

Peter Curran highlighted some key challenges in meeting internal audit deadlines. He pointed out that revising dates for internal audit actions could be complex and that original dates may sometimes be unrealistic.

Trish Mills acknowledged there were several reasons for revising dates, including other pressures and capacity issues. She emphasised that the Trust was aware of this and was working to improve the process to ensure management actions and the associated implementation dates are realistic. Osian Lloyd added that it was important to ensure that dates assigned to matters arising/actions were realistic and would engage with colleagues to ensure that actions and associated due dates are achievable.

RESOLVED: The Committee:

(1) Received assurance that the management actions for the audits within the purview of this Committee, and overall were being effectively and appropriately managed, closed off in quarter or clarity provided on dates which have moved and rationale;

(2) Received and reviewed any Internal Audits and Audit Wales reviews within their remit where relevant. For this meeting these were the following internal audits:

- **Internal Audit: Volunteer Governance (noting this was discussed at the People and Culture Committee on 30 August 2024);**
- **Internal Audit: Disciplinary Case Management (noting this was discussed at the People and Culture Committee on 30 August 2024);**
- **Internal Audit: Risk Management.**

46/24 POLICY REPORT

Julie Boalch explained that the purpose of the report was to provide the Committee with assurance on the status of the Trust's policy work programme, which aimed to bring key policies up to date. A work programme was established following the pandemic to address the number of policies that were not within their review date, which had fallen to below reasonable levels during that period. Since then, 45% of Trust policies identified as a priority for review were now within their review date.

It was expected that 52% of all Trust Policies will be within their review date after the next round of approvals in October and November 2024. This was an improvement from 14% overall reported in July 2023 at the time the prioritisation exercise was undertaken. This figure does not include policies developed by NHS Wales or the NHS Employers Unit, which were adopted by the Trust.

A detailed report on the progress of the work plans and the status of all policies is provided to the Executive Leadership Team (ELT) following each Policy Group meeting via the Alert, Advice, Assure (AAA) reports.

A review of the policy prioritisation list will take place at the ELT on 25 September 2024 to consider those policies that are yet to be reviewed and determine whether these remain a priority, given the context that the Trust is operating within.
Members acknowledged the significant progress made in the policy review process. Damon Turner highlighted the volume of work being undertaken and expressed appreciation from a staff perspective, noting that the governance processes for policies were robust.

RESOLVED: The Committee noted the update.

47/24 QUALITY AND PERFORMANCE MANAGEMENT FRAMEWORK

Rachel Marsh provided an update on the Quality and Performance Management Framework (QPMF). It was noted that in line with its Terms of Reference, the Committee is required to oversee the implementation of the QPMF, and its attention was drawn to the following update.

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The work to implement the QPMF was managed through a Steering Group which includes Rachel Marsh, Trish Mills, and Liam Williams. The Steering Group has undertaken a corporate level self-assessment against the 24 organisational requirements and has developed a programme of work based on this self-assessment.

There were 18 actions on the Trust's level work programme, with the current status as follows: two completed; eight on target; three paused (for example, due to issues beyond the Trust's control); one not started (a 2024/25 action); and four where additional focus was required. Progress has been slower than desired due to capacity issues.

Trish Mills highlighted the role of the Finance and Performance Committee (FPC) in evaluating the effectiveness of the QPMF and ensuring the value of outcomes. She proposed that after the internal audit report is received by the ARAC in November 2024 that the Committee transfer the oversight of the effectiveness of the framework to the FPC, in line with the respective Committee Terms of Reference. This proposal was agreed by the Committee.

Ceri Jackson sought – via written comment to the Committee Chair - for further information on the three actions in respect of the Trust level work programme that were beyond the Trust's control and that were currently paused. It was agreed that Rachel Marsh would provide this information at the next meeting.

The Committee:

(1) NOTED that the Trust has a Quality & Performance Management Framework.

(2) NOTED the updated terms of reference for the Quality & Performance Management Steering Group as approved in May 2024 ELT.

(3) NOTED that ELT has considered an organisational self-assessment undertaken by the Quality & Performance Management Steering Group against the organisational requirements and the resultant Quality & Performance Management Steering Group's work plan.

(4) NOTED the progress made on the work programme.

(5) CONSIDERED whether the Framework, Q&PMF Steering Group, its ToR, the completion of an organisational level self-assessment against the Framework, a work programme and the performance management of the framework, gave sufficient assurance;

(6) **AGREED that the approach to the oversight of the continued implementation and effectiveness of the Quality and Performance Management Framework would move to the Finance and Performance Committee, in line with the respective Committee Terms of Reference.**

48/24 ASSURANCE TO THE COMMITTEE ON SPEAKING UP SAFELY ARRANGEMENTS AT WAST

The Committee was asked to receive assurance on the arrangements for Speaking Up Safely at the Trust, note that the People and Culture Committee will continue its oversight of the area through this annual report to the Committee regarding the arrangements. Trish indicated that receipt of this assurance report from the Chair of the People and Culture Committee was a key part of this assurance process.

Peter Curran read out a comment by Ceri Jackson as the Chair of the People and Culture Committee (PCC) that noted that for 2025/26this update be received by the PCC prior to being received by the ARAC. Due to the placement of meetings this year this preferred sequencing was not possible.

Additionally, Ceri indicated that speaking up safely was a key priority for the Committee and a key dependency for the Trust in achieving cultural change. It is important to note that the employee relations cases have been increasing as predicted with our focus on ensuring colleagues feel safe to speak up. The People and Culture Committee continue to receive updates on these numbers and whether the issues are being addressed.

RESOLVED: The Committee received assurance on the arrangements for Speaking Up Safely at the Trust and noted that the People and Culture Committee will continue its oversight of this area, reporting annually to ARAC.

49/24 LOSSES AND SPECIAL PAYMENTS – 1 APRIL 2024 TO 31 JULY 2024

Chris Turley advised that this report presented to the Committee gave details of Losses and Special Payments made during the four months from 1st April 2024 to 31st July 2024.

Chris Turley explained that the position after four months was a negative net position of £340K. This was due to the timing difference between when expenses were incurred and when reimbursements from the Welsh Risk Pool were received.

During June the Welsh Risk Pool reimbursements amounted to £0.975m. The vast majority of which related to the reimbursement of 1 medical negligence case against the Trust for incorrect medical diagnosis.

During July the Damages costs amounted to £0.377m of which £0.282m related to 1 medical negligence case against the Trust in relation to the handling and treatment of a patient.

In terms of any significant payments, especially those related to clinical negligence or personal injury, were subject to the necessary approval processes and were handled within delegated authorities.

RESOLVED: The Losses and Special Payments Report for the period 1 April 2024 to 31 July 2024 was received.

50/24 ALL WALES AUDIT COMMITTEE CHAIRS OPERATING ARANGEMENTS

Peter Curran explained that the report was for noting. He highlighted key outputs from the recent meeting of the All-Wales Audit Committee Chairs network that he had attended:

Meeting Attendance: Attendance was low, likely due to a scheduling conflict with other Audit Committee meetings.

Audit Tracker: There was a detailed discussion about the audit tracker, with various Health Boards and Trusts sharing their methods. He highlighted that the Trust was particularly advanced in this area.

Counter Fraud Update: Matthew Evans provided an update on counter fraud activities across Wales.

Board Secretaries Update: Hazel Lloyd discussed the work of Board Secretaries, including the importance of induction training for Committee Members.

51/24 CYCLE OF BUSINESS MONITORING REPORT AND COMMITTEE PRIORITIES

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

RESOLVED: The Committee NOTED the update.

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52/24 REFLECTIONS & SUMMARY OF DECISIONS AND ACTIONS

The following three actions were recorded:

1. Disciplinary Case Management Compassionate Practices:- The need for a clearer explanation and context of the underlying reasons that contributed to this Limited Assurance was requested from Angela Lewis.
2. Wales Audit reports: - In terms of the digital deep dive scheduled for 2024/25 as part of the Structured Assessment., whether this was being cross correlated across Wales. Further information was requested from Audit Wales regarding how this was fed into National Frameworks.
3. QPMF:- Further information was requested on the three actions in respect of the Trust level work programme that were beyond the Trust's, control that were currently paused from Rachel Marsh.

The Committee continued to welcome the hybrid meetings.

RESOLVED: The actions were noted.

Meeting concluded at 11:52.

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ACTION LOG

WELSH AMBULANCE SERVICES UNIVERSITY NHS TRUST - AUDIT, RISK AND ASSURANCE COMMITTEE - As at 12 November 2024

Ref	Date	Agenda Item	Action Note	Responsible	Due Date	Progress/Comment	Status
42/24	12 September 2024	Internal Audit Reviews	Disciplinary Case Management Compassionate Practices. The need for a clearer explanation and context of the underlying reasons that contributed to this Limited Assurance was requested.	Angela Lewis	21 November 2024	Update for 21 November 2024 Following advice from the Board Secretary, the Chair of ARAC has confirmed that no further context or follow up is required on the actions generated from the 'Disciplinary Case Management' internal audit, as the matters arising were accepted and have corresponding actions. It is acknowledged that good progress has been made on compassionate practices however there is still improvement to be made. Given all these actions were due to be implemented by the end of September 2024 it will be for the ARAC to monitor the progress against the actions and the extent to which they have been completed via receipt of the Audit Tracker. It is proposed that this action be closed.	Complete
43/24	12 September 2024	Wales Audit Reports	In terms of the digital deep dive scheduled for 2024/25 and whether this was being cross correlated across Wales, further information was requested regarding how this information was fed into National Frameworks.	Fflur Jones	21 November 2024	Update for 21 November 2024 The review will be undertaken at each body across Wales to assess how well bodies understand current and future digital and data risks, challenges and opportunities, how they are planning to mitigate these challenges and risks and how they are delivering and monitoring their digital plans. The review will also seek to understand the role of Welsh Government and DHCW in the management of digital services across Wales, particularly within the DHCW-specific report. Audit Wales will share the project brief with committee members in due course.	Complete
47/24	12 September 2024	Quality and Performance Management Framework	Further information was requested on the three actions in respect of the Trust level work programme that were beyond the Trust's control that were currently paused.	Rachel Marsh	21 November 2024	Update for 21 November 2024 Verbal Update	Open

Audit, Risk and Assurance Committee Update – Welsh Ambulance Services University NHS Trust

Date issued: November 2024

Document reference: 4584A2024

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

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About this document

1. This document provides the Audit Committee with an update on our current and planned accounts and performance audit work at the Welsh Ambulance Services University NHS Trust. We presented our most recent Audit Plan to the committee on 7 June 2024.
2. We also provide additional information on:
   - Other relevant examinations and studies published by the Audit General.
   - Relevant corporate documents published by Audit Wales (e.g. fee schemes, annual plans, annual reports), as well as details of any consultations underway.
3. Details of future and past Good Practice Exchange (GPX) events are available on our website.

Accounts audit update

4 Exhibit 1 summarises the status of our current and planned accounts audit work.

Exhibit 1 – Accounts audit work

Area of work	Executive Lead	Current status
2023-24 Independent Examination of the Charitable Funds' Financial Statements	Executive Director of Finance and Corporate Resources	The Independent Examination of the Charity's annual report and accounts is due to start mid-December with the intention of certifying and filing by the Charity Commission deadline of 31 January.

Performance audit update

5 Exhibit 2 summarises the status of our current and planned performance audit work.

Exhibit 2 – Performance audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Structured Assessment – deep dive into financial efficiencies	Executive Director of Finance and Corporate Resources	Given the significantly challenging financial position across NHS Wales, this review is examining the approaches NHS bodies are taking in respect of achieving cost improvements, efficiencies, and financial sustainability.	Complete.	November 2024
Structured Assessment - core	Director of Corporate Governance / Board Secretary	This work will review the following core areas: • Board and committee effectiveness, cohesion, and transparency. • Corporate systems of assurance. • Corporate planning arrangements. • Corporate financial planning arrangements.	Complete.	November 2024

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
		This work will also seek to provide an update on the Trust's progress in addressing audit recommendations made in previous structured assessment reports.		
Follow up Review of Quality Governance Arrangements	Executive Director of Quality and Nursing	This review is examining the Trust's progress in responding to the audit recommendations arising from our 2022 Review of Quality Governance Arrangements, which was reported to the committee in September 2022.	Clearance - draft report issued	March 2025
Review of Unscheduled Care	Executive Director of Operations	This work examines different aspects of the urgent and emergency care system in three parts: • Part One: Flow out of hospital (not applicable to the Trust). • Part Two: accessing urgent and emergency care. • Part Three: national arrangements and leadership structures.	Part Two: Drafting Part Three: Scoping	March 2025

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Structured Assessment - deep dive review of investment in digital systems to support service resilience and transformation	Director of Digital Services	This audit will examine digital arrangements, with a particular focus on how NHS bodies are investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency.	Scoping	To be confirmed

Other relevant publications

6 Exhibit 3 provides information on other relevant examinations and studies published by the Auditor General in the last six months. The links to the reports on our website are provided.

Exhibit 3 – Relevant examinations and studies published by the Auditor General

Title	Publication Date
The National Fraud Initiative in Wales 2022-23	October 2024
Active Travel (and Data Tool)	September 2024
Affordable Housing	September 2024
NHS Wales Finance Data Tool	August 2024
Community Pharmacy Data Matching Pilot	May 2024.

Additional information

7 Exhibit 4 provides information on corporate documents published by Audit Wales since the last committee update. Links to the documents on our website are provided. There are no relevant Audit Wales consultations currently underway.

Exhibit 4 – Audit Wales corporate documents

Title	Publication Date
Annual Report and Accounts 2023/24	August 2024

Audit Wales

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

Review of Cost Savings Arrangements – Welsh Ambulance Services University NHS Trust

Audit year: 2023

Date issued: August 2024

Document reference: 4448A2924

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We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

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

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Introduction

1 NHS Wales is facing unprecedented financial challenges. The legacy of the COVID-19 pandemic on service demand, the rising costs associated with staffing, energy, medicines, maintaining an ageing estate; and tackling the increasingly complex health conditions associated with an ageing population all contribute to the worsening financial situation across the NHS.

2 Despite the Welsh Government making an additional £425 million available to the NHS in October 2023, the 2023-24 year-end audited position for NHS Wales was a collective deficit of £183 million. Whilst some NHS bodies were able to achieve year-end financial balance, the position for others - particularly some Health Boards - was challenging with several not being able to deliver the control total deficit expected by Welsh Government.

3 The position for 2024-25 is equally, if not more challenging. Health bodies will need to ensure that they have robust approaches in place to identify and deliver in year cost improvement opportunities and to also take a longer-term approach to achieving financial sustainability that moves away from short-term approaches to ones where savings are achieved by transforming service models and ways of working.

Objectives and scope our work

4 Given the challenges outlined above, the Auditor General has undertaken a programme of work examining NHS bodies' approaches to identifying, delivering, and monitoring sustainable cost savings opportunities. Whilst our more detailed work has been targeted at health boards, we have also undertaken high level work at Special Health Authorities and NHS Trusts, linked to the specific functions of those bodies. The findings from that high level work at the Welsh Ambulance Services University NHS Trust (the Trust) are set out in this report.

5 The work has been undertaken to discharge the Auditor General's statutory duty under Section 61 of the Public Audit (Wales) Act 2004 to be satisfied that the Trust has proper arrangements in place to secure economy, efficiency, and effectiveness in its use of resources.

6 We undertook the bulk of our work between February 2024 and May 2024. The methods we used to deliver our work are summarised in **Appendix 1**.

Key findings

7 Overall, we found that **the Trust exceeded its overall 2023-24 savings target and continues to enhance its arrangements for identifying, delivering, and monitoring efficiencies and sustainable cost savings. However, opportunities exist for the Trust to reduce its reliance on non-recurrent savings, strengthen financial capabilities across the organisation, and refine its savings reporting to Board.**

8 The findings that support our overall conclusion are summarised below under the following headings:

- Identifying cost improvement opportunities.
- Delivering cost improvement opportunities.
- Monitoring and overseeing cost improvement opportunities.

Identifying cost improvement opportunities

9 The Trust has a good understanding of its cost drivers, which are clearly set out in its 2023-24 Financial Plan. Its key cost drivers include pay, utilities, vehicle fuel, general non-pay inflation and costs related to service pressures, particularly those created by ambulance handover delays. In January 2023, the Trust introduced a Recruitment Control Process as one of the levers within its wider Financial Sustainability Programme (FSP) to deliver on its statutory duty to achieve financial balance. Whilst we recognise that vacancy management supports the Trust's overall approach to controlling high spend areas, there are risks associated with being overly reliant on non-recurrent savings of this nature to achieve its overall savings targets. We discuss this further in **paragraph 12**.

10 The Trust appropriately uses data from a wide range of sources to inform its approach to identifying cost improvement opportunities. For example, at the time of our work, the Trust had recently completed an Administrative Services Review and was in the process of finalising its organisation-wide Services Review. These reviews drew on internal data and benchmarking, including data from its Wales Improvement and Innovation Network (WiiN)[1], to identify key actions which, when implemented, should identify additional efficiencies and areas for savings. Whilst Trust staff can currently submit ideas and suggestions via the WiiN portal, the Trust intends to further enhance staff engagement by providing clearer information about

[1] The Trust launched WiiN in 2017 to drive consistent quality improvement across the organisation. The cross-directorate network, coordinated by the Quality Improvement Team, supports staff with quality improvement projects, training, and communications. The network is also a key link for improvement bodies and teams across other organisations and health bodies, aiding cross working.

the savings process on SIREN[2] and strengthening the way in which the FSP works in conjunction with WiiN.

11 The Trust has a clear approach to selecting cost improvement schemes through a risk based three-phase process[3]. This approach enables the Trust to identify the benefits of savings schemes as well as to assess their risks and impacts on patients and quality. As part of this process, the Trust deselects schemes where the impacts outweigh the benefits. The Trust's initial 2023-24 Financial Plan included a savings target of £6 million, which in March of 2023 had £2.6 million of unidentified savings. However, it had identified sufficient savings schemes to cover this shortfall by Month 3 2023-24. To deliver a balanced financial plan for 2024-25, the Trust has set itself a savings target of £6.4 million or 2.2% of its cost baseline. At the time of publishing its 2024-25 Financial Plan in March 2024, it had identified all these savings. Whilst there are challenges associated with the non-recurrent nature of some of the savings schemes this approach to quickly identifying savings opportunities should give the Trust sufficient time to identify further schemes if agreed savings schemes start to fall behind their planned delivery during the year.

Delivery of cost improvement opportunities

12 The Trust has a good track record of achieving its overall savings target, although it does this largely through delivering non-recurrent savings. In 2022-23, the Trust achieved its cost savings target of £4.3 million, and in 2023-24 it exceeded its £6million savings target by £0.5 million. However, over 55% of the savings delivered by the Trust in 2023-24 were non-recurrent with a significant proportion (39%) of these being vacancy management savings. There is a risk that an over reliance on non-recurrent savings will ultimately become unsustainable and put pressure on the Trust's services and future financial plans. (**Recommendation 1**)

13 The Trust's planning arrangements for the delivery of its savings and cost improvements are continuing to improve. The Trust's FSP has two key areas of focus: savings / efficiencies and income generation. Underpinning this programme is a Financial Sustainability Delivery Framework (FSDF). Whilst the FSDF has provided a necessary framework for the delivery of its financial efficiencies and savings, the Trust recognises that it needs to improve aspects of its planning for savings through, for example, ensuring that there is greater alignment between the FSP and workstreams delivering operational efficiencies and Value Based Health Care.

14 One of the Trust's key learnings from its end of year evaluation of the FSP recognised that it needed to invest in developing financial literacy and

[2] 'SIREN' is the Trust's internal intranet portal.

[3] The three phases of the savings process are: 1. The 'Identification Phase' of savings opportunities; 2. The 'Viability Phase' where the opportunities are assessed to determine if they are viable; and 3. The 'Project Phase' where viable opportunities are implemented.

competencies across all levels of staff to enable them to effectively contribute to the organisation's financial sustainability. The evaluation also identified that there was a lack of expertise and capability in some specific areas, such as commercial income generation. It will be important, therefore, for the Trust to ensure that it addresses any gaps in its financial literacy, competencies, and expertise if it is to maximise the identification and delivery of savings and efficiencies in 2024-25 and beyond. (**Recommendation 2**)

Monitoring and oversight of cost improvement opportunities

15 The Trust has effective arrangements for overseeing the delivery of its Financial Sustainability Programme. A well-established Strategic Transformation Board (STB) is in place which provides senior-level oversight of key programmes, such as the FSP. Collectively, these programmes support delivery of the Trust's Long-Term Strategic Framework and 2024-2027 Integrated Medium-Term Plan (IMTP). There is regular oversight of financial spending and savings performance at both Executive and Board level. Board members clearly understand the current financial situation and continue to provide an appropriate level of scrutiny and challenge to support improvement in meetings of the Board and its Finance and Performance Committee (F&PC).

16 However, the Trust's internal reporting arrangements on savings has the potential to cause confusion. Whilst the Trust regularly reports on its savings performance to both the Board and F&PC, there are examples of where the figures used within these reports are different. For example, for the March 2024 Board meeting, the Monthly Integrated Quality and Performance Report for Month 11 2023-24 stated that the Trust had achieved £4.949 million of savings. However, the Month 11 2023-24 Finance Report to the same meeting stated that £6.079 million of cost improvements had been achieved. This is due to the fact that the latter report included savings generated from income generation. Whilst both of these figures were technically correct, there is a potential that reporting different figures may lead to confusion and undermine confidence in the robustness of the Trust's savings reporting. (**Recommendation 3**)

17 More broadly, the Trust has improved the clarity of the way it reports savings to the STB, the Executive Management Team, and the F&PC. In 2023-24, these reports did not include sufficient detail on the split between recurrent and non-recurrent savings to support effective monitoring and oversight. However, since Month 3 2024-25, these reports now include this level of detail which should aid understanding of the sustainability of the Trust's savings schemes and their ability to help address the Trust's future financial challenges.

18 The Trust has recently reviewed the key risks for its FSP, and these now form part of the new FSP 2024-25 Tracker Plan. The Trust's FSP is also recognised as both a key control and source of assurance for two of the Trust's key corporate risks

around its funding levels and achieving its statutory financial duties. These risks are regularly reviewed by the Audit, Risk and Assurance Committee and F&PC which, in turn, provide an additional level of assurance to the Board that the Trust is taking the necessary steps to meet its financial duties through its delivery of savings.

19 The Trust has a proactive approach to learning and applying lessons to improve its approach to savings. As noted above, the Trust has recently undertaken a detailed evaluation of its progress on delivering its 2023-24 savings through the FSP. This proactive evaluation has provided a helpful end of year progress update on each savings scheme area and has also identified several other key points of learning, including the need to make improvements in areas such as process, communication, documentation, developing key skills, and exploring the reasons behind why some schemes did not deliver as anticipated. Undertaking this type of reflection is positive and embedding the learning should strengthen the Trust's arrangements for identifying and delivering its savings. (**Recommendation 4**)

Recommendations

20 **Exhibit 1** details the recommendations arising from this audit. The Trust's management response to our recommendations is summarised in **Appendix 2**.

Exhibit 1: Recommendations

Recommendations
R1 The Trust should strengthen its approach to identifying and delivering recurrent savings. This will enable it to reduce its reliance on non-recurrent savings in areas such as vacancy management and place its financial savings plans on a more sustainable footing. **(Paragraph 12)**
R2 The Trust should ensure it takes forward work to address gaps in staff skill sets in respect of the identification and delivery of savings and efficiency opportunities. **(Paragraph 14)**
R3 The Trust should ensure that its savings reports to Board and F&PC, are consistent or provide a clear explanation of the differences between the reported savings performance. This will aid understanding, reduce confusion, and maintain the credibility of the Trust's savings reporting. **(Paragraph 16)**

Recommendations

R4 The Trust should ensure that it fully implements the learning from its recent gateway review of its Financial Sustainability Programme. This will ensure that it further strengthens its savings arrangements and maximises its savings opportunities. **(Paragraph 19)**

Appendix 1

Audit methods

Exhibit 2 below sets out the methods we used to deliver this work. Our evidence is limited to the information drawn from the methods below

Element of audit approach	Description
Documents	We reviewed a range of documents, including: • Board and Committees agendas, papers, and minutes. • Key organisational strategies and plans. • Savings benchmarking data. • Key risk management documents, including the Board Assurance Framework and Corporate Risk Register. • Key reports and plans relation to organisational finances and savings. • Reports prepared by the Internal Audit service.
Interviews	We interviewed the following senior officers: • Executive Director of Finance and Corporate Resources

Element of audit approach	Description
	• Deputy Director of Finance and Corporate Resources • Executive Director of Operations • Senior Programme Manager (Financial Sustainability Programme) • Director of People and Culture • Deputy Director of People and Culture

Appendix 2

Management response to audit recommendations

Exhibit 3: Welsh Ambulance Services University NHS Trust management response to our audit recommendations.

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R1	The Trust should strengthen its approach to identifying and delivering recurrent savings. This will enable it to reduce its reliance on non-recurrent savings in areas such as vacancy management and place its financial savings plans on a more sustainable footing. **(Paragraph 12)**	There will always be an element of non-recurring savings in relation to the theme of corporate vacancy management savings due to historic time to advertise, recruit and appoint when posts become vacant. Recommendations from the services review will be assessed and, where possible, any recurrent efficiencies via organisational structural changes will be implemented. 2024/25	31st March 2025	Executive Director of FinCoR

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
		currently has a split of 56.7% recurrent and 43.3% non-recurrent savings, with any in year over delivery being helpfully in recurring as opposed to non-recurrent schemes. The 2025/26 Financial plan savings target will aim for a minimum of c65% recurrent themes.		
R2	The Trust should ensure it takes forward work to address gaps in staff skill sets in respect of the identification and delivery of savings	The outcome of the recent Administrative & Corporate Services Review highlighted need for additional training and investment in colleagues, which is currently being actioned via ADLT-owned Action	Next detailed reviews: - ADLT re Admin Review – 31st March 2025 - Following appointment of Head of	Director of P&C (as SRO for FSP) and Executive Director of SP&P

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	and efficiency opportunities. **(Paragraph 14)**	Plan, and the upcoming finalisation of the Service Review is also expected to highlight areas of under or over resourced service ensuring most appropriate investment of resource in the right areas. Specifically focussing on the income generation and commercialisation agenda, included in the 2024/25 financial plan is c£0.250m to directly support this. This will include recruitment of dedicated resources to drive this forward, including the investment in a Head of Commercial post alongside Commercial structure to enhance specialist knowledge. This project and recruitment is underway.	Commercialisation – 30th June 2025	(as lead for commercialisation)

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R3	The Trust should ensure that its savings reports to Board and F&PC, are consistent or provide a clear explanation of the differences between the reported savings performance. This will aid understanding, reduce confusion, and maintain the credibility of the Trust's savings reporting. **(Paragraph 16)**	Finance Reports from M03 2024/25 to Trust Board and F&PC include further detailed analysis reporting of savings which includes split of recurrent and non-recurrent themes. WAST Monthly Monitoring Returns (MMR) submitted to WG also flow through committees and board. Further classification included in the proforma to be completed now include further breakdowns (i.e. Income Generation) so this allows clearer reconciliation for 2024/25 and beyond.	Actioned – as at 31st August 2024	Executive Director of FinCoR
R4	The Trust should ensure that it fully implements the learning from its recent gateway review of its Financial	The Gateway Review provided opportunity to self-assess the successes and challenges of the	Various – as per the attached.	Various, but led by Director of P&C as SRO for FSP

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	Sustainability Programme. This will ensure that it further strengthens its savings arrangements and maximises its savings opportunities. **(Paragraph 19)**	Financial Sustainability Programme at the end of Financial Year 2023/24. With this self-assessment are 11 key lessons, all of which are reviewed on an ongoing basis, and many of which underpin the FSP's 2024/25 objectives. Overall, the FSP has implemented a number of recommendations to date, including improved communication and engagement, and enhanced investment in a financially sustainable future, including a commercial structure in-house. Those recommendations not yet implemented will either be done before the end of the 2024/25 financial year, or will look to be	Likely next detailed review / Gateway post 2024/25 – 30th June 2025	

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
		included in the operational plan of the incoming Head of Commercial Role. Attached as an appendix is the full list of lessons learnt, including an update as to current position as of August 30th, 2024. We will look to provide regular updates as we progress throughout the year, via both the Finance and Performance Committee, Strategic Transformation Board, and Audit, Risk and Assurance Committee as part of the wider set of recommendations.		

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

Structured Assessment 2024 – Welsh Ambulance Services University NHS Trust

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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 2024 structured assessment work at the Welsh Ambulance Services University NHS Trust (the Trust). Our structured assessment work is designed to help discharge the Auditor General's statutory requirement under section 61 of the Public Audit (Wales) Act 2004 to be satisfied that NHS bodies have made proper arrangements to secure economy, efficiency, and effectiveness in their use of resources.

2 Our 2024 structured assessment work took place at a time when NHS bodies were continuing to respond to a broader set of challenges associated with the cost-of-living crisis, the climate emergency, inflationary pressures on public finances, workforce shortages, and an ageing estate. In addition, NHS bodies are still dealing with the legacy of the COVID-19 pandemic. More than ever, therefore, NHS bodies and their Boards need to have sound corporate governance arrangements that can provide assurance to themselves, the public, and key stakeholders that the necessary action is being taken to deliver high-quality, safe and responsive services, and that public money is being spent wisely.

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:

- corporate approach to planning;
- corporate systems of assurance;
- board transparency, cohesion, and effectiveness; and
- corporate approach to financial management.

We have not reviewed the Trust's operational arrangements as part of this work.

4 Our work has been informed by our previous structured assessment work, which has been developed and refined over a number of years. It has also been informed by:

- model Standing Orders, Reservation and Delegation of Powers;
- model Standing Financial Instructions;
- relevant Welsh Government health circulars and guidance;
- the Good Governance Guide for NHS Wales Boards (Second Edition); and
- other relevant good practice guides.

We undertook our work between August and September 2024. The methods we used to deliver our work are summarised in **Appendix 1**. Our work was conducted in accordance with the auditing standards set by the International Organisation of Supreme Audit Institutions.

5 We also provide an update in this report on the Trust's progress in addressing outstanding recommendations identified in previous structured assessment reports in **Appendix 2**.

Key findings

6 Overall, we found that **the Trust's corporate arrangements generally support good governance and the efficient, effective, and economical use of resources. Positively, the Trust is transforming its clinical services to better manage operational pressures and demand and is making good progress in enhancing key systems of assurance to strengthen Board focus on strategic risks. Whilst its financial performance is good, the Trust needs to move away from its reliance on non-recurrent savings to maintain organisational resilience.**

- We considered whether the Trust has a sound corporate approach to producing strategies and corporate plans and overseeing their delivery**. We found that the Trust continues to have a generally sound approach to producing strategies and corporate plans, including the development of an ambitious Clinical Model Transformation Programme. However, opportunities remain to strengthen Board oversight of the development and delivery of the Trust's Integrated Medium-Term Plan.**
- We considered whether the Trust has a sound corporate approach to managing risks, performance, and the quality and safety of services. **We found that the Trust continues to strengthen its corporate systems of assurance and is taking positive steps to enhance its Board Assurance Framework. However, opportunities remain to strengthen the Trust's framework for managing organisational performance and overseeing the quality and safety of services.**
- We considered whether the Trust's Board conducts its business appropriately, effectively, and transparently. **We found that recent changes to Board membership have been managed well and the Board has continued to conduct its business effectively. The Trust continues to demonstrate a strong commitment to public transparency and continuous improvement. The Trust remains committed to hearing from patients, staff, and other stakeholders; however, opportunities remain to enhance these arrangements further.**
- We considered whether the Trust has a sound corporate approach to managing its financial resources. **We found that the Trust continues to have strong financial performance supported by effective financial planning. However, the Trust needs to improve its arrangements for identifying and reporting recurrent saving schemes.**

Recommendations

7 **Exhibit 1** details the recommendations arising from our work. The Trust's response to our recommendations is summarised in **Appendix 3**.

Exhibit 1: 2024 recommendations

	Recommendations
R1	The Trust should ensure that Board members are given the opportunity, either within a formal meeting or through circulation outside of meetings, to discuss and scrutinise a draft version of the Integrated Medium-Term Plan ahead of its submission for formal ratification and approval. **(Paragraph 14)**
R2	The Trust should update its Quality and Performance Management Framework to reflect recent changes in key internal roles **(Paragraph 35)**
R3	The Trust should apply to staff stories the process it has in place for patient stories to provide clarity on how the Trust has recorded the story, how the story has been used for assurance or improvement purposes, and how the Trust has responded to the individual who shared their experience. **(Paragraph 71)**

Detailed report

Corporate approach to planning

8 We considered whether the Trust has a sound corporate approach to producing strategies and corporate plans and overseeing their delivery.

9 We found that **the Trust continues to have a generally sound approach to producing strategies and corporate plans, including the development of an ambitious Clinical Model Transformation Programme. However, opportunities remain to strengthen Board oversight of the development and delivery of the Trust's Integrated Medium-Term Plan.**

Corporate approach to producing strategies and plans

10 We considered whether the Trust has a sound corporate approach to producing, overseeing, and scrutinising the development of strategies and corporate plans. We were specifically looking for evidence of:

- a clear Board approved vision, appropriate objectives and a long-term strategy in place which are future-focused, rooted in population health, and informed by a detailed and comprehensive analysis of needs, opportunities, challenges, and risks;
- the long-term strategy underpinned by an appropriate Board approved long-term clinical strategy;
- appropriate and effective corporate arrangements in place for developing and producing the Integrated Medium-Term Plan (IMTP), and other corporate plans; and
- the Board appropriately scrutinising the IMTP and other corporate plans prior to their approval.

11 We found that **the Trust has generally good arrangements for producing strategies and corporate plans and is making good progress in developing a new Clinical Model Transformation Programme to transform service delivery. Whilst the Trust was able to produce an approvable Integrated Medium-Term Plan for 2024-27, the Board should have been more involved in scrutinising the draft version prior to approving the final plan.**

12 The Trust continues to pursue the vision and objectives of its long-term strategic framework (the Framework) - 'Delivering Excellence, Our Vision for 2030'. The organisational strategy outlines the Trust's vision on altering the Trust's traditional service model to manage demand differently. This includes increasing the provision of remote advice and treatment as well as access to pathways that enable patients to stay in their communities rather than be conveyed to hospital. The Framework also sets out the Trust's ambitions for its staff and how it will pursue innovation, value and quality.

13 In 2023, the Trust undertook a high-level assessment of progress to-date against the Framework. Building on this, during May and June 2024, the Trust held

workshops to explore how it could accelerate plans to achieve its vision through changes to the organisation's clinical model. As a result, rather than the current operational structures of three separate service provisions[1], the Trust is proposing to move to a single fully integrated model of care[2] with the aim of reducing waits and cases of avoidable harm. The Board has been kept informed of the development of this work through Board Development Days. This activity has been termed the Trust's Clinical Model Transformation Programme, which will be supported by annual delivery plans.

14 The Trust's Integrated Medium-Term Plan for 2024-27 (IMTP 2024-27) was approved by the Board on 25 March 2024 and submitted to Welsh Government within the required timeframe. Welsh Government has approved the IMTP 2024-27. The Trust demonstrated a strong commitment to internal and external engagement to support the development of its IMTP 2024-27. This included considering patient stories, conducting staff surveys, and engaging with the new Joint Commissioning Committee which replaced the Emergency Ambulance Services Committee in 2024. The Finance and Performance Committee and the Board were kept up to date on the process for developing the IMTP, as well as receiving aspects of the IMTP through board development days. However, despite a paper stating the Finance and Performance Committee and Board would formally receive draft copies of the IMTP in January 2024, neither were given an opportunity to review a full version of the IMTP until March 2024 when it was formally approved for submission to Welsh Government. Sharing a draft version, either in a formal meeting setting or by circulating it to members with sufficient time ahead of the submission deadline would provide the board with greater opportunities to discuss and comment on the plan **(Recommendation 1).**

15 On 30 June 2024, the Trust became a listed organisation under the Well-being of Future Generations (Wales) Act 2015. In line with the Act, the Trust will be required to set well-being objectives in accordance with the sustainable development principle, with its first set of objectives due by April 2025. At the time of writing this report, the Trust was establishing an organisational-wide task and finish group to plan and oversee the development of the well-being objectives and associated work under the new requirements.

16 The Board has also approved a Strategic Equality Plan 2024-28 (as required under The Equality Act 2010) and a Digital Plan 2024-29 in March 2024 and July 2024 respectively. Our 2022 structured assessment report commented on the lack of clarity around how the previous Digital Strategy was to be funded as it did not contain clear costing information. We also commented that it was difficult for Board members to clearly monitor delivery of the strategy. It is positive to note that the

[1] Emergency Medical Services, National 111 Service, Ambulance Care Service.

[2] Patients with an emergency, urgent or routine health need will be able to access services via different methods, be assessed, including (as necessary) via rapid clinical screening and receive the right response and outcome for their specific need.

new Digital Plan is much clearer on resource requirements and the risks of failure to invest, including an impact on cybersecurity vulnerabilities and operational inefficiencies. The Trust has also identified new key performance indicators to enable robust monitoring of plan delivery.

17 The IMTP 2024-27, Strategic Equality Plan and Digital Plan are publicly available on the Trust website (see **Appendix 2, 2023 Recommendation 2**).

Corporate approach to overseeing the delivery of strategies and plans

18 We considered whether the Trust has a sound corporate approach to overseeing and scrutinising the implementation and delivery of corporate plans. We were specifically looking for evidence of:

- corporate plans, including the IMTP, containing clear strategic priorities/objectives and SMART[3] milestones, targets, and outcomes that aid monitoring and reporting; and
- the Board appropriately monitoring the implementation and delivery of corporate plans, including the IMTP.

19 We found that **the Trust's IMTP 2024-27 contains clear objectives and outcome-based milestones and there is greater focus on the impact of plan delivery in progress reports. However, the Trust needs to urgently clarify to Board the impact of the Clinical Model Transformation Programme on wider delivery of the Integrated Medium-Term Plan for 2024-27.**

20 The IMTP 2024-27, which is appropriately aligned to the Trust's long-term strategy and strategic priorities, has a strong focus on delivery, with each section setting out clear objectives and a description of what good will look like in 2027. Each objective lists the outcome-based milestones the Trust aims to achieve in each of the three years of the plan (see **Appendix 2, 2023 Recommendation 3**).

21 Overall delivery of the IMTP 2024-27 continues to be overseen by the Strategic Transformation Board. However, the supporting delivery structures have been refreshed since the approval of the IMTP 2024-27 to incorporate the Clinical Model Transformation Programme. Actions under the Clinical Model Transformation Programme (which are not reflected in the IMTP 2024-27 as the programme was developed after the IMTP) are monitored by the Clinical Model Transformation Board, whereas actions within the IMTP 2024-27 that are not aligned to the Clinical Model Transformation Programme are overseen by the Integrated Strategic Planning and Development Group.

22 The Finance and Performance Committee and Board continue to receive quarterly IMTP 2024-27 progress updates. At the time of writing, the Trust were reporting that the introduction of the Clinical Model Transformation Programme had not yet

[3] Specific, measurable, achievable, relevant, and time-bound

resulted in the need to pause of delay any of its IMTP 2024-27 commitments to release capacity**.** Any potential changes will be reported to the Finance and Performance Committee during the year.

23 Our 2023 structured assessment report suggested that the Strategic Transformation Board should also consider performance information to better understand the impact of IMTP actions. The IMTP 2024-27 progress report to the Finance and Performance Committee in September 2024 included a section on outcomes for some workstreams, which provided information against metrics and the 'what good will look like in 2027' information contained in the plan. Some metrics were still in development as of September 2024. Where metrics have been developed, the progress report included a RAG (Red, Amber, Green) rating to indicate whether performance was in line with expectations (see **Appendix 2, 2023 Recommendation 4**). Whilst this change provides Board members with a valuable insight into the impact of delivering IMTP 2024-27 actions, these reports could be strengthened further by, for example, providing a summary or dashboard to enable members to quantify overall progress against all actions. Furthermore, whilst the IMTP 2024-27 contains milestones and target dates, these are not included within the progress reports**.**

Corporate systems of assurance

24 We considered whether the Trust has a sound corporate approach to managing risks, performance, and the quality and safety of services.

25 We found that **the Trust continues to strengthen its corporate systems of assurance and is taking positive steps to enhance its Board Assurance Framework. However, opportunities remain to strengthen the Trust's framework for managing organisational performance and overseeing the quality and safety of services.**

Corporate approach to overseeing strategic risks

26 We considered whether the Trust has a sound corporate approach to identifying, overseeing, and scrutinising strategic risks to the delivery of strategic priorities / objectives as well as corporate risks. We were specifically looking for evidence of:

- an up-to-date and publicly available Board Assurance Framework (BAF) in place, which brings together all of the relevant information on the risks to achieving the organisation's strategic priorities / objectives;
- the Board actively owning, reviewing, updating, and using the BAF to oversee, scrutinise, and address strategic risks;
- an appropriate and up-to-date risk management framework in place, which is underpinned by clear policies, procedures, and roles and responsibilities; and

- the Board providing effective oversight and scrutiny of the effectiveness of the risk management system and corporate risks.

27 We found that **the Trust is undertaking a significant programme of work to strengthen its risk management arrangements, including enhancing the Board Assurance Framework to ensure it focuses more on risks to achieving strategic objectives.**

28 The Risk Management Transformation Programme[4], which we have discussed in previous structured assessment reports, has entered its third and final year and continues to be overseen and monitored by the Audit, Risk, and Assurance Committee (ARAC). As part of the programme, the Trust's Risk Management Policy, which replaces the Risk Strategy, was approved by the ARAC and endorsed by the Board in March 2024.

29 Our 2023 structured assessment report commented on how the Trust's Board Assurance Framework (BAF) focuses on corporate risks, rather than strategic risks to the achievement of the Trust's strategic objectives. In August 2024, Internal Audit issued a reasonable assurance rating report on the Trust's risk management arrangements. The report notes that whilst recording, monitoring, and reporting of risk is done well, a clear audit trail for the management of local and directorate risks is not always available or held centrally. The report also acknowledged that there are challenges with the fact the BAF is currently manually updated and the limitations the format has in enabling effective and consistent risk management. Internal Audit made six medium priority recommendations, including ensuring risk assessment forms are consistently completed for each risk.

30 In early 2024, the Trust commissioned external consultants, BDO Ltd, to provide good practice guidance on three elements of its risk management framework - building a strategic BAF, developing risk appetite statements, and repositioning the Trust's long-standing highest-ranked risks. BDO Ltd's key findings, guidance, and recommendations were presented at the September 2024 ARAC meeting. It recommended aligning the BAF with the Trust's strategic objectives, revising principal risks to differentiate between risks that are within and outside of the Trust's control, and reviewing the effectiveness of internal controls. The Trust was in the process of developing a plan to implement the recommendations at the time of our review. The Trust was also recruiting to a new Risk Manager post to support it to make effective and timely progress, but it recognises that these wider changes will also require support and engagement across the organisation to become effectively embedded.

31 The ARAC receives a Corporate Risk Register (CRR) summary and the BAF at each meeting. Furthermore, other committees continue to review, scrutinise, and

[4] The Trust's Risk Transformation Programme was introduced in 2022-23 and is a three-year plan to improve risk management by re-articulating principal risks, developing risk management policies and procedures, and progressing a strategic Board Assurance Framework.

challenge the risks relevant to their remit at each of their respective meetings. The Trust's Assistant Director Leadership Team and Executive Leadership Team continue to oversee and manage risks at an operational level. Our observations of Board and committee meetings found evidence of agendas and discussions appropriately focussing on the Trust's significant operational risks. Again for 2024, these risks include the timeliness of operational 999 response, quality of care and outcomes, and providing a civil contingency response in the event of a major incident.

32 However, the Trust's two highest rated risks remain at the highest score of 25, despite the Trust completing most of the actions within its control to mitigate these risks. At the time of our fieldwork (and in line with the work undertaken by BDO Ltd) the Trust was holding discussions to consider a different approach to managing and monitoring those areas that are within the Trust's control and those that are not.

Corporate approach to overseeing organisational performance

33 We considered whether the Trust has a sound corporate approach to identifying, overseeing, and scrutinising organisational performance. We were specifically looking for evidence of:

- an appropriate, comprehensive, and up-to-date performance management framework in place, underpinned by clear roles and responsibilities; and
- the Board and committees providing effective oversight and scrutiny of organisational performance.

34 We found that **the Trust continues to have reasonable performance management arrangements in place, with appropriate action taken to address areas of underperformance. However, the framework for managing Trust performance requires some updating.**

35 The Trust continues to manage performance in line with its Quality and Performance Management Framework 2022-25 (the QPMF), which was approved in March 2022. The QPMF has been updated to reflect the new Duties of Candour and Quality and it references the Well-being of Future Generations (2015) Act. Whilst the QPMF includes clear roles and responsibilities, there is a need to update some of the job titles listed **(Recommendation 2).** The QPMF will also need to be aligned to the Trust's revised risk management arrangements in due course.

36 The Executive Team reviews the metrics within the Monthly Integrated Quality and Performance Reports (MIQPR) on an annual basis to ensure they continue to represent the best way of tracking progress against the Trust's plans. The Finance and Performance Committee considered and approved the small amendments made as part of the updated metrics for 2024-25 in July 2024. The Trust continues to report its performance against the approved metrics via the MIQPR, which is presented at each Board and committee meeting. Committees also receive specific

reports which provide a focus on metrics within their remit. Despite consistent performance issues, the Board continues to provide appropriate challenge and scrutiny that seeks to encourage improvement.

37 Recent performance reports show that the Trust has seen a significant increase in calls categorised as red (serious and immediately life-threatening) in 2024 compared to 2023. However, the Trust has broadly maintained the level of performance in reaching red calls within eight minutes and the median time for responding to amber calls. The Trust has also seen an increase in hours lost due to delays in handing patients over to hospitals across 2024 compared to 2023. Whilst performance continues to be challenging, the Trust has been able to mitigate this to an extent through its focus on decreasing levels of sickness absence and maintaining ambulance production levels. The Trust also continues to hold discussions with health boards to drive improvements to handover delays, including by gaining direct access to alternative pathways to Accident and Emergency Departments. The new clinical model, once in place, should also enable the Trust to address some of its performance challenges by streamlining and improving access to healthcare advice provided by the Trust to keep patients at home where appropriate.

Corporate approach to overseeing the quality and safety of services

38 We considered whether the Trust has a sound corporate approach to overseeing and scrutinising the quality and safety of services. We were specifically looking for evidence of:

- the Board providing effective oversight and scrutiny of the effectiveness of the quality governance framework;
- clear organisational structures and lines of accountability in place for clinical/quality governance; and
- the Board and relevant committee providing effective oversight and scrutiny of the quality and safety of services.

39 We found that **the Trust continues to have a reasonably sound corporate approach to overseeing and scrutinising the quality and safety of services, but opportunities remain to strengthen these arrangements further.**

40 The Trust is currently developing a Quality Plan to replace its previous Quality Strategy 2021-24. The Quality, Patient Experience, and Safety Committee (QuESt) has been kept up to date on the development of the new plan.

41 We recently undertook a follow-up review of the recommendations we made in our 2022 Review of Quality Governance Arrangements, which also incorporated a review of the steps being taken by the Trust to implement the new Duty of Quality and Duty of Candour under the Health and Social Care (Quality and Engagement) (Wales) Act 2020. We found that the Trust needs to take steps to ensure that the ambitions of its new Quality Plan are achievable and resourced, given that the

implementation of the previous Quality Strategy was slower than intended due to resource and capacity constraints. We also made new recommendations relating to strengthening reporting of progress in relation to its quality ambitions, enhancing clinical audit progress updates, increasing compliance rates for Duty of Quality training, and ensuring review of policies include a quality lens.

42 The Trust has strengthened its organisational structures and lines of accountability for clinical / quality governance over the past two years. This includes a Senior Quality Team, consisting of heads of service and business partners, which oversees delivery of the Quality Strategy, a Quality Management Group which supports the Trust's quality management system, as well as a Clinical Quality Governance Group which escalates issues relating to quality governance to the QuESt for assurance and oversight. Work is continuing to ensure each of the groups have agreed Terms of Reference and clear documentation. We found strong views among those we spoke to that the new governance framework is having a positive impact. However, the Trust recognises there are ongoing areas of improvement, relating to attendance at Quality Management Group meetings as well as the quality of information presented to those meetings. The Trust is taking steps to manage these challenges.

43 QuESt continues to appropriately review key quality information, focusing on the high level of risk of patient harm. During 2023-24, the Trust has seen a sustained increase in the number of concerns received and serious incidents shared with health board colleagues to investigate under the Joint Investigation Framework, as well as an increase in requests for information from Coroners.

44 In addition to increasing numbers across quality performance metrics such as complaints and concerns and poor response times, the Trust was seeing increased pressure on its capacity caused by requirements under the Duties of Quality and Candour. In response, the Trust undertook an organisational change process and secured investment in additional resources, including a new Head of Putting Things Right. In May 2024, QuESt received a Putting Things Right Recovery Plan, with all actions set to be complete by April 2025. At the August 2024 meeting of QuESt the Trust stated briefly that the recovery plan delivery was on track.

Corporate approach to tracking recommendations

45 We considered whether the Trust has a sound corporate approach to overseeing and scrutinising systems for tracking progress to address audit and review recommendations and findings. We were specifically looking for evidence of:

- appropriate and effective systems in place for tracking responses to audit and other review recommendations and findings in a timely manner.

46 We found that **the Trust continues to strengthen its corporate approach to tracking progress to address audit and review recommendations.**

47 The Trust continues to strengthen its systems for tracking and actioning audit recommendations and findings. The Trust has worked with Digital Health and Care

Wales (DHCW) on an automated tracking system, which should be in place for April 2025. In the meantime, the Trust's Corporate Governance Team has continued to review all outstanding recommendations with management with regular reporting to the ARAC. The Trust also continues to refer relevant extracts of the audit tracker to each committee to support oversight and scrutiny of recommendations relating to their remit. The tracker has been further developed to include reasons why actions to recommendations are overdue, whether progress has been achieved, and if there is a new proposed completion date. The Corporate Governance Team has provided assurance to the ARAC that it applies strong challenge to requests to delay the completion of management actions, and that dates can be moved a maximum of three times.

48 However, it is concerning that our 2024 Follow-up Review of Quality Governance Arrangements identified that several actions had been closed on the tracker which we considered to be ongoing. This included providing consistent information on mortality review activity and reporting the outcomes of clinical audit. The Trust has responded to this and is considering ways to encourage clearer commitments to actions within management responses to recommendations.

Board transparency, effectiveness, and cohesion

49 We considered whether the Trust's Board conducts its business appropriately, effectively, and transparently.

50 We found that **recent changes to Board membership have been managed well and the Board has continued to conduct its business effectively. The Trust continues to demonstrate a strong commitment to public transparency and continuous improvement. The Trust remains committed to hearing from patients, staff, and other stakeholders; however, opportunities remain to enhance these arrangements further.**

Public transparency of Board business

51 We considered whether the Board promotes and demonstrates a commitment to public transparency of board and committee business. We were specifically looking for evidence of Board and committee:

- meetings that are accessible to the public;
- papers being made publicly available in advance of meetings; and
- business and decision-making being conducted transparently.

52 We found that **the Trust continues to demonstrate a strong commitment to public transparency of Board and committee business.**

53 The Trust continues to hold in-person public Board meetings which are broadcast live on Facebook, with recordings made available on YouTube shortly afterwards. While the Trust held each of its 2023 public Board meetings in Cardiff, it is in discussion about resuming its previous practice of rotating meetings around Wales

to provide further opportunities for Board members to meet with staff from different areas.

54 The Trust continues to provide opportunities for members of the public to submit questions ahead of public Board meetings. Whilst our review of papers found low numbers of questions submitted for recent meetings, minutes clearly evidence the Board's commitment to providing comprehensive and appropriate responses, including use of the action log to track responses provided outside of the meeting.

55 Committee Chairs determine whether meetings are held virtually only or using a hybrid approach, where members can join either in-person or online. The majority of the Trust's committees meet virtually, which is decided during agenda setting meetings. Information is available on the Trust website on how members of the public can submit requests to observe committee meetings which are not broadcast live.

56 Papers for Board and committee meetings are almost always made available on the Trust website in advance in accordance with Standing Orders. There are very few exceptions where some papers are not published seven days in advance, which includes financial presentations to the Finance and Performance Committee due to the proximity of meetings to the submission of information to Welsh Government. The Trust continues to minimise the use of private (or closed) sessions of Board and committee meetings, with appropriate issues reserved for sensitive and confidential reasons.

57 Following our 2023 structured assessment, the Trust now provides a written Chair's Report for each public Board meeting to further support transparency (see **Appendix 2, 2023 Recommendation 1a**). The Trust also agreed to provide a timely record of committee meetings by publishing its Alert, Assure, and Advise Highlight Reports within 14 days of meetings. This has broadly been completed during the year. However, our review of papers found that no reports were available for two meetings due to the timing of the subsequent Board meeting, where the Highlight Reports were delivered verbally instead. The Trust has stated that it will provide further clarity on the website to ensure the public understand how to access a timely record of key decisions and discussions taken during committee meetings (see **Appendix 2, 2023 Recommendation 1b**).

Arrangements to support the conduct of Board business

58 We considered whether there are proper and transparent arrangements in place to support the effective conduct of Board and committee business. We were specifically looking for evidence of formal, up-to-date, and publicly available:

- Reservation and Delegation of Powers and Scheme of Delegation in place, which clearly sets out accountabilities;
- Standing Orders (SOs) and Standing Financial Instructions (SFIs) in place, along with evidence of compliance; and

- policies and procedures in place to promote and ensure probity and propriety.

59 We found that **the Trust continues to have proper and transparent arrangements in place to support the effective conduct of Board and committee business, with significant progress achieved to bring policies up to date.**

60 The ARAC and Board continue to regularly review the Trust's Standing Orders, including the Standing Financial Instructions and Scheme of Reservation and Delegation (SoRD). The Trust amended its Standing Orders four times[5] since our 2023 structured assessment to:

- reflect the Model Standing Orders issued by Welsh Government;
- alter the delegations between Executive Team members;
- recognise the new Joint Commissioning Committee; and
- update the Trust's name following the achievement of University Trust status.

In March 2024, Internal Audit issued a reasonable assurance rating on the Trust's Vehicle Replacement Programme that highlighted non-compliance with approval of contracts by the Board. This prompted the Trust to undertake a broader examination of the SoRD, culminating in amendments to clarify established practices and the development of a Governance Practice Note. Each change was discussed by the ARAC and approved by the Board. The formal, up-to-date Standing Orders are publicly available on the Trust website.

61 In 2023, the Trust reported that only 14% of its policies were within their expected review date. In September 2024, the ARAC received assurance on the significant progress made to address this, with 45% of Trust policies that were identified as a priority having been reviewed. It is expected that 52% of all Trust Policies will be within their review date by December 2024.

62 The Trust continues to publish declarations of interests and the Register of Gifts and Hospitality on its website. However, we note that the number of submissions of gifts and hospitality remain very low for an organisation of the Trust's size. The Trust continues to encourage higher compliance through communications activity, including posters to raise awareness amongst staff of the need to declare gifts. The Trust has undertaken significant work during 2024 to broaden its process for recording declarations of interest which now includes over 250 decision makers. Beyond the registers, the Trust informs us that there is a more transparent culture around declarations of interest with staff proactively seeking support and guidance from the Corporate Governance Team.

[5] September 2023, November 2023, April 2024, and July 2024

Effectiveness of Board and committee meetings

63 We considered whether Board and committee meetings are conducted appropriately and effectively, supported by timely and high-quality information. We were specifically looking for evidence of:

- an appropriate, integrated, and well-functioning committee structure in place, which is aligned to key strategic priorities and risks, reflects relevant guidance, and helps discharge statutory requirements;
- clear and timely Board and committee papers that contain the necessary / appropriate level of information needed for effective decision making, scrutiny, and assurance;
- Board and committee agendas and work programmes covering all aspects of their respective Terms of Reference as well being shaped on an ongoing basis by the Board Assurance Framework;
- well-chaired Board and committee meetings that follow agreed processes, with members observing meeting etiquette and providing a good balance of scrutiny, support, and challenge; and
- committees receiving and acting on required assurances and providing timely and appropriate assurances to the Board.

64 We found that **Board and committee meetings continue to be conducted appropriately and effectively with good coverage of key issues and risks.**

65 The Trust continues to have an integrated and well-functioning committee structure. Board and committee meetings in 2023-24 were all quorate. The Trust has updated the terms of reference for each committee during 2023-24, which were approved by the Board in May 2024. Each committee has an Executive Director and / or Director lead who work closely with the Chair and Director of Corporate Governance to set the agenda for meetings and plan the committee's cycle of business. In due course, the Trust will need to consider how best to reflect and embed the requirements of the Wellbeing of Future Generations (Wales) Act 2015 into routine Board and committee business and decision making. We are aware that Non-Executive Directors did not meet regularly as a group in the first half of 2024, but positively, we note that these have recently resumed.

66 The Board and its committees continue to receive generally good quality information to support effective scrutiny, support, and challenge. Papers are available in advance of meetings, and their quality continues to be generally high. However, the Trust recognises the ongoing need to ensure reports present analysis, rather than simply data, to provide members with stronger assurance. Our 2024 Follow-up Review of Quality Governance Arrangements also stated the need to consistently present trend information to support members' understanding. The Trust is currently exploring options, such as training and digital solutions, to strengthen Board and committee reports and presentations to ensure they are informative and succinct.

67 Our observations of Board and committees found that meetings run well. The Board and committees follow agreed processes, including ensuring declarations of interest are made and the register is kept up to date. The Trust is also planning to develop meeting etiquette guidance to further support committee Chairs. Meetings are well-chaired and there is good discussion with an appropriate level of challenge around operational risks and issues. Committees continue to escalate issues to the Board via the Alert, Assure, and Advise Highlight Reports. During the past year, issues which have been escalated include the high levels of handover delays and the effect of the backlog and volume of concerns on the Putting Things Right and operational quality teams.

68 The Board places an increasing reliance on the assurances provided by the committees, which has led to shorter public Board meetings. The Trust recognises it must remain mindful of clearly demonstrating to the public that sufficient scrutiny has taken place during committee meetings. As work on its Board Assurance Framework and risk appetite progresses (see **paragraph 31**), the shorter public Board meetings should provide an opportunity for the Board to spend more time focussing on its strategic priorities and risks.

Board commitment to hearing from patients/service users and staff

69 We considered whether the Board promotes and demonstrates a commitment to hearing from patients/service users and staff. We were specifically looking for evidence of:

- the Board using a range of suitable approaches to hear from a diversity of patients/service users, the public and staff.

70 We found that **the Board and its committees continue to make good use of patient and staff stories; however, opportunities remain to use other approaches to hear from patients and staff.**

71 The Trust continues to make good use of patient and staff stories to assist Board members to understand the experiences of service users and staff. Our observations found that Board and committee members highly value these stories as they prompt further discussion and usefully set the tone for meetings. The Trust tracks each patient story and reports back to the QuESt on the actions, progress, and outcomes following the receipt of the story at the subsequent meeting. From September 2024, Llais[6] will also be attending public Board meetings which will provide further opportunities to hear patient perspectives. However, staff stories do not currently follow the same process for patient stories, and it is not always clear

[6] From 1 April 2023 Llais replaced the work of Wales' seven Community Health Councils. It is an independent body which aims to gather and share experiences of citizens in Wales with health and social care services and provide support for those making complaints.

how the Trust is using this intelligence to provide assurance or promote improvement **(Recommendation 3).**

72 In our 2023 structured assessment report, we noted that work was ongoing to resolve our 2022 recommendation to identify actions to address issues identified in patient experience reports. Our recent review of the patient experience report shows that it continues to highlight themes of negative feedback but without reference to actions the Trust is taking in response (see **Appendix 2, 2022 Recommendation 2**).

73 Our 2024 Follow-up Review of Quality Governance Arrangements found that the Trust has developed a Standard Operating Procedure for Board visits. Whilst there have been challenges in securing consistent geographical and service coverage, we are aware there has been an increase in the number of visits and geographical coverage since April 2024 compared to 2023-24. We also found that there is scope to strengthen the process for feeding back the intelligence from visits. As previously stated, the Trust is considering resuming the geographical rotation of public Board meetings, as well as using Non-Executive Director meetings as mechanisms for sharing intelligence which would provide greater opportunities for members to triangulate the information they formally receive in Board and committee meetings.

Board cohesiveness and commitment to continuous improvement

74 We considered whether the Board is stable and cohesive and demonstrates a commitment to continuous improvement. We were specifically looking for evidence of:

- a stable and cohesive Board with a cadre of senior leaders who have the appropriate capacity, skills, and experience;
- the Board and its committees regularly reviewing their effectiveness and using the findings to inform and support continuous improvement; and
- a relevant programme of Board development, support, and training in place.

75 We found that **the Board continues to demonstrate a commitment to continuous improvement, and the Trust has managed several recent changes to Board membership well.**

76 The Trust has seen several changes to Board membership in recent months. Following the retirement of the Medical Director in late 2023, the Director of Paramedicine was made an Executive Director with voting rights. The Interim Vice-Chair secured the role on a substantive basis in July 2024 and there are three new Non-Executive Directors, including the Chair of ARAC, Chair of the Finance and Performance Committee, and a University Member of the Board. The Trust has one further Non-Executive Director vacancy and was receiving applications at the time of writing this report. Changes have been managed well, ensuring meetings are quorate and new members had access to a supportive induction process. The

Trust's process for filling Board member vacancies continues to be informed by an analysis of Board member skill-mix which helps it to identify where it may need to secure additional specific experience. It also has a comprehensive Board member induction programme which incorporates learning from the experiences of the most recent Board appointments.

77 The Board Development Programme continued in 2023-24. The Trust has stated that the seven scheduled sessions were well attended. Sessions focussed on a variety of topics, including the organisational strategy and review of MIQPR metrics, team building activities informed by Insights Discovery[7] sessions, and the development of the IMTP 2024-27. Progress with developing an externally facilitated medium-term Board Development Programme has been paused due to the vacancies at Board level and the changes that are likely to occur following development of the BAF and the introduction of the Clinical Model Transformation Programme. Despite this, those we spoke to were highly complementary about the value of current Board Development Sessions, citing they provide a useful space for honest discussion as well as opportunities for learning.

78 In early 2024, the Board and committees completed effectiveness reviews. However, Board members expressed concern at the low response rates for some committees, particularly the ARAC (29%) and People and Culture Committee (30%). The ARAC is working to improve rates by completing its effectiveness review in stages throughout the year rather than as an annual exercise. Findings from the effectiveness reviews were reported to the Board in May 2024. Feedback included views that committees are transparent and focus on key risks, but other comments relayed an eagerness to have a committee induction programme. We understand the Trust is intending to provide committee induction programmes, but they are delayed due to capacity issues within the Corporate Governance Team.

Corporate approach to managing financial resources

79 We considered whether the Trust has a sound corporate approach to managing its financial resources.

80 We found that **the Trust continues to have strong financial performance supported by effective financial planning. However, the Trust needs to improve its arrangements for identifying and reporting recurrent saving schemes.**

Financial objectives

[7] Insight Discovery is a framework to understand and adapt various communication styles based on four dominant personality areas.

81 We considered whether the Trust has a sound corporate approach to meeting its key financial objectives. We were specifically looking for evidence of the organisation:

- meeting its financial objectives and duties for 2023-24, and the rolling three-year period of 2021-22 to 2023-24; and
- being on course to meet its objectives and duties in 2024-25.

82 We found that **the Trust continued its strong performance of meeting key financial objectives and is on course to meet them again in 2024-25.**

83 The Trust continued its good record of meeting its financial duties in 2023-24, recording a small surplus of £85,000, and achieving breakeven over the rolling three-year period 2021-24. The Trust spent its capital expenditure in line with the plans, and compliance with the public sector payment policy was on track, with 96.4% of non-NHS invoices paid within 30 days of receipt against the 95% target.

84 As of Month 5 2024-25, the Trust was reporting a small underspend of £31,000 against budget and forecasting a year-end breakeven position. Capital expenditure is forecast to be fully spent by the end of the year and the public sector payment policy is on track.

Corporate approach to financial planning

85 We considered whether the Trust has a sound corporate approach to overseeing and scrutinising financial planning. We were specifically looking for evidence of:

- clear and robust corporate financial planning arrangements in place;
- the Board appropriately scrutinising financial plans prior to their approval;
- sustainable, realistic, and accurately costed savings and cost improvement plans in place which are designed to support financial sustainability and service transformation; and
- the Board appropriately scrutinising savings and cost improvement plans prior to their approval.

86 We found that **whilst the Trust has a clear approach to financial planning, its ongoing reliance on non-recurrent savings creates a risk to organisational resilience and financial sustainability.**

87 The Board and Finance and Performance Committee scrutinised the Trust's Financial Plan as part of the IMTP 2024-27 ahead of its formal submission to Welsh Government in March 2024. The Financial Plan appropriately identifies the current financial challenges and risks facing the Trust. However, the financial risks articulated within the Financial Plan show there is very little contingency for unforeseen cost pressures or savings under-delivery. Some cost pressures identified within the Financial Plan have materialised during the year, including that relating to the re-banding of a cohort of Emergency Medical Technicians. The Trust has plans to manage these costs, including seeking additional funding and managing vacancies.

88 Our 2024 Review of Cost Savings Arrangements found that the Trust appropriately uses data from a wide range of sources to inform its approach to identifying cost improvement opportunities. We also found that whilst the Trust has a good track record of achieving its overall savings target, it has done this largely through delivering non-recurrent savings. In 2023-24, the Trust exceeded its £6 million savings target by £0.5 million. However, over 55% of the savings delivered by the Trust in 2023-24 were non-recurrent, with a significant proportion (39%) of these being vacancy management savings.

89 The Trust's savings target for 2024-25 is £6.4 million, which equates to around 2.2% of the organisation's baseline budget. £3.6 million (57%) of this savings target is recurrent and the remaining £2.8 million (43%) is non-recurrent. However, some of the schemes have been categorised as recurrent savings where they relate to non-recurrent measures or efficiencies, for example, accident repair, balance sheet flexibility and operational pay cost management. Once again, the Trust is relying on a significant proportion of its savings (35%) to come from corporate pay vacancy management. This is a risk for the Trust due to the strain on capacity caused by holding vacancies. We raised this risk within our 2024 Review of Cost Savings Arrangements and recommended the Trust strengthen its approach to identifying and delivering recurrent savings. The Trust has responded that it will assess the findings of its services review to implement further recurrent savings, where possible.

90 As of Month 5 2024-25, the Trust had achieved £3.3 million of savings against a year-to-date target of £2.8 million, with recurrent schemes slightly over-performing and non-recurrent schemes slightly under-performing.

Corporate approach to financial management

91 We considered whether the Trust has a sound corporate approach to overseeing and scrutinising financial management. We were specifically looking for evidence of:

- effective controls in place that ensure compliance with Standing Financial Instructions and Schemes of Reservation and Delegation;
- the Board maintaining appropriate oversight of arrangements and performance relating to single tender actions, special payments, losses, and counter-fraud;
- effective financial management arrangements in place which enable the Board to understand cost drivers and how they impact on the delivery of strategic objectives; and
- the organisation's financial statements for 2023-24 were submitted on time, contained no material misstatements, and received a clean audit opinion.

92 We found that **the Trust continues to have a sound corporate approach to overseeing and scrutinising financial management.**

93 There have been no changes to the Trust's financial systems and controls since 2023. The ARAC continues to oversee and scrutinise information on losses and special payments in its public session, and counter-fraud activity, procurement controls and single tender actions in the private session of each meeting. There have been no material changes in the volume or nature of single tender awards and waivers or counter fraud investigations this year. The programme of Internal Audit work during the previous year did not identify any significant concerns relating to financial or budgetary control and no significant financial control issues were reported to the ARAC.

94 The Trust submitted draft financial statements for 2023-24 for audit within the required Welsh Government timeframe. Our audit identified a number of misstatements, both corrected and uncorrected, though the misstatements were not material and had no impact (individually or in aggregate) on the Trust's retained surplus position. Following Board approval of the accounts, we issued an unqualified audit opinion on 12 July 2024.

Board oversight of financial performance

95 We considered whether the Board appropriately oversees and scrutinises financial performance. We were specifically looking for evidence of the Board:

- receiving accurate, transparent, and timely reports on financial performance, as well as the key financial challenges, risks, and mitigating actions; and
- appropriately scrutinising the ongoing assessments of the organisation's financial position.

96 We found that **while the Board appropriately oversees and scrutinises financial performance, opportunities remain to strengthen the content and presentation of finance reports.**

97 As reported in our 2024 Review of Cost Savings Arrangements, we found that there is regular oversight of financial spending and savings performance at both Executive and Board level. As reported in our 2023 structured assessment report, the proximity of Finance and Performance Committee meetings to the submission of financial reports to Welsh Government means that members do not receive the presentation in advance of meetings. This is done to avoid the committee being presented with financial information which is over a month out-of-date. Instead, a presentation is given on the day of the meeting. Despite this, Board members demonstrate a clear grasp of the current financial situation and provide an appropriate level of scrutiny and challenge to support improvement during committee meetings.

98 Following our 2023 structured assessment, the Trust's 2024-25 Financial Plan provides a table which clearly shows which schemes are recurrent and non-recurrent. The finance report to the Finance and Performance Committee also provides a table on the latest performance of recurrent and non-recurrent schemes (see **Appendix 2, 2023 Recommendation 5**). However, our Review of Cost

Savings Arrangements recommended clearer reporting of savings performance within reports to the Finance and Performance Committee and the Board. This was due to the potential for confusion between savings figures quoted within reports, which was caused by some containing income generation money. The Trust is responding to this recommendation with a more detailed breakdown of performance within reports. In addition, we noted that the narrative description of a small number of savings schemes within the Month 5 finance report varied from the description within the original Financial Plan. These reflect some consolidation for the purposes of monthly and in-year reporting. Where this occurs it would be helpful for the Trust to briefly highlight it within its reports to support clarity and to enable committees to more easily reconcile in-year reporting with the Financial Plan.

Appendix 1

Audit methods

Exhibit 2 below sets out the methods we used to deliver this work. Our evidence is limited to the information drawn from the methods below.

<table>
<tr><th>Element of audit approach</th><th>Description</th></tr>
<tr><td>Observations</td><td>We observed Board meetings as well as meetings of the following committees:
Audit, Risk, and Assurance Committee;
People and Culture Committee;
Finance and Performance Committee; and
Quality, Safety, and Patient Experience Committee.</td></tr>
<tr><td>Documents</td><td>We reviewed a range of documents, including:
Board and Committee Terms of Reference, work programmes, agendas, papers, and minutes;
key governance documents, including Schemes of Delegation, Standing Orders, Standing Financial Instructions, Registers of Interest, and Registers of Gifts and Hospitality;
key organisational strategies and plans, including the IMTP;
key risk management documents, including the Board Assurance Framework and Corporate Risk Register;
key reports relating to organisational performance and finances;
Annual Report, including the Annual Governance Statement;
relevant policies and procedures; and
reports prepared by the Internal Audit Service, Health Inspectorate Wales, Local Counter-Fraud Service, and other relevant external bodies.</td></tr>
</table>

Element of audit approach	Description
Interviews	We interviewed the following Senior Officers and Independent Members: • Chair of Board; • Chair of Audit Committee; • Chief Executive Officer; • Executive Director of Strategic Planning and Performance; • Executive Director of Finance; and • Director of Corporate Governance / Board Secretary.

Appendix 2

Progress made on previous-year recommendations

Exhibit 3 below sets out the progress made by the Trust in implementing recommendations from previous structure assessment reports.

Recommendation	Description of progress
Patient experience reporting (2022) **R2** Improve quarterly patient experience reporting to QuESt by ensuring a balance of both positive and negative feedback and providing information on what is being done to address the negative themes arising in the report	**In progress.** See paragraph 72
Transparency of Board and committee business (2023) **R1** Opportunities exist to further enhance the transparency of Board and Committee business. The Trust should: a) provide a written Chair's Report to each Board meeting; and b) review and publish unconfirmed minutes of committee and Board meetings within 14 days of the meeting.	**Complete.** See paragraph 57
Public access to key strategies and plans (2023) R2 The Trust should publish key plans on the Trust's website, including the most recent IMTP and the People and Culture Plan.	**Complete.** See paragraph 17

Recommendation	Description of progress
Clarity of IMTP objectives/actions (2023) R3 We found that the Trust's IMTP does not include SMART actions, many do not include a specific measurable outcome, and it is also unclear in the IMTP which year each action is due for delivery. However, delivery milestones are set out elsewhere. The Trust should ensure all actions set out in future IMTPs are SMART by specifying measurable outcomes and delivery milestones.	**Complete.** See paragraph 20
Oversight of IMTP delivery (2023) R4 Whilst there have been recent improvements to the reporting of IMTP progress to Committee and Board, there is scope to provide better clarity on whether the actions delivered have achieved the intended impact. The Trust should ensure all plan delivery progress reports include information about the impact achieved.	**Complete.** See paragraph 23
Oversight of savings plans (2023) R5 The Trust does not clearly specify in its finance plans and reports whether savings schemes are recurrent or non-recurrent. To strengthen oversight of savings, the Trust needs to specify whether schemes are recurrent or non-recurrent in its financial plans and reports.	**Complete.** See paragraph 98

Appendix 3

Management response to audit recommendations

Exhibit 4: Welsh Ambulance Services University NHS Trust response to our audit recommendations

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R1	The Trust should ensure that Board members are given the opportunity, either within a formal meeting or through circulation outside of meetings, to discuss and scrutinise a draft version of the Integrated Medium-Term Plan ahead of its submission for formal ratification and approval. **(Paragraph 14)**	Accepted. Given the timing of board and committee meetings, this will be done by way of email circulation.	March 2024	Rachel Marsh

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R2	The Trust should update its Quality and Performance Management Framework to reflect recent changes in key internal roles **(Paragraph 35)**	Accepted. A review of the framework will take place in Q4.	May 2024	Rachel Marsh
R3	The Trust should apply to staff stories the process it has in place for patient stories to provide clarity on how the Trust has recorded the story, how the story has been used for assurance or improvement purposes, and how the Trust has responded to the individual who shared their experience. **(Paragraph 71)**	Accepted. This has already commenced. Suggest this remains open for a period of two cycles of People and Culture Committee and the Board to see the pattern.	May 2024	Trish Mills

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

Internal Audit Progress Report

Audit, Risk and Assurance Committee

November 2024

Welsh Ambulance Services University NHS Trust

NWSSP Audit and Assurance Services

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Appendix A: Progress against 2024/25 Internal Audit Plan 6

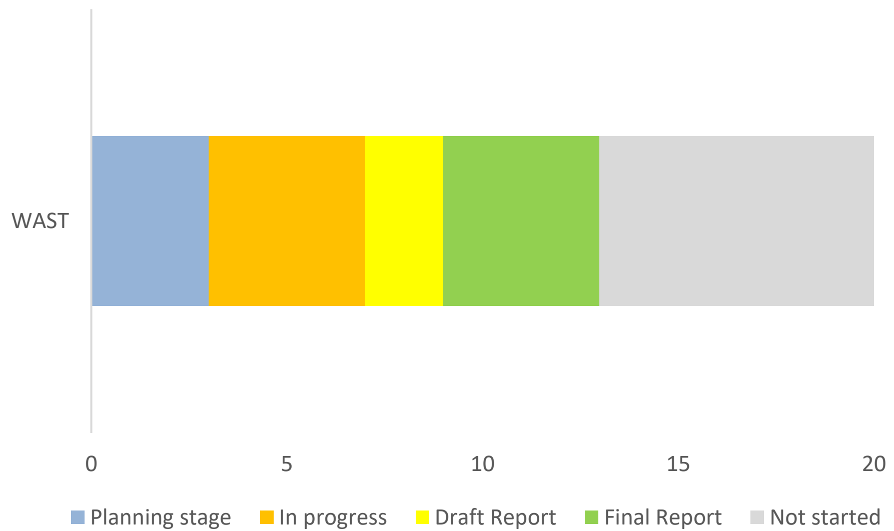
1. Introduction

The purpose of this report is to:

- highlight progress of the 2024/25 Internal Audit Plan to the Audit, Risk and Assurance Committee; and
- provide an overview of other activity undertaken since the previous meeting.

2. Progress against the 2024/25 Internal Audit Plan

There are 20 reviews in the 2024/25 Internal Audit Plan, and overall progress is shown below.



Detailed progress in respect of each of the reviews in the 2024/25 Internal Audit Plan is summarised in Appendix A.

3. Proposed changes to approved plan

No further changes are proposed in respect of the 2024/25 Internal Audit Plan.

4. Engagement

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

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

5. Key Performance Indicators

Correct on 31 October 2024

Indicator	Status	Actual	Target
Operational Audit Plan agreed for 2023/24		March	By 30 June
Audits reported over planned		6	6
Work in progress		3	
Report turnaround: time from fieldwork completion to draft reporting [10 days]		5 out of 6	80%
Report turnaround: time taken for management response to draft report [15 days]		2 out of 3	80%
Report turnaround: time from management response to issue of final report [10 days]		2 out of 2	80%

Key:

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

6. New Global Internal Audit Standards

In January 2025 new Global Internal Audit Standards (GIAS) will become effective. The body that sets Internal Audit Standards for UK Public Sector Organisations, the UK Public Sector Internal Audit Standards Advisory Board (the IASAB), has determined that the new Standards will apply to Public Sector audits from 1 April 2025 to align with the financial year. As the new Standards have been developed to apply to all sectors, the IASAB will be producing a practice note setting out any sector specific interpretations or other material needed to make them suitable for UK public sector use.

The new GIAS requirements seek to elevate internal audit practice in five domains that cover the profession's purpose, ethics and professionalism, governance, management and performance.

We are currently undertaking preparatory work to understand the impact of the new GIAS on our work, and to ensure that we can appropriately apply these standards from 1 April 2025.

At this point we do not anticipate that there will be many changes needed to our audit approach. However, one potential change is around how we monitor and evidence the implementation of agreed management actions.

We will update the Committee at the next meeting if we identify that any other changes are needed to our approach.

7. Recommendation

The Audit, Risk and Assurance Committee is invited to note the above.

Appendix A: Progress against 2024/25 Internal Audit Plan

Review	Status	Rating	Key matters arising	Anticipated Audit Committee[1]
Risk Management and Assurance	Not started			June 2025
Follow Up	Not started			June 2025
Contract Management	Planning			March 2025
Vehicle Accident Management	In progress			March 2025
Integrated Quality and Performance Management Framework	Final report	Reasonable	Review of the Communication Plan and the Quality & Performance Management Framework's work programme to ensure that actions are clearly defined and achievable; Review of the governance structure to ensure there is sufficient oversight over the Framework and its implementation.	November 2024
Seasonal Forecasting and Modelling	Not started			June 2025
Exposure to Fumes	Draft report	Reasonable		November 2024 / March 2025
Patient Experience and Community Involvement	Draft report	Reasonable	Development of clear engagement objectives/targets for the PECI Team; Regular review of survey questions posed to ensure relevancy and provision of meaningful feedback for service providers; Enhancement of the detail included in the log of public engagements; Enhancement to reporting on the impact and outcomes that engagement activities has had on service delivery.	November 2024 / March 2025
Rollout of Penthrox	Planning			March 2025
Overtime Controls	Final report	Reasonable	The reporting of amendments to overtime allocations should be strengthened and supported by a documented audit trail of the rationale applied; Consideration of	November 2024

[1] May be subject to change

Review	Status	Rating	Key matters arising	Anticipated Audit Committee[1]
			an automated process in the payment of overtime.	
Start of Shift Procedure	Not started			June 2025
Emergency Nurse Communications System Implementation	Not started			June 2025
111 Wales Website	Not started			March / June 2025
111 Digital Operations	In progress			March 2025
Data Quality	Final report	Reasonable	The focus within the Trust, due to capacity, has been on the EMS CAD system, which is the main driver of national reporting, however, there is recognition that there is a need to strengthen data quality processes and controls across the other data sets and systems. The following matters are aimed at strengthening current position: Out-of-date policies and guidance; Lack of assessment of staff digital literacy skills, and data quality specific training; Incomplete Information Asset Register; Improvements required in respect of data quality assurance reporting.	November 2024
Resourcing Policy	Final report	Limited	The Resourcing Policy to be reviewed and updated; Ongoing significant process mapping exercise to be completed to inform the development of functional Standard Operating Procedures. The different approaches being applied between services and local arrangements across Wales result in an inconsistent application of the Resourcing Policy; Working Time Directive breaches are not reviewed or reported on; The process for Time Off In Lieu requires clarity; Whilst Outside Resource Authorisations decisions are recorded on GRS, there is currently no reason code assigned	November 2024

Review	Status	Rating	Key matters arising	Anticipated Audit Committee[1]
			to them; There are timeframes for actions for both the Resource Team and staff included in the Resourcing Policy, however there is currently no Key Performance Indicator reporting.	
Occupational Health and Wellbeing Support	In progress			March 2025
Speaking Up Safely	Planning			March / June 2025
Capital & Estates				
Capital Systems	Not started			June 2025
Energy Management	In progress			March 2025

[1] May be subject to change

Integrated Quality & Performance Management Framework

Final Internal Audit Report

November 2024

Welsh Ambulance Services University NHS Trust

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Final report issued:	8 November 2024
Auditors:	Osian Lloyd (Head of Internal Audit); Felicity Quance (Deputy Head of Internal Audit); Lisa Harte (Audit Manager)
Executive sign-off:	Liam Williams (Executive Director of Quality & Nursing) Rachel Marsh (Executive Director of Strategy, Planning & Performance)
Distribution:	Kate Blackmore (Senior Quality Governance Lead); Hugh Bennett (Assistant Director of Commissioning & Performance); Trish Mills (Board Secretary)
Committee:	Audit, Risk & Assurance Committee

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

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

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Executive Summary

Purpose

To review the deployment of the Quality & Performance Management Framework (Framework) and assess the extent it is being embedded across the Trust.

Overview

We have issued reasonable assurance on this area.

Reporting to the September 2024 Audit, Risk & Assurance Committee (ARAC) highlighted the resource constraints that has impacted the development and progress with the QPMF's work programme. Improvements are being made as a result of recent appointments, but at the conclusion of our review, there was a post that still required backfilling.

We note that there is also a balance in delivering priorities while recognising the challenges the Trust faces with the wider system pressures for urgent and emergency care, which are not always within its control. This could negatively impact on patient flow and lead to avoidable patient harm and death.

The matters requiring management attention include:

- Review of the Communication Plan and the Quality & Performance Management Framework's work programme to ensure that actions are clearly defined and achievable.
- Review of the governance structure to ensure there is sufficient oversight over the Framework.

Report Opinion

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

Assurance summary[1]

	Objectives	Assurance
1	Embedding Arrangements	Limited
2	Performance Monitoring & Reporting	Reasonable
3	Governance Arrangements	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
1	Framework Delivery	1	Design	High
2	Communication Plan	1	Design	Medium
3	Governance Arrangements	3	Operation	Medium

1. Introduction

1.1 A core value detailed in Welsh Government's, '*A Healthier Wales: our Plan for Health and Social Care*' (2021) is, "*putting quality and safety above all else – providing high-value evidence-based care for our patients at all times*." The Health and Social Care (Quality and Engagement) (Wales) Act 2020, which came into force in April 2023, places an enhanced duty of quality and an organisational duty of candour on NHS bodies to strengthen their approach in providing high quality and safe care.

1.2 During 2022/23, an Audit Wales' review of Quality Governance arrangements identified weaknesses in the reporting arrangements at the Welsh Ambulance Services University NHS Trust (the Trust) and its capturing of outcomes for patients. As per the latest position on the Trust's recommendation tracker, we note that one of the recommendations relating to quality performance reporting and learning has not been fully implemented.

1.3 We have held discussions with Audit Wales to understand the themes arising from their work in relation to their follow up review of Quality Governance Arrangements at the Trust.

1.4 One of the key elements of the Trust's Quality Strategy is to develop and embed Quality Management Systems, the Quality & Performance Management Framework forms part of this. Audit Wales reported in its Structured Assessment (November 2023) that the "*Framework, approved in March 2022, is comprehensive and sets out clear roles and responsibilities for staff. The Quality and Performance Management Steering Group oversees the ongoing development of the framework which includes trialling and reviewing best approaches for effectively incorporating the new requirements placed by the Duty of Quality and Duty of Candour. Despite this, operational performance remains extremely challenged due to increased demand, wider system pressures and the consequential inefficiencies. Together, these challenges are leading to avoidable patient harm*."

1.5 The Trust's Integrated Medium-Term Plan (IMTP) 2024 – 2027 details the following key objective, "*Being Quality Driven and Clinically Led*," and key actions in relation to quality that will be implemented over the three-year period, which include the deployment of the Quality & Performance Management Framework.

1.6 The risk considered in this review is that quality and safety governance arrangements are ineffective with issues not escalated to and addressed by the Trust, potentially resulting in poor quality services and / or patient harm.

1.7 The audit has reviewed the oversight of quality governance arrangements within the Trust, but not encompassed the operational reporting at directorate/service level nor the external reporting arrangements, e.g. to the commissioner.

2. Detailed Audit Findings

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

	Recommendation Priority			
	High	Medium	Low	Total
Control Design	3	2	-	5
Operating Effectiveness	-	3	-	3
Total	3	5	-	8

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

Objective 1: The Trust is effectively embedding its Quality Strategy and Quality & Performance Management Framework across the organisation, providing clear direction and structure for its quality governance arrangements.

2.3 The Quality Strategy for 2021-2024, framed around the introduction of the Health and Social Care (Quality and Engagement) (Wales) Act 2020, was approved by the Trust Board on 27 May 2021. Reporting to the Quality, Patient Experience & Safety Committee (QuESt) (13 August 2024) requested an extension of the current Strategy for the current financial year (2024/25) and noted the proposed approach to developing the Quality Plan 2025-2028 to support the Trust's overall Strategy, '*Delivering Excellence: Our Vision for 2030*'. Audit Wales noted in their follow up review of Quality Governance Arrangements (see paragraph 1.3) that staffing capacity, "*has impacted the Trust's ability to deliver all of the actions of its Quality Strategy at the pace it intended*."

2.4 The Quality & Performance Management Framework (Framework), a key element of the Quality Strategy, was approved by the Trust Board on the 24 April 2022. The Framework details that it will be formally reviewed every three years but that the responsibility for the ongoing development will be discharged to the QPMF Steering Group, which is detailed within their terms of reference.

2.5 We acknowledge this ongoing development and note that the Framework has been reviewed during 2023 to ensure the duty of quality was appropriately reflected and embedded in the Framework. The amended version was submitted to the Executive Leadership Team (ELT) (22 May 2024). At the conclusion of our review, arrangements for formally reviewing the Framework are being considered.

2.6 The Framework sets out 24 organisational requirements and the Steering Group has undertaken a corporate self-assessment against these principles, which was reported to ELT (22 May 2024). Reporting to Audit, Risk & Assurance Committee (ARAC) (12 September 2024) noted that, "*the Trust has strong arrangements for quality & performance at the corporate level, but there is more variation at a*

directorate/service level (*there is some very good practice*)*, whilst at an individual staff level, the vast majority of staff receive an appraisal*". Where areas for improvement have been identified within the self-assessment, they have been incorporated into the QPMF work programme, which is monitored and updated by the QPMF Steering Group monthly.

2.7 The organisational self-assessment had not been reviewed since it was initially completed, and there was not always a clear link between earlier versions of the work programme and the self-assessment, e.g. OR4, 12 and 21. However, we are satisfied that the latest version of the work programme (29 August 2024) has rectified these issues and advise that the organisational self-assessment is reviewed periodically to alleviate any further issues.

2.8 There are 18 actions on the QPMF work programme (29 August 2024) with only two actions recorded as being completed to date:

	29 August 2024	27 June 2024	2 January 2024
Completed	2	5	2
Paused/Delayed	2	2	3
Open	14	9	9
Total	**18**	**16**	**14**

2.9 The work programme would benefit from a review to confirm that actions have the correct status (an earlier version of the work programme (27 June 2024) recorded five actions as completed); that actions have a defined timescale (three were recorded as, 'continuous' or 'dependent on learning'); realistic timescales are recorded (five had missed their target date for completion); and that the work programme details the original time frame for completion as well as any revisions, e.g. the action detailing the completion of three self-assessment pathfinders is currently recorded with a timeframe of 31 March 2025, but earlier versions of the work programme recorded this as 31 December 2023 for the completion of two pathfinders (see **Matter Arising 1**).

2.10 The Framework details that the work programme will be reported to ELT and Finance & Performance Committee (FPC). While ELT received a copy of the work programme (22 May 2024) and there was reporting to ARAC (12 September 2024), who have oversight over the Framework's implementation, there have not been regular updates on the progress with the programme's delivery (see **Matter Arising 1**).

2.11 The Framework details that both corporate and operational managers will be required to assess their own systems and processes, culminating in their arrangements for quality and performance management being documented in a series of local frameworks. Further work is needed to determine exactly what these

frameworks will entail and the number of self-assessments that will be required within the Trust (see **Matter Arising 1**).

2.12 The Resource Service pathfinder, supported by a work programme, is currently the only self-assessment to be completed, but timescales for improvement actions are not always defined (see **Matter Arising 1**). Four further self-assessments are due for completion by 31 March 2025 for Governance, Emergency Medical Service Co-ordination (EMSC), Strategy, Planning and Performance; and Quality, Safety & Patient Experience.

2.13 Reporting to the Quality, Patient Experience & Safety Committee (QuESt) (13 August 2024) detailed the work that has been undertaken to strengthen the quality management arrangements within the Trust, including the appointment of senior quality leads following the internal Organisational Change Process (OCP); developing a Quality Improvement Hub; delivery of a Quality Event (2 July 2024) introducing the Framework; and the inclusion of Duty of Quality and Duty of Candour training on the Learning Management System (LMS 365) to mitigate previous issues experienced, e.g. measuring compliance with attendance. We note that Audit Wales has raised a recommendation in relation to increasing compliance rates for Duty of Quality and Duty of Candour training as part of their follow-up review of Quality Governance Arrangements (see paragraph 1.3).

2.14 A Communication Plan (June 2024) has been developed to ensure there is regular communication and engagement of the Framework that includes completed actions such as having visibility of Duty of Quality, Duty of Candour, and the Framework on the Trust's intranet.

2.15 Noting that the Communication Plan is now a standing agenda item for the QPMF Steering Group (effective from September 2024), the action plan would benefit from an update to ensure that the status of actions is clear (one action had no status; and the other detailed 'to be discussed'); there are clearly defined timescales (some actions had timescales recorded as 'ongoing' or nothing recorded); and there are robust actions to cover the later phases of the Framework (75% of actions were recorded for Phases 1-3) (see **Matter Arising 2**).

2.16 The Executive Director of Quality & Nursing explained that it was not only staffing capacity that has impacted on the embedding of quality management arrangements within the Trust, but also data limitations. We were advised that these digital issues are being addressed separately to the Framework's implementation.

Conclusion:

2.17 Resource pressures have clearly impacted on the embedding of quality management arrangements across the Trust including the development of local frameworks and putting in place an appropriate level of communication and engagement of the Framework. While there has been investment in staffing resources, including the recent appointments of the senior quality leads and a Senior Performance Analyst, which will provide dedicated support to strengthen the structure for quality management, capacity to progress the work programme

has been an issue. Enhancements to the reporting of the work programme will ensure there is appropriate oversight where delivery of the Framework is at risk. We assign this objective **limited** assurance.

Objective 2: Key indicators have been identified to support the monitoring of the quality of services and patient outcomes.

2.18 Audit Wales reported in its Structured Assessment (November 2023) that, "*the Trust has reasonable performance management and monitoring arrangements, operational performance continues to be extremely challenging*". It also noted that, "*despite consistent performance issues the Board continues to provide challenge and scrutiny that seek to encourage improvement. The Trust reviewed its approach for performance reporting in May 2023. This led to an improved and more rounded set of performance metrics*".

2.19 One of the key principles of the Framework is to develop a coherent set of performance measures and targets and it also details that measures should be FAST (frequently discussed, ambitious, specific and transparent) and have clear milestones for delivery. Actions in relation to this have been documented within the QPMF work programme, e.g. developing scorecards, completing self-assessment pathfinders (see paragraph 2.11), and publishing the Monthly Integrated Quality & Performance Report (MIQPR) on the Trust's intranet.

2.20 The Quality and Performance Management Steering Group commissioned a MIQPR Dashboard from the Health Informatics Team with the aim of providing a consistent set of metrics for use within the Trust. The first phase of this Dashboard has been published and is available on the intranet.

2.21 There is also regular oversight and monitoring of performance through reporting the MIQPR to the Quality Management Group, QuESt, People & Culture Committee (PCC), FPC, ELT, and the Board. The MIQPR metrics have been reviewed recently and presented to both FPC and the Board (July 2024). A new metric, 'length of lie' for fallers, will be incorporated in reporting going forward. Further adjustments to the metrics will be considered as the Trust evolves its clinical model and continues to address the Duty of Quality.

2.22 MIQPR reporting (June/July 2024) to QuESt (13 August 2024) noted that:

- "*The red 8-minute response performance for July 2024 was 48.2%, remaining below the 65% target; however, the Trust is reaching more red patients in 8 minutes, but the denominator (demand) has also grown".* This could lead to avoidable patient harm, but the Trust was continuing to work on actions within its control to mitigate this risk.
- "*Handover outside Emergency Departments remains the critical component of long waiting times and patient safety incidents. 19,596 hours were lost during July 2024*".
- Data quality issues have been identified in 111, which are currently being addressed. 111 call handling performance has stabilised post-delivery of the

new 111CAS system, but the abandonment rate was at 11.9% in June 2024 and off target (5%), although demand was 4.76% higher than June 2023.
- Ambulance Care, in particular, Non-Emergency Patient Transport Service's (NEPTS) performance was stable.
- Staff sickness absence was 7.44% in July 2024 and the IMTP ambition is to reach 6%. PADR rates did not achieve the 85% target in July 2024 but have been improving (76.76%) (this was a recommendation within Audit Wales' Quality Governance (2022) review, which is still recorded as 'in progress'). Compliance for Statutory and Mandatory training increased to 84.47%, just below the 85% target.

2.23 Benchmarking of performance has been carried out, e.g. Operational Research in Health (ORH) were commissioned to carry out an independent review of frontline operations and EMSC with their performance compared to other organisations.

Conclusion:

2.24 There are several mechanisms for monitoring the performance of the quality of services and patient outcomes within the Trust, and frequent reporting to senior management, the Trust's Board and its various committees on the wider quality management arrangements. Wider consideration of other performance measures is being pursued as part of the Framework to ensure that there are appropriate measures at every level of the Trust. Therefore, we provide **reasonable** assurance for this objective.

Objective 3: An appropriate governance framework is in place to provide oversight of quality and safety issues within the Trust, ensuring key risks and issues are reported and escalated where necessary.

2.25 There is a Quality Management Group (QMG), chaired by the Senior Quality Governance Lead, whose role includes assisting in embedding an effective quality management system across the Trust. The QMG's terms of reference have been recently reviewed and submitted to the Clinical Quality Governance Group (CQGG) for discussion (15 August 2024) who has oversight of the Group. The amended terms of reference were due to be presented for approval at the next meeting (September 2024).

2.26 The meetings have a different area of focus each week rotating between Emergency Medical Service (EMS), Ambulance Care, Integrated Care, and Resourcing and Corporate Services. Review of three QMG meetings held during July 2024 confirmed that they are well managed as both the action and decision logs are updated following each meeting and Alert, Advise, Assure (AAA) reports have been regularly submitted to the CQGG. Improvement is needed as there were several verbal updates rather than written reports provided. However, we note that arrangements are embedding, and this has already been identified as an improvement area by the Chair, therefore we are not raising a recommendation.

2.27 The Senior Quality Governance Lead also attends the QPMF Steering Group, which has oversight over the Framework. The Group is chaired by the Director of Strategy, Planning & Performance, but also includes other executive representation as both the Executive Director of Quality & Nursing and the Board Secretary attend the monthly meetings as well as relevant assistant directors. Their terms of reference have been reviewed and approved by ELT (22 May 2024), who has oversight of the Steering Group.

2.28 While an action log was maintained and written reports supplied for agenda items at the QPMF Steering Group, enhancements are needed to the administration of these meetings. Reporting to ELT (22 May 2024) noted that meetings have been cancelled several times in recent months and that quoracy has been an issue so decisions cannot be made; and the decision log has not been populated (see **Matter Arising 3**), which we understand forms part of a wider issue within the Trust.

2.29 Terms of reference for the Steering Group require that AAA reports should be submitted to ELT on a monthly basis, but the process has not yet embedded. For the period January to August 2024, reporting had been undertaken for March and April (to the May Steering Group); and June and July (to the August meeting). We note that January's meeting was cancelled, but there was no AAA report submitted following the February or May meetings; and AAA reporting for March does not detail the attendance of members to confirm quoracy (see **Matter Arising 3**).

2.30 Similarly, there has been a lack of oversight of the Framework's implementation at committee level (see **Matter Arising 3**). When the Framework was originally approved by Trust Board (22 March 2022), it was recommended that there would be annual reporting of the Framework and the Steering Group's work. While there was initial reporting to FPC (14 November 2022), the governance arrangements were revised to ARAC overseeing the Framework's implementation, with FPC to have oversight of its effectiveness following implementation. The Steering Group's terms of reference was amended to reflect this detailing that they will receive regular reporting on the implementation of the Framework.

2.31 ARAC's cycle of business details that it will receive bi-annual reporting of the Framework. However, there has been minimal reporting with ARAC receiving a verbal update in November 2023; and a written report in September 2024 (following a deferral from the March 2024 meeting) providing an update on progress with the delivery of the Framework and the associated work programme.

2.32 As per para 2.6, it has been recognised that further enhancements to the wider governance arrangements within the Trust are required particularly with operational governance. An integrated governance map, mapped to the Framework's objectives, is being developed, which includes principles that aim to ensure there is effective oversight and accountability across its meetings; provide clarity over roles and responsibilities; and improve the administration of meetings.

2.33 Audit Wales identified in its review of '*Quality Governance Arrangements'* (August 2022) (see paragraph 1.3) that while the QuESt Committee is well served with

quality information, there were opportunities for improvement, e.g. develop a system to triangulate learning themes across its quality assurance reports, develop patient outcome measures to support its existing quality measures, etc.

2.34 Their Structured Assessment (November 2023) detailed that the Trust is focussing on service quality, with good committee oversight. This included QuESt continuing to appropriately review key quality information, focussing on the high level of risk of patient harm, applying constructive challenge, and is escalating concerns such as these to the Board.

2.35 There has been regular reporting to ensure that senior management, committees and the Trust Board receive information on quality and patient safety including updates to QuESt on the Quality Strategy, Duty of Quality, and Duty of Candour implementation, MIQPR reporting (see paragraph 2.22), and annual reporting of the Duty of Quality. There is a specific paper that the Chief Executive Officer presents to each Board meeting, which the Trust is considering refreshing, that includes quality and performance information by directorate.

2.36 The Trust Board and committees regularly focus on their highest rated risks 223 (the Trust’s inability to reach patients in the community causing patient harm and death) and 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). The risk score remains at 25 due to the sustained and extreme pressure that is negatively impacting on patient flow and leading to avoidable patient harm and death. Further mitigations of these risks have been undertaken, but there is recognition that there are areas that are not under the Trust’s control and therefore, an ambition to consider these risks differently in terms of how they are managed.

Conclusion:

2.37 Noting that arrangements are continuing to embed, there is currently a lack of oversight over the implementation of the Framework and the administration of the Steering Group meetings needs enhancing to confirm decisions made and ensure there is prompt escalation of key risks and issues to ELT. However, there is regular monitoring and reporting on wider quality and safety issues, including through QMG. Further developments are planned to strengthen existing structures with the implementation of integrated governance and the changes to the management of the Trust’s highest scoring risks in relation to patient harm. Therefore, we assign this objective **reasonable** assurance.

Appendix A: Management Action Plan

Matter Arising 1: Framework Delivery (Design)	Impact
Work Programme: A work programme was developed to provide focus on the delivery of actions in line with the Quality & Performance Management Framework. Progress with implementing the actions has been impacted by capacity issues: • Of the 18 actions detailed on the latest version (29 August 2024), 11% of actions have been completed; 36% of actions have missed their original timescale for completion; and 21% of actions did not detail a defined timeframe, e.g. 'continuous' or 'dependent on learning'. • While the latest version of the work programme (29 August 2024) has been updated to include revised timeframes, it does not fully capture the length of time it has taken to implement improvement actions. • The actions would also benefit from a review to confirm that they have the correct status (actions in relation to OR3, OR6 and OR10 were shown as 'complete' on an earlier version of the work programme but have now been re-opened), or whether new actions should be created for further enhancements to be made. • The Framework details that the work programme will be reported to ELT and Finance & Performance Committee. While ELT received a copy of the work programme (22 May 2024) and there was reporting to ARAC (12 September 2024), there have not been regular updates on the progress with delivery. **Local Frameworks:** Capacity issues have also impacted the development of the process for local frameworks, e.g. the design of the framework and what should be incorporated within it and determining how many self-assessments will be required within the Trust. The Resource Service pathfinder's work programme did not always clearly define the timescales for implementing actions.	Potential risk of: • Performance is not effectively monitored or reported impacting on the Trust's quality of services and patient outcomes and delivery of the Quality & Performance Management Framework.

Recommendations		Priority
1.1	The Quality & Performance Management Framework's work programme should be reviewed and incorporate SMART criteria to define success and provide realistic timescales for delivery. Similarly, any work programmes that are designed to support the pathfinder, e.g. Resource Service, should provide realistic timescales for delivery.	**High**

1.2	Regular performance reporting should provide effective oversight of progress with the delivery of the QPMF's work programme that clearly defines risks and enables prompt action to be taken where issues are escalated.		
1.3	The development of the process for local frameworks should be concluded and incorporate the areas of the Trust that will require a framework to be implemented; and take account of the design and content of the frameworks through providing guidance and templates.		
Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	The current work programme has recently been reviewed, including amendments based on IA feedback during the audit. It continues to be reported into Q&PMF Steering Group each month. Timescales are considered realistic, but subject to on-going performance management. An annual review will also be undertaken, with time-out in December programmed to start to build programme for 2025/26.	November 2024 March 2025	Assistant Director, Commissioning & Performance
1.2	ELT to be supplied with AAA after every Q&PMF Steering Group, with the AAA including progress on the work programme.	March 2025	Assistant Director, Commissioning & Performance
1.3	The Trust is not planning to develop local frameworks for every area of the Trust. The approach is proportionate. Every area is required to complete a self-assessment, governance map, cycle of quality & performance business and work programme. Timetable to be developed to ensure completion across Trust.	December 2024	Assistant Director, Commissioning & Performance

Matter Arising 2: Communication Plan (Design)	Impact
A Communication Plan (June 2024) has been developed to ensure there is regular engagement of the Framework. The Plan details the progress with delivery of sixteen actions across six phases with 31% of actions completed (in Phases 1 and 2):	Potential risk of: • Opportunities to raise internal and external awareness may be missed.

	Actions Completed	Actions Paused	Actions on Target	Actions off Target	Status Unclear	Total
Phase 1 – Awareness of Framework	2	2	1	0	0	**5**
Phase 2 – Understand the Concept	3	0	1	0	1	**5**
Phase 3 – What Does it Mean to Me?	0	0	2	0	0	**2**
Phase 4 – Where to Find Information & Support	0	0	1	0	0	**1**
Phase 5 – How Framework Is Being Made to Happen	0	0	0	1	0	**1**
Phase 6: Importance of Framework	0	0	1	0	1	**2**

18% of actions detailed within the Plan, encompassing six phases, were either off target, had no status, or detailed 'to be discussed'. Some actions had timescales recorded as 'ongoing' or nothing recorded so it was unclear if deadlines for completing actions had been missed. Alert, Advise, Assure (AAA) reporting to the Executive Leadership Team (ELT) (14 August 2024) detailed the delivery of actions had been mainly within Phase 1 (Awareness of Framework), but focus was now required on the later phases (12 of the 16 actions contained within the Plan were for Phases 1-3).

Recommendations		Priority
2.1	The Communication Plan's action plan should be revised to include additional actions pertaining to the later phases. SMART criteria should be incorporated to clarify the current status of actions and provide realistic timescales for delivery.	**Medium**
2.2	Following the amendments, the plan should be shared at an appropriate forum and appropriate staff engagement should be carried out to ensure that arrangements continue to be embedded.	

Agreed Management Action		Target Date	Responsible Officer
2.1	Communications Plan to be updated accordingly.	December 2024	Assistant Director, Commissioning & Performance
2.2	Q&PMF Steering Group will approve the communications plan.	December 2024	Assistant Director, Commissioning & Performance

<table>
<tr><th>Matter Arising 3: Governance Arrangements (Operation)</th><th>Impact</th></tr>
<tr><td>
There has been a lack of oversight of the Framework's implementation and the work of the QPMF's Steering Group to both committees and the Executive Leadership Team (ELT).
<u>Reporting to Committee:</u>
When the Framework was originally approved by Trust Board (22 March 2022), it was recommended that the Finance & Performance Committee (FPC) receive a six-month update on the Framework and a short annual report. A written report was presented to the FPC (14 November 2022) providing a six-month update of progress.
A verbal update was provided at FPC (15 May 2023) advising that as the QPMF was a framework for assurance, it would be more appropriate for it to be reviewed and endorsed by the Audit, Risk & Assurance Committee (ARAC). The FPC would continue to monitor performance; however, the ARAC will oversee the implementation of the Framework. Subsequently, a verbal update was provided to ARAC (30 November 2023), and a written report was also supplied (12 September 2024) providing an update on the work of the Steering Group, their Terms of Reference, and progress with the work programme.
Clarity of both the FPC's and ARAC's role for the Framework was provided to FPC (19 March 2024) by the Board Secretary. ARAC's cycle of business confirms that reporting of the Framework will be bi-annual but notes that it was agreed that an update on the Framework was not required for the March 2024 meeting.
<u>Reporting to ELT:</u>
Terms of reference for the QPMF's Steering Group require that Alert, Advise and Assure (AAA) reports should be submitted to ELT after each meeting, but this has been done intermittently, e.g. there were no AAA reports prepared following the Steering Group's February and May 2024 meetings; delays in AAA reporting to ELT following the Steering Group's March and June 2024 meetings; and the attendance at Steering Group is not always recorded (March 2024). This would assist in monitoring quoracy which has been highlighted as an issue in AAA reporting to ELT.
Administration of the Steering Group meetings could be further enhanced by ensuring that the decision log is populated and formulating the arrangements for formally reviewing the Framework.
</td><td>
Potential risk of:
Unclear roles and responsibilities or ineffective reporting could result in poor decision making and a lack of accountability and oversight.
</td></tr>
</table>

Recommendations		Priority
3.1	There should be regular reporting to both the Executive Leadership Team and at committee level to ensure there is effective oversight of the Quality & Performance Management Framework.	**Medium**
3.2	Attendance and key decisions arising from the QPMF Steering Group meetings should be appropriately recorded.	
3.3	Both the Framework and the Steering Group's terms of reference should be updated to clarify arrangements or reflect any amendments.	

Agreed Management Action		Target Date	Responsible Officer
3.1	Production of AAA after each Q&PMF Steering Group and onward supply to ELT. It has been agreed by ARAC that one further update will be provided this financial year and thereafter 6 monthly reports to FPC.	November 2024	Assistant Director, Commissioning & Performance
3.2	The AAA does record attendance, but production of the AAA to date has been intermittent. See 3.1 above.	March 2025	Assistant Director, Commissioning & Performance
3.3	The ToR has been through several iterations and updates and is considered up to date, however, there is a F2F Q&PMF workshop planned for Dec-24, which will provide a further opportunity for review. Going forward the review will be at least annually.	March 2025	Executive Director of Strategy, Planning & Performance

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
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Overtime Controls

Final Internal Audit Report

November 2024

Welsh Ambulance Services University NHS Trust

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Review reference:	WAST-2425-10
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Management response received:	1 November 2024
Final report issued:	5 November 2024
Auditors:	Osian Lloyd, Head of Internal Audit; Felicity Quance, Deputy Head of Internal Audit; Henry Wellesley, Audit Manager
Executive sign-off:	Lee Brooks, Executive Director of Operations
Distribution:	Chris Turley, Executive Director of Finance & Corporate Culture; Angela Lewis, Director of People & Culture; Judith Bryce, Assistant Director of Operations & Support; Jonathan Edwards, Assistant Director of Operations; Liz Wedley, Head of Service
Committee:	Audit, Risk & Assurance Committee

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

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

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Executive Summary

Purpose

To provide assurance on the adequacy of the processes in place to control and monitor the level of overtime allocation, in line with the Trust's Financial Savings Plan.

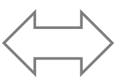
Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- Review of the communication of the overtime allocation amendments; and
- Consideration of an automated process in the payment of overtime.

Report Opinion

		Trend
Reasonable	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.	 2016/17

Assurance summary[1]

	Objectives	Assurance
1	Processes and procedures	Reasonable
2	Determination and authorisation of overtime allocations	Reasonable
3	Overtime payments	Reasonable
4	Reporting and monitoring	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
1	Overtime allocation amendments	2	Operation	Medium
2	Overtime payment process	4	Design	Medium

1. Introduction

1.1 The Welsh Ambulance Services University NHS Trust's (the Trust) Operations Directorate has a Standard Operating Procedure in place for 'Overtime Allocation'. As stated in this procedure, *the Operations Directorate receives a set annual budget to support the provision of overtime allocation. The allocation of overtime within Emergency Medical Services (EMS) (managerial and clinical) may be called upon to support a safe level of service provision for patient/scene response, clinical outcomes, and patient experience.*

1.2 It is vital that a clear and robust process is adopted for the allocation of overtime to ensure that overtime spending remains within budget.

1.3 The Trust's Financial Savings Group has worked to identify the Operations Directorate's contribution to the Trust's broader savings target. In June 2023, an Operations Directorate Official Notice was published which detailed that *…there must be controls of overtime spending. Overtime allocations have been provided to each Health Board area of EMS in a targeted approach determined by the needs of the service, and within the available financial envelope*.

1.4 Embedding a transformative savings plan and regular reviews of savings targets are included as key controls to manage the following major risk (139), "*Failure to Deliver our Statutory Financial Duties in accordance with legislation*" detailed within the Corporate Risk Register.

1.5 The potential risks considered as part of this review were as follows:

- Financial loss due to unnecessary usage or incorrect payment of overtime;
- Staff are working unsafe and unsustainable hours which could affect their wellbeing and/or lead to patient harm; and
- Failure to achieve planned savings.

1.6 This audit only covers planned overtime and did not include within its scope a review of unplanned overtime such as overruns, for example where ambulance staff are delayed by patient handover.

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
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.

Objective 1: Documented processes and procedures are in place for the allocation and authorising overtime.

2.3 The Trust has a Resourcing Policy, which is dated 2014, and provides guidance on the methodology for approval of overtime. The detail of this policy is subject to a separate audit and we will not replicate the recommendation regarding the need for review/update at this report.

2.4 In March 2024, the Operations Directorate put in place an Overtime Allocation Standard Operation Procedure (SOP), following a pilot of the operations between July 2023 to March 2024. The purpose of the SOP is to provide assurance that a robust and financially viable process is in place for the allocation of overtime within budget. It was sent to senior managers on 6 March 2024, to be disseminated to locality managers who would operate the SOP.

2.5 The SOP currently relates only to the overtime allocation for Emergency Medical Services (EMS) within the Operations Directorate and describes the process that all localities within each Service area of EMS must follow, to enable the allocation of overtime within the allocated financial envelope.

Conclusion:

2.6 The Trust's Resourcing Policy includes overtime; however, it has not been reviewed in the last ten years. There is a SOP in place which details the procedures for allocating overtime within EMS of the Operations Directorate, which has been issued to senior managers. However, this has only been recently introduced and will take time to mature. Therefore, we have provided **reasonable** assurance in this area.

Objective 2: Overtime allocations are appropriately determined and authorised; and are considerate of the savings targets applied.

2.7 As per para 2.5, a clear process for the allocation of overtime was developed for use by EMS from 2024/25.

2.8 The SOP lays out the process for the annual allocation of overtime and the end of month review process in-year. Overtime allocations are provided to each Health Board area of EMS in a targeted approach determined by the needs of the service, and within the available financial envelope; which is £2.4m in 2024/25. The EMS Head of Service lead, works closely with the finance and resourcing leads to determine the initial monthly overtime budget profile (see paras 2.25 and 2.26), for the forthcoming financial year:

- To support setting the overtime budget, a recruitment plan (including vacancy numbers) for the whole financial year is provided by the Workforce Transformation and Planning Business Partner as this has a direct impact on the financial envelope.
- The Resourcing Manager provides information to determine the historic abstractions and production (UHP) in each area, which is combined with known seasonal implications i.e. abstractions go up in July and December, experience of likelihood of overtime being taken, additional demand forecast around events and key dates.

2.9 This information, combined with the number of current staff vacancies by Health Board area, is used to provide intelligence to plan the overtime allocation for each area, from the overall budget, on a month-by-month basis.

2.10 Each month the Head of Service of EMS along with the Resourcing Manager and Senior Finance Partner conducts a review of overtime allocation, in order to determine the underspend or overspend of previous month's overtime allocation. Justification is determined for any variance, and the balance is brought forward to adjust individual Health Board area allowances to ensure the planned overtime remains within budget.

2.11 A spreadsheet is maintained which is updated each month with the allocated overtime, versus used allowance across the seven Health Board localities and is used to inform the individual Health Board overtime allocation percentage for the following month. The breakdown in the following three tables details the allocation, as budgeted for at the start of the year, for April, May and June 2024, across the seven areas:

Apr-24	per day	557	30	Per month	16710
Health Board	**OT Allocation %**	**OT Hour Month**	**OT Weekly Hours**	**Shifts Per Week**	**Shifts Per Day**
BCU	38%	6,349.80	1,481.62	129	18
Powys	15%	2,506.50	584.85	51	7
C&V	9%	1,503.90	350.91	31	4
AB	9%	1,503.90	350.91	31	4
CTM	9%	1,503.90	350.91	31	4
SB	9%	1,503.90	350.91	31	4
HD	11%	1,838.10	428.89	37	5
	100%	16,710.00	3,899.00	339	48

	Mav'24	per day	557	30	Per month	16710
Health Board		OT Allocation %	OT Hour Month	OT Weekly Hours	Shifts Per Week	Shifts Per Day
BCU		38%	6,349.80	1,481.62	129	18
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SB		9%	1,503.90	350.91	31	4
HD		11%	1,838.10	428.89	37	5
		100%	16,710.00	3,899.00	339	48

change the percentage attributed the hours will update					20.05.2024
Jun-24	per day	685	30	Per month	20550
Health Board	OT Allocation %	OT Hour Month	OT Weekly Hours	Shifts Per Week	Shifts Per Day
BCU	30%	6,165.00	1,438.50	125	18
Powys	15%	3,082.50	719.25	63	9
C&V	11%	2,260.50	527.45	46	7
AB	10%	2,055.00	479.50	42	6
CTM	11%	2,260.50	527.45	46	7
SB	10%	2,055.00	479.50	42	6
HD	13%	2,671.50	623.35	54	8
	100%	20,550.00	4,795.00	417	60

2.12 Post the monthly meetings, Heads of Service and Service Managers are provided with an updated allocation, for the following month. Review of these updates noted such doesn't detail the rationale for the changes to the initial budget i.e. additional allocation to achieve a certain UHP level, help manage vacancies or higher sickness absence rates in another area, support required for a large event. See **Matter Arising 1**

2.13 A review of the allocation spreadsheet up to July showed that whilst overall usage across the seven areas balanced with the allocated (budgeted hours), some areas were considerably over their allocated hours these are summarised below:

Table 1: Overtime hours against allocation

Health Board Area	Allocated Hours (Apr – Jun) [1]	Hours used	Variance	Variance %
Betsi Cadwaladr	14,838.00	15,250.25	(587.01)	(4%)
Hywel Dda	4,949.12	7,275.90	(2,249.38)	(45.5%)
Swansea Bay	4,620.82	5,043.50	(422.68)	(9%)
Powys	5,927.58	3,987.25	1,940.33	32.7%
Aneurin Bevan	3,990.15	3,060.25	929.89	23.3%
Cardiff & Vale	3,990.14	3,831.00	159.14	4%

Health Board Area	Allocated Hours (Apr – Jun) [1]	Hours used	Variance	Variance %
Cwm Taf Morgannwg	4,460.96	4,231.00	229.96	5.2%
Total			**0.25**	

[1] The allocated hours are different than those the tables in para 2.8, as the May and June allocation was amended as per the SOP, to reflect changing intelligence.

2.14 The allocation process includes an additional contingency of 10% which is unallocated, but can be drawn on by Heads of Service or Service Managers if facing any specific challenges, to mitigate any in month overspend. This meant that when the Pan Wales position was balanced for the period April to June, the contingency budget/allocation remained untouched and overall savings where overachieved in the first quarter. From review of the monthly overtime allocation updates, there was no indication of consideration for amendments to address the locality variances. See **Matter Arising 1**.

2.15 We also reviewed the systems in place to ensure compliance with Working Time Regulations. The Global Resource System (GRS) has reports in place to identify breaches in addition to an alter in the system should there be an attempt to allocate a shift to a member of EMS which would cause a breach i.e. if there was a lack of an 11-hour break between shifts. However, we note that the reporting functionality of the system is not routinely used – the detail of which has been addressed within a separate review (see para 2.3) and we will not seek to replicate the recommendation at this report.

Conclusion:

2.16 Whilst some of the variances of overtime used versus allocated overtime in some areas was significant, overtime allocations were found to be appropriately determined and were reviewed in consultation with Heads of Service and Service Managers. Allocations were recalculated each month, based on the process outlined in the SOP, and where necessary allocations were transferred between areas. However, there was minimal documentation to support the rationale for these amendments. We have therefore determined **reasonable assurance** in this area.

Objective 3: Overtime is appropriately paid at the correct rate.

2.17 Where the SOP applies, the process followed requires locality managers to prioritise shifts and for these shifts to be made available via the Trust's Global Resourcing System (GRS) ten days in advance. Staff have access to the GRS system and can volunteer to fill shifts. If shifts have not being filled, Resourcing will send a blanket text out to staff to ask for volunteers.

2.18 The Emergency Medical Technicians (EMT) workforce is band 4 and Paramedics are typically a band 6. These shifts are described as emergency ambulance shifts and can be undertaken by either, when the opportunity arises. Despite the difference in banding (4 & 6) any overtime undertaken is paid at the individual's band; and

this has been confirmed through sample testing undertaken at this review (see para 2.18).

2.19 Band 7 staff, such as Duty Operations Managers and more Senior Paramedics, can undertake overtime at their own roles and attract overtime at the same pay grade. However, as these groups of staff are also clinicians (i.e., EMTs and paramedics) they can also undertake overtime at their respective clinical grade, but will only be paid at the clinical grade that they work. To allow these staff to work overtime as clinicians and to attract the correct rate of pay, they are issued with secondary assignment numbers. There overtime timesheet for the clinician grade will be against their secondary assignment number.

2.20 Band 8's and above cannot attract overtime at their substantive grade. However, as described above, a large number of these managers are also clinicians, so if they desire, they are able to undertake overtime at their clinician grade, using a secondary assignment number.

2.21 To establish if overtime had been paid at the correct rates, we tested a sample of 20 employment payments between March and July 2024 across the Operations Directorate, which were largely focused on EMS. Each payment was checked to confirm:

- the Salary Return Spreadsheet sent to Payroll matched the timesheet;
- the overtime payment was made within the correct Agenda for Change range of rates; and
- timesheets were authorised.

2.22 In one instance, it was identified that an employee had not been paid at the enhanced overtime rate for the full shift. It was also noted that a member of clinical contact centre staff was working a grade higher in their bank role, however, such had been approved.

2.23 Through completion of our testing, it was noted that the process is largely manual, from paper timesheets which need to be checked and input into spreadsheet payroll returns, which are then keyed into the payroll system. It was observed that the level of manual input is time intensive and increases the risk of error, although it is acknowledged that it would require considerable resource to automate the system **(Matter Arising 2)**.

Conclusion:

2.24 Testing has confirmed that overtime was authorised, timesheets match the payroll returns sent to Payroll and matched the payments made, with one minor exception noted. The process is very manual and time consuming, and we recognise that it would require significant development to become more automated. We have therefore provided **reasonable assurance** in this area.

Objective 4: Appropriate, accurate and timely reports on overtime are produced and distributed to budget holders and other relevant groups or committees within the Trust, and are subject to effective scrutiny with actions taken where required.

2.25 We were able to confirm that there is a reporting framework in place within the Operations Directorate. The framework includes monthly updates to Heads of Service, and quarterly updates to the Senior Operations Team and SLT. From SLT reporting goes to the People and Culture and the Finance & Performance Committees.

2.26 The Head of Service lead produces an annual profile report, that is presented to Senior Operations Team (SOT) and ratified by the Senior Operations Team (SLT). For 2024/25, this was completed in April 2024. There is subsequent quarterly reporting to SOT and SLT to detail the overtime usage for the previous quarter, including analysis against budget, and to highlight the overtime allocation position for the following quarter.

2.27 In addition to the quarterly updates, there are monthly updates to Heads of Service (see para 2.10).

2.28 Narrative updates from SLT are provided to both the People & Culture Committee and the Finance & Performance Committee. We note an action was raised at the January Finance and Performance Committee to seek assurance that the overtime reduction in EMS was not exacerbating the problem of system pressures and ambulance delays, i.e. impacting the capacity and ability to respond to emergency requests. We note the response provided stated that '*the Operations Directorate review Unit Hours Production (UHP) on a daily and weekly basis and the overtime reductions during that period were focused and more efficient in that the need for overtime was monitored and efforts were focused on maintaining a good UHP'.* However, as per **Matter Arising 1**, there is scope to better demonstrate the linkage as the thought process/rationale isn't documented clearly at present.

Conclusion:

2.29 Appropriate, accurate and timely reports on overtime are produced and distributed to budget holders, the Senior Operations Team, the Strategic Leadership Team and to Board-level committee. However, there is scope to better demonstrate the linkage of the review of hours with the rationale being applied to amendments in overtime allocation. Accordingly, **reasonable assurance** has been determined.

Appendix A: Management Action Plan

<table>
<tr><th colspan="3">Matter Arising 1: Allocation amendments (Operation)</th><th>Impact</th></tr>
<tr><td colspan="3">Overtime allocations are updated on a monthly basis, with details of the updates communicated to the Heads of Services and Service Managers.

The detail provided is quantitative, with minimal qualitative information provided regarding the changes to the initial budget i.e. additional allocation to achieve a certain UHP level, help manage vacancies or higher sickness absence rates in another area, support required for a large event.

Further, whilst recognising the variances of actual vs allocated balances pan Wales was balanced, there was no indication of consideration for amendments to address the individual locality variances – Hywel Dda being the most significant at 45.5% for the period April to June 2024.</td><td>Potential risk of:
• Inefficient use of resources.</td></tr>
<tr><th colspan="3">Recommendations</th><th>Priority</th></tr>
<tr><td>1.1</td><td colspan="2">The reporting of amendments to overtime allocations should be strengthened and supported by a documented audit trail of the rationale applied.</td><td rowspan="2">Medium</td></tr>
<tr><td>1.2</td><td colspan="2">Recognising the individual variances, against allocations reported at health board areas, consideration should be given to their re-mapping to a more reasonable expectation.</td></tr>
<tr><th colspan="2">Agreed Management Action</th><th>Target Date</th><th>Responsible Officer</th></tr>
<tr><td>1.1</td><td>SOT will consider and agree a formal mechanism to capture any changes to allocations in month. This will be recorded at SLT and documented through the AAA reporting process to SLT.</td><td>December 2024</td><td rowspan="2">Liz Wedley, Head of Service</td></tr>
<tr><td>1.2</td><td>SOT will review and reassess the overtime allocation at Health Board levels, recognising the variable nature of all that may affect allocations.</td><td>March 2024</td></tr>
</table>

<table>
<tr><th colspan="3">Matter Arising 2: Overtime payment process (Design)</th><th>Impact</th></tr>
<tr><td colspan="3">In the 20 payments checked we identified one, non-material, payment which was not at the correct rate.

However, from review of the process undertaken, it was noted that the system is largely manual, from paper timesheets which need to be checked and inputted into spreadsheet payroll returns, which are then keyed into the payroll system. It was observed that the level of manual input is time intensive and increases the risk off error, although it is acknowledged that it would require considerable resource to automate the system</td><td>Potential risk of:
• Increased risk of error.
• Inefficient use of resources.</td></tr>
<tr><th colspan="3">Recommendations</th><th>Priority</th></tr>
<tr><td>2.1</td><td colspan="2">Consideration should be given to whether it would be possible to automate parts of the process, to reduce the amount of manual input by managers.</td><td>Medium</td></tr>
<tr><th colspan="2">Agreed Management Action</th><th>Target Date</th><th>Responsible Officer</th></tr>
<tr><td>2.1</td><td>The Trust accepts this recommendation. Electronic timesheet development and implementation is a feature of the current IMTP. Scope work has begun in this financial year, however progress on implementation is expected to be in 2025/26 provided it is included in the forthcoming IMTP.</td><td>March 2026</td><td>Jon Edwards, Assistant Director Operations</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:

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Prioritisation of Recommendations

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

Priority level	Explanation	Management action
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Data Quality

Internal Audit Report

October 2024

Welsh Ambulance Services University NHS Trust

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Executive sign-off:	Jonny Sammut, Director of Digital
Distribution:	Leanne Smith, Assistant Director of Digital Services: Data & Analytics; Jon Hopkins, Head of Information
Committee:	Audit, Risk & Assurance Committee

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

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Executive Summary

Purpose

To review the structures and processes for ensuring data quality and accurate reporting within the Trust.

Overview

We have issued **reasonable** assurance on this area. Overall, the Trust recognises the criticality of data quality and its commitment to improve is highlighted in the recently refreshed Digital Strategy and Data Quality Policy.

The focus within the Trust, due to capacity, has been on the EMS CAD system, which is the main driver of national reporting, however, there is recognition that there is a need to strengthen data quality processes and controls across the other data sets and systems.

The Trust is forging a good data culture through its quality assurance processes, however, the matters requiring management attention below are aimed at strengthening current position:

- Out-of-date policies and guidance;
- Lack of assessment of staff digital literacy skills, and data quality specific training;
- Incomplete Information Asset Register; and
- Improvements required in respect of data quality assurance reporting.

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

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	Data quality guidance	Reasonable
2	Quality assurance checks	Reasonable
3	Monitoring and reporting	Limited

[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
1	Policies & Guidance	1	Operation	Medium
2	Data Quality Training	1	Design	Medium
3	Information Asset Register	2	Operation	High
4	Data Quality Reporting	3	Operation	High

1. Introduction

1.1 The Welsh Ambulance Services University NHS Trust (the Trust) recognises the importance of data being of sufficient quality to enable robust decision making. High quality data is important to any organisation. Within the NHS it can lead to improvements in patient care and patient safety. 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. Data quality measures how well suited a dataset is to serve its specific purpose, with measures of data quality being based on characteristics such as accuracy, completeness, consistency, validity, timeliness and precision.

1.2 The Trust uses a variety of data types, with processes being different for each. The key data types that the audit seeks to provide assurance over are:

- Data warehouse layer;
- Reporting and Dashboarding layer; and
- Manual data points.

1.3 The potential risks considered as part of this review were as follows:

- poor decision making;
- failure to achieve performance measures and organisational objectives;
- patient harm; and
- exposure to financial loss and reputational damage.

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	5	2	9
Total	2	6	2	10

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

Objective 1: Guidance is in place that sets out the requirements and responsibilities for data quality across the Trust.

2.3 To provide the very best patient-centric care, the importance of data quality cannot be overstated. Informed decision-making, precise diagnostics, and personalised patient care heavily rely on reliable data. Data quality assurance encompasses a set of practices aimed at enhancing data accuracy, completeness, and consistency.

During the course of our review, we interviewed a number of individuals - mainly from the Digital Team, and we positively note that the importance of data quality is well understood, and proactive efforts are being made to identify and correct data quality issues as they arise. The Trust's recognition of the criticality of data quality and its commitment to improve is highlighted in the recently refreshed Digital Strategy and Data Quality Policy.

2.4 In July 2024, the Board approved the updated Digital Strategy, which commits to enhancing the data quality provision and assurance strategy under one of the five identified key pillars; Data, Information and Insight. In May 2024, the Trust approved the revised Data Quality Policy which sets out the framework for the management of and accountability for data quality, with a commitment to secure a culture of high data quality throughout the organisation.

2.5 The Policy sets out the definitions for the key data quality characteristics (Validity, Completeness, Consistency, Precision, Accuracy and Timeliness), and during the course of our review we have considered how each characteristic is assured.

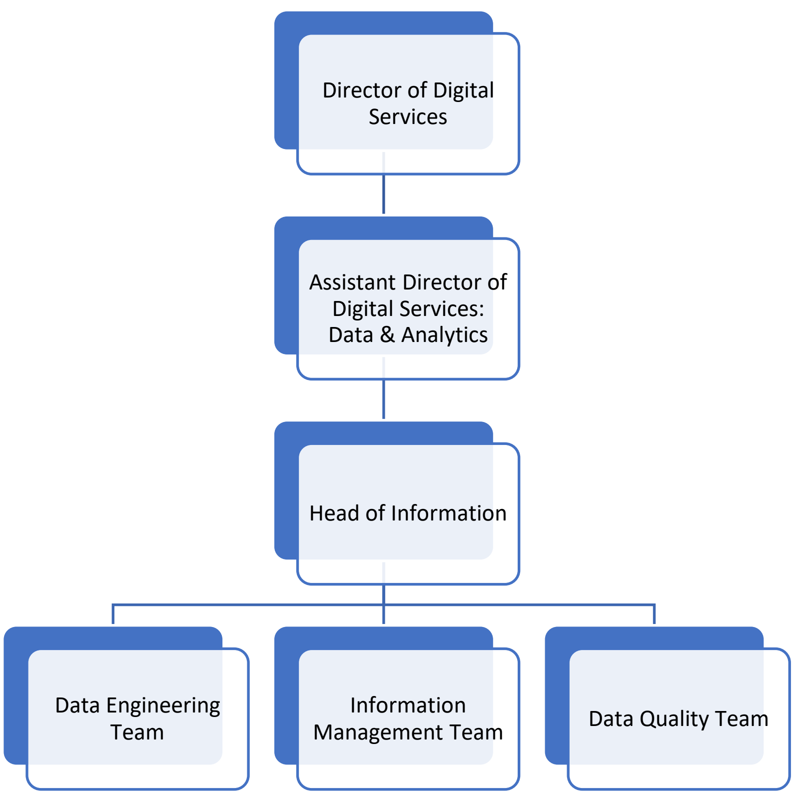
2.6 The Data Quality Policy states that it is underpinned by a suite of legislation and guidance, however, our review noted that some of these policies are out of date including:

- Information Governance (IG) Policy, due for review October 2021.
- Records Management Policy, due for review October 2021.
- Freedom Of Information (FOI) Policy is still in development.

2.7 We further note that the Trust's policies are not published on their website. Whilst the Trust's Publication Scheme was updated in April 2024 and notes under *Data Protection, Records Management and Caldicott Guardian,* that policies relating to Information Security, Data Protection, Records Management and Confidentiality Code of Conduct are available on request to the FOI Team, they should be published on the Trust's website as per the Information Commissioner's Office's Model Publication Scheme. **See Matter Arising 1 at Appendix A**.

2.8 Within the Trust, data quality is considered under the wider umbrella of Information Governance. The Data Quality Policy sets out the Trust-wide expected roles and responsibilities and notes that the Data Quality Lead and Head of Information will regularly monitor to ensure that measures to control data quality risks are being fully implemented and remain effective. This includes the regular and continual review of exception reporting and liaising with other Trust services.

2.9 The Trust's Data Quality Team is part of the wider Health Informatics (HI) Directorate as depicted below.



2.10 The breakdown of the HI teams is as follows:

- five engineers within the Data Engineering Team.
- eight analysts in total within the Information Management Team (IMT), 4 of which are ringfenced to other areas such as Power BI development, Ambulance Care, Medical and Clinical, and Joint Emergency Services Group. We were informed that recruitment of a further two HI analysts posts will begin imminently.
- 0.4 whole time equivalent (WTE) Data Quality Lead (DQL) within the Data Quality Team.

2.11 During the course of our review, we have noted that the Trust is data rich with many pools and silos. As established in detail under objective 2, the data collated to inform the Official Statistics submission to Welsh Government (WG), and Ambulance Service Indicators reportable to the NHS Wales Joint Commissioning Committee (JCC) are subject to rigorous data quality checks and assurance processes. However, due to the capacity of the HI team, in particular the Data Quality Team, scrutiny of other data sets is limited. Resource shortfalls within the Digital Directorate were highlighted as part of the recent Digital Plan Refresh process, and the Trust has recognised that it will need to address these gaps to ensure the successful implementation of the new Strategy.

2.12 Comprehensive guidance is in place within HI, such as step-by-step guides to completing the Official Statistics Report and a living document providing Technical Guidance on addressing data quality issues within the Emergency Medical Services Computer-Aided Dispatch System (EMS CAD). As the 111 system has recently

moved to the same provider as EMS CAD, the Data Quality Lead is looking to develop similar guidance. Whilst we would expect guidance in place for all systems used within the Trust, we have only focussed on a sample of systems due to capacity, for this review.

2.13 From our review of the data warehouse, which is noted in detail under objective 2, we observed that guidance documents in relation to the EMS CAD are out of date. The Data Engineering Team are aware, however, due to capacity constraints they have not been able to review and update. **See Matter Arising 1 at Appendix A**.

2.14 We noted that currently there is no specific training on data quality, however, it is touched upon within the mandatory IG training for all staff. As at March 2024, the compliance figure for this module was at 73.34%, which did not meet the 75% 'Minimum Expectations' compliance requirement. As of 1st April 2024, the minimum requirement has increased to 85% in line with Welsh Government recommendations. The Data Quality Policy has identified that training and awareness provision needs to be in place to make an explicit improvement, and states that the understanding of all staff and partners shall be assessed and appropriate training and guidance provided as necessary. As data quality is business critical, all staff should be explicitly made aware of its importance, how to follow acceptable standards of data quality throughout their everyday work and why what they do matters. We also note from our meetings with key contacts that the general digital literacy of operational staff could be improved, which would positively impact upon the quality of data at point of entry. We have established that is a common theme amongst other NHS Wales organisations. **See Matter Arising 2 at Appendix A.**

2.15 From meeting the Data Quality Lead, Principal Information Analyst and Principal Clinical Information Officer we noted that where data quality issues are found, training, guidance and support is offered to staff. Where persistent issues are found, processes are in place to escalate as appropriate. The EMS Coordination Systems Manager also sends out best practice bulletins with themes identified through investigations.

Conclusion:

2.16 The Trust recognises the importance of data quality and has recently refreshed its Digital Strategy and Data Quality Policy, however, some of the underpinning policies are out of date. We noted that there is limited capacity within Health Informatics, particularly the Data Quality and Data Engineering teams, to scrutinise all of the Trust's systems for data quality issues to the same level as the EMS CAD. Whilst data quality is touched upon in the mandatory IG training, it would be beneficial for all staff to have stand-alone training to ensure that they fully understand how and why data quality is business critical. Consequently, we have concluded **reasonable** assurance for this objective.

Objective 2: There are adequate quality assurance checks to ensure the data reported is complete, valid, timely, accurate, consistent and precise.

2.17 The HI teams manage data from various systems including telephony, EMS CAD, Electronic Patient Clinical Record (ePCR), 111 Clinical Assessment Service (CAS), Emergency Communication Nurse System (ECNS), Cleric (Ambulance Care), select ESR, the Trust website, Datix, Global Rostering System (GRS), and internal web applications. We were informed that there are other data silos in Finance, Estates, Fleet, Wiin (Innovation Network), ICT, and vehicle Mobile Data Terminal, among others. The Trust recognises that it does not hold a complete central record of all its data sources. Whilst we understand that an Information Asset Register is in existence, we were not provided with a copy but were informed that it is incomplete. **See Matter Arising 3 at Appendix A.**

2.18 Data quality assurance encompasses a set of practices aimed at enhancing the data characteristics defined under objective 1: completeness, validity, timeliness, accuracy, consistency and precision. We positively note that good communication is used as a tool between teams to collectively resolve data quality issues, and we noted enthusiasm for continuous improvement from key contacts interviewed.

2.19 Our approach to this review was to examine three data types; manual entry, data warehouse, and dashboard and reporting, to establish the quality assurance processes in place. We selected the ePCR and EMS CAD systems and reviewed their data layers. We further looked at the known silo of data within the Fleet Department to understand how their data quality is assured.

Fleet Data

2.20 The Fleet Department predominantly use a Fleet Management Tool called Chevin FleetWave. Data quality is mainly enforced through validation at the point of entry. The system has been developed to avoid the use of free text fields and uses mandatory fields. Data entry is mostly limited to predefined lists of acceptable values, implemented using dropdown lists or tick boxes, which is considered data quality best practice.

Electronic Patient Clinical Record (ePCR)

2.21 TerraPACe ePCR is a software-based application and was deployed in the Trust in December 2021 to replace traditional handwritten notes. The application allows frontline emergency crews to manually record information on an iPad, enhancing the precision of data compared to the former DigiPen system, which also facilitates the sharing of real-time information with healthcare partners.

2.22 After an incident has been resolved, the ambulance crew member should close the ePCR record. Following closure, the data warehouse will pull the data from TerraPACe every hour. If the crew fails to close the record, it will stay open in the system. However, there are safeguards to ensure that it will automatically close after a maximum of 12 hours without activity. Due to the nature of incidents dealt with by ambulance crews, there are no mandatory fields within the application and data is not cleansed or transformed prior to data warehouse transfer. As records are required to be a true account, they become sealed records of care following

closure. Cleansing of source data is not performed for this reason, and a "lift and shift" approach is used to transfer data into the warehouse.

2.23 As noted in a previous audit of the ePCR Clinical Compliance (WAST-2324-008), a number of PowerBI dashboards have been developed, with bespoke user group access and refresh schedules. One dashboard in particular looks at ePCR compliance, with the purpose of monitoring staff interaction with the application and to improve data quality by highlighting areas that may require targeted guidance and / or training. The ePCR Compliance Dashboard is refreshed daily with a 2-day lag and monitors incident recording compliance such as whether crews have appropriately closed down the records, how many incidents have been auto-closed, whether crews have validated automatic Welsh Demographic Service (WDS) patient lookups and whether the closure page has been completed in full.

2.24 Whilst this review is not intended to be a follow-up of the previous audit, as part of our fieldwork we positively noted that a review of the dashboard's terms and nomenclature has been undertaken and additional clarifying information has been added as recommended, for example, references to 'total ePCRs' signifies the total number of crew-closed ePCRs.

2.25 We requested a data warehouse extract of ePCR data from 25 July 2024 - 30 July 2024 to undertake testing of the figures presented within the ePCR Compliance Dashboard and we can confirm that no issues were found, and our analysis concluded with the same information as presented. We further note that we observed steady improvement in compliance across all metrics since ePCR was implemented to the current average of approximately 85%. The dashboard is monitored by the Clinical Intelligence and Assurance Team (CIAT) and Clinical Information Assurance Group (CIAG).

2.26 CIAT monitor and review ePCR data for clinical purposes and will identify and flag any quality issues with the Records Team. As incidents cannot be amended following closure, the team will add an annotation to the record highlighting the issue. CIAT perform audits and deep dives of reportable Clinical Indicators such as patients presenting with fractured neck of femur (#NOF), Stroke, ST segment elevation myocardial infarction (STEMI), Hypoglycaemia, and Return of spontaneous circulation (ROSC) at hospital in Cardiac Arrest.

2.27 By adopting a deep dive approach, CIAT have identified that there are data quality issues within ePCR and as such, there has been an iterative approach to improving the user interface and system architecture through change requests, which are overseen by the ePCR Clinical Reference Group (CRG). Recent changes include field validation to restrict fields to defined acceptable values. For example, range limits have been deployed for observation fields such as pulse rates, respiratory rates and blood pressure.

2.28 Furthermore, a moderate risk with a current score of 8 was raised by CRG and recorded on Datix in August 2023 noting that '*poor awareness of the implications to ePCR Data Quality due to human factors and systematic issues could impact on secondary data use including the improvement of patient care.* The impact has been described as *sub-optimal ePCR data quality in terms of, Consistency,*

Accuracy, Timeliness, Efficiency, Validity and Completeness. This will impact on the ability to identify trends and patterns, draw comparisons, predict future outcomes and evaluate services. Consequently, risking missing opportunities to improve decision making and improve services.'

2.29 Current controls include extra assistance offered to staff who would like to improve their digital literacy and reminders are circulated on ePCR completion best practice. Barriers to data quality were stated as '*heavy workload, mobile workforce, lack of detailed information for specific secondary use and research, no standard terminology definitions, limited retrieval / reporting capabilities, large amounts of unstructured data, challenges with patient identification and matching, problems with data extraction and unfamiliar with data quality assessment.'* Whilst the risk has not been reviewed since November 2023, efforts to mitigate the risk and improve data quality have continued.

2.30 In June 2024 a new function (nudge tool) on the ePCR was activated to provide crew members with a reminder in the absence of important clinical information. This occurs at the point of closure, and the record cannot be closed until the information is recorded. We noted from the published Clinical Directorate Clinical Notice on 18 July 2024, that the function was tested for analgesia in #NOF. If crew members attempt to close a record without recording analgesia, a prompt appears reminding them to either do so or record a reason why they were unable to as a justified exception. The Clinical Notice states that compliance with documented analgesia for #NOF has improved and following positive feedback and successful testing, nudges for other areas of the ePCR will be implemented. Following implementation of the tool, the ePCR Compliance Approval Group (CAG) has been established to ensure that appropriate processes and governance are in place for the approval of internally managed changes resulting from utilising the 'at point of ePCR closure' capability. The CAG is responsible for the approval, monitoring and reporting for the effectiveness of the changes, and for the cessation of implemented changes as required. Activity to improve data quality in a system-wide approach is ongoing.

2.31 Whilst we have noted the issues with data quality, these have been acknowledged by the Trust; a risk has been raised with planned actions to address and improve. This matter was also raised as high priority finding in our recent ePCR Clinical Compliance review, therefore, we have not raised an additional matter arising. The Trust acknowledges that further work is required to reduce the significant use of free text fields, and note that this will also require a big shift in terms of culture.

Data Warehouse

2.32 Data is collected from source systems within the Trust and loaded into the warehouse, either via the Data Academy X-Series or SQL Server Integration Services (SSIS) warehousing tools used to perform data transformations and integrations. Data from systems such as ePCR and ESR are loaded via SSIS, and data from EMS CAD, Datix, CAS 111, GRS and telephony systems are loaded via Data Academy, initially into a staging environment where transformations take place to configure data into a standardised format ready for the warehouse end

tables. Typically, load orchestrations run nightly and should any fail the Data Engineering Team receives notifications via a shared mailbox to investigate further.

2.33 We selected the EMS CAD which holds the 999 calls dataset to review in more detail. Data cleansing is undertaken to ensure completeness, consistency and accuracy. For example, within the CAD system the patient age field is free text and therefore, not inputted in a consistent way. Capturing this accurately is essential for reporting purposes, therefore, the data is cleansed to become an integer. We established that new loads and transformations undergo quality assurance and testing through collaboration between the Data Engineering Team, Data Quality Lead and Information Management Team (IMT) to ensure proper data flow. Specific flags, determined by the operational team and IMT, must be set to confirm that fields are correct for official reporting. Whilst many metrics are calculated in the warehouse and are accurate at the time of initial setup, we established that there is a lack of an audit process to verify their continued accuracy. HI teams regularly attend meetings to stay informed of operational changes which typically require approval from several change management boards, however, some changes may be overlooked, highlighting the benefit of an automated process to ensure data integrity over time. **See Matter Arising 4 at Appendix A.**

EMS CAD

2.34 The Trust operates a C3 CAD System in support of its 999 EMS operations across its three Clinical Contact Centres. The primary focus of the Data Quality Lead has been to improve the data quality of 999 calls as the data is reportable as part of the Trust's Official Statistics return to WG and Ambulance Quality Indicators (AQIs) to the JCC. In April 2024, a new 111 CAS was implemented utilising the same provider as the C3. We note that data quality issues have been identified in the new system, as reported via the Monthly Integrated Quality & Performance Dashboard to the Finance and Performance Committee (FPC) in July 2024 and that these are being addressed. We established that the Data Quality Lead, in collaboration with wider Health Informatics teams, is reviewing ways in which the data quality issues can be resolved with ongoing scrutiny in the same manner as the CAD. **See Matter Arising 5 at Appendix A.**

2.35 Handling a 999 call is often a time of heightened emotion and it is inevitable human error will occur when navigating a system with urgency. The Data Quality Lead recognises this and has taken the approach to sit with call handlers during live calls to fully understand where and how errors can be made. The same approach is currently being adopted for the new 111 CAS system.

2.36 The Data Quality Lead also sits in on Clinical Prioritisation and Assessment Software Group meetings, which reviews the clinical aspect of answering calls. Any intended changes such as implementation of new Medical Priority Dispatch System protocols or clinical process changes can affect official reporting. This insight informs discussions with the wider HI teams to offer training and guidance and to develop exception handling reports to ensure the issues are captured and rectified if required.

2.37 An '*Incidents with Cause for Concern'* webpage is in place, which is refreshed daily and lists the records that appear to have anomalies which require further investigation and / or correction. Duty Managers should check the page daily and either correct the source record in the CAD or confirm that it has been reviewed with no correction required. Incidents remain open for a maximum of five days before they are automatically locked with a password. After this time, a password and a reason for access must be entered to view or alter a record and only select members of the EMS Coordination Systems team (EMSC) are able to do so. The reason is recorded as an audit trail on the record with a date/timestamp and user. We were informed that on the whole incidents are investigated in a timely manner and resolved within the 5-day window, although there is no routine assurance reporting in this respect, and those that remain often require further investigation with the assistance of the DQL and / or EMSC Systems Manager to reach resolution. **See Matter Arising 5 at Appendix A**.

2.38 Complementing the report are a series of exception handling reports built by the IMT for the Data Quality Lead to run on a weekly and monthly basis, and share with the EMSC Systems Manager and EMSC Systems Administrator for collaborative investigation. The combination of data quality checks is key to enabling the accurate reporting of verified incidents as part of the Official Statistics submission to WG and AQIs to the JCC. The reports flag records with anomalies such as:

- Hospital name missing
- Incidents with no outcome
- Long handovers with lost hours
- Longest response times
- Manual alterations that affect performance
- Method of call HCP not used
- Non-verified incidents with attendance at scene

2.39 The above flags can impact on verified incident counts therefore, accuracy and timely resolution is essential. To avoid double-counting incidents, if multiple calls have been received relating to a single incident, only one incident should be counted. Verified incidents are calculated in the data warehouse by counting all incidents recorded in the CAD system, but excluding the following stop codes;

- Incidents closed as Duplicate (DUPL);
- Information call only (INFO);
- Call entered in error (ERRO);
- Call passed to another Ambulance Service (OTHE); and
- Test call (TEST).

2.40 It's important to note that not all flagged incidents require correction following investigation, particularly for matters such as high lost hours and longest response times, as although they may look anomalous the figures can be accurate reflecting the impact of wider system pressures. We selected a sample of incidents for each flag from the April 2024 Exception Report and met with the EMSC Systems Manager to ascertain if the records had been investigated and / or corrected. Out of 10

incidents reviewed, only 3 required correction and had been appropriately resolved. The other 7 had been investigated and deemed correct.

2.41 We established that once a record has been corrected, the incident is closed, and the update is flagged in the CAD with a corresponding date and time. During the next data warehouse load, the updated information will be pulled in as an incremental load. We confirm that for the 3 corrected incidents, the updated information was successfully loaded into the warehouse.

2.42 Whilst the sample of data quality exceptions tested during the audit had been appropriately investigated and resolved, and we note that audit trails of amendments can be downloaded on demand, there is no routine assurance reporting of data quality exceptions. It would be beneficial for the Trust to understand the number and nature of data quality issues recorded, and to demonstrate that they have all been appropriately investigated along with their outcomes to inform trend analysis, interface improvement work and demand and capacity reviews. **See Matter Arising 5 at Appendix A**.

2.43 We established that in addition to reactive correction of data quality issues, the EMSC team will proactively check for trends in errors. If for example, it is identified that the same call handler is repeatedly making the same error, they will inform their manager and advise to converse with them and offer guidance if appropriate. If there are wider learnings to be made, then the EMSC team will send out coaching bulletins to the Control Centres.

2.44 As part of the collation of data to submit to WG, the IMT perform a further series of data quality checks on each reportable measure. As incidents remain open for investigation and correction for 5 days, the team don't begin their checks until the 5th of each month to ensure that all incidents are resolved from the previous month.

2.45 Every incident recorded in the CAD system generates an incident ID in sequence. The initial check is to verify that incidents are in sequence and that the clock start calculation is working correctly to ensure that there are no gaps, for example due to a system outage. For “Red” incidents, clock start times are recorded when the patient’s location and the chief complaint has been established. For “Amber” and “Green” incidents, clock start times are recorded when the patient’s location and the dispatch code have been established from the call. The clock start is the starting point for response time targets and the team will check that each incident is within an hour of the previous incidents clock start time and investigate if they are not.

2.46 Further checks are conducted such as verification of incidents marked as "out of area", as they are not reportable by the Trust and excluded vehicles at the time of reporting, such as test vehicles. A data extract is then taken from the data warehouse and compared against the CAD source data to ensure precision. Once the statistics have been collated, they are sent to the rest of the IMT with a minimum of two analysts performing quality assurance checks. Once the statistics have been deemed correct, they are then disseminated internally in the form of a

pre-release for final sign off by the Principal Information Analyst and Head of Information prior to being uploaded to the WG portal and officially submitted.

2.47 We selected 3 measures from the submitted June 2024 Official Statistics report as below and requested to be shown how the figures were obtained. The Principal Information Analyst performed an SQL Query via screen-share against the data warehouse, and we can confirm that the returned figures matched those that were reported as below.

Date	LHB	Measure	Number
Jun24	All Wales	RED Incidents	5127
Jun24	All Wales	RED incidents resulting in an emergency response	5044
Jun24	All Wales	RED incidents resulting in an emergency response at the scene within 1 minute	255

2.48 The Trust's official performance statistical outputs are defined as National Statistics and are required to comply with the Code of Practice for Official Statistics. We can confirm that the Trust have met all WG submission deadlines over the last 18 months.

Conclusion:

2.49 Our review has highlighted that the Trust is aware of the importance of good data quality, evidenced by its recent update of the Data Quality Policy. Whilst our audit has included focus across the three data types outlined in the introduction section, our work has been limited to looking at these aspects across only a small number of the key systems used by the Trust.

2.50 We noted robust quality assurance processes are in place to scrutinise EMS CAD data sets to ensure that they meet the defined data characteristics, however, it is recognised that there is a need for the same level of control and scrutiny over other systems such as the 111 CAS and ePCR. Proactive actions are being taken to prevent data quality issues, such as the exception handling reports for EMS CAD data and the iterative approach of improving the ePCR user interface. However, there is a lack of routine assurance reporting to demonstrate that exceptions have all been appropriately investigated and managed.

2.51 Through targeted training, guidance and support the Trust is beginning to forge a good data quality culture, however, this could be strengthened by improving the general digital literacy of operational staff and ensuring that they understand the concept of good data quality; why it is important, what the data is used for and how staff can improve on their current position.

2.52 We noted that the Trust has an IAR, however, we understand that this is incomplete. Whilst we acknowledge that current capacity is limited with ever-changing priorities and business-as-usual work, capturing all information assets within the Trust will provide a clear overview, facilitating better organisation and data management, of which data quality is a fundamental part.

2.53 Whilst many metrics are calculated in the warehouse and are accurate at the time of initial setup, it would be beneficial to have an automated audit process to verify

their continued accuracy. Accordingly, we have concluded **reasonable** assurance for this objective.

Objective 3: There is appropriate monitoring and reporting of data quality within the Trust.

2.54 As established in detail under objective 2, the Trust has many ways of monitoring and reporting the quality of its data, and some data is subject to more robust scrutiny than others. Also noted under objective 2 are the Groups with oversight of the data quality within their respective areas, such as CIAG for the ePCR. CIAG is a sub-group of the Clinical and Quality Governance Group (CQGG) which is accountable to the Executive Leadership Team (ELT).

2.55 In wider terms, the Information Governance Steering Group (IGSG) which meets monthly, has delegated authority from ELT to cover all matters of information security, information governance, records management compliance and Caldicott Principles. IGSG reports directly to ELT by way of an Alert, Advise, Assure (AAA) highlight report. Our review of IGSG agendas, papers and minutes from February 2024 – April 2024 noted limited discussion of data quality matters, and that data quality does not appear as a standing agenda item. **See Matter Arising 5 at Appendix A.**

2.56 Broader digital topics inclusive of Digital Key Performance Indicators (KPIs) relating to Data & Analytics, ICT Systems, Digital services, projects & programmes, and progress against the IMTP items with Digital involvement, are reported to the FPC, which meets bi-monthly and provides highlight reports to the Board. Our review of FPC papers and highlight reports from January 2024 – July 2024 confirms that adequate detail relating to data quality matters, such as the identified issues with the new 111 CAS system, is received and reported. However, our review of the Digital KPIs noted a lack of metrics specifically relating to Data Quality. **See Matter Arising 5 at Appendix A.**

2.57 Our review of Board papers from November 2023 to March 2024 noted that it was informed of matters relating to data quality through the aforementioned FPC highlight report, and a Monthly Integrated Quality & Performance Dashboard report.

2.58 As noted under objective 1, the Trust's recently approved Digital Strategy commits to enhancing the data quality provision and assurance strategy under one of the five identified key pillars; *Data, Information and Insight*. The initiative focuses on the strategic use of data, analytics, and visualisation tools to generate actionable insights and transforming raw data into meaningful information that guides the Trust's actions and policies. In July 2024 the FPC received the refreshed Digital Plan and were asked to endorse for implementation. Following its full approval, the Trust should ensure that its implementation is fully monitored and reported upon.

Conclusion:

2.59 Our review has highlighted that data quality is overseen in many forums and that the Board is kept informed on related matters. Whilst data quality is considered under the umbrella of Information Governance, we noted a lack of detail being

received by the IGSG. The Finance and Performance Committee receives updates on broader digital topics and data quality issues by exception, however, our review of the Digital KPIs noted a lack of metrics specifically relating to Data Quality. Consequently, we have concluded **limited** assurance for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Policies and Guidance (Operation)			**Impact**
The Data Quality Policy states that it is underpinned by a suite of legislation and guidance, however, our review noted that the Trust's IG Policy and Records Management Policy are out of date and have not been reviewed since 2018. We further note that there is currently no Freedom of Information Policy in place but understand that this is currently in development. The Trust's policies are not published on their website. Whilst the Trust's Publication Scheme notes under *Data Protection, Records Management and Caldicott Guardian,* that policies relating to Information Security, Data Protection, Records Management and Confidentiality Code of Conduct are available on request to the FOI Team, they should be published on the Trust's website in line with the Information Commissioner's Office (ICO) Model Publication Scheme. We noted that Data Warehouse guidance relating to the EMS CAD are also out of date. As the 111 system has recently moved to the same provider as EMS CAD, the Data Quality Lead is looking to develop similar guidance. Whilst we would expect guidance in place for all systems used within the Trust, we have only focussed on a sample of systems due to capacity, for this review.			Potential risk of: Failure to update policies and procedures in line with new legal requirements can lead to non-compliance, financial penalties and security breaches and reputational damage.
Recommendations			**Priority**
1.1	Management should ensure that policies and guidance which underpin the Trust's commitment to improving data quality are reviewed and / or developed and aligned with new legal requirements and current best practice.		**Medium**
1.2	Management should ensure that current written protocols for delivering the Trust's functions and responsibilities are proactively published on the Trust's website or otherwise made available as a matter of routine.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**

1.1	The Trust's Data Quality policy was reviewed, approved and published earlier in 2024. The Records Management Policy is currently under review and due for submission for approval in November 2024, in order to support the IG Toolkit Improvement Action Plan. The Information Risk Policy is scheduled for Policy Group in December 2024. The Confidentiality and Code of Conduct policy is scheduled for Policy Group in February 2025. The Information Governance Policy is still tba.	November 2024	Assistant Director of Digital Services: Data & Analytics
1.2	As it is not current practice to publish any Trust policies on the public website, this recommendation is not one that can be actioned without a significant and disproportionate change to procedure in WAST. Policies are available on Siren (intranet) for all staff, and for the public / non-WAST employees a copy of any policy can be requested. There is a plan, led by the Corporate Governance Directorate, to begin reviewing the approach to policy publication in 2025/26. As such, no action will be taken specifically for data-related policies until completion of this wider review.	N/A	N/A

Matter Arising 2: Data Quality Training (Design)			Impact
We noted that currently there is no specific training on data quality, however, it is touched upon within the mandatory IG training for all staff. As at March 2024, the compliance figure for this module was at 73.34%, which did not meet the 75% 'Minimum Expectations' compliance requirement. As of 1st April 2024, the minimum requirement has increased to 85% in line with Welsh Government recommendations. The Trust has identified through its Data Quality Policy that training and awareness needs to be in place make an explicit improvement in this area. Whilst bespoke on-demand training and guidance is offered to staff where data quality issues have been identified, it would be beneficial to develop data quality awareness training for all staff and included within the induction of new staff to ensure conformance with required standards.			Potential risk of: Poor quality data, which could lead to: • poor decision making; • failure to achieve performance measures and organisational objectives; • patient harm; and • exposure to financial loss and reputational damage.
Recommendations			**Priority**
2.1	Management should consider assessing the digital literacy of all staff and developing data quality awareness training to complement the newly updated Data Quality Policy.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	A full programme for assessing & improving Digital Literacy is planned for Tranche 2 (i.e. 2025-26) under the refreshed Digital Plan. In the meantime, a Data Quality awareness training module will be made available across the Trust via an existing platform (i.e. ESR, LMS365 or MetaCompliance – tbc) to minimise any additional cost.	December 2024	Head of Information

Matter Arising 3: Information Asset Register (Operation)			Impact
The HI teams manage data from various systems including telephony, EMS CAD, Electronic Patient Clinical Record (ePCR), 111 Clinical Assessment Service (CAS), Emergency Communication Nurse System (ECNS), Cleric (Ambulance Care), select ESR, the Trust website, Datix, Global Rostering System (GRS), and internal web applications. We were informed that there are other data silos in Finance, Estates, Fleet, Wiin (Innovation Network), ICT, and vehicle Mobile Data Terminal, among others. The Trust recognises that it does not hold a complete central record of all its data sources. Whilst we understand that an Information Asset Register is in existence, we were not provided with a copy but were informed that it is incomplete.			Potential risk of: Poor quality data, which could lead to: • poor decision making; • failure to achieve performance measures and organisational objectives; • patient harm; and • exposure to financial loss and reputational damage.
Recommendations			**Priority**
3.1	Management should ensure that the Information Asset Register accurately reflects the Trust's information landscape to ensure that a singular, consistent catalogue of information assets is in place to monitor compliance and efficiency.		**High**
Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	IGSG has already agreed to establish an Information Asset Owners Group. This sub-group will be responsible for the further development and ongoing maintenance of the Trust's Information Asset Register. Until the two vacant Data Protection Compliance Manager posts are filled (expected November 2024) there is not capacity within the IG function to help establish and run such a group.	April 2025	Assistant Director of Digital Services: Data & Analytics

<table>
<tr><th colspan="3">Matter Arising 4: Automated Audit Process (Operation)</th><th>Impact</th></tr>
<tr><td colspan="3">We established that new loads and transformations undergo thorough quality assurance and testing through collaboration between the Data Engineering Team, Data Quality Lead and Information Management Team (IMT) to ensure proper data flow. Specific flags, determined by the operational team and IMT, must be set to confirm that fields are correct for official reporting. Whilst many metrics are calculated in the warehouse and are accurate at the time of initial setup, we established that there is a lack of an audit process to verify their continued accuracy. HI teams regularly attend meetings to stay informed of operational changes which typically require approval from several change management boards, however, some changes may be overlooked, highlighting the benefit of an automated process to ensure data integrity over time.</td><td>Potential risk of:
Poor quality data, which could lead to:
• poor decision making;
• failure to achieve performance measures and organisational objectives;
• patient harm; and
• exposure to financial loss and reputational damage.</td></tr>
<tr><th colspan="3">Recommendations</th><th>Priority</th></tr>
<tr><td>4.1</td><td colspan="2">Management should consider utilising an automated data quality tool to develop automated audit processes to reduce the need for manual intervention and improving overall data accuracy and consistency.</td><td>Low</td></tr>
<tr><th colspan="2">Agreed Management Action</th><th>Target Date</th><th>Responsible Officer</th></tr>
<tr><td>4.1</td><td>Implementation of a new tool is a significant digital project, however, some functionality may be available in existing platforms which would offer a minimum viable product. Action is to conduct a gap analysis on automated data quality functionality within the Trust and make a recommendation to IGSG for a way forward.</td><td>January 2025</td><td>Head of Information</td></tr>
</table>

Matter Arising 5: Data Quality Reporting (Operation)	Impact
The Information Governance Steering Group (IGSG), which meets monthly, has delegated authority from ELT to cover all matters of information security, information governance, records management compliance and Caldicott Principles. ISGS reports directly to ELT by way of an Alert, Advise, Assure (AAA). Our review of IGSG agendas, papers and minutes from February 2024 – April 2024 noted limited discussion of data quality matters, and that data quality does not appear as a standing agenda item. Whilst broader digital topics are routinely reported to the Finance and Performance Committee (FPC) and members are informed of data quality issues such as those identified in the new 111 CAS system, we noted that there are no reportable KPIs in relation to data quality. Whilst the sample of data quality exceptions tested during the audit had been appropriately investigated and resolved, and we note that audit trails of amendments can be downloaded on demand, there is no routine assurance reporting of data quality investigations. It would be beneficial for the Trust to understand the number and nature of data quality issues recorded, and to demonstrate that they have all been appropriately investigated along with their outcomes to inform trend analysis, interface improvement work and demand and capacity reviews.	Potential risk of: Poor quality data, which could lead to: • poor decision making; • failure to achieve performance measures and organisational objectives; • patient harm; and • exposure to financial loss and reputational damage.

Recommendations		Priority
5.1	Management should ensure that reporting arrangements for Data Quality are reviewed and formalised with a clear route to ELT and the Board.	**High**
5.2	Management should ensure that the progress to address 111 CAS data quality issues and arrangements for ongoing scrutiny are appropriately reported.	**Medium**
5.3	Management should ensure that assurance in relation to data quality exception handling and the Incidents with Cause for Concern is appropriately reported.	**Medium**
5.4	Management should ensure reportable data quality KPIs are developed and are appropriately reported.	**Medium**

5.5	Management should consider developing a standard reporting template for data quality matters.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
5.1	Standard Digital reporting on plans, systems and compliance, has a passage through to Finance & Performance Committee bi-monthly. In addition to this, DQ is an element of the IG reporting which goes to IGSG by exception and for broader discussion on a monthly basis. These reporting routes are articulated in both the TORs of FPC and IGSG.	October-24	Assistant Director of Digital Services: Data & Analytics
5.2	An update on the 111 CAS reporting and data quality efforts will be offered in future IG Highlight reports which pass to IGSG.	November-24	Head of Information
5.3	Following recent investment in the Digital Directorate, two new Data Quality JDs have been submitted for evaluation to support recruitment of additional expertise into this function. Once in post, as per the TOR, DQ representation will resume in IGSG, and we expect any large-scale / system level data quality issues such as this to be brought to the group for awareness and support in a timely manner.	March-25	Assistant Director of Digital Services: Data & Analytics
5.4	A monthly KPI report passes through IGSG, already with a placeholder for Data Quality metrics. The development of these metrics is dependent upon recruitment into the proposed new DQ posts.	April 2025	Assistant Director of Digital Services: Data & Analytics
5.5	Following recent investment in the Digital Directorate, two new Data Quality posts are planned to be created. Capacity to build standard DQ reporting is dependent on having more than the current 0.4 FTE, and so this action is to demonstrate movement towards a more resilient Data Quality team with the development of a template form to ensure a standardised method of recording, escalating and resolving Data Quality issues as they are discovered.	December-24	Head of Information

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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Resourcing Policy

Final Internal Audit Report

November 2024

Welsh Ambulance Services University NHS Trust

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Auditors:	Osian Lloyd, Head of Internal Audit; Felicity Quance, Deputy Head of Internal Audit; Johanna Butt, Principal Auditor
Executive sign-off:	Lee Brooks, Executive Director of Operations
Distribution:	Judith Bryce, Assistant Director of Operations, National Operations and Support; Jonathan Edwards, Assistant Director of Operations, Resourcing & EMS Coordination; Siobhain Frain, Service Manager, Resourcing; Ian Bellamy, Resource Manager - Central & West 111/CSD; Carl Melville, Resource Manager - North; Danni Green, Resource Manager – South East; James Roberts, Rostering Systems Manager.
Committee:	Audit, Risk & Assurance Committee

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

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

Disclaimer notice - please note:

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

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

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with the Welsh Ambulance Services NHS Trust. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Executive Summary

Report Opinion

		Trend
Limited	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.	N/A - no previous audit.

Assurance summary[1]

	Objectives	Assurance
1	Appropriate Resourcing Policy in place.	Limited
2	Systems in place to capture key requirements of Resourcing Policy.	Reasonable
3	Consistent application and management of processes.	Limited
4	Reporting of exceptions / deviations.	Reasonable

Purpose

To review the Trust's Resourcing Policy, its compliance with national terms and conditions, and to assess its application as an enabler for effective resource production.

Overview

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

- The Resourcing Policy to be reviewed and updated;
- Ongoing significant process mapping exercise to be completed to inform the development of functional Standard Operating Procedures (SOPs). The different approaches being applied between services and local arrangements across Wales result in an inconsistent application of the Resourcing Policy;
- Working Time Directive breaches are not reviewed or reported on;
- The process for Time Off In Lieu (TOIL) requires clarity;
- Whilst Outside Resource Authorisations (ORAs) decisions are recorded on GRS, there is currently no reason code assigned to them; and
- There are timeframes for actions for both the Resource Team and staff included in the Resourcing Policy, however there is currently no Key Performance Indicator (KPI) reporting.

Key Matters Arising

	Key Matters Arising	Objective	Control Design or Operation	Recommendation Priority
1	Resourcing Policy and SOPs	1	Design	High
2	Working Time Directive breaches	2	Design	High
3	Process for agreement of TOIL	2	Operation	Medium
4	Outside Resource Authorisations (ORAs)	2	Operation	Medium
5	KPI Reporting	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 To meet demand placed upon its services, Welsh Ambulance Services University NHS Trust (the 'Trust') is required to make arrangements to manage the deployment of its workforce efficiently and effectively and within Agenda for Change terms and conditions of employment. In doing so, it must continue to deliver care which is of the highest quality to its service users. Effective resourcing is fundamental to ensuring that staff are deployed in the most efficient way to ensure the best use of public money in the delivery of NHS services, and that the needs of the patient are placed firmly at the centre of the management of the workforce.

1.2 The risks considered during the course of this review included the application of ineffective resourcing practices and arrangements resulting in breach of terms and conditions, inefficient use of staff and resources, increased financial costs, an adverse impact on staff wellbeing, and patient harm.

1.3 Our review has not included an assessment of the adequacy of the rosters in place or the method for uploading these onto the relevant systems, which is outside the scope of this review.

1.4 Further, our review has not included testing of the information included on the Global Rostering System (GRS) or ShiftTrack against any expected records that should be maintained by the manager or individual.

1.5 Discussions with Locality Managers and staff have not been undertaken during the course of our review. Rather, we have considered the corporate arrangements in place and how the regional Resourcing Teams (North, South-East; and Central and West) manage such arrangements.

2. Detailed Audit Findings

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

	Recommendation Priority			
	High	Medium	Low	Total
Control Design	5	1	-	6
Operating Effectiveness	-	3	-	3
Total	5	4	-	9

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

Objective 1: There is a clear and documented policy in place for the effective deployment of staff, which is compliant with applicable employment terms and conditions.

2.3 The Resourcing Policy (the 'Policy') has been in place since March 2014 and has not been updated since its issue date. See **Matter Arising 1.** We understand that the Trust had started to review the Policy in 2019. However, this was paused due to the COVID-19 pandemic and progress since was impacted by industrial action.

2.4 The purpose of the policy is "*to ensure that annual leave, time off in lieu of General Public Holiday (GPH) and time off in lieu (TOIL) and other planned absences are managed effectively, fairly and consistently across Wales. This should be in accordance with the entitlements and arrangements defined under NHS Terms & Conditions, the European Working Time Directive and within financial allocations to provide the required levels of resources*". It states that the principals within the document are applicable to all staff and managers within the organisation.

2.5 Review of the Policy confirms that it lacks clarity in certain sections. For example, it makes reference to the "*Green Book*" which does not exist. Additionally, it includes references "*local arrangements/agreements*", some of which we understand may result from custom and practice but are not defined (for further details refer to *audit objective 3*). See **Matter Arising 1**. We acknowledge, however, that the Policy was produced with reference to the NHS Terms & Conditions Handbook, which is referenced throughout. We also note that the individual contractual hours are reflected in the systems (see para 2.9) in place.

2.6 Some Standard Operating Procedure (SOPs) have been produced to support the Policy, including the '*Resource Procedure for 111 / NHS Direct Wales (NHSDW)*'; '*Resource Services: Red Flag Day Procedure (High Priority Rest Day for Relief)*'; '*Resource Services Standard Operating Procedure: Change of Duties*'; and '*Resource Services Standard Operating Procedure: Relief Shift Allocation Prior to a Period of Leave*'.

2.7 We acknowledge that the Trust has also decided to produce functional SOPs for each area i.e. the 111 service; Clinical Support Desk (CSD); Emergency Medical Services (EMS) Co-ordination; Ambulance Care and finishing with EMS staff (the largest cohort and most complex in respect of local arrangements). To date, the Trust has produced a draft SOP for the 111 service which, at the time of our review, had not been approved as final. See **Matter Arising 1**.

Conclusion:

2.8 The Policy in place has not been updated in 10 years. However, we acknowledge that a review process commenced in 2019 but progress was impacted by both the COVID-19 pandemic and, more latterly, industrial action. We understand that there are a number of local arrangements in place, and were informed that these differ, however such is currently not quantified or formally defined. The Trust has a plan to develop functional Standard Operating Procedures for each area to provide further clarity to support the operation of the Policy. We have therefore assessed this objective as **limited** assurance.

Objective 2: Systems are in place to capture the key requirements of the Resourcing Policy e.g. annual leave, sickness, time in lieu, trade union time etc.

2.9 Global Rostering System (GRS) is the main system in place to capture the key requirements of the Resourcing Policy, as it covers the majority of services including Clinical Support Desk (CSD), Emergency Medical Services (EMS) Co-ordination, Ambulance Care and EMS. ShiftTrack is used for resourcing 111 service staff only (circa 200 whole time equivalent (WTE) staff). The relevant regional Resourcing Teams (of which there are three – North; South East; and Central & West) are responsible for the administration of the respective systems.

2.10 Requests for all leave types should be requested on GRS / ShiftTrack in advance, in line with defined timescales set out in the Policy. These are subject to review and approval by the Resourcing Team, who refer to the abstraction rate and UHP % as part of their decision-making process before approving or declining the request.

Abstraction Reporting:

2.11 The Resourcing Team generates weekly abstraction reports from the systems and issues to localities and directorate service areas. These reports vary in format and content with EMS, EMS Coordination and Ambulance Care containing the most detail, including in relation to abstractions, sickness, overtime hours and annual leave booking compliance.

Unit Hour Production reporting:

2.12 Weekly Unit Hour Production (UHP) reports are also produced for each function. These detail the expected staffing levels (i.e. what the core rosters produce to meet the demand profile) against the actual staffing levels (i.e. what they have subject to establishment, vacancies and abstraction levels e.g. annual leave, sickness leave, training). These reports are generated by GRS, which has a live feed; and as such all reports are accessible to the resourcing team and operational managers to support decision making regarding short notice abstraction requests. Examples of such include annual leave and TOIL within the 6-week planning cycle, along with resourcing relief planning and administration of shift changes with the rota.

2.13 For reports in relation to the 111 service, manual intervention is required due to the reporting capabilities of the ShiftTrack system. However, we acknowledge that the process is less complex and there are fewer staff on the system, as reflected by the production of a draft SOP for the 111-service (see para 2.7).

Working Time Regulations:

2.14 Working Time Regulations set out rules limiting working hours and provide for rest breaks and paid holidays. The GRS system flags when a member of staff is expected to breach based on the shifts / hours worked an allocated to them. However, this can be overridden on the system. See **Matter Arising 2**.

2.15 A Working Time breach analysis report can be generated from GRS, but we were informed that this is not routinely produced and reviewed currently. We requested

the report and this highlighted a significant number of breaches. The ShiftTrack system doesn't currently have this capability and no checks are undertaken. See **Matter Arising 2**.

Time off in Lieu (TOIL):

2.16 As stated in the Resourcing Policy: '*The NHS Terms & Conditions Handbook asserts that "Staff may request to take time off in lieu as an alternative to overtime payments. However, staff who, for operational reasons, are unable to take time off in lieu within three months must be paid at the overtime rate.'*

2.17 As per Appendix 3 of the Policy, where a TOIL day is required and 8+ days' notice has been provided "*applications will not normally be refused - each application will be considered on its own merits*". There is currently no cap or accepted level of abstraction in relation to TOIL. As such, when TOIL requests are made, this presents a challenge for Resource Co-ordinators as it is reasonable for staff to expect that, provided the required notice has been provided, TOIL will never be declined irrespective of the demand and capacity for that day. See **Matter Arising 3**. We note that this has been raised recently during discussions with Trade Union partners.

Sickness leave:

2.18 Sickness leave is captured on both GRS and Electronic Staff Record (ESR); however we understand that there is currently no reconciliation to ensure that the information is consistent and complete on both systems. Audit Wales recommended in their 'Review of Workforce Planning Arrangements' report (issued in November 2023) that "*the Trust Systems that hold workforce information including Electronic Staff Record (ESR), Global Rostering System (GRS) and finance systems interconnect, where possible*". The Trust responded that "*use of Power BI reporting feeding into the Integrated Technical Planning Group is in development by the workforce planning team. This will be used for reporting and maintenance of the data*." This action was due for completion in September 2024 but we understand that there have been some delays in the work required with the GRS provider in the first instance. We have therefore not raised a recommendation within this report.

Facility time:

2.19 The arrangements in place to capture and record facility time were reviewed as part of our Trade Union Release Time review (issued July 2023, limited assurance). We concluded that whilst the Facilities Agreement recommends processes to follow, such were not mandated, and several methods of recording facility time were in place. The lack of integrated systems for capturing this data at an organisational level, further reduces visibility and compliance. At the date of reporting, the recommendations raised at this report remain open on the Trust's audit tracker.

Conclusion:

2.20 The systems in place capture the key requirements of the Resourcing Policy in respect of annual leave, sickness, time in lieu, trade union time. There is weekly reporting from both the GRS and ShiftTrack systems including the UHP and

Abstraction reports. However, there is a lack of review and reporting on Working Time breaches and the process for TOIL requires further clarity. There is no reconciliation of sick leave between GRS and ESR, although we note the limitation with interconnectivity between the systems and the development being undertaken by the Trust to address this. Noting this, we have assessed this objective as **reasonable** assurance.

Objective 3: There is consistent application and management of the processes across Wales.

2.21 The Trust has recognised that the application and the management of the process across Wales differs; and we acknowledge that the Resourcing Policy (see para 2.5) allows for such inconsistencies as it highlights and allows for local arrangements. At the date of our audit fieldwork, the Resourcing Team were at the early stages of process of mapping the different resourcing processes across the regions and services, and we recognise that this is a significant piece of work to be undertaken. See **Matter Arising 1**.

2.22 We acknowledge that there are some documented notes for use by the Resource Managers/Coordinators reflecting local arrangements within their regions, such as details of some stations which have rostered leave, some with self-roster leave and others with 'lettered leave'; but also recognise that not every nuance used is documented. Some of the local arrangements may work well across all localities, but without a point of consolidation such cannot be effectively considered/implemented.

2.23 Outside Resource Authorisations (ORAs) are captured for any annual leave, TOIL, or change of shift requests that have been authorised by line managers but would not have been so if processed via the Resourcing team in accordance with the Policy. For the period 01 April 2024 to 30 September 2024, a total of 1,969 ORAs were recorded. Our understanding is that these local authorisations typically override decisions already taken by the Resourcing Team. We acknowledge that there may be valid reasons for the line manager's decision and the approval of the request appropriate, noting the application of local arrangements throughout the Trust. However, there is no reason code within GRS, therefore there is currently no management information regarding the underlying reason for the ORA. See **Matter Arising 4**.

Conclusion:

2.24 The Trust has recognised that there are inconsistent processes, both across the services and throughout Wales at both a regional and local level; and at the date of reporting was in the early stages of process mapping these. We acknowledge that the Resourcing Policy currently allows for local arrangements and these processes might work well at individual stations, but there is a need for such to be consolidated to ensure a fair, consistent and effective process. We also note the need to enhance the ORA reporting. Noting this, we have assessed this objective as **limited** assurance.

Objective 4: Appropriate reporting mechanisms are in place for any exceptions or deviations from the requirements of the Resourcing Policy.

2.25 It is recognised that monthly abstractions from the rosters are key to managing the number of hours the produces, along with the number of staff in post. As per paras 2.11 and 2.12, weekly UHP and Abstraction reports are produced and distributed which include compliance against elements of the resource policy e.g. the percentage of annual leave booked. Such are considered through the performance meetings for each of the individual functions, which can range from daily, weekly and twice weekly. In addition, Service Managers and Locality Managers have system access to view live data.

2.26 There is regular reporting of Ambulance Abstractions and Production Indicators as part of the Monthly Integrated Quality and Performance Report (MIQPR) reporting. This includes analysis and commentary on the performance against the accepted abstraction rate as detailed in the policy, being approximately 30%, and unit hours production, along with remedial plans and actions. The most recent report, presented to the September 2024 Finance and Performance Committee highlighted that the abstractions benchmark has been achieved a number of times this year, with the highest proportion of abstractions being due to annual leave 17% followed by sickness absence at 7.5%.

2.27 Additionally, Regional Resource Managers send more detailed reports to Locality Managers relating to the requirement of the Resourcing Policy, these have included, but not limited to:

a. annual leave summaries;

b. TOIL credits which are older than 3 months and due for payment; and

c. contractual hours balances, by individual, detailing that where staff have excessive balances for both credits or debits these will be managed through relief planning; and

d. Sickness absence report detailing which sickness certificates are overdue.

2.28 However, as detailed within *audit objective 2*, there is currently no review or reporting of Working Time Regulation breaches. **See Matter Arising 2**.

2.29 The Resourcing Policy includes key timeframes for making and authorising requests, however, there is currently no reporting on these. See **Matter Arising 5**.

Conclusion:

2.30 There is regular reporting and analysis on UHP and abstractions throughout the Trust, including within the MIQPR reported at Board and Committee level. Locality, Operational and Line managers are also provided with more detailed reporting and have system access to view live data. The Policy includes timeframes for submitting and authorising requests yet there is no reporting of performance against these. Noting this, we have assessed this objective as **reasonable** assurance.

Appendix A: Management Action Plan

Matter Arising 1: Resource Policy and SOPs (Design)		Impact
The Resourcing Policy (the 'Policy'), which is applicable to all staff and managers within the organisation, has been in place since 2014 and has not been updated since its issue date of March 2014. Review of the Resourcing Policy confirms that it lacks clarity in certain sections. For example, it makes reference to the "Green Book" which does not exist. Additionally, it includes references "local arrangements/agreements", some of which we understand may result from custom and practice but are not defined. We acknowledge that the Trust has decided to produce functional Standard Operating Procedure (SOPs) for each area i.e. 111; Clinical Contact Desk (CCD), Emergency Medical Services (EMS) Co-ordination, Ambulance Care and finishing with EMS staff (the largest cohort and most complex in respect of local arrangements). To date, the Trust has produced a draft SOP for 111 which at the time of our review had not been approved as final. We recognise that the Policy allows for local arrangements and the Trust has recognised the variation of the process across Wales but that such isn't quantified. At the date of our audit fieldwork, the Resourcing Team were already at the early stages of process of mapping the different resourcing processes across the regions – we recognise that this will take a significant amount of time to complete as details of local arrangements are consolidated.		Potential risk of: • Inconsistent application of the Policy.
Recommendations		**Priority**
1.1	The mapping exercise should be completed to ensure that all local arrangements or differences in application of the Policy are appropriately recorded.	**High**
1.2	The functional SOPs for each area should be completed, approved and communicated to all staff.	
1.3	The Resourcing Policy should be reviewed and revised (or re-drafted), approved at an appropriate forum and communicated to all staff.	

Agreed Management Action		Target Date	Responsible Officer
1.1	Resourcing Policy allows for local arrangements, which results in variation of process across the Trust which currently is not quantified. Resourcing will complete the process mapping and documentation of all local arrangements and differences in the application of the Policy across operational HBs by function. This will be submitted via the Resourcing monthly management team meetings.	November 2024	Siobhain Frain, Service Manager Resourcing
1.2	Resourcing will construct departmental Standard Operating Procedures to support consistent application relevant to individual functions. SOT will review and agree each of the SOPS will be published and communicated to staff and resourcing teams.	March 2025	Siobhain Frain, Service Manager Resourcing
1.3	The Trust accepts this recommendation, and the Resourcing Policy will be reviewed and revised. A Resourcing Policy Group, in partnership with Trade Unions, will convene to review the existing policy. Governance arrangements including SOT, SLT and ELT will ensure changes are agreed and recorded.	October 2025	Jonathan Edwards, Assistant Director of Operations Resourcing & EMS Coordination

Matter Arising 2: Working Time breaches (Design)	Impact
(see below)	Potential risk of: • Breach in legislation.

Matter Arising 2: Working Time breaches (Design)

Working Time Regulations requires that staff have a minimum of 11 hours off between shifts - daily rest; and an average weekly rest of 1 day off in 7 (averaged over 2 weeks). The Trust has taken the decision, through the Resourcing Policy to combine this with the minimum 11hrs daily rest, therefore 35hrs minimum per week, however, the combined 2-week average has been set as 70hrs.

The GRS system flags where a shift is not compliant with the 11-hour daily rest period or where a member of staff has exceeded 12 working days without a rest period. However, this can be overridden. There is no similar flag on ShiftTrack, where Resourcing staff would have to manually review the roster to identify any such incidents.

There is a report available on GRS, namely, 'WT breach analysis' report. We were informed that this report is not currently used or reviewed. We requested the report and this highlighted instances of minimum length between shifts of less than 11 hours, and continuous days working over 12 days:

Region	01/04/2023 – 31/03/2024		01/04/2024 – 30/09/24	
	11-hour breach	12-day breach	11-hour breach	12-day breach
Central and West	83	-	40	-
North	95	5	14	2
South East	203	-	53	-
Integrated Care	38	-	22	-
Grand Total	**419**	**5**	**129**	**2**

Resource Managers reviewed the reports and we were informed that some included breaches where shifts are defined as "RLF 0" or certain display names that have predefined hours underneath but may not necessarily be an actual breach. As such, the true number of breaches may be lower than the report, but without going through the report on a line-by-line basis the true WT Breach figure is not known.

Impact

Potential risk of:

- Breach in legislation.

Recommendations		Priority
2.1	Resource Managers should undertake regular review of the WT breach analysis reports, within GRS and ShiftTrack, to identify whether it is a "true" breach and these should be reported.	High
2.2	Resource Managers should consider whether there is a training need for Resource Co-ordinators or for wherever the WT breach originated e.g. if it was as a result of local arrangements or shift changes.	

Agreed Management Action		Target Date	Responsible Officer
2.1	The requirement for review the Working Time (WT) breach analysis reports has been included as part of the Quality Control and Audit Management processes. Resource Managers will undertake a monthly review of the Working Time (WT) breach analysis reports, to identify whether it is a "true" breach and if these should be reported. Any true breaches are passed through to Heads of Service for action.	November 2024	Siobhain Frain, Service Manager Resourcing
2.2	Resource managers, following the monthly audit of the WT breach analysis report, will identify any individual or system trends and issues and any remedial actions addressed through line management structures.	November 2024	Siobhain Frain, Service Manager Resourcing

Matter Arising 3: Process for agreement of TOIL (Operation)			Impact
As per Appendix 3 of the Resourcing Policy, where a TOIL day is required and 8+ days' notice has been provided "*applications will not normally be refused - each application will be considered on its own merits*". There is currently no cap or accepted level of abstraction in relation to TOIL. As such, when requests are made, this presents a challenge for Resource Co-ordinators as it is reasonable for staff to expect that, provided the required notice has been provided, TOIL will never be declined – irrespective of the demand and capacity for that day.			Potential risk of: • Negative impact on workforce due to lack of clarity; and • Negative impact on delivery of service.
Recommendations			**Priority**
3.1	The process for TOIL should be reviewed, revised, agreed and communicated to provide clarity for both the Resource co-ordinators and staff.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	The process for agreeing TOIL will be reviewed, revised, agreed and communicated as part of the Resourcing Policy review **(see Management Action response 1.3**). This will provide clarity for both the Resource co-ordinators and staff.	October 2025	Jonathan Edwards, Assistant Director of Operations Resourcing & EMS Coordination

Matter Arising 4: Outside Resource Authorisations (ORAs) (Operation)			Impact
Outside Resource Authorisations (ORAs) are captured for any annual leave, TOIL or change of shift requests that are authorised by line managers but would not have been so, if processed via the Resourcing Team under the resourcing policy. Not all ORAs are decisions that have had the opportunity to be passed via the Resourcing Team in the first instance e.g. a line manager might approve the request before advising the Resourcing Team. We acknowledge that there may be valid reasons for the line manager decision, and the approval of the request may be appropriate. For the period 1 April 2024 – 30 September 2024, a total of 1,969 ORAs were recorded. From discussion with Management it was confirmed that ORA is included as a drop-down choice under GRS abstraction report group 'Other'. At the time of our audit there wasn't a reason code included to capture the rationale for the decision, which might provide the Trust with useful management information to understand the different reasons for the ORAs.			Potential risk of: • Lack of management information that could provide clarity on the reasons for ORAs.
Recommendations			**Priority**
4.1	The Trust should consider revising the GRS structure to include ORA as an abstraction report group with a drop-down list detailing the reason for the ORA.		**Medium**
4.2	The reasons for ORAs, if captured, should be reported and monitored.		
Agreed Management Action		**Target Date**	**Responsible Officer**
4.1	The Trust will revise the GRS structure to include ORA Absence Group and SOT will agree associated ORA Absence types for implementation to the rostering system. This will be agreed through SOT.	December 2024	Siobhain Frain, Service Manager Resourcing
4.2	Once ORA Absence Types are agreed by SOT and implemented into the rostering systems, a self-service reporting guide will be provided to operational teams to permit local monitoring. Formal quarterly reporting by Resourcing dept will be provided to SOT to monitor.	January 2025	Siobhain Frain, Service Manager Resourcing

Matter Arising 5: KPI Reporting (Design)		Impact
The Resourcing Policy includes key timeframes for making requests and authorising requests, including, but not limited to: a. *Employees will be notified of the outcome of their request within four calendar days. This will potentially be reduced to 3 calendar days on the first review of this procedure;* b. *Staff wishing to request a cancellation of their previously submitted leave must inform their Line Manager or relevant Resource Centre as soon as practicable. As a guide, four weeks' notice of this request would be good practice;* c. *All vacant shifts will be visible on GRS web or Workforce Manager (i.e. ShiftTrack) and available to the workplace level 28 days prior to the shift needing to be covered;* d. *Where there are no local agreements: Overtime will be offered with up to 10 days' notice given;* e. *Notification of acceptance of overtime shift will be confirmed by the Resource Centre five days in advance of the overtime shift being worked unless this is to cover short notice absence.* However, there is currently no reporting on these.		Potential risk of: • Lack of performance monitoring.
Recommendations		**Priority**
5.1	The Trust should ensure that performance against all expected timeframes within the Resourcing Policy are reported and monitored.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
5.1	The Trust accepts this recommendation. The KPIs listed within the report are based on the existing resourcing policy. A reporting framework will be developed as part of the Resourcing Policy Review (**see Management Action response 1.3**). There are however two areas that have been completed or superseded as per below:	October 2025	Siobhain Frain, Service Manager Resourcing

	• Action 5.1c – visibility of vacant shift. This functionality exists and is evident within the GRS system options. **This is complete.** • Action 5.1 d & e. Availability and acceptance of overtime - These KPIs are no longer applicable due to the implementation of the overtime allocation SOP and Financial Savings Plans.		

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	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.
Unsatisfactory assurance	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
Assurance not applicable	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

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

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

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AGENDA ITEM No	8
OPEN or CLOSED	Open
No of ANNEXES ATTACHED	4

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

MEETING	Audit, Risk and Assurance Committee
DATE	21 November 2024
EXECUTIVE	Trish Mills, Director of Governance / Board Secretary
AUTHOR	Julie Boalch, Assistant Director of Corporate Governance & Risk
CONTACT	Julie.Boalch@wales.nhs.uk

EXECUTIVE SUMMARY

1. The purpose of the report is to provide a progress report on the risk management transformation programme and assurance in respect of the management of the Trust's principal risks.

2. A comprehensive update was provided to Committee in September 2024 including a high level synopsis of the 2023/24 Risk Management Internal Audit and the BDO Consultancy Report.

Risk Management Transformation Programme

3. The next phase of the Risk Transformation Programme is underway with details drawn out throughout the report. This includes the development of a Strategic Board Assurance Framework, a suite of Risk Appetite statements, an electronic risk management solution and continued work to reposition the Trust's highest rated Risks 223 and 224.

2023/24 Internal Audit Risk Management Review

4. The recommendations within the review are being actioned; however, it should be acknowledged that work to streamline the method of reporting of directorate risks will take time given the usability issues with the current Datix system. This will be improved by the implementation of a new digital risk management solution and the recruitment of a Band 7 Risk Manager to support this work and to provide a clear, centrally held audit trail of the monitoring, management and escalation of local and directorate risks.

Board Assurance Framework

5. A summary of the principal risks (Annex 1) and a detailed description contained within the Board Assurance Framework (BAF) (Annex 4) is included in the report.

6. The more detailed description contained within the BAF provides the Committee with an opportunity to review the controls in place against each principal risk and the assurance provided against those controls where applicable. This will assist Members in evaluating current risk ratings supported by the scoring matrix (Annex 2).

7. The principal risks are updated as at 23 October 2024 having been reviewed in line with the agreed schedule (Annex 3). Focus has continued to be given to the risk ratings, controls, assurances, gaps, and mitigating actions identified and taken to support risks to achieve their target score.

8. Updates are highlighted in blue on the BAF which show changes to actions, controls, and assurances.

9. The Trust's highest rated risks: **Risk 223** (*the Trust's inability to reach patients in the community causing patient harm and death*) and **Risk 224** (*Significant handover of care delays outside accident and emergency departments impacts on access to definitive care being delayed and affects the Trust's ability to provide a safe & effective service for patients*), remain at the highest score of 25. These scores reflect individual cases of avoidable harm, highlighting ongoing challenges in the unscheduled care system due to the levels of handover delays.

10. A workshop took place on the 6 September 2024 with the Risk Owners and teams to consider a different approach to managing and monitoring those areas that are within the Trust's control and those that are not. Work began on stratifying all controls into six internal and external themes. Further workshops have been established in December to finalise the work on both risks. The outcome of this will be reported through the next round of governance.

11. Members are asked to note the reduction in scores for **Risks 594** *The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death* from 20 (4x5) to 15 (3x5) and **Risk 163** *Maintaining Effective & Strong Trade Union Partnerships* from 16 (4x4) to 12 (3x4). Both risks will remain on the Corporate Risk Register for ongoing monitoring and mitigation.

12. Whilst there have been no further material changes made during this period, the BAF includes a commentary for each risk for the Risk Owner to describe the rationale for each of the risk ratings which is particularly important where ratings have remained static or increased.

13. Detailed reviews, discussion and challenge continue to take place with the Executive Leadership Team (ELT) and Assistant Director Leadership Team (ADLT) on each of the risks monthly in support of achieving this activity and movement on the CRR and BAF.

RECOMMENDATION:

14. Members are asked to consider and discuss the contents of the report and:
    a) Note the progress of the Risk Management Transformation Programme: specifically, the development of risk appetite statements and strategic Board Assurance Framework.
    b) Note the next steps in relation to a digital risk management solution.
    c) Note the ongoing repositioning of Risks 223 and 224.
    d) Note the reduction in score for Risk 163 from 16 (4x4) 12 (3x4) and Risk 594 from 20 (4x5) to 15 (3x5). Both risks will remain on the Corporate Risk Registers for ongoing management.
    e) Receive assurance on the review and attention to the principal risks, including their review at ADLT, ELT and at relevant Committees.
    f) Note the ratings and mitigating actions for each principal risk.

KEY ISSUES/IMPLICATIONS

The key issues and implications are set out in the Executive Summary above.

REPORT APPROVAL ROUTE

Each of the Principal Risks have been or are due to be considered by the following Committees, as relevant to their remit, during the forthcoming reporting period:

- Assistant Directors Leadership Team (14 October 2024)
- Executive Leadership Team (23 October 2024)
- Quality, Safety & Patient Experience (05 November 2024)
- People & Culture Committee (14 November 2024)
- Finance & Performance Committee (19 November 2024)
- Audit, Risk and Assurance Committee (21 November 2024)
- Trust Board (29 November 2024)

REPORT ANNEXES

SBAR report.
Annex 1 - Summary table describing the Trust's Principal Risks.
Annex 2 – Scoring Matrix
Annex 3 – Frequency of Risk review
Annex 4 - Board Assurance Framework

REPORT CHECKLIST

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

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

SITUATION

1. The purpose of the report is to provide a progress report on the risk management transformation programme and assurance in respect of the management of the Trust's principal risks.

BACKGROUND

2. The Risk Management Transformation Programme is reported and monitored through the Corporate Governance Directorate's Local Directorate Plan and through to the Strategic Transformation Board and the Audit, Risk & Assurance Committee for oversight.

3. Principal risks are allocated to appropriate Directors to drive the reviews and actions to mitigate the Trust's principal risks. In addition to directorate reviews there are formal risk review discussions with the Assistant Directors Leadership Team (ADLT) and the Executive Leadership Team (ELT) in relation to risk escalation, changes in ratings, and any new risks for inclusion on the CRR.

4. This report highlights the focus that is maintained on management of these risks, not only because of risk discussions in the various forums but also because of broader attention to planned mitigations across the system.

ASSESSMENT

5. The direction of travel and next steps for the Risk Management Transformation Programme was presented in detail to and supported by the ELT and Committee in September 2024 and supported by the recommendations made by our external consultants, BDO.

6. This is in addition to a substantial programme of work to be undertaken with respect to the next stage of our enterprise risk management, as highlighted in the 2023/24 Internal Audit Review.

7. The ELT approved the principal risk activity described in this paper and considered the full review of each risk undertaken throughout August and September 2024 by Risk Owners and the ADLT.

<u>Risk Management Transformation Programme</u>

8. The next phase of the Risk Transformation Programme is underway which provides for the development of a Strategic Board Assurance Framework (BAF), a

suite of Risk Appetite statements, consideration of an electronic risk management solution and the continuation of work to reposition the Trust's highest rated Risks 223 and 224.

9. These key areas of work align with the advice and recommendations made by external consultants as to what should be done now, next and later.

10. A further scope has been shared across the procurement frameworks to commission additional external support to work alongside the Board and key stakeholders across the Trust on the development of the series of risk appetite statements. These will define the level of risk that the Trust is willing to take or accept in pursuit of its strategic objectives to ensure better outcomes for our patients, our people and communities and in working with our partners and stakeholders.

11. The closing date for consultancy submissions was 07 November 2024 and assessment of these submissions is underway to ensure the timely delivery of two specific work streams in this area; the first is risk appetite training that offers insights on how this can be employed as a key strategic tool to enhance decision making. The second is a risk appetite workshop to define the appetite of the Trust and refine risk appetite statements against the strategic objectives; both of which will involve the Board and key stakeholders from across the Trust.

12. The risk appetite training is scheduled for the 02 December 2024 and the workshop is planned for the 20 February 2025 as an agreed session of the Board Development Programme.

13. Additionally, planned work is underway within the team to develop the strategic BAF which will provide assurance to the Board that the key risks to the Trust's strategic objectives are being managed effectively.

14. It will include two key components: a dashboard of all strategic risks aligned with the strategic objectives, including risk appetite, and a map of the various assurance activities in place to mitigate or manage these risks. It will consolidate all relevant information on these risks and serve as a methodology for the Board to oversee these risks within the Trust's strategic context.

15. The goal is to This will provide the Board with a clear and comprehensive view of both the strategy and its risks and the effectiveness of the controls in place to manage them and support the Board in its strategic decision making.

16. In relation to the electronic risk management solution; Legal & Risk Services have confirmed that Welsh Health bodies can choose to remain on the current Datix Risk Web module at no additional cost until November 2027. This means that the Trust does not have to migrate to the new cloud based, Datix Cymru Module as

originally thought as it has been agreed that this would be a retrograde step for many organisations given the transformative work that has been undertaken since the original scope of the project was developed. Most organisations are now pursuing other options.

17. The Trust's team is considering several digital solutions with the support and expertise of digital colleagues inside and outside the Trust. This includes options to buy then build our own electronic platform within two years. The expectation is that a digital solution will be in place before the end of the financial year that supports our enterprise risk management, strategic risk management and the production of a digital BAF.

Principal Risks

18. Each of the risks have been reviewed during this reporting period in line with the agreed schedule detailed at Annex 3 with continual and dynamic focus on the highest rated risks scoring 15-25. Attention has been given to the risk ratings of each principal risk and the mitigating actions identified and taken to ensure that risks achieve their target score. This is in addition to the standard and regular review of all controls, assurances, and any gaps.

19. The Trust's highest rated Risks 223 *the Trust's inability to reach patients in the community causing patient harm and death* and Risk 224 *significant handover delays outside A&E departments impacts on access to definitive care being delayed and affects the trust's ability to provide a safe and effective service*, remain static at the highest score of 25. The score is not based on the volume of cases of catastrophic harm, it is based on any one individual that experiences avoidable harm. The quality dimension of each of these risks will always be a challenging one to reduce whilst patients and the Trust are experiencing delays in the way in which they currently are.

20. The sustained and extreme pressure continues across the Welsh NHS urgent and emergency care system which is negatively impacting on patient flow and leading to avoidable patient harm and death.

21. The number of lost hours due to handover delays remained significant in September 2024 at 20,693 which is higher than the same period in 2023.

22. Handover delays continue to present patient safety risks and extended waits in the community with a deteriorating Red performance being outside of what is acceptable to deliver a safe emergency service. Delays are also presenting as a theme in the Medical Examiner Service referrals for the first two quarters of 2024/25.

23. The risks continue to be reported to the Trust Board, with a focus on the actions to mitigate these two risks that are within its control, and these are highlighted in the avoidable harm action plan which is presented at each Board meeting. Further mitigations and transformative actions are described in the Integrated Medium Term Plan (IMTP) to address these risks.

24. There are a range of efficiencies described in the report that the Trust has undertaken in mitigation of these two risks. Two key ones being the number of calls being closed safely and efficiently by clinicians through the Consult and Close initiative in the contact centres as well as a an improvement in sickness and attendance levels.

25. Most of the Trust's actions in the action plan have been completed and a several efficiencies and improvements implemented that have stabilised performance; however, the Trust is unable to mitigate the scale of handover lost hours due to the environment which it is operating in or make improvements in performance because of the continued challenges in the urgent and emergency care system.

26. To support the continued, detailed review and mitigation of these risks, a workshop took place on the 6 September 2024 with the Risk Owners and teams to consider a different approach to managing and monitoring those areas that are within the Trust's control and those that are not.

27. The work began to brigade controls into six internal and external themes and will be finalised in December 2024. The outcome of this will be reported through the next round of governance.

28. The Quality, Patient Experience and Safety Committee (QUEST) reviewed both risks at its meeting in November 2024 with the Agenda items reflecting the controls and mitigations discussed at this meeting. These risks continue to be escalated to the Board via the meeting's Alert, Assure and Advise (AAA) report.

29. Additionally, both risks were presented to the Finance & Performance Committee (FPC) and the People & Culture Committee (PCC) meetings in November 2024 to continue to ensure that all perspectives and elements of the risks are considered and reviewed.

30. Risk 160 *High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service*, whilst there has been a significant reduction in absence levels, the score of 20 (5x4) remains static during this quarter; however, this will remain under review given the significant work undertaken to strengthen the controls, assurances, and mitigating actions and the position in August that showed an uncommon but positive decrease in levels for that time of year. The data will be assessed over the next four months to

establish whether the improvement in levels is sustained. Should this be the case, then it is likely that this risk score will be reduced

31. Risk 201 *A loss of stakeholder confidence that damages the Trust's reputation*, remains static at a score of 20 (4x5) given that many of the mitigations are outside the Trust's control. Whilst the risk remains static, it is inextricably linked to several of the metrics measured and discussed at the People & Culture Committee.

32. Risk 594 *The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death* has reduced in score from 20 (4x5) to 15 (3x5) reflecting that the mitigations and actions have been implemented including the revised agreement of the Immediate Release Protocol and assurance from Chief Operating Officers that the agreement will be honoured to release ambulances in the event of a major incident. The risk will remain on the CRR and will be monitored through the normal governance channels.

33. Further work to determine resources following the Manchester Arena Inquiry remains underway.

34. Risk 163 *Maintaining Effective & Strong Trade Union Partnerships* has reduced in score from 16 (4x4) to (12 (3x4) this quarter reflecting the positive engagement and partnership working operating well and ongoing discussions on a range of organisational change issues.

35. Risks 542 *Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan* at a score of 16 (4x4) continues to be reviewed and remains unchanged.

36. Risk 260 *A significant and sustained cyber-attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems* remains static at a score of 15 (3x5), Risk 558 *Deterioration of staff health and wellbeing as a consequence of both internal and external system pressures* and Risk 623 *Failure to comply with Data Protection Legislation* all remain unchanged this period and static at a score of 15 (3x5).

37. Risk 100 *Failure to persuade JCC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience* remains unchanged at a score of 12 (3x4); however, following discussion at the Executive Leadership Team, this risk will undergo a full and thorough review in the next round which may lead to a potential reduction in risk score.

38. Risk 139 *Failure to Deliver our Statutory Financial Duties*. This is due to the reasonable revenue position for 2024/25; however, separate risks may be considered in the future relating to capital funding and vehicle/fleet.

RECOMMENDED

39. Members are asked to consider and discuss the contents of the report and:
    a) Note the progress of the Risk Management Transformation Programme: specifically, the development of risk appetite statements and strategic Board Assurance Framework.
    b) Note the next steps in relation to a digital risk management solution.
    c) Note the ongoing repositioning of Risks 223 and 224.
    d) Note the reduction in score for Risk 163 from 16 (4x4) 12 (3x4) and Risk 594 from 20 (4x5) to 15 (3x5). Both risks will remain on the Corporate Risk Registers for ongoing management.
    e) Receive assurance on the review and attention to the principal risks, including their review at ADLT, ELT and at relevant Committees.

Annex 1 – Corporate Risk Register Summary

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
223 QuEST	The Trust's inability to reach patients in the community causing patient harm and death.	**IF** significant internal and external system pressures continue **THEN** there is a risk of an inability and/or a delay in ambulances reaching patients in the community **RESULTING IN** patient harm and death	Executive Director of Operations	**25 (5x5)** ➡
224 QuEST	Significant handover delays outside A&E departments impacts on access to definitive care being delayed and affects the trust's ability to provide a safe and effective service.	**IF** patients are significantly delayed in ambulances outside A&E departments **THEN** there is a risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised **RESULTING IN** patients potentially coming to harm and a poor patient experience	Executive Director of Quality & Nursing	**25 (5x5)** ➡
160 PCC	High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service.	**IF** there are high levels of absence **THEN** there is a risk that there is a reduced resource capacity **RESULTING IN** an inability to deliver services which adversely impacts on quality, safety and patient/staff experience	Director of People & Culture	**20 (5x4)** ➡
201 PCC	A loss of stakeholder confidence that damages the Trust's reputation.	**IF** there is an inability of the Trust to deliver its core services because of system or organisational pressures **THEN** there will be a loss of stakeholder confidence in the Trust **RESULTING IN** a lack of stakeholder support for the Trust's long term	Director of Partnerships & Engagement	**20 (4x5)** ➡

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		strategic vision, a failure to deliver its strategic ambition, damage to reputation and increased external scrutiny		
542 FPC	Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan	**IF** there is a lack of resources and available technology and infrastructure **THEN** there will be a failure to deliver the commitments outlined in the action plan and within the Welsh Government timelines **RESULTING IN** negative environmental and social impacts causing and reputational damage	Executive Director of Finance & Corporate Resources	**16** **(4x4)** ➡
260 FPC	A significant and sustained cyber-attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems.	**IF** there is a large-scale cyber-attack on WAST, NHS Wales and interdependent networks which shuts down the IT network and there are insufficient information security arrangements in place **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)** ➡
558 PCC	Deterioration of staff health and wellbeing in as a consequence of both internal and external system pressures	**IF** significant internal and external system pressures continue **THEN** there is a risk of a significant deterioration in staff health and wellbeing within WAST **RESULTING IN** increased sickness levels, staff burnout, poor staff and patient experience and patient harm	Director of People & Culture	**15** **(3x5)** ➡

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
594 FPC	The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death.	**IF** a major incident or mass casualty incident is declared **THEN** there is a risk that the Trust cannot provide its pre-determined attendance as set out in the Incident Response Plan and provide an effective, timely or safe response to patients **RESULTING IN** catastrophic harm (death) and a breach of the Trust's legal obligation as a Category 1 responder under the Civil Contingency Act 2004.	Executive Director of Operations	**15 (3x5)** ↓ **20 (4x5)**
623 FPC	Failure to comply with Data Protection Legislation	**IF** the Trust fails to comply with and demonstrate it is meeting the accountability requirements under the Data Protection Act, the UK General Data Protection Regulation (GDPR) and the Common Law Duty of Confidentiality **THEN** the Trust will breach its legal obligations and potentially cause the personal or sensitive data to be compromised, lost, or inappropriately used **RESULTING IN** unauthorised data breaches/loss, financial or compensatory penalties, an increased regulatory scrutiny or enforcement as well as stakeholder mistrust and reputational damage.	Director of Digital Services	**15 (3x5)** →
100 FPC	Failure to persuade JCC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of	**IF** WAST fails to persuade JCC/Health Boards about WAST ambitions	Executive Director of Strategy Planning & Performance	**12 (3x4)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
	patient safety and experience.	**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		
163 PCC	Maintaining Effective & Strong Trade Union Partnerships	**IF** the response to tensions and challenges in the relationships with Trade Union partners is not effectively and swiftly addressed and trust and (early) engagement is not maintained **THEN** there is a risk that Trade Union partnership relationships increase in fragility and the ability to effectively deliver change is compromised **RESULTING IN** a negative impact on colleague experience and/or services to patients.	Director of People & Culture	**12** **(3x4)** ↓ **16** **(4x4)**
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	Executive Director of Finance & Corporate Resources	**8** **(2x4)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		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		

Annex 2 - Risk Scoring Matrix

Consequence:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
Safety & Well-being - Patients/ Staff/Public	Minimal injury requiring no/minimal intervention or treatment. No time off work. Physical injury to self/others that requires no treatment or first aid. Minimum psychological impact requiring no support. Low vulnerability to abuse or exploitation - needs no intervention. Category 1 pressure ulcer.	Minor injury or illness, requiring minor intervention. Requires time off work for >3 days Increased hospital stay 1-3 days. Slight physical injury to self/others that may require first aid. Emotional distress requiring minimal intervention. Increased vulnerability to abuse or exploitation, low level intervention. Category 2 pressure ulcer.	oderate injury/professional intervention. Requires time off work 4-14 days. Increased hospital stay 4-15 days. RIDDOR/Agency reportable incident. Impacts on a small number of patients. Physical injury to self/others requiring medical treatment. Psychological distress requiring formal intervention by MH professionals. Vulnerability to abuse or exploitation requiring increased intervention. Category 3 pressure ulcer.	Major injury leading to long-term disability. Requires time off work >14 days. Increased hospital stay >15 days. RIDDOR Reportable. Regulation 4 Specified Injuries to Workers. Patient mismanagement, long-term effects. Significant physical harm to self or others. Significant psychological distress needing specialist intervention. Vulnerability to abuse or exploitation requiring high levels of intervention. Category 4 pressure ulcer.	Incident leading to death. RIDDOR Reportable. Multiple permanent injuries or irreversible health effects. An event which impacts on a large number of patients.
Quality/ Complaints/ Assurance/ Patient Outcomes	Peripheral element of treatment or service suboptimal. Informal complaint/inquiry.	Overall treatment/service suboptimal. Formal complaint (Stage 1). Local resolution. Single failure of internal standards. Minor implications for patient safety. Reduced performance.	Treatment/service has significantly reduced effectiveness. Formal complaint (Stage 2). Escalation. Local resolution (poss. independent review). Repeated failure of internal standards. Major patient safety implications.	Non-compliance with national standards with significant risk to patients. Multiple complaints/independent review. Low achievement of performance/delivery requirements. Critical report.	Totally unacceptable level or quality of treatment/service. Gross failure of patient safety. Inquest/ombudsman/inquiry. Gross failure to meet national standards/requirements.
Workforce/ Organisational Development/ Staffing/ Competence	Short-term low staffing level that temporarily reduces service quality (< 1 day).	Low staffing level that reduces the service quality.	Late delivery of key objective/service due to lack of staff. Unsafe staffing level (>1 day)/competence. Low staff morale. Poor staff attendance for mandatory/key professional training.	Uncertain delivery of key objective/ service due to lack/loss of staff. Unsafe staffing level (>5 days)/competence. Very low staff morale. Significant numbers of staff not attending mandatory/key professional training.	Non-delivery of key objective/service due to loss of several key staff. Ongoing unsafe staffing levels or competence/skill mix. No staff attending mandatory/professional training.
Statutory Duty, Regulation, Mandatory Requirements	No or minimal impact or breach of guidance/statutory duty.	Breach of statutory legislation. Reduced performance levels if unresolved.	Single breach in statutory duty. Challenging external recommendations/improvement notice.	Enforcement action. Multiple breaches in statutory duty. Improvement notices. Low achievement of performance/ delivery requirements. Critical report.	Multiple breaches in statutory duty. Zero performance rating. Prosecution. Severely critical report. Total system change needed.
Adverse Publicity or Reputation	Rumours. Low level negative social media. Potential for public concern.	ical media coverage - short-term reduction in public confidence/trust. ort-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:	01/10/2024		TREND	25 (5x5)
			Date of Next Review:	01/11/2024		➡	
IF significant internal and external system pressures continue	**THEN** there is a risk of an inability and/or a delay in ambulances reaching patients in the community	**RESULTING IN** patient harm and death		Likelihood	Consequence	Score	
			Inherent	4	5	20	
			Current	5	5	25	
			Target	2	5	10	

IMTP Deliverable Numbers: 1, 2, 3, 4, 5, 6, 7, 8, 10, 14, 15, 20, 22, 24, 25, 27

EXECUTIVE OWNER	Director of Operations	ASSURANCE COMMITTEE	Quality, Safety and Patient Experience Committee

Risk Commentary Q1 2024/2025

The risk score remains constant at 25 (almost certain & catastrophic). Internal and external assurances remain weak as there remains a daily risk of actual patient harm and death because of the Trust not being able to reach patients in the community. The Trust continues to receive Prevention of Future Death Reports (Regulation 28) from Coroners across NHS Wales. **Handover lost hours in June were 22,230, July were 19,599 and August were 17,540.**

The impacts on patients waiting for extended periods of time both in the community and then outside emergency departments is well documented (AACE Delayed Hospital Handovers: Impact assessment of patient harm, 2021) and includes pressure damage, acute kidney injury, deconditioning, poorer outcomes, and extended recovery times. Delays across the system continue to be the focus of patient safety incidents, complaints, Coronial enquires and redress / claims. The effectiveness of our controls in many areas are dependent on external partners acknowledging and having ownership of the risk across the urgent and emergency care system. Key to moving the position is to continue to work in collaboration influencing system partners, being present and engaging in key conversations, whilst continually seeking opportunities internally to swiftly identify and mitigate the risks within our control and share those with relevant system partners that we cannot control. Of note, recent data analysis highlights the increased levels of red activity which has doubled since the pre covid period, plus an average increased on scene time of circa 10 minutes. Both measures are reflective of an increasingly challenged system with WAST crews fully exploring admission avoidance alternatives.

Improvement actions led by Welsh Government and system partners include: -

a) Audit Wales's investigation of Urgent and Emergency Care System. Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time? (E)
b) Consideration of additional WAST schemes to support risk mitigation through winter (I)
c) NHS Wales reduces emergency department handover lost hours by 25% (E)
d) NHS Wales eradicates all emergency department handover delays in excess of 4 hours (E)
e) Alterative capacity equivalent to 1000 beds (E)
f) Implement nationwide approach to emergency department 'Fit 2 Sit' (E)
g) Implementation of Same Day Emergency Care services in each Health Board (E)
h) National Six Goals programme for Urgent and Emergency Car (E)

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. Regional Escalation Protocol	1. Daily conference calls to agree RE levels in conjunction with Health Boards
2. Immediate release protocol	2. The Immediate Release Protocol is a Nationally agreed NHS Wales protocol. Refusals by Health Boards are Datixed by WAST and compliance report shared weekly with the Health Board Chief Operating Officers (COOs). **V1.3 has been reviewed, updated and released (August 2024).**
3. Resource Escalation Action Plan (REAP)	3. Weekly review by Senior Operations team with assessment of action compliance. The Senior Leadership Team convenes every Tuesday as the Weekly Performance Meeting to review performance and demand data, and review/assign REAP Levels as appropriate. Dynamic escalation via Strategic Command structure. REAP has undergone an annual review with v4.1 released in November 2023.
4. 24/7 Operational Delivery Unit (ODU)	4. Shift reports from ODU & ODU Dashboard received by Exec, SOT and On-Call Team at start/end. Provides operational oversight with dynamic CSP review and system escalation as required.
5. Strategic, Tactical and Operational 24 hour/ 7 day per week system to manage escalation plans	5. Same as 4 - Shift reports from ODU & ODU Dashboard received by Exec, SOT and On-Call Team at start/end. Provides operational oversight with dynamic CSP review and system escalation as required. On Call cover is reviewed weekly at SLT Performance Meetings.
6. Limited Alternative Care Pathways in place	6. Limited Assurance - Health Informatics reports, APP dashboard monitors, reports on app use by Consultant Connect, APP development and expansion, and bids for additional prescribing APPs.
7. Consult and Close (previously Hear and Treat)	7. The Trust ambition is to attain 17% Consult and Close rate, with an improvement plan in place to achieve this. The Trust has however already achieved the inclusion of Mental Health Practitioners in CSD, a key contributor to the achievement of Consult and Close rates. Reported through integrated quality meeting. Whilst Consult and Close is in place, the action to increase compliance is detailed in the action plan.
8. Advanced Paramedic Practitioner (APP) deployment model / APP Navigation	8. WAST has attempted to secure additionality within its APP numbers, as the evidence illustrates a dramatic impact upon ED avoidance with more people being managed within the community. At this stage, no additional funds have been secured. However, it remains the case the prospective APPs are completing their education and could be deployed into the operational

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			Inherent	4	5	20	
			Current	5	5	25	
			Target	2	5	10	

	setting to mitigate the risk. ELT has therefore agreed to grow the APP numbers further this year, redirecting existing operational spend to bolster APP growth. This is part of the IMTP Deliverables 2024-2027.
9. Clinical Safety Plan	9. Clinical agreement – agreeing escalation to higher levels, ODU dashboard, AACE paper through National Director of Operations group. In December 2023, Version 2.21 of the Clinical Safety Plan was released. The subsequent reduction in the demand is the assurance which is dynamically monitored via ODU.
10. Recruitment and deployment of CFRs	10. 11 new onboarding courses for June to December with projection of 110 new CFRs by 3rd December 2024. Currently 400 volunteers supporting 6500 hours every month. Response data indicates that our CFRs are reaching more patients, especially those with life threatening conditions in 8 minutes compared to this time last year. Numbers of CFR's, percentage of contribution to performance a governance framework is in place. Monitoring through AD 1:1's and volunteer highlight report (IMTP).
11. ETA scripting	11. The ETA Dashboard is a tactic that was signed off by ELT. The dashboard supports scripting analysed by comparing with real time data. ETA performance is reviewed weekly at SLT weekly performance meeting. The effect of the ETA scripting results in cancellations of ambulances which is monitored through algorithmic review process.
12. Clinical Contact Centre (CCC) emergency rule	12. Emergency Rule is incorporated into CSP 999 levels.
13. National Risk Huddle	13. This is a tactic contained in REAP ratified through SPT and EPT. Daily risk huddles are recorded, and documented actions are shared with stakeholders and progress monitored via the ODU.
14. Summer/Winter initiatives	14. Monitoring through SLT and STB. Senior Planning Team (SPT) was stood up for the duration of Winter 2023/24. Christmas Planning Meetings established from April 2024 for winter period 2024/2025.
15. CHARU implementation	15. Recruitment of 153 WTE has continued; To lift further, a trial of a rotational model is due to be trialled in Aneurin Bevan Health Board area.
16. Clinical Model and clinical review of code sets	16. Reported through CPAS and DCR Review reporting through CQGG
17. Remote clinical support enabling discharge at scene	17. Strategic Transformation Board – IMTP deliverable; Providing support to the Community Welfare Responders (CWR) initiative and supporting CFRs to discharge at scene with current non conveyance rates for CFRs in excess of 40%
18. Trust Board paper (28/07/22) detailing actions being taken to mitigate the risks (see actions section for details of specific work streams being progressed to mitigate this risk)	18. Formally documented action plan – actions captured are contained within and monitored via the Mitigating avoidable harm paper from PIP.
19. Information sharing	19. Information Sharing: Patient Safety Reports, Chief Operating Officer (COO) Data Pack, Immediate Release Declined (IRD) Reports.
20. Completed EMS Roster Review	20. Helps to ensure that we have the maximum available capacity to respond to dispatch to 999 calls received in a timely manner. Monitor production against the rosters weekly at performance meeting and that provides a level of UHP as a percentage.
21. Delivered a reduction in the number of multiple vehicle attendances dispatched to red calls	21. This will increase vehicle availability generally across the Trust and is monitored through SLT weekly performance meeting.
22. Transfer of Care	22. WAST has clearly articulated to the Health Board COOs the risk associated with delayed handovers. Consequently, work has commenced to withdraw WAST staff from portering duties on hospital premises, cease the practice of ED swaps and cease the use of WAST equipment in EDs across Wales. Please refer to the following documents: i) Letter to COO Handover Delays 30.03.2023 ii) Letter to COO Handover Delays iii) WAST – Transfer of Care Brief
23. Virtual Ward – Connect Support Cymru	23. Multi phased approach commenced in Dec 2022 with St John Ambulance Cymru virtual ward responder, a digital and telehealth platform, and a Community Welfare Responder model to enhance community resilience. • Phase 1 delivered through St John Ambulance Cymru with a further extension in place. • Funding also obtained through external grant funding to pilot a volunteer phase. which went live mid-October with twelve teams piloting the approach and has now completed. • Work ongoing to recruit CWR volunteers with engagement taking place with organisations across Wales. • St John Ambulance Cymru virtual ward now extended to the end of May2024.

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24. ARA – - YGC, Swansea Bay and GUH	24. ARA in GUH finished 31st March 2024. Holding area in Swansea and YGC remains ongoing.
25. WAST Serious Clinical Incident Forum (SCIF) is in place to discuss patient safety incidents, learning and improvement actions to prevent future harm, working in collaboration with Health Boards / NHS Wales Executive Delivery Unit under the Joint Investigation Framework which was formalised in the National Patient Safety Policy in May 2023. Sharing of potential case of serious avoidable harm/death with Health Boards for investigation when response delay associated with system congestion is the primary cause. CNO and CMO plus peer group and COOs regularly updated on patient safety incidents. Patient safety reporting and escalation through the Serious Clinical Incident Panel (SCIF), Patient Safety Highlight Reports, Health Board specific reports in place with escalation through WAST governance framework.	25. Patient safety reporting and escalation through the Serious Clinical Incident Panel (SCIF), Patient Safety Highlight Reports, Health Board specific reports in place with escalation through WAST governance framework.
26. WAST membership of the working group (Executive Director of Quality & Nursing) to reform the Framework for the Investigation of Patient Safety Serious Incidents (SIs) national investigation framework with system partners. Chaired by the Deputy Chief Ambulance Commissioner and commenced in August 2022.	26. Workshop with system partners in place with executive directors of nursing attendance and to date is working well with good engagement from health board colleagues. Following the last meeting on 25.01.2023 it was agreed that sub-groups would be formed to meet more frequently to gather themes / evaluation / develop more consistency which would include aligning the outputs / outcomes with the 'Six Goals for Urgent and Emergency Care' work.
27. Undertake the next 5-year strategic EMS Demand and Capacity review (the 2019 version will run out this year – 2024)	**27. Review has been undertaken and has been reported to close F&P committee July 2024 and Trist Board July 2024. This review details the level of resourcing required in different handover lost hour scenarios with different ways to respond to it e.g. traditional model or evolved CRN.**
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Acknowledgement and acceptance of risk by Health Boards and balancing the risks across the whole system	1. Improvement in handover delays across Cardiff and Vale and more latterly across AB have led to improved handovers at Eds. This has now been sustained for some months across C&V in a phased programme of improvement with no delays in excess of 2 hours. Programme of improvement underway in AB, commencing at 4hour tolerance with a plan to reduce over time. In other Health Boards, there remains little or no controls, with variation in both handovers and risk levels across Health Boards. An extraordinary incident declared by WAST on 22 October 2023 as direct result of system risk associated with handover delays at Morrison hospital has increased focus on handover delays with external partners and across the media. Some plans are in train (detailed in actions) following a meeting with Swansea Bay COO to include mobile imaging, pathways to bypass ED and a pod solution ahead of winter.
2. Blockages in system e.g., internal capacity within Health Boards which affect patient flow	
3. Local delivery units mirroring WAST ODU	
4. Handover delays link to risk 224	
5. There is an ambition that no handover should exceed 4 hours and for lost hours to handover to be reduced by 25% but given the track record over last 12 months there is a low confidence in attaining this.	5. The majority of Health Boards have failed to deliver on this ambition; With the exception of Cardiff and Vale University Health Board, the remaining 5 Health Boards with acute Trusts that were required to deliver on this target, have failed to do so.
6. Handover Improvement Plans agreed between WAST and Health Boards	6. Performance targets for Handover with Health Boards have been introduced by the commissioner.
7. Access to Same Day Emergency Care (SDEC) for paramedic referrals	7. This forms part of the handover improvement plans in place with Health Boards; however, assurance is limited given that the uptake is low (less than 1% of total demand). There is an inconsistency in approach from Health Boards on eligibility and availability; The national Once for Wales acceptance criteria has not been uniformly deployed by Health Bards across Wales.
8. Mental Health users connecting via the 999 system to 111 press 2 services. Discrepancies in pathway between 111 and CSD – point of entry influences pathway.	
9. Volunteer Alternative Responder Scheme (VARS)	9. Live from June 2024 with further scheme due to rollout across Wales.
10. There is currently no JCC implementation plan associated with the 2023 Demand and Capacity Review	10. The requirements for a funded implementation plan for the review i.e. resource envelope change from the JCC. The review is being reported to JCC board development session in August 2024 and is expected to go to JCC committee later this year. The expectation is that the 2025/26 commission intentions will respond to the review.
Please note that the gaps listed are not WAST's and are therefore outside of the control of WAST	

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			Inherent	4	5	20	
			Current	5	5	25	
			Target	2	5	10	

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Exploring Rural model options (Paused during Pandemic Response) – subject to funding through IMTP. Now refreshed to wider rural model opportunities to include recruitment of CFRs. Additional funding has been sourced to increase posts within the volunteer function.	Assistant Director of Operations EMS / Assistant Director of Operations – National Operations & Support	Superseded	Rural model superseded by Action 9 below (Recruitment and deployment of CFRs)
2. Leading Change Together (forum to progress workforce related work streams jointly with TUPs)	ADLT Sub-Group	30.09.22 - Superseded	
3. Recruit and train more Advanced Paramedic Practitioners – Value Based Healthcare Fund bid for up to 50 WTE (I) [Source: Action Plan presented to Trust Board 28/07/22]	Director of Paramedicine / Director of People & Culture	**Superseded**	WAST has attempted to secure additionality within its APP numbers, as the evidence illustrates a dramatic impact upon ED avoidance with more people being managed within the community. At this stage, no additional funds have been secured. However, it remains the case the prospective APPs are completing their education and could be deployed into the operational setting to mitigate the risk. ELT has therefore agreed to grow the APP numbers further this year, redirecting existing operational spend to bolster APP growth. May24 - Initial bid unsuccessful however an action within the new IMTP to grow our APP workforce by up to 40 per year for the next 3 years. Updates will progress through the IMTP within quarters. Milestone changed from March 2024 to June 2024.
4. APP recruitment	Assistant Director of Operations	**March 2025**	Aug24 – Modelling of APP growth trajectory to be modelled through the APP recruitment Steering Group for approval at ELT. Numbers to be confirmed at point of approval.
5. IMTP Deliverables 2027-2027 – implementation of new clinical model.	Assistant Director of **Integrated Care (with SRO through CMT Board)**	March 2025	Phase 1 for winter May24 – Ops engagement commenced April 2024. Temporary ADO recruited to support winter actions. Plans to deployment between October 2024 and March 2025.
6. Overnight Falls Service extension (I) [Source: Action Plan presented to Trust Board 28/07/22]	Assistant Director of Quality & Governance / Head of Quality Improvement	Ended March 2023	The temporary extension of the SJAC contract for overnight provision was evaluated, demonstrating on available evidence a positive performance impact over the period of operation (Jan-April 2023). The evaluation report was presented to EMT on 5 April 2023. The contract extension (as a temporary arrangement) ceased on 5 April 2023. Falls service enhanced day and night provision remains in place and utilisation of resources is reviewed at weekly performance meetings by Operations SLT.
7. New 2023 EMS Demand and Capacity (roster) review	Assistant Director of Planning & Performance	**Completed**	ORH modelling underway. Initial findings January 2024, full report to Trust Board and EASC in March. May24 - The review is scheduled to be presented to Trust Board end of July 2024. Milestone changed from March 2024 to August 2024.
8. Connected Support Cymru – is initially designed to utilise NHS and voluntary-sector resources and responders to enable patients to be supported in their own home whilst waiting for an urgent healthcare need to be managed. The service will employ digital health technologies to connect patients, communities and clinicals to achieve better health outcomes. The initiative will improve patient experience and safety, while supporting the healthcare system in directing patients to the right pathway at an appropriate time for their care need. It is expected this will help reduce unnecessary demand upon Emergency Departments.	Assistant Director of Quality Governance	**Superseded with the implementation of the new model (ref: Action 5)**	**Multi phased approach commenced in Dec 2022 with St John Ambulance Cymru virtual ward responder, a digital and telehealth platform, and a Community Welfare Responder model to enhance community resilience.** **• Phase 1 delivered in partnership with St John Ambulance Cymru to deliver the CWR element. Initial phase due to conclude in March**

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			Current	5	5	25	
			Target	2	5	10	

Action	Owner	Date	Progress
			2024, further extended to May 2024 due to SJAC funding accommodating extension arrangement. • **NHS Charities Together (grant) funding obtained through external application, to develop internal volunteer capacity/volunteer workforce as CWRs. Piloting of the CWR model commenced in Spring 2024, with an expansion of the model in mid-October. Recruitment, onboarding and training continues with aspiration to recruit CWRs across Wales.** • **The SBRI innovation challenge has supported a phase 2 delivery of the digital ward model: enabling remote clinicians to care for patients in a 'virtual ward' capacity. It is envisioned this will enable patients to reach to right care at the right time, whilst being monitored remotely. The pilot has commenced for care homes in Wales, and a dedicated remote clinician is supporting the initiative generating organisational learning to expand remote care planning role the Trust can provide for the NHS Wales. The pilot initiative will conclude in March 2025.** • **The nature of this project of work aligns to the RICs workstream of the Clinical Model Transformation programme; the work will form part of the RICs workstream from September 2024.**
9. Maximise the opportunity from Consult and Close: - Successful resolution without ambulance (double EMS) - Successful resolution without conveying to ED		March 2025	Trust ambition is to improve Consult and Close rate, with an improvement plan in place to achieve this. The Trust has however already achieved the inclusion of Mental Health Practitioners in CSD, a key contributor to the achievement of Consult and Close rates. Consult and Close compliance remains around 14%. Action plan activities therefore continue with a review of triage processes which may lead to shorter triage durations, along with increase in staffing, which together will enable more triages to take place, thus increasing the number of successful resolutions without a double EMS ambulance and numbers conveyed to an ED.
10. Palliative Care Paramedic Unit	Assistant Director of Operations	Extended to May 2024 - **new date TBC**	Reducing demand via APPs – 15th January Start. 15/04/2024 - 3 Month Health Board funded trial ended. Whilst utilisation was low, the results demonstrated a circa 75% ED avoidance therefore local decision made to extend for a further 2 months, however, opening the trial up to wider community and crew referrals. 21/06/2024 - Unit still ongoing.
11. Audit Wales investigation of Urgent and Emergency Care System: Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time?	CEO	Q1 2024-2025	• **01/10/2024 - The review of the unscheduled care report part 2 (accessing urgent and emergency care) is underway and will come to the committee in November 2024.** • Conducted in three phases Audit Wales will independently investigate and report on patient flow out of hospital: access to unscheduled care services and national arrangements (structure, governance, and support) • WAST will proactively support this work and offer best practice examples from other jurisdictions that can support benchmarking and improvement activities.

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			Inherent	4	5	20
			Current	5	5	25
			Target	2	5	10

			• Expected outcomes in 2023/24.
12. Royal Glamorgan Early Diagnostic	Executive Director of Operations	**August 2024**	• Initial data from Qlik shows that there has been no reduction in N2H times however data received from Health Board show indication of patient benefit to reach earlier diagnostic. Local meetings this month to discuss findings and explore opportunities. • May 24 – No improvement in N2H time. Local management having discussions with Health Board for review and next steps.

Risk ID 224	Significant Handover of Care Delays Outside Accident and Emergency Departments Impacts on Access to Definitive Care Being Delayed and Affects the Trust's Ability to Provide a Safe & Effective Service for Patients	Date of Review:	06/09/2024	TREND	25 (5x5)
		Date of Next Review:	06/10/2024	➡	

IF patients continue to be significantly delayed in ambulances outside Accident and Emergency Departments	**THEN** there is a continued risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised	**RESULTING IN** patients coming to significant harm and a poor patient experience

	Likelihood	Consequence	Score
Inherent	5	5	25
Current	5	5	25
Target	3	2	6

IMTP Deliverable Numbers: 1, 3, 8, 14, 15, 22, 23, 24, 25, 26, 27, 30, 31

EXECUTIVE OWNER	Director of Quality & Nursing	ASSURANCE COMMITTEE	Quality, Safety and Patient Experience Committee

Risk Commentary Q2 2024/25

- The risk score remains constant at 25 for quarter 2 2024/25 (almost certain & catastrophic). Internal and external assurances remain weak as there remains a daily risk of actual patient harm due to handover of care delays. JCC EASC set a target of 15,000 hours lost by the end of Q2 and 12,000 hours lost by the end of Q3. Handover lost hours in April 2024 were 23,614 compared to 23,082 in April 2023. Eradication of handover waits of > 4 hours: there were 3,404 over four-hour patient handovers in April 2024, compared to 2,730 in April 2023. The expectation is that these would have been eradicated by end of 2023/24. Cardiff & Vale UHB has demonstrated material improvement and is a positive outlier when compared to other health boards. Recently, Welsh Government have re-iterated to Health Boards that the reduction in long handovers is a priority for this year with an expectation that over 1 hour waits would be reduced by 30% by December 2024.The impacts on patients waiting for extended periods of time both in the community and then outside emergency departments is well documented (AACE Delayed Hospital Handovers: Impact assessment of patient harm, 2021) and includes pressure damage, acute kidney injury, deconditioning, poorer outcomes, and extended recovery times. Delays across the system continue to be the focus of patient safety incidents, complaints, coronial enquiries and redress / claims. The Trust continues to receive Prevention of Future Death Reports (Regulation 28) from Coroners across NHS Wales. The Trust received the first Prevention of Future Deaths Report in February 2024 relating to pressure damage, which is a joint Report with Swansea Bay University Health Board. On 22.02.2024 a Prevention of Future Deaths Report was sent solely to the Minister for Health and Social Services, Welsh Government in respect of delays responding to a patient in community which also references handover of care delays. The effectiveness of our controls in many areas are dependent on external partners acknowledging and having ownership of the risk across the urgent and emergency care system. Key to moving the position is to continue to work in collaboration influencing system partners, being present and engaging in key conversations, whilst continually seeking opportunities internally to swiftly identify and mitigate the risks within our control and share those with relevant system partners that we cannot control. WAST CEO and Directors have ensured that system safety and avoidable harm remain a live topic of discussion in all relevant forums and continue to seize opportunities as they emerge that can contribute to mitigating avoidable harm. Given the long-standing nature of the system pressures and long handover times, we have commenced work to better define mitigations to safety risks and quality of care deriving from extended periods in an ambulance; these include the application of Mental Capacity Act and Deprivation of Liberty Safeguards and, Fundamentals of Care including pressure area care, mobilisation and nutrition. One specific area of focus is the development of a prototype mattress for our ambulance trolleys.

Improvement actions led by Welsh Government and system partners include:

a) Right care, right place, first time Six Goals for Urgent and Emergency Care - A policy handbook 2021–2026. Goal 4 'Improving ambulance patient handover, ensuring no one arriving by ambulance at an Emergency Department waits more than 60 minutes from arrival to handover to a clinician – (Welsh Government) ***by the end of April 2025***
b) National Six Goals programme for Urgent and Emergency Care: Led by the NHS Wales Deputy Chief Executive this programme seeks to modernise access to and the provision of Urgent and Emergency Care across Wales. WAST is represented on the Clinical Reference Group by the Director of Paramedicine and on the overarching programme board by the Executive Director of Strategy, Planning & Performance.
c) The Trust also has a presence on all the individual goal boards. The Trust has been asked to provide a presentation on its offer to the system at the next Six Goals Programme Board (24 January 2024).
d) NHS Wales eradicates all emergency department handover delays more than 4 hours (LHB CEOs) ***revised to March 2023/24.***
e) Alternative capacity equivalent to 1,000 beds project (LHB CEOs) – 678 additional beds delivered, a significant achievement, but short of the target of 1,000.
f) Investigation of Urgent and Emergency Care System: Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time? (Audit Wales)
g) Implement nationwide approach to emergency department 'Fit 2 Sit' (Welsh Government: Chief Medical Officer and Chief Nursing Officer) – paused. Health boards have previously been required to develop handover reduction action plans, which are monitored at their Integrated Quality, Planning & Delivery (IQPD) meetings by Welsh Government. Handover is also discussed at the Integrated Commissioning Action Plan (ICAP) meetings (currently paused as commissioning arrangements transition into the new Joint Commissioning Committee) which are held monthly between the CASC, the Trust and each Health Board.

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. WAST Serious Clinical Incident Forum (SCIF) is in place to discuss patient safety incidents, learning and improvement actions to prevent future harm, working in collaboration with Health Boards / NHS Wales Executive Delivery Unit under the Joint Investigation Framework which was formalised in the National Patient Safety Policy in May 2023. Sharing of potential case of serious avoidable harm/death with Health Boards for investigation when response delay associated with system congestion is the primary cause. CNO and CMO plus peer group and COOs regularly updated on patient safety incidents.	1. Patient safety reporting and escalation through the Serious Clinical Incident Panel (SCIF), Patient Safety Highlight Reports, Health Board specific reports in place with escalation through WAST governance framework.
2. WAST membership of the working group (Executive Director of Quality & Nursing) to reform the Framework for the Investigation of Patient Safety Serious Incidents (SIs) national investigation framework with system partners. Chaired by the Deputy Chief Ambulance Commissioner and commenced in August 2022.	2. Workshop with system partners in place with executive directors of nursing attendance and to date is working well with good engagement from health board colleagues. Following the last meeting on 25.01.2023 it was agreed that sub-groups would be formed to meet more frequently to gather themes / evaluation / develop

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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

	more consistency which would include aligning the outputs / outcomes with the 'Six Goals for Urgent and Emergency Care' work. An event reviewing the effectiveness of the Joint Investigation Framework is currently being scoped nationally.
3. WAST and system compliance with National Standards - 15-minute handover (NHS Wales Hospital Handover Guidance v2 (May 2016)	3. Monthly Integrated Quality and Performance Report, Health Informatics reports, APP dashboard on app use by Consultant Connect and shared at local and corporate meetings regarding patient safety and handover of care position across NHS Wales and NHS England.
4. WAST Clinical Notice in place - Escalating a clinical concern with a deteriorating patient outside the Emergency Department (11.02.2021). National Early Warning Score (NEWS) trigger of 5 or above for escalation to hospital clinicians. NEWS data available via EPCR (electronic patient care record).	4. NEWS data now available via ePCR and escalation system in place via local managers and the Operational Delivery Unit.
5. Workstreams put in place to meet requirements of *Right care, right place, first time Six Goals for Urgent and Emergency Care A policy handbook 2021–2026.* Goal 4 incorporates the reduction of handover of care delays through collective system partnership.	5. Monthly Integrated Quality and Performance Report and WAST is represented on the Clinical Reference Group by the Director of Paramedicine and on the overarching programme board by the Executive Director of Strategy, Planning & Performance. The Trust also has a presence on all the individual goal boards.
6. Hospital Ambulance Liaison Officer (HALO) (Some Health Boards).	6.
7. Regional Escalation Protocol and Resource Escalation Action Plan (REAP). Proactive and forward-looking weekly review of predicted capacity and forecast demand. Deployment of predetermined actions dependant on assessed level of pressure. Consideration of any bespoke response/actions plans in the light of what is expected in the coming week. WAST has updated the REAP in advance of winter, including revised triggers (higher) for handover lost hours.	7. The Senior Leadership Team convenes every Tuesday as the Weekly Performance Meeting to review performance and demand data, and review/assign REAP Levels as appropriate. Dynamic escalation is via the Strategic Command structure. REAP has undergone an annual review with v4.1 released in November 2023.
8. Staff from WAST, Health Boards and third sector organisations assisting to meet patient's Fundamentals of Care as best they can in the circumstances.	8. Confirmed through Healthcare Inspectorate Wales (HIW) workshops and Health & Care Standards self-assessment process and Putting Things Right Quarterly Reports to Clinical Quality Governance Group and QuEST
9. 24/7 operational oversight by ODU with dynamic Clinical Safety Plan review and system escalation as required. Realtime management and escalation of risks and harm with system partners. Triggering and escalation levels within CSP to best manage patient safety in the context of prevailing demand and available response capacity. Monitoring, escalation and reporting of extreme response or handover delays.	9. Shift reports from ODU & ODU Dashboard received by Executive Management Team (EMT), Senior Operations Team (SOT) and On-Call Team at start/end. Realtime management and escalation of risks and harm with system partners. Triggering and escalation levels within CSP to best manage patient safety in the context of prevailing demand and available response capacity. Monitoring, escalation and reporting of extreme response or handover delays. In December 2023, Version 2.21 of the Clinical Safety Plan was released. The reduction in the demand is the assurance which is dynamically monitored via ODU.
10. Gold/Strategic, Silver/Tactical and Bronze/Operational 24 hour/ 7 day per week system to manage escalation plans.	10. Shift reports from ODU & ODU Dashboard received by EMT, SOT and On-Call Team at start/end. On Call cover is reviewed weekly at SLT Performance Meetings.
11. Escalation forums to discuss reducing and mitigating system pressures.	11. Daily risk huddles are recorded, and documented actions are shared with stakeholders and progress monitored via the ODU.
12. WAST Education and training programmes include deteriorating patient (NEWs), tissue viability and pressure damage prevention, dementia awareness, mental health.	12. Monthly Integrated Quality and Performance Report (April 2024 overall 82% - Safeguarding is 78% and dementia awareness remains over 91%).
13. Clinical audit programme in place.	13. Clinical audit programme in place (dynamic document) with oversight from the Clinical Quality Governance Group and QuEST.
14. Workshop set up by the Deputy Chief Ambulance Commissioner to respond to the findings in the Health Care Inspectorate Wales (HIW) Report *Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover* (undertaken 2021). WAST has senior representation at this meeting. – assurance is that HIW approve and sign off WAST elements and Health Board elements of recommendations.	14. Workshop set up by the Deputy Chief Ambulance Commissioner to respond to the findings in the Health Care Inspectorate Wales (HIW) Report Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover (undertaken 2021). WAST has senior representation at this meeting. A collective response from WAST and Health Boards is being overseen by 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.	15. Monthly Integrated Quality and Performance Report, CEO Reports to Trust Board including 'Actions to Mitigate Avoidable Patient Harm Report' (last presented to Trust Board May 2024) and Board sub-committee oversight and escalation through 'Alert, Advise and Assure' reports.

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			Inherent	5	5	25
			Current	5	5	25
			Target	3	2	6

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."	
16. Implementation of Duty of Quality, Duty of Candour, and new Quality Standards requirements in April 2023.	16. Welsh Government Road Map in place (soft launch) with milestones for organisations – baseline assessment and monthly updates (RAG ratings) in place with Trust Board oversight. The current internal assessment overall as of May 2024 is 'Implementing and operationalising'. The Trust has representation on the All Wales Duty of Candour Implementation Group and is actively engaged in developing resources. From April 2024 the Trust will publish an annual quality report and compliance with Duty of Candour. Operational oversight occurs at the Quality Management Group and Executive oversight is via the Clinical & Quality Governance Group.
17. Clinical Support Desk First in place	17.
18. Summer/Winter initiatives	18. Monitoring through SLT and STB. Senior Planning Team (SPT) is now stood up for the duration of Winter 2024/25.
	External Sources of Assurance Management (1st Line of Assurance)
	1. Monitoring and oversight of the Ambulance Quality Indicators (AQIs) including handover of care timeliness and Commissioning Framework by the Chief Ambulance Services Commissioner (CASC), the Emergency Ambulance Services Committee (EASC) including the Integrated Commissioning Action Plans (ICAPS) and Joint Executive Team (JET) meetings with Welsh Government (I&E).
	2. Healthcare Inspectorate Wales (HIW) 'Review of Patient Safety, Privacy, Dignity and Experience whilst waiting in Ambulances during Delayed Handover' Report and system wide improvement plan with working group in place with WAST senior representation. Oversight by HIW and EASC
	3. Duty of Quality and Duty of Candour readiness returns assessment by Welsh Government.
	4. Internal Audit Report (April 2024) Serious Incidents: Joint Investigation Framework (WAST internal processes) provided 'Reasonable Assurance' with low to moderate impact on residual risk exposure until resolved. Improvement actions are monitored via the Audit Tracker.
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Lack of capacity in the Putting Things Right Team to deliver across the functions due to competing priorities resulting from sustained system pressures – recruitment in line with Organisational Change Process is progressing with full establishment expected by July 2024.	
2.	1. Implementation of the revised Joint Investigation process with good engagement seen by system partners. Several overdue patient safety investigations remain presenting a risk to patient safety across the system. The Trust has 56 overdue nationally reportable incident (NRI) investigations, with 63 NRIs open in total. Shared system learning from the Joint Investigation Framework is currently limited with no new learning identified to date.
3. Lack of implementation and holding to account regarding the NHS Wales of the Handover Guidance v2 and recognition of the patient safety risks pan NHS Wales.	2. 15-minute handover target is not being achieved pan-Wales consistently and has led to a substantial growth in emergency ambulance handover lost hours. In October 2023, 23,232 hours were lost with 1,888 +4 hour delayed patient handovers.
4. Variation in responsiveness at Emergency Departments to the escalating concerns regarding patients' NEWS.	3. Strengthening of patient safety reports and audit processes as e PCR system embeds.

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5. Variation pan Wales / England as position not implemented across all emergency departments.	4. New Quality Management System in development which will include monitoring of the new Quality Standards & Enablers and underpinning governance structure.
6. National steer required to confirm the accountability arrangements regarding patients in ambulances outside of the emergency departments. The seven Local Health Boards (LHBs) in Wales are responsible for planning and securing delivery of primary, community, secondary care services, and also the specialist services for their areas.	5. HIW approve and sign off WAST elements of recommendations.
	External Gaps in Assurance 1. Lack of escalation and response to AQIs by the wider urgent care system and regulators

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Handover checklist implementation – Nationally WAST Quality Improvement (QI) Project	WAST QI Team (QSPE)	TBC – Paused	• Timeframes awaited via Emergency Department Quality & Delivery Framework (EDQDF).
2. Implement patient safety dashboards (live and look back data) triangulating quality metrics / KPIs and performance data sourcing health informatics resource.	Assistant Director of Quality & Nursing	Q3 2024/25	• Incremental improvements to quality and safety data and information to enable triangulation / collective intelligence at Trust and system level. • Access to ePCR data (NEWS) now available and access for the Patient safety Team is being explored. Work on-going with Health Informatics regarding patient safety and health board dashboards capacity in Health Informatics impacting and dates revised. • Local dashboards have been developed but requiring manual data extraction
3. Continued Health Board interactions – my next patient (boarding), patient safety team dialogue – proactive conversations with Health Board Directors of Quality & Nursing.	Executive Director of Quality & Nursing	Monthly and as required.	• Monthly meetings continue to be held and networking through EDoNS.
4. Recruit and train more Advanced Paramedic Practitioners.	Director of Paramedicine	Q4 2024/25	• The Trust uplifted its APP establishment by a further 15.7 FTEs in • 2023/24 (funded through internal movements). For 2024/25 the Trust • is funding a further uplift of 32 APPs (additional funding, not internal • movements). • The above uplifts will increase the APP establishment to 120.7 FTEs.
5. Overnight falls service extension and future modelling	Executive Director of Quality & Nursing	31.09.2024	•Overnight falls service extension and future modelling • Night Car Scheme extension agreed to 31 September 2024 (2 regional resources) • Utilisation rates continue to be monitored: • Nighttime utilisation: - Q2 65% Q3 64% Q4 to date 64% April 2024 - 67% • Daytime utilisation: - Q2 57% Q3 56% Q4 to date 58% April 2024 – 54% • Combined day and night Q2-Q3 58% Combined day and night Q4 to date 59% Combined day and night April 2024- 55% There is now also an additional Level1 nighttime resource through RPB and Gwent Resilience Plan ringfenced to ABUHB. AB dedicated level 1 62% for April 2024

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			Inherent	5	5	25
			Current	5	5	25
			Target	3	2	6

			The 2023 EMS Demand & Capacity Review has completed its modelling of falls level 1 and level 2 resources. This will now need to be considered further by the Trust, commissioners and health boards. There is an immediate focus on the contract beyond September 2024. The 2023 EMS Demand & Capacity Review will be formally reported to Trust Board in July 2024.
6. Duty of Quality, Duty of Candour and new Quality Standards implementation from April 2023 with development of a Quality Monitoring System supporting monitoring and oversight systems in place and embedded. Quality Report development underway – mandatory requirement to publish 2024/25 (no fixed date for publication nationally).	Executive Director of Quality & Nursing	Q4 2024/25	• Monthly updates to progress against actions following the baseline assessment and readiness returns continued. • RL Datix Dashboards and KPIs under development nationally by National Quality & Safety Group. • Key policies updated and approved further updates following release of revised Putting Things Right Regulations which is delayed now expected release by Welsh Government in Autumn 2024 therefore timescale amended. • Participation in the All Wales Duty of Candour implementation group by Patient Safety Team – monthly.
7. Connected Support Cymru is initially designed to utilise NHS and voluntary-sector resources and responders to enable patients to be supported in their own home whilst waiting for an urgent healthcare need to be managed. The service will employ digital health technologies to connect patients, communities and clinicals to achieve better health outcomes. The initiative will improve patient experience and safety, while supporting the healthcare system in directing patients to the right pathway at an appropriate time for their care need. It is expected this will help reduce unnecessary demand upon Emergency Departments.	Executive Director of Quality & Nursing	Q2 2024/25	• Currently awaiting WG feedback on the submitted business case. • Further meetings arranged with between the Executive Director of Quality & Nursing and Six Goals Programme/WG/. Trust has also approach WG with a smaller ask to facilitate 7 FTE CSD clinicians to provide a continuation of the Luscii solution - this would enable a proof of value pilot to further inform a business case.
8. Organisational change process (OCP) of Putting Things Right Team (PTR) to enable increased capacity across all functions to manage increasing complexity and demands.	Executive Director of Quality & Nursing	Q2 2024/25	• OCP commenced 25.09.2023 and the consultation period has concluded with the final new structure confirmed. Next steps are to recruit to vacant positions which has commenced. It is anticipated that all positions will be filled by May 2024 (taking notice periods into account). Recruitment is progressing well with multiple applications for each post and some internal promotion opportunities. • Final posts due to be recruited to and in place by July 2024.
9. Audit Wales investigation of Urgent and Emergency Care System: Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time?	CEO	Q2 2024/25	• Conducted in three phases Audit Wales will independently investigate and report on patient flow out of hospital: access to unscheduled care services and national arrangements (structure, governance, and support). • WAST will proactively support this work and offer best practice examples from other jurisdictions that can support benchmarking and improvement activities. Expected outcomes in 2023/24. • The audit is proceeding. Trust awaiting the outcome. AD Commissioning & Performance has requested an update from Audit Wales. • Audit Wales have confirmed this has been reprofiled into 2024/25.
10. Patient handover actions.	Executive Team	Under review	• Some English ambulance services operate a system whereby handovers are mandated or forced after a certain period e.g. WMAS and LAS. This will be reviewed by the Executive team.
11. Work in progress to better define mitigations to safety risks and quality of care deriving from extended periods in an ambulance; these include the application of Mental Capacity Act and Deprivation of Liberty Safeguards and Fundamentals of Care including pressure area care, mobilisation and nutrition. One specific area of focus is the development of a prototype mattress for ambulance trolleys.	Executive Director of Quality & Nursing	Q3 2024/25	• Fundamentals of Care meeting, chaired by the Executive Director of Quality & Nursing held on 08.03.2024.
12. Trust to produce its own six goals plan (Goal 4 links to handover of care)	Executive Director of Strategy, Planning &		• Trust to produce its own six goals plan (Goal 4 links to handover of care)

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:	26/09/2024	TREND	20 (5x4)
		Date of Next Review:	26/10/2024	➡	

IF there are high levels of absence e.g., sickness and alternative duties.	THEN there is a risk that there is reduced resource capacity	RESULTING IN an inability to deliver services which adversely impacts on quality, safety, and patient/staff experience

	Likelihood	Consequence	Score
Inherent	4	4	16
Current	5	4	20
Target	3	4	12

IMTP Deliverable Numbers: 13, 14, 15, 22, 24, 25, 26

EXECUTIVE OWNER	Director of People & Culture	ASSURANCE COMMITTEE	People and Culture Committee

Risk Commentary

Sickness absence remains one of the key challenges for the organisation. Whilst there has been a significant reduction in absence levels over the past 18 months, rates remain higher than desired and therefore a continued focus on supporting good attendance at work is needed by both managers and the People and Culture team. Increased pressures on our people like handover delay, missed breaks and cost of living impact on health and wellbeing. **Whilst the sick absence rates went up in July it was positive to note the decrease in August. Traditionally, the school holiday period had often seen an increase in absence rates; therefore we intend to assess the data for the next four months to establish whether the improvement is sustained. If there is a sustained improvement, then it is likely that this risk score will be reduced.**

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. Managing Attendance at Work Policy/Procedures in place and followed	1. (a) Audits undertaken by People Services Team (b) Outputs reviewed
2. Respect and Resolution Policy- recognising issues at work may contribute to sick absence	2. R&Rs addressed in timely way to reduce risks of sickness absence. Compassionate Practices approach engaged. Referral of colleagues to appropriate levels of support
3. Updated Freedom to Speak Up Policy replacing the Raising Concerns Policy- recognising issues at work may contribute to sick absence	3. Policy reviews to ensure policies and procedures are fit for purpose in line with agreed time frames Completed - 28/11/23 Freedom to speak Up Safely process introduced from the start of October 2023 including three Trust guardians.
4. Health and Wellbeing Strategy – key document that outlines commitment to wellbeing and supportive culture	4. Regular reference to strategy to ensure themes are addressed and linked to wider people and culture plan 28/11/2023 Health and Wellbeing Strategy coming to an end in 2024 to be replaced with a new plan with a focus on employee experience in line with the All-Wales Framework and the People and Culture Plan 2023-2026
5. Operational Workforce Recruitment Plans - provide evidence of sufficient resources and identify any gaps or potential areas of increased workload pressure	5.
6. Roster Review & Implementation- to support demand and capacity which can have an impact on absence levels	6. Roster Review for EMS completed. Review in 111 underway
7. Return to Work interviews are undertaken - SharePoint Sway document ensuring accurate reporting of reason for absence and identifying any additional support required	7. Process regularly reviewed and managers provided with relevant training and coaching on process and importance of carrying out return to work interviews promptly
8. Training on all aspects of Managing Attendance – ensures focus is high and understanding of why this is important is maintained	8. Regular bitesize training provided for managers, adapted to reflect feedback and to ensure all aspects of managing attendance is understood
9. Directors receive monthly email with setting out ESR sickness data - ensures ownership and awareness.	9. Monthly reporting provided with opportunity for discussion with relevant people services lead and Director
10. Operational managers receive daily sickness absence data via GRS- ensures ownership and awareness	10. Provided daily, with opportunity for discussion with relevant people services lead and operational managers
11. People Services & Occupational Health & Wellbeing support/Employee Assistance Programme- providing professional support	11. Monthly reporting on services provided, volume of referrals and timeframes for accessing support.
12. WAST Keep Talking (mental health portal) additional measures to offer support	12. Quarterly reporting on numbers accessing and regular promotion of service. Reported in MIQPR
13. Suicide first aiders- additional layer of support	13. Quarterly reporting of numbers of trained suicide first aiders and numbers who have access. Mental Health Team deliver this
14. TRiM- additional layer of support	14. Quarterly reporting on access to TRiM and promotion of service Included in MIQPR
15. Peer Support network- additional level of support	15. Promotion of network and support provided
16. Coaching and mentoring framework- additional level of support	16. Promotion of network and support provided 28/11/2023 on pause to focus on Leadership Framework with a focus on culture and its impact on the experience of work and workplace wellbeing
17. Staff surveys- assess levels of engagement and wellbeing	17. New HIVE survey tool will provide data on overall engagement and wellbeing 28/11/2023 the NHS Wales Staff Survey has also just closed and will provide information in the new year to inform us further.

Risk ID 160	High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service	Date of Review:	26/09/2024	TREND	20 (5x4)
		Date of Next Review:	26/10/2024	➡	

IF there are high levels of absence e.g., sickness and alternative duties.	**THEN** there is a risk that there is reduced resource capacity	**RESULTING IN** an inability to deliver services which adversely impacts on quality, safety, and patient/staff experience

	Likelihood	Consequence	Score
Inherent	4	4	16
Current	5	4	20
Target	3	4	12

18. Stress risk assessments- identify measures that can be taken to address issues	18. Reference to the assessments during attendance management line manager training and to the TUS 28/11/2023 OH to lead on a refresh of stress risk assessments use
19. Sickness statistics are reported to SLT, SOT, People & Culture Committee, Trust Board and the CASC	19. Sickness forms part of Workforce Scorecard to People & Culture Committee and is also supported by PCC deep dives into sickness. Reporting is also shared with CASC and EASC. Discussions on sickness are reported in minutes and AAA to Board
20. External agencies support e.g., St John Ambulance, Fire and Rescue- if needed at times of increased demand pressure	20.
21. Monthly reviews of colleagues on Alternative duties	21. Action plans arising from meetings with colleagues implemented through monthly diarised meetings
22. Manager guidance on managing Alternative duties	22. Evidence of managers guidance in place and referenced in attendance management training
23. Monthly report on absence to ELT and report to every meeting of People & Culture Committee via the Workforce Report and provision of deep dives when requested.	23.
24. Sickness audits for localities- provides additional level of detail	24. Audits carried out and actions taken forward
25. Additional support for areas with higher-than-average absence – emphasis is on understanding reasons and developing action plans	25. Dedicated meetings taking place and support from people services for areas with absence with local plans in place to address specific issues
26. Review of top 100 cases -carried out monthly	26. Provides a focus on cases with a clear focus on support and making sure there are plans attached to each case.
27. Deep dives on specific issues and reasons for absence	27. Enables wider consideration of additional measures that may be adopted and identifies themes and keeps focus on absence management e.g. – mental health and causes 28/11/23 Recognition of the impact of employee experience and workplace conditions and link to absence. Reported to ELT for information
28. Implementation of the Managing Attendance Project 2022-23 completed and ongoing activities maintained	28. BAU evaluating for delivery
29. Implementation of Behaviours Refresh Plan completed	29. BAU evaluated for delivery
30. 2023 10-point action plans shared with EMT for assurance and RAG rated to track progress quarter	30. Offers assurance to ELMT on the activities and measures in place. Figures on absence are being reported monthly to ELT which is reflected in the minutes and AAA reports
31. Work in Confidence system implemented and Freedom to Speak Up Month in October 2023 focused attention on this	31. External Management (2nd Line of Assurance)
32. Actions from Audit of Nov 22 completed	32. Audit actions completed
33. Strengthen Freedom to Speak Up Arrangements policy and advice and roll out of platform for raising concerns (in relation to Freedom to Speak Up Arrangements) (Having additional mechanisms in place for individuals to speak up potentially reducing work related stress and anxiety which is a key reason for absence)	33. Monitor FTSU concerns and they are dealt with in agreed timeframes and assessed whether absence related to mental health and anxiety reduces.
34. Health and Wellbeing Steering Group in place	34. Monitored through numbers of FTSU concerns raised and continual promotion via Comms and Roadshow Events.
35. Actions identified from the Managing Attendance Audit implemented	35. Agendas, minutes etc.
36. PADR review undertaken and now including wellness questions	36. Underway and now BAU – we need to say what this means by way of assurance
37. Scrutinising on a monthly basis all long-term sickness absence case to ensure there is a tailored, individual action plan which identifies interventions that will support a return to work as soon as reasonably possible.	37. PADRs undertaken and questions asked; Discussion on levels of long-term sick absence is undertaken in a variety of forums including EASC, ELT and PCC.
38. Accountability meetings on attendance management between People Services and senior ops managers to ensure this issue is given sufficient focus on priorities.	38. Meetings taking place and active discussions on operational areas experiencing high levels of absence
39. Senior Ops Managers have accountabilities sessions on attendance management with their Heads of Service.	39. Meetings taking place and active discussions on operational areas experiencing high levels of absence
40. Specific issues associated with muscular skeletal conditions is discussed regularly at the H&S Committee and relevant additional interventions are identified	40. It is on each agenda and outcomes are available for discussion at H&SC.

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:	26/09/2024	TREND	20 (5x4)
		Date of Next Review:	26/10/2024	➡	

IF there are high levels of absence e.g., sickness and alternative duties.	**THEN** there is a risk that there is reduced resource capacity	**RESULTING IN** an inability to deliver services which adversely impacts on quality, safety, and patient/staff experience

	Likelihood	Consequence	Score
Inherent	4	4	16
Current	5	4	20
Target	3	4	12

41. Review of top 100 cases by the wider People & Culture Team - monthly (Wellbeing, OCC Health, People Services). This takes place to consider whether any of those cases required additional interventions.	41. Director of People & Culture receives assurance from the team following each of the monthly meetings.
	Independent Assurance (3rd Line of Assurance)
	1b. Internal Audits scheduled through Shared Services Partnership. Last audit on attendance was November 2022 and the last actions from this due at the end of December 2023. (last audit November)
	2. Audit Wales – Taking Care of the Carers report in October 2021
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
(a) Consistency and Application in Managing Attendance at Work Policy	There are other factors that impact on sickness which can't be controlled
9 and 10 It is not known what is undertaken with respect to the data covered in assurances 9 and 10 once it is received	9, 10 and 19 Absence data is not updated in a timely manner into ESR by managers
1 – 22 Education and communication with managers about resources available and how to implement it e.g., stress risk assessments	1.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Develop guidance and training for line managers to equip them with the confidence and skills to have meaningful and sensitive conversations related to attendance.	Head of Culture	31/01/25	Measured through ongoing participation in development sessions and feedback from TU regarding management handling of absence cases. Piloting bite size chunks in Autumn with results in January 2025.
2. Case studies developed on examples of areas of business where attendance management has improved significantly to share learning across WAST	Deputy Director of People & Culture	31/10/24	Case studies will be published, shared and discussed at leadership meetings and evidence of good practice adopted
3. Connect to other Ambulance sector organisations to identify additional interventions they have implemented to address attendance management, share learning and consider whether to adopt in WAST	Deputy Director, People and Culture	31/01/25	Discuss at P&C Business Meeting and share at ELT/PCC with recommendations.
4. Targeted culture change reviews are undertaken in areas of the business where levels of absence are high and other metrics such as turnover indicates concerns. Alongside this these areas are also experiencing significant change.	Director of People & Culture	Ongoing	Culture review action plans are produced and taken forward. Sick absence in these areas is evaluated and monitored to assess whether reductions are achieved.
5. Implementation of new approach to regularly checking in with staff. Piloting a simple conversation framework for Managers to use with their staff on a monthly basis which provides a focus on wellbeing, goals and personal development.	AD for Culture, Inclusion & Wellbeing	Ongoing	Evaluation of pilot after 6 months to assess if there has been a reduction in sick absence in specific areas where this approach has been adopted.
6. Development of the 2024/25 Managing Attendance Plan (see below for individual actions.	Deputy Director, People and Culture	To commence 30/05/24	Key plan actions noted below
7. Delivery of actions to support managers handling attendance issues with skills, capability and confidence	Deputy Director, People and Culture	31.03.2025	
8. Coaching for managers on cases on one and locality basis.	Deputy Director, People and Culture	31.03.2025	
9. Increase manager support on data interpretation and analysis	Deputy Director, People and Culture	31.03.2025	
10. Increase manager understanding of options for colleagues who are not able to sustain their attendance e.g. flexible hours, reduced hours etc	Deputy Director, People and Culture	31.03.2025	
11. Culture work on creating the sense of team and peer responsibility / ownership	AD for f Culture Inclusion and Wellbeing	31.03.2025	
12. Analyse link between hot spots and the culture in these areas to address cultural issues	AD for Culture, Inclusion & Wellbeing	31.03.2025	

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:	26/09/2024	TREND	20 (5x4)
		Date of Next Review:	26/10/2024	➡	

IF there are high levels of absence e.g., sickness and alternative duties.	**THEN** there is a risk that there is reduced resource capacity	**RESULTING IN** an inability to deliver services which adversely impacts on quality, safety, and patient/staff experience

	Likelihood	Consequence	Score
Inherent	4	4	16
Current	5	4	20
Target	3	4	12

13. Improve preventative measures and pro-active work	Deputy Director of People and Culture	31.03.2025	
14. Identify opportunities to improve roles – flexibility, control, confidence	Deputy Director of People and Culture / ADs, Operations	31.03.2025	
15. Opportunities to adapt the work environment – overruns, shift patterns, rest and recuperation	Deputy Director of People and Culture / ADs, Operations	31.03.2025	
16. Review workloads	Deputy Director of People and Culture / ADs, Operations	31.03.2025	
17. Review patterns of absence	Deputy Director of People and Culture	31.03.2025	
18. Development of a mental health referral pathway	AD for Culture, Inclusion and Wellbeing	31.03.2025	
19. Develop the team around the person model / individual support network	Deputy Director of People and Culture	31.03.2025	
20. Increase lifestyle advice and guidance	AD for Culture, Inclusion and Wellbeing	31.03.2025	
21. Undertake proactive testing to identify undiagnosed conditions	AD for Culture, Inclusion and Wellbeing	31.03.2025	
22. Review reporting on OH	AD for Culture, Inclusion and Wellbeing	31.03.2025	
23. Review opportunities on men's mental health e.g. support groups	AD for Culture, Inclusion and Wellbeing	31.03.2025	

Risk ID 201	A loss of stakeholder confidence that damages the Trust reputation	Date of Review:	26/09/2024	TREND	20 (4x5)
		Date of Next Review:	26/10/2024	➡	

IF there is an inability of the Trust to deliver its core services because of system or organisational pressures	**THEN** there will be a loss of stakeholder confidence in the Trust	**RESULTING IN** a lack of stakeholder support for the Trust's long term strategic vision, a failure to deliver its strategic ambition, damage to reputation and increased external scrutiny		Likelihood	Consequence	Score
			Inherent	4	5	20
			Current	4	5	20
			Target	3	5	15

IMTP Deliverable Numbers: 1, 2, 3, 4, 5, 6, 7, 8, 9,10, 11, 12, 13, 16, 25, 27

EXECUTIVE OWNER	Director of Partnerships and Engagement	ASSURANCE COMMITTEE	People and Culture Committee

Risk Commentary Q3 2024/25

The risk score remains constant at 20 (highly likely and catastrophic). The organisation's reputational risk is one which is long-standing and entrenched. **At the time of writing, conversations with key, mission critical stakeholders remain live in respect of the Trust's proposed clinical service model/transformation programme. The outcome of these discussions will inform the next steps in relation to proposed transformation and, as such, are critical in terms of the Trust's reputation. Similarly, with winter approaching, and the attendant pressures and risks that come with it, the risk to Trust reputation remains significant**.

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. CEO and DSP meeting with HB CEOs throughout Q4 to informally discuss strategic ambition	1. Feedback reported via ELT, TSAG etc/
2. Revision of engagement framework delivery plan (approved by Board Jan 2023) to reflect feedback from stakeholders and revised timelines for strategy engagement	2. Will report via strategy programme architecture plus discussion at Board development/PCC etc. Included in 2024/25 IMTP
3. Challenging of media reports to ensure accuracy	3. Programme of daily media engagement documented on digital system
4. Media liaison to ensure relationships developed with key media stakeholders	4. Programme of daily media engagement documented on digital system
5. Routine stakeholder and staff engagement, including the recent round of Executive roadshows and WAST Live.	5. Agendas, minutes, and documents of engagement events. Informal feedback via ELT and reported via Trust Board (CEO update)
6. Engagement governance and reporting structures are in place	6. Relevant information which impacts on reputation is reported and scrutinised via all internal committees e.g., ELT, FPC, PCC, QuEST & Audit Committee – minuted meetings and action logs.
7. Annual deep dives on reputation in place	7. Reported to Committees, documented in minutes, action logs and papers
8. Engagement of the Board on matters of reputation in development sessions. If required, escalation procedure for issues to the Board where circumstances dictate, following discussion at ELT	8. Minuted meetings, action logs and Board papers
9. Regular engagement with senior stakeholders e.g., Ministers, senior Welsh Government officials, commissioners, elected politicians and NHS Wales organisational system leaders	9. Informal feedback reported via ELT and occasionally in formal correspondence (nature of discussion often precludes formal recording)
10. Monitoring external factors that may affect the Trust	10. ELT verbally updated on a regular basis with written notes if appropriate
11. Board oversight, scrutiny and challenge of performance, concerns, quality	11. What is the assurance that this control is effective
12. Internal Quality and Performance monitoring in the Trust and raising system issues	12. What is the assurance that this control is effective - reports at ELT, Finance and Performance Committee, Quality, Safety and Patient Experience Committee, People and Culture Committee, Audit Committee
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. The delivery plan is currently under review and is subject to further agreement	1.
2. Managing the narrative of the media	2.
3. Strategic collaboration – further work needed to formalise opportunities	3.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Reputation audit year two planned	Director of Partnerships & Engagement	**Complete**	Audit launched on 09 April 2024 and ran until 01 May 2024. High-level results presented at People and Culture Committee on 09 May and at Board Development on 27 June **to assist the Trust to understand the impact of the reputation audit and to support our approach to stakeholder engagement.**
2. Agree Stakeholder Influencing Plan	Director of Partnerships & Engagement	Q2 24/25	Currently in development **and will be considered by the CMT Programme Board in September 2024. This will be a live document and evolve with the programme.**
3. Roll out of Stakeholder Influencing Plan	Director of Partnerships & Engagement	Q2-3 24/25 onwards	**Roll out underway**.
4. Reputation Audit deep dive on findings to be presented at Board Development	Director of Partnerships & Engagement	**Complete**	Findings were also presented at the 09 May People and Culture Committee meeting **and will inform the approach to stakeholder engagement plan**.

Risk ID 542	Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan	Date of Review:	26/09/2024	TREND	16 (4x4)
		Date of Next Review:	26/10/2024	→	

IF	THEN	RESULTING IN		Likelihood	Consequence	Score
IF there is a lack of resources and available technology and infrastructure	**THEN** there will be a failure to deliver the commitments outlined in the action plan and within the Welsh Government timelines	**RESULTING IN** negative environmental and social impacts causing and reputational damage	**Inherent**	5	4	20
			Current	4	4	16
			Target	2	4	8

IMTP Deliverable Numbers: 17, 18, 33

EXECUTIVE OWNER	Executive Director of Finance and Corporate Resources	**ASSURANCE COMMITTEE**	Finance and Performance Committee

Risk Commentary

Challenges continue around resources and technology, and currently there is not an ability to reduce this score. Decarbonisation Programme Board met. Noting some progress on positive movement to actions within the DAP

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. Oversight of implementation and delivery of Decarbonisation project and monitoring of action plan at Decarbonisation Programme Board and Capital Management Board	1. Regular meetings of the Decarbonisation Programme Board quarterly. Requirements of the Decarbonisation project have been presented to the Trust Board & Finance and Performance Committee. Challenges of the project have also been highlighted. Report goes regularly to FPC and then onto Trust Board
2. Capital and Estates directorate lead support – Director of Finance (DOF)	2. Regular briefings to DOF
3. Partnership working via Communications/Stakeholder liaison group with NHS Wales, Welsh Government and other bodies to gain support and knowledge- with the anticipation of working in collaboration.	3. Sharing of knowledge via partnership working through various forums is documented in minutes of meetings held. Requirements also form part of the action plan
4. Approach changed for heating/lighting/energy systems to become more energy efficient- replacing old inefficient plant with more sustainable technology such as natural gas boilers for air source heat pumps	4. (i) Estate Survey undertaken every 5 years. This is a 6-facet survey to understand where the back log is and the requirements for energy systems. (ii) Approved Estates SOP (iii) Estate Retrofit Guide and framework used to prepare schemes
5. Changing procurement practices for fleet, Estates, equipment, supplies, and ICT to reduce emissions	5. Fleet SOP shows move to ULEV vehicles. BJC 2024/25 details intention for move to EV for smaller and support vehicles
6. Board Development sessions with respect to Decarbonisation to raise awareness of decarbonisation requirements, additional sessions will be required.	6. Board Development session occurred on 8th November 2021 – presentation slides are available.
7. Finance & Performance Committee has oversight of decarbonisation project, decarbonisation to become a standard agenda item.	7. (i) Routine updates at every other FPC meeting (3 times a year) (ii) Annual report (which includes a Sustainability section) is approved by the Finance & Performance Committee
8. KPIs with respect to energy transmissions are communicated to Estates team annually by sustainability manager	8. KPIs to Estates team includes energy use at all WAST managed buildings
9. ISO14001 accreditation in place	9. ISO14001 – Annual audits are undertaken against the accreditation. Environmental Coordinators act as champions in the organisation.
10. Environment Strategy in place	10. Environment strategy has been approved by the Trust Board. This covers the next 5 years
11. Programme Board Risk Register	11. Programme Risk Register reviewed at every Decarbonisation Programme Board meeting
12. Reporting to WG via DCR reporting, qualitative, and quantitative reports and emissions reporting	12. Submissions to WG – quarterly DCR reporting. Annual qualitative and quantitative reporting
13. Membership of National Programme Board (WG), Transport Task and Finish Group and BELP Project Board	13. Minutes and papers of meeting
	External - Independent Assurance: • Sustainability section in Annual Report audited by Internal Audit. Annual audits by BSI on accreditation

GAPS IN CONTROLS	GAPS IN ASSURANCE
1. Establishment of further workstreams to address a Programme Plan to support strategy requirements	
2. Ability to deliver on EV infrastructure plan including electrical capacity issues for the purposes of electronic charging points for vehicles	
3. Procurement of an electronic fleet of vehicles – this is not currently possible for anything other than a car/van (limited)	

Risk ID 542	Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan	Date of Review:	26/09/2024	TREND	16 (4x4)
		Date of Next Review:	26/10/2024	➡	

IF there is a lack of resources and available technology and infrastructure	**THEN** there will be a failure to deliver the commitments outlined in the action plan and within the Welsh Government timelines	**RESULTING IN** negative environmental and social impacts causing and reputational damage		Likelihood	Consequence	Score
			Inherent	5	4	20
			Current	4	4	16
			Target	2	4	8

4. NED support ended April 2022	
5. Resources to be able to deliver extent of DAP – work ongoing to establish actions required and potential cost impacts. Note detailed schemes are challenging to work up without appropriate resource which in turn allow for realistic financial estimates to be made about cost.	

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Establishment of potential further workstreams to address a Programme Plan to support strategy requirements: Consider further workstreams required in support of delivering DAP actions, including grouping of similar actions	Capital Development and Estates Team	**Not needed. Action closed.**	Workstreams were set up to manage delivery of the EFAB projects and the transport element (Transport Project Board). Links are also made into ongoing work to develop the IMTP and develop longer term strategies e.g. Fleet Vehicle Procurement Strategy 2025 – 30.
2. Ability to deliver on EV infrastructure plan including electrical capacity issues for the purposes of electronic charging points for vehicles: develop an investment strategy/prioritised list of sites where further EV charging is required. Will need further investment.	Decarbonisation Programme Board	March 2025 (in line with the IA recommendation action)	
3. Procurement of an electronic fleet of vehicles – this is not currently possible for anything other than a car/van (limited): development of specifications for vehicles considering achievable and safe ULEV options where possible. NOTE: will be dependent on confirmation of 2024/25 BJC funding	Fleet Team	March 2025	
4. NED support ended April 2022: A new NED will need to be nominated to champion this risk/project at Trust Board level	Director of Corporate Governance / Board Secretary	**30.09.24**	To be further discussed with relevant Directors.
5. Resources to be able to deliver extent of DAP – work ongoing to establish actions required and potential cost impacts. Note detailed schemes are challenging to work up without appropriate resource which in turn allow for realistic financial estimates to be made about cost: Development of an investment requirements schedule (also aligned to IA recommendations). Contribute resources to support the Decarbonisation Strategy action plan	Director of Finance & Corporate Resources	31.03.25	

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:	25/09/2024	TREND	15 (3x5)
		Date of Next Review:	25/10/2024	→	

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

IMTP Deliverable Numbers: 1, 15, 19, 24

EXECUTIVE OWNER	Director of Digital Services	ASSURANCE COMMITTEE	Finance and Performance Committee

Risk Commentary

The risk has been fully reviewed in the cycle and the score remains static. Latest National Cyber Security Centre (NCSC) assessment indicates that the threat of Cyber-attacks remains unchanged with activities of state actors and criminal gangs still high. Whilst the Trust and wider NHS Wales organisations have in place several layers of technology to protect the Trust and its information systems, there is still a risk that users will be fooled by phishing emails which are becoming ever more sophisticated. To raise user awareness of cyber threats the Trust ICT department run regular phishing exercises as well as short security training packages, reporting the results and uptake through IGSG and into FPC. A deep dive of the risk was undertaken during the closed session of FPC on the 16.07.2024 with no concerns raised in respect to the management of the risk.

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1. Appropriate policy and procedures in place for Information/Cyber Security	1. Information Security Policy reviewed every 3 years (currently due for renewal). Incident Policy and Procedure put in place in February 2022 – renewed annually.
2. Trust Business Continuity Procedure and Incident Response Plan	2. Debrief from significant business continuity incidents captured within organisational learning spreadsheet. Governance with respect to this goes through SOTs. Full review of Incident Response plan every 3 years - currently undergoing a partial review. BCPs and BIAs should be reviewed annually by their owners. Annual schedule of testing
3. IT Disaster Recovery Plan	3. Organisation-wide tabletop exercise undertaken in March 2022 with all BC leads and Digital teams.
4. Relevant expertise in Trust with respect to information security	4. Staff undertake relevant training courses e.g., CISSP to increase knowledge and expertise
5. Data Protection Officer in post	5. In job description of Head of ICT
6. Cyber and information security training and awareness	6. Training statistics are available on ESR and from Phish threat module
7. Mandatory Information Governance training which includes GDPR	7. Training statistics reported on by Information Governance department
8. ICT tests and monitoring on networks & servers	8. Any issues would be identified and flagged and actioned
9. Information Governance framework	9. WAST self-assesses its Information Governance Framework against the Welsh Information Governance toolkit.
10. Internal and NHS Wales governance reporting structures in place	10. Internal WAST Information Governance Steering Group & All Wales Information Governance Management Advisory Group (IGMAG) meets quarterly, National Ambulance Information Governance Group (NIAG) meets every 2 weeks, Operational Security and Service Management Board (OSSMB) (national) – daily/weekly meetings and minuted meetings every 2 months. Minutes and actions logs available for meetings.
11. Checks undertaken on inactive user accounts	11. Software in place to run check on inactive accounts as and when
12. Business Continuity exercises	12. Annual schedule of testing
13. Operational ICT controls e.g., penetration testing, firewalls, patching	13. Monthly scans on infrastructure. Penetration testing has occurred for different systems. 2 physical firewalls on networks to monitor traffic. Monthly patching occurs or as and when. 04/08/23 – Exploring procurement of additional penetration tests with the aim of annual testing of all critical systems.
14. Security alerts	14. Daily alerts are received. Anti-virus alerts received as and when threat discovered
15. Cyber/Info Security KPI are reported to senior management and committees	15. Monthly KPI reports now being generated routinely and fed into the Digital Leadership Group, ELT, IGSG and FPC
16. Regular cyber awareness campaigns are conducted	16. Cyber training is provided to staff and regular phishing campaigns are conducted. These are reported as part of the KPI reports

<table>
<tr><td>Risk ID 260</td><td colspan="3">Significant and Sustained Cyber Attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems</td><td>Date of Review:
Date of Next Review:</td><td>25/09/2024
25/10/2024</td><td>TREND
➡</td><td>15 (3x5)</td></tr>
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<tr><td rowspan="5">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</td><td rowspan="5">THEN there is a risk of a significant information security incident</td><td rowspan="5">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</td><td></td><td>Likelihood</td><td>Consequence</td><td>Score</td></tr>
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<tr><td>17 IT recovery Plan does include a cyber response</td><td>17. Cyber response incorporated into IT Disaster Recovery Plan</td></tr>
<tr><td>18.Information Security Policy refreshed and approved</td><td></td></tr>
<tr><td>19. Suite of business continuity exercises that departments can undertake to test their plans are available via EPRR.</td><td>19.</td></tr>
<tr><td>20. The cyber risk is reviewed and monitored</td><td>20. The ongoing cyber threat to the organisation is continually monitored using daily comms feeds and automated alerts from various external sources via ICT security team and reported to AD of Digital and DPO. The corporate cyber risk assessment will be reviewed monthly at the Digital Leadership Group informed by the threat and intelligence monitoring and national strategic trends.</td></tr>
<tr><td></td><td>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</td></tr>
<tr><td>GAPS IN CONTROLS</td><td>GAPS IN ASSURANCE</td></tr>
<tr><td>1. Lack of understanding and compliance with policy and procedures by all staff members</td><td>1.</td></tr>
<tr><td>2. No organisational information security management system in place</td><td>2. SIRO in place and ISMS evolving in line with refresh of Trust information Security Policy</td></tr>
<tr><td>3. 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</td><td></td></tr>
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Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Development of a Cyber Improvement Plan	Senior ICT Security Specialist	Next checkpoint date 25.10.2024	Implementation of Cyber Improvement Plan actions ongoing and regularly reported into ICT SMT, DLG, IGSG and FPC.

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:	02/10/2024	TREND	15 (3x5)
		Date of Next Review:	02/11/2024	→	

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: 13, 14, 21, 26

EXECUTIVE OWNER	Director of People & Culture	**ASSURANCE COMMITTEE**	People & Culture Committee

Risk Commentary

This risk should be considered alongside Risk 160 as the resulting increased sickness levels mentioned above will be addressed by the same controls and assurances. However, the ongoing system pressures including long handover delays, overruns, missed breaks and the perpetuating impact of increased sickness levels continues to mean this risk remains static. WAST continues to work in partnership with the system to pilot viable options for addressing the external factors. Although there has been some success in some areas, we are yet to see these being scaled to an extent that the employee experience has been impacted. Since 2020 we have not seen the previous pattern of easing over the summer months and with the current public health risk of measles and continuing risks of covid this risk remains static. The People and Culture Plan 2023-2026 is a good summary of the controls and actions addressing this risk. The old Health and Wellbeing Strategy and its replacement build on this. Nationally the Health and Wellbeing Framework due for publication in Summer 2024 also addresses the system wide employee experience challenges. The ongoing system challenges remain with long handover delays which are likely to worsen again as we head into winter pressures. Work on reducing shift overruns continues with various pilots being run to test viable options which could be implemented. Front line operations had little respite over the summer months.

CONTROLS	**ASSURANCES**
	Internal Management (1st Line of Assurance)
13. Health and wellbeing strategy 2020-2024 in place and shared across the Trust. The new Health and Wellbeing Plan 2025-2028 has now been drafted and is out for consultation. The aim of the new plan is to expand on consideration of employee experience to recognise that individual wellbeing interventions are not sufficient in mitigating system wide pressures.	14. New Health and Wellbeing Plan 2025-2028 aligned closely to People and Culture Plan and delivery monitored via the Health and Wellbeing Steering Group, reporting into the People and Culture Business Meetings. New All Wales Framework also in development with an emphasis on workplace experience due for publication in June 2024.
14. Occupational Health & Wellbeing team with range of support options for individual mental health interventions, MSK support, reasonable accommodations and recommendations, supported by mental and physical health expert clinicians.	15. Current waiting times now within SLA of 6 days, self-referrals and self-appointment booking. External providers meet quarterly and provide monthly engagement figures. Reporting into OHW operational team meeting and MIQPR.
15. Wellbeing support and training for line managers a peer support network and TRiM intervention for trauma information.	16. Rolling programme of workshops, attendance at team events when requested, evaluation and numbers trained reported at OHW operational meetings. Diarised meetings, webinars and workshops in place through a rolling programme. Have these happened and what was the benefit? How do we measure it.
16.	17. Tools are available on WAST intranet.
17. TRiM	18. TRiM Coordinator has regular dialogue with TRiM managers and practitioners. Project plan and training schedule in place.
18. Acting on results of staff surveys relating to staff experience, data triangulated with pulse surveys and other cultural metrics as detailed in the People and Culture Plan.	19. Each Directorate has developed their own action plan to address staff surveys. NHS staff survey high level results released 19/02/204 with directorate specific data released in April 2024.
19. HSE stress risk assessments	20. Undertaken by managers and advice is provided on how to use them by Occupational Health and Health and Safety teams.
20. KPIs are reported fortnightly to regarding Occupational Health and Wellbeing activity	21. Received at OHW operational team meeting and reported in MIQPR.
21. Wellbeing drop-in sessions for CCC and 111 staff	22. These sessions are now part of business as usual across services and a user experience form is being designed to collate more formal quantitative feedback for OHW operational team meetings. Data to date has been qualitative and the quantitative has been measured by engagement with the service.
22. Fast track physiotherapy to address MSK issues.	23. Regular review meetings with physiotherapy provider and monthly monitoring information received at People and Culture Business meetings and MIQPR
23. Occupational Health team inclusion in sickness and absence meetings	24. Have the meetings been of benefit and how do we measure it
24. Stress risk assessments	25. These are part of the IOSH Managing Safely Training.
	External - Independent Assurance - Audit Wales – Taking Care of the Carers report in October 2021 – all actions complete
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
	4. Reporting on wellbeing training take up this is now being reported into OHW Operational Team Meetings.
11. Need to increase the education and communication with managers about stress risk assessments. Presentation developed and shared with people services. Delivery dates being agreed in conjunction with Health and Safety. With the arrival of the new OH Manager these discussions have restarted, and	Lack of awareness about staff wellbeing services, this continues to be a challenge due to small team, non-wired colleagues and competing communication messages.

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:	02/10/2024	TREND	15 (3x5)
		Date of Next Review:	02/11/2024	➡	

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

colleagues are directed to the stress risk assessment information and education sessions will be started in Q1 & Q2.	
	Effects of elevated reap status affecting the ability of staff to engage with staff health and wellbeing services. Important to recognise the consistent reports of the impact of culture on wellbeing. Attendance at all events by operational staff consistently low due to service pressures.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. People and Culture Plan 2023-2026 relevant Actions	Assistant Director for Inclusion, culture and wellbeing	Annual Plan	First year due to be reviewed at next People and Culture Committee May 2024 23/7/24 Final year review included in consultation process for new plan
2. Health and Wellbeing Plan 2025-2029	Assistant Director for Inclusion, culture and wellbeing	To be agreed at board autumn 2024.	New plan out for consultation until June 2024 16/4/2024 Ongoing 23/7/24 Extended consultation period until end of August 2024 **2/10/24 Consultation drawing to a close and final plan due to ELT on 23/10/24**

RISK ID 594	The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death	Date of Review:	01/10/2024	TREND	15 (3x5)
		Date of Next Review:	01/11/2024		

IF a major incident or mass casualty incident is declared	THEN there is a risk that the Trust cannot provide its pre-determined attendance as set out in the Incident Response Plan and provide an effective, timely or safe response to patients due to vehicles not being released from hospital sites	RESULTING IN catastrophic harm (death) and a breach of the Trust's legal obligation as a Category 1 responder under the Civil Contingency Act 2004

	Likelihood	Consequence	Score
Inherent	4	5	20
Current	3	5	15
Target	2	5	10

IMTP Deliverable Numbers: 1, 5, 6, 7,14, 15, 24

EXECUTIVE OWNER	Director of Operations	ASSURANCE COMMITTEE	Finance & Performance Committee

Risk Commentary Q1 2024/2025

The challenges across the unscheduled care system**.** Handover lost hours in **June were 19,599, July were 23,220 and August were 17,540.** There is a direct correlation with ambulance availability and high levels of resources unavailable due to protracted waits at hospital E.Ds. Several incidents declared have failed to provide sufficient on the ground assurance that vehicles would be released. Health Boards have declined to incorporate testing of vehicle release into a recent mass casualty exercise. Further, a recent workshop undertaken by the EPRR team as part of the Manchester Arena Inquiry assurance process which has tested our ability to fulfil the PDA in North and South Wales, both in and out of hours, has confirmed that we would only meet the PDA in one of these four mass casualty scenarios.

After a thorough review and assessment of Risk 594 within the Corporate Risk Register at SLT on 02/10/2024, we propose reducing the risk score from 20 to 15 (likelihood from 4 to 3) due to the following reasons:

· Mitigation/Controls have been Implemented: We have several controls measures that directly address the identified risk and are content we have exhausted all opportunities for additional controls. These controls are embedded within the corporate risk register.

· Immediate Release Protocol: The revised version of the IR protocol v1.3 has been agreed and shared at COO group and published which has included the release schedule for ambulances at the declaration of an incident as set out below:

·50% of vehicles released within 10 minutes

· 75% of vehicles released within 20 minutes

· 100% of vehicles released within 30 minutes

· Monitoring and Review: We will continue to monitor the risk within the normal governance channels (SOT/SLT/ADLT etc) to ensure that mitigations are still in place and any emerging risks are promptly identified and addressed.

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1. Immediate release protocol	1. The Immediate Release Protocol is a Nationally agreed NHS Wales protocol. Refusals by Health Boards are Datixed by WAST and compliance report provided weekly to the DG for Health & Social Services. **V1.3 has been reviewed, updated and released (August 2024).**
2. Resource Escalation Action Plan (REAP)	2. The Senior Leadership Team convenes every Tuesday as the Weekly Performance Meeting to review performance and demand data, and review/assign REAP Levels as appropriate. Dynamic escalation via Strategic Command structure. REAP has undergone an annual review with v4.1 released in November 2023.
3. Regional Escalation Protocol	3. Daily conference calls to agree RES levels in conjunction with Health Boards
4. Incident Response Plan	4. The Incident Response Plan has been ratified via EMT
5. Mutual Aid arrangement with NARU	5. AACE National Policy on mutual aid in place
6. Clinical Safety Plan	6. CSP adopted by EMT and operational; reviewed annually by SLT in December 2023, Version 2.21 of the Clinical Safety Plan was released. The reduction in the demand is the assurance which is dynamically monitored via ODU.
7. Operational Delivery Unit 24/7 cover	7. Shift reports from ODU & ODU Dashboard received by Exec, SOT, and On-Call Team at start/end of shift and cover review at weekly performance meeting
8. In hours and Out of hours command cover	8. Civil Contingency requirement as set out in the Command Policy and Incident Response Plan. Cover review at weekly performance meetings
9. Notification and Escalation Procedure	9. Published procedure in operation, reviewed 3 yearly by SLT
10. Continued escalation of risk to partners and stakeholders	10. Referenced by the Executive Director of Operations in correspondence sent to health board Chief Operating Officers dated 30 March 2023. It was further emphasised at the face-to-face COO Peer Group meeting on 14 April 2023.
	External Independent Assurance N/A
11. CEO letter to Health Boards dated 3 Jan 2023, and DOO letter to Chief Operating Officers dated 30 March 2023 to seek assurance on plans.	11. Acknowledgement and acceptance of risk by HBs and balancing the risk across the whole system. Improvement in handovers in C&VHB and ABUHB. This has been sustained form some months across C&V in a phased programme of

RISK ID 594	The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death	Date of Review:	01/10/2024	TREND	15 (3x5)
		Date of Next Review:	01/11/2024		

IF a major incident or mass casualty incident is declared	**THEN** there is a risk that the Trust cannot provide its pre-determined attendance as set out in the Incident Response Plan and provide an effective, timely or safe response to patients due to vehicles not being released from hospital sites	**RESULTING IN** catastrophic harm (death) and a breach of the Trust's legal obligation as a Category 1 responder under the Civil Contingency Act 2004

	Likelihood	Consequence	Score
Inherent	4	5	20
Current	3	5	15
Target	2	5	10

	improvement with no delays more than 2 hours. Programme of improvement underway in ABUHB commencing at 4-hour tolerance with a plan to reduce over time. In other HBs there remains little or no controls with variation in both handovers and risk levels across HBs.
12. Health boards are asked to provide assurance of existing and tested plans to immediately reduce emergency ambulances on incident declaration.	12. All Health Boards responded with assurance of plans except BCU.
13. Multi Agency Exercise to be arranged.	13. This exercise has taken place although Health Boards declined to incorporate vehicle release plans
14. Meeting with Welsh Government to outline this risk; WG agreed to write to HBs seeking assurance from EPRR leads in HBs on the ability to clear EDs and release vehicles. WG agreed to incorporate testing into the forthcoming mass casualty exercise, and a timeframe for vehicle release was proposed by WAST with 30% of vehicles released within 10 minutes of an incident declaration, 50% within 20 minutes and 100% within 40 minutes.	14. WG have confirmed that they have written to HB EPRR leads. Health Board COOs approved the proposals for vehicle release as outlined.
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
Despite the controls listed, the single most limiting factor in providing a pre-determined response in line with the Incident Response Plan is the lost capacity due to hospital handover delays. In this area, WAST has no control. – link to CRR 223 on CRR.	The Trust is not assured that Hospital sites have plans in place that are trained and tested to release ambulances effectively and immediately in the event of an incident declaration.
	Following two incidents (Pembroke Dock Ferry fire on 11th February 2023 and the Swansea gas explosion on 13 March 2023), The Trust is not assured by the effectiveness of assurances given by Health Boards (responses provided following correspondence from WAST CEO – formal returns received from LHBs except BCU). Despite these two incidents being lower-level incident declarations where the pre-determined attendance was met, the experience does not add confidence to the ability to release all resources from hospitals which would support assurance. Further testing of the pre-determined attendance levels has been undertaken as part of the Manchester Arena Inquiry recommendations; This tested the Trust's ability to fulfil the PDA in North Wales and South Wales in the event of a mass casualty scenario both in hours and out of hours. This simulation concluded that in three of these four scenarios, the Trust would be unable to fulfil the PDA. A further declared major incident at Treforest Industrial Estate in December 2023 following an explosion, failed to release resources from Morriston Hospital, Wales's dedicated burns unit (formal debrief still to be conducted).

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Review of Manchester Arena Inquiry	Assistant Director of Operations	**March 2025**	This programme of work is underway, and a workshop has confirmed that the PDA would be unable to be met in three out of four simulated mass casualty scenarios. The financial case associated with MAI is planned to be familiarised with ELT and EASC during Jan and Feb 2024, with the final outline case to ELT in March 2024. A revised timeline for the governance process for the final MAI reports has been agreed, commencing in May 2024 and finalising at Trust Board the end of July 2024. **01/10/2024 - Progress against the 68 recommendations, directly or through partnership working, that relate to the Trust continues. The Trust has undertaken a detailed review of its provision as part of its obligation under recommendations 105 and 106 and has recently produced an evidence-based series of reports aimed at addressing the identified gaps. This has been supported further by the development of three Quality Impact Assessments that have been approved by the Clinical Quality Governance Group. The work identified 20 recommendations for which there is a financial dependency. The submission to commissioners of the Trust's reports relating to these recommendations has now occurred and the Trust awaits their considered response. The remaining recommendations continue to be progressed and it is anticipated these will conclude within the next six months. To ensure the continued visibility of these report findings within the Trust, a corporate risk is being developed for inclusion in the Trust's risk register. This will enable the alignment of outstanding MAI recommendations with a**

RISK ID 594	The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death	Date of Review:	01/10/2024	TREND	15 (3x5)
		Date of Next Review:	01/11/2024		

IF	THEN	RESULTING IN
IF a major incident or mass casualty incident is declared	**THEN** there is a risk that the Trust cannot provide its pre-determined attendance as set out in the Incident Response Plan and provide an effective, timely or safe response to patients due to vehicles not being released from hospital sites	**RESULTING IN** catastrophic harm (death) and a breach of the Trust's legal obligation as a Category 1 responder under the Civil Contingency Act 2004

	Likelihood	Consequence	Score
Inherent	4	5	20
Current	3	5	15
Target	2	5	10

			clearly defined business-as-usual framework, ensuring proper governance of capability gaps while awaiting financial decisions from commissioners and the implementation of necessary changes.
2. Further correspondence to Welsh Government to seek assurance of testing plans following recent mass casualty exercise where Health Boards declined to incorporate vehicle release plans	Assistant Director of Operations	**November 2024**	Correspondence with Welsh Government remains ongoing. 22/02/2024 - Risk 594 has also been referenced in the context of MAI presentation to Welsh Government (6th Feb 2024). Further follow up will be provided as MAI progresses. Welsh Government has been and will continue to be kept up to date on the developing case, as have the JCC.
3. Request from COO network to share Action cards related to risk	Executive Director of Operations	Q1	May24 – LB will follow up with COO network on the sharing of their action cards to WAST. March 24 – This risk was discussed at both EASC management and in the COO meeting.
5. Ref: Control 1 of 594 – Immediate Release Protocol	Executive Director of Operations	**Complete**	**01/10/2024 - Reviewed, updated and released the immediate release protocol and has included the schedule for health board to release vehicles august 2024 (v1.3).** WAST is currently reviewing the immediate release protocol, and it is our aim to include the release schedule as agreed by COOs. The release protocol schedule for Health Boards to initiate in the event of a major incident is set out as follows: - 50% of vehicles released within 10 minutes - 75% of vehicles released within 20 minutes - 100% of vehicles released within 30 minutes

Risk ID 623	Failure to comply with Data Protection Legislation	Date of Review:	26/09/2024	TREND	15 (3x5)
		Date of Next Review:	26/10/2024	➡	

IF the Trust fails to comply with and demonstrate it is meeting the accountability requirements under the Data Protection Act, the UK General Data Protection Regulation (GDPR) and the Common Law Duty of Confidentiality	**THEN** the Trust will breach its legal obligations and potentially cause the personal or sensitive data to be compromised, lost, or inappropriately used.	**RESULTING IN** unauthorised data breaches/loss, financial or compensatory penalties, an increased regulatory scrutiny or enforcement as well as stakeholder mistrust and reputational damage

	Likelihood	Consequence	Score
Inherent	4	5	20
Current	3	5	15
Target	2	5	10

IMTP Deliverable Numbers: 1, 13, 14, 18, 19

EXECUTIVE OWNER	Director of Digital Services	ASSURANCE COMMITTEE	Finance & Performance Committee

Risk Commentary

The consequences of this risk depend on the worst-case scenario which crosses of a number Domains on the Risk Scoring Matrix e.g. Loss of, or access to mass clinical data, the reputational damage this would cause, subsequent high-level involvement of ICO, Regulatory Body and Government involvement the subsequent fall out, fines and reduction in the level of clinical care. The likelihood would be small NB Just like pandemics. However, there are lower consequences of failure of statutory compliance which would warrant a higher level of likelihood even daily but in this case like near misses they indicate the need for change/improvement to demonstrate managing the risks. Therefore, the consequences will always be 5 but improvements are needed to lower the risk, and should we demonstrate meeting Statutory Requirements even if a serious incident/event/failure arises evidence provided would reduce / mitigate against the consequences.

In addition, the Confidentiality Advisory Group (CAG), an independent body advising the Health Research Authority, have indicated that for organisations across NHS Wales who are not able to demonstrate compliance with legislation via the IG Toolkit by November 2024, requests for using sensitive patient information for research purposes are unlikely to be approved – further resulting in risk to WAST's academic partnerships and reputation, and strategic research endeavours.

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. Data Protection Expertise: 1 FTE Data Protection and Compliance Manager (DPCM); 1 FTE Information Governance Officer, 1 FTE Cyber Security Officer	1. Two Data Protection and Compliance Managers **were** employed on a consultancy basis to provide cover and support backlog clearance (E). **Both contractors have now left the organisation (funding ceased for the first in Jun-24, and the contract ended Sep-24 for the second).** 2. **Two new permanent Data Protection and Compliance Managers have been recruited and are due to start employment with WAST in November 2024, bringing capacity of this skillset up to 3 x FTE.**
2. Temporary Data Protection Officer position held by Head of ICT	3. Temporary Data Protection Officer
3. Data Protection and Information Governance Policies and Procedures (Incl. DPIAs and Cloud Assessments) a. Procedure for auditing Welsh Clinical Portal usage (by WAST staff) has been updated (Jun24).	4. Monthly Information Governance Steering Group which includes progress DPC, DSA and DPIA reviews (I) IG Training IG Toolkit (System for providing a level of assurance of compliance (I) Incident Reporting Accountability to ELT Development of reporting (dashboard) which supports IGSG, ELT and Finance & Performance Board Committee for scrutiny.
4. Contracts and agreements: Data processing, Data Sharing and Employment & Consultancy	
5. Register of information assets and data flows (outdated)	
6. Staff training on updated training module (Apr 2023)	
7. Incident Reporting and management (DATIX)	
8. NIIAS for auditing access to personal information	
9. Digital Notices / comms Ongoing (see Siren & recent Lock-screen notices)	
10. Proactive engagement outbound (not inbound to team)	

Risk ID 623	Failure to comply with Data Protection Legislation	Date of Review:	26/09/2024	TREND	15 (3x5)
		Date of Next Review:	26/10/2024	➡	

IF the Trust fails to comply with and demonstrate it is meeting the accountability requirements under the Data Protection Act, the UK General Data Protection Regulation (GDPR) and the Common Law Duty of Confidentiality	THEN the Trust will breach its legal obligations and potentially cause the personal or sensitive data to be compromised, lost, or inappropriately used.	RESULTING IN unauthorised data breaches/loss, financial or compensatory penalties, an increased regulatory scrutiny or enforcement as well as stakeholder mistrust and reputational damage		Likelihood	Consequence	Score
			Inherent	4	5	20
			Current	3	5	15
			Target	2	5	10

GAPS IN CONTROLS	GAPS IN ASSURANCE
1. WAST has been carrying a DPCM vacancy since January 2023. There have now been two unsuccessful attempt to fill the position which has led to capacity constraints. - There are now two DPCM vacancies (following additional investment in the Digital team for 24/25) **successful candidates are due to start employment with WAST in November 2024.**	1. See 21. Further Actions (1)
2. Unfilled and unfunded permanent DPO position which is required to meet Article 39 UK GDPR 2018. *The DPO must also be independent, an expert in data protection, adequately resourced, and report to the highest management level* [DPA 2018].	2. This is a stop gap.
3. Resource capacity constraints to update, implement or monitor the controls; and lack of engagement by management and staff which either bypass the requirements or stalled engagement.	3. Even with increased capacity without engagement by managers and staff to meet their compliance requirements there will continue to be information reported to IGSG which will demonstrate low levels of assurance i.e. Reports on DPIA log, DSA log, Training Levels, IG Toolkit, and Implementation Plan
4. Personal identifiable information (PII) is being processed or shared with no data processing contracts (DPC) or data sharing agreements (DSA) when legally required; or incomplete DPC or DSA due to stalled engagement.	4. Lack of Data Protection pre procurement controls which form part of Data Protection by Design and Default means that Departments could purchase IT systems, hire document scanning companies, external data consultants and analytical firms and bypass WAST's controls for appropriate due diligence or legislative required controls in managing these risks.
5. New data, or new data processes which have either bypassed the controls or there are no information asset owner and therefore doesn't get on to the asset register or the dataflow is not mapped and creates a weakness in assurance (See 3)	5. Data Protection and Compliance Risks not fully realised. **IGSG have approved the establishment of a sub-group to manage activities related to Information Asset Register and Ownership, however, due to vacancies and limited capacity in the IG team, this action will not be able to be progressed until January-25.**
6. Currently not meeting levels of IG staff training.	6. **Some data errors in ESR reporting for IG mandatory training has been identified, requiring manual effort to calculate Trust-wide compliance percentages.**
7. Lack of Data Protection pre procurement controls which form part of Data Protection by Design and Default means that Departments could purchase IT systems.	
8. The Confidentiality Advisory Group (CAG) notified WAST (via DHCW) in June 24 that for organisations with a 23-24 IG Toolkit outcome of "standards not met", any CAG approvals for research & non-research requests are likely to be rejected unless the organisations' IG Toolkit Improvement Action Plan can be met and evidenced by Nov 24 (instead of the original target date for this plan of Mar 25)..	8. The Confidentiality Advisory Group (CAG) required WAST to submit an IG Toolkit Improvement Action Plan (via DHCW) with adjusted timelines to show a path to a "minimum standards met" position by Nov 24. The Improvement Action Plan has been adjusted and shared, and internal stakeholders notified. This will be managed by ADLT and monitored via IGSG.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Recruitment of Data Protection and Compliance Manager(s)	Leanne Smith	Q2 2024/25	**Two candidates expected in post November 2024.**
2. Seeking funding to recruit/upskill/resource DPO who will encourage engagement. Additional funding into Digital for 24/25 allowed a permanent DPO position to be created within the structure.	Jonny Sammut	Q3 2024/25	**JD evaluated and translated.** **Awaiting approval by Recruitment Control Panel to commence recruitment.** Expected Recruitment and in post **Q4 24/25.**
3. Ensure compliance with the appropriate IG level training across all Directorate and Departments a. Demonstrate a regular series of comms on IG and DP b. Regular monitoring of training compliance through IGSG c. Targeted training compliance reporting to line manager on individuals to ensure that 85% target is reached. **d.** BAU on Siren training notices and specific guidance or advice	Leanne Smith	Q2 2024/25	Lock screen issued 04/24 in relation to WhatsApp and training. This will be refreshed in 06/24. Siren notice drafted for ELT 05/24. IG training compliance still below 85% target. An Action Plan for training has been created, and a training needs analysis being progressed with L&D team. Procedures, such as audit of Welsh Clinical Portal usage, has been updated.

Risk ID 623	Failure to comply with Data Protection Legislation		Date of Review:	26/09/2024	TREND	15 (3x5)
			Date of Next Review:	26/10/2024	➡	

IF the Trust fails to comply with and demonstrate it is meeting the accountability requirements under the Data Protection Act, the UK General Data Protection Regulation (GDPR) and the Common Law Duty of Confidentiality	**THEN** the Trust will breach its legal obligations and potentially cause the personal or sensitive data to be compromised, lost, or inappropriately used.	**RESULTING IN** unauthorised data breaches/loss, financial or compensatory penalties, an increased regulatory scrutiny or enforcement as well as stakeholder mistrust and reputational damage		**Likelihood**	**Consequence**	**Score**
			Inherent	**4**	**5**	**20**
			Current	**3**	**5**	**15**
			Target	**2**	**5**	**10**

			Paper to ADLT Jun24 seeking support for increased awareness & training compliance **Direct contact to individuals who have been non-compliant for a significant period of time, with escalation through their line management structures as required.**
4. Report on physical security to IGSG – working with fleet and estates team	Leanne Smith and Aled Williams	Q2 2024/25	Reporting to IGSG and FPC
5. Assurance of "standards met" for all IG Toolkit requirements: gain support of all Directorates' leadership to complete the IG Toolkit Improvement Action Plan and ensure compliance for the 24-25 IG Toolkit submission	Leanne Smith	Nov24 for IG Toolkit Improvement Action Plan (with evidence to CAG)	Paper to ADLT Jun24 seeking support for completion of the IG Toolkit improvement action plan. To ensure no impact to CAG approvals for WAST research, this improvement action plan must now be met and evidenced by Nov24.

Risk ID 100	Failure to persuade JCC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience		Date of Review:	02/10/2024	TREND	12 (3x4)
			Date of Next Review:	02/01/2025	➡	

IF WAST fails to persuade JCC/Health Boards about WAST ambitions	THEN there is a risk of a delay or failure to receive funding and support	RESULTING IN a catastrophic impact on services to patients & staff and key outcomes in the IMTP not being delivered		Likelihood	Consequence	Score
			Inherent	4	4	16
			Current	3	4	12
			Target	2	4	8

IMTP Deliverable Numbers: 7, 9, 11, 12, 14, 15, 20, 24, 25, 32

EXECUTIVE OWNER	Executive Director of Strategy, Planning & Performance	ASSURANCE COMMITTEE	Finance and Performance Committee

Risk Commentary

From the 01 April 2024 111, emergency ambulance and Ambulance Care are all commissioned by the Joint Commissioning Committee (JCC). This is viewed as a positive development by the Trust, supporting the development of an organisational ambition.

The ambition is appropriate levels of patient safety and good working conditions for our staff across the 111 pathway, emergency ambulance care pathway and Ambulance Care pathway. Clearly neither of these are currently being achieved in the emergency ambulance care pathway as evidenced by the long waits, shift overruns and volume of concerns and reportable incidents. The Trust is currently commissioned on the assumption of 6,000 hours of handover lost hours, with current levels at 26,000 (Jan-24). EASC **had** an ambition to achieve 12,000 handover lost hours by the beginning of quarter four 2023/24, which has not been achieved, but even if it was achieved, it would still be double what the EMS rosters are predicated on. **The Trust is now looking to recruit up to the modelled 153 CHARU FTEs and connected to this focus on CHARU productivity. CHARU UHP in August 2024 was 80%, which is the highest it has achieved, and it is now seeking to close the remaining gap through the recruitment of fully qualified paramedics.** Similarly, the Trust has made the decision (delivered) to recruit another intake of APPs, an additional 16 FTEs, but this is also being funded through internal movements, with a planned temporary relief gap to fund these. A further funded 32 APPs are being recruited in 2024/25 along with 23.2 FTEs to Integrated Care. The 111-call abandonment rate has not been achieved for the last **seven** months. Ambulance Care performance is stable.

NEPTS is also commissioned via **JCC** (it is commissioned at NEPTS, not Ambulance Care), with agreement that in Q1 2024/25 there should be a joint collaborative workshop between the Trust, the JCC and health boards (completed).

The previous controls are currently transitioning into the new JCC arrangements, so are currently a bit fluid. Quarter **3** should see the arrangements stabilise.

CONTROLS	ASSURANCES
	Internal & External Management (1st Line of Assurance)
1. JCC/WAST Forward Plan for EMS and NEPTS in place and monitored at JCC meetings	1. Minutes of meetings and a standard agenda item
2. EASC and its 2 sub-committees established as a forum to discuss WAST's strategy (sub-committees currently under review as part of move into JCC).	2. Minutes of meetings and a standard agenda item
3. Weekly catch up between Interim Director of 111 & Ambulance Commissioning /CEO	3. Meetings are diarised every week
4. Collaboration between JCC and WAST on specific projects e.g. Evolving clinical model.	4. Representatives are co-opted onto meetings and frequency is between 3–6 weeks. Set agendas with NCCU reps co-opted.
5. Monthly CASC Quality and Delivery Meeting established (currently paused as part of move into JCC).	5. Formal meeting with agendas, minutes, and action logs available.
6. Patient Safety information e.g. Appendix B incidents, weekly/monthly patient safety reports produced	6. These reports supplied to Director of Quality and Nursing in Health Boards and other senior stakeholder's fortnightly
7. Programme structure has been established for evolving the clinical model including commissioners	7. This is now an established programme of work with the Trust making an offer to the system via the Six Goals Programme in January 2024.
8. Commissioning intentions.	8. In year progress reported each quarter to the relevant commissioning meeting and 24/25 commissioning intentions approved for 111Wales and expected to be approved by Mar-24 EASC (approved).
9. Governance arrangements for 111 commissioning: 111 Board, 111 Commissioning Board + 111 DAG etc.	9. Minutes of meetings and a standard agenda item
	External Management (1st Line of Assurance) 1. Plans go to every bi-monthly meeting 2. Meet bi-monthly and agendas, minutes and action logs available

Risk ID 100	Failure to persuade JCC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience	Date of Review:	02/10/2024	TREND	12 (3x4)
		Date of Next Review:	02/01/2025	➡	

IF WAST fails to persuade JCC/Health Boards about WAST ambitions	**THEN** there is a risk of a delay or failure to receive funding and support	**RESULTING IN** a catastrophic impact on services to patients & staff and key outcomes in the IMTP not being delivered

	Likelihood	Consequence	Score
Inherent	4	4	16
Current	3	4	12
Target	2	4	8

GAPS IN CONTROLS	GAPS IN ASSURANCE
1. JCC remit is wider than just ambulances and will reduce the agenda time dedicated to WAST's three patient pathways.	1. A shorter provider brief will go to the JCC with more detailed discussions taking place at its sub-committees.
2. Governance coordination between the JCC) and WAST to be improved.	2. Identified need for a governance meeting between JCC and WAST to manage the overall commissioner/provider interface. Actioned, but has lapsed due to capacity and resourcing in NCCU team. This will be further reviewed as the JCC goes live in April-24 (period of transition likely to extend through Q1). This has lapsed at this time, but request to re-establish it sent to commissioners.
3. WAST's ability to influence hospital handover delays (this is outside of the Trust's control and a Health Board responsibility)	3. Ministerial direction on handover reduction with significant pressure being applied to health boards through the NHS Leadership Board and NHS Executive accountability arrangements. The Welsh Government target is no waits > one hour, which equates to 7,000 lost hours.
4. Funding does not flow in a manner to balance demand with capacity (outside of WAST's control)	4. Strategic demand and capacity review being undertaken with output due to be reported to JCC in Q2 2024/25, with initial findings already shared. On advice from the CASC, formally reporting the findings of the review has been re-programmed into Q2 2024/25, for the new JCC. JCC dates to be determined.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Agree and influence JCC/Health Boards that sufficient funding to be provided to WAST	CEO WAST	NEW Checkpoint Date	30.09.22 Additional £3m provided for +100 FTEs into Response by 23/01/23. 12/01/23 Recurrent funding for the +100 not secure. 02.05.23 Recurrent funding still not secure. 16.04.24 Recurrent funding for +100 FTEs now secured. 28.07.23 Funding secure for 23/24, but not recurring. 18.01.24 Offer being made to the system in January 2024 via the Six Goals Programme. The reception of the Trust's offer was mixed. A key area of focus in the 2024/25 IMTP will be data linking that enables the Trust to better prove the value of investing in the Trust; (16/04/24) and the development of system metrics dashboard that enables the Trust to track its impact on the wider system (currently under development). 26.06.24 Funding for a 32 FTE APPs secured for 2024/25 and 23.2 FTEs into Integrated Care. 06/08/24 WAST briefing on evolved CRM and 2023 EMS Demand & Capacity Review to JCC Board Development session in Aug-24.
2. Agree and influence JCC/Health Board of the need for significant reduction in hospital handover hours	CEO WAST	NEW Checkpoint Date	30.09.22 4-hour handover backstop agreed and -25% reduction in handover from October 2021 baseline. 12/01/23 There has been a significant worsening picture. 02.05.23 Continued worsening picture with almost 29,000 lost in March 2023. 28.07.23 There has been some reduction, but levels remain extreme. 18.01.24 NHS Leadership Board is increasing accountability and focus of health board handover reduction actions. The emerging 2023 EMS Demand & Capacity Review models the level of resource required with no handover reduction and the level of resource required if there is a handover reduction to 12,000 hours 26/04/24 This modelling has been further supplemented by modelling the Ministerial target of no handovers of more than one hour. 26/06/24 May-24 levels at 24,000, which is higher than 2023 and concerning as an indicator of the winter the Trust may expect. Trust moving at pace to evolve clinical response model, with Welsh Government full sighted on impact of handover hours on the Trust.
3. Increased understanding of NEPTS by JCC	Executive Director of Strategy Planning and Performance	02/08/23 30/06/24 20/08/24	30.09.22 "Focus on" session in May 2022 EASC and NCCU represented on Ambulance Care Programme Board. 12/01/23 F&P Deep Dive made available to NCCU. 02.05.23 Continued attendance by NCCU at Ambulance Care Transformation Programme. 28.07.23 EASC want WAST to develop a LTS for NEPTS, which will increase the focus on it. 18.01.24 Ambulance Care strategy sessions held as part of the inverting the triangle programme and IMTP development held, which will now be taken forward into a collaborative workshop with commissioners in Q1 2024/25. 16/04/24 Workshop arranged for April 2024 (completed). 26/06/24 Workshop results reported to newly established Interim Ambulance Commissioning Committee.

Risk ID 100	Failure to persuade JCC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience	Date of Review:	02/10/2024	TREND	12 (3x4)
		Date of Next Review:	02/01/2025	➡	

IF WAST fails to persuade JCC/Health Boards about WAST ambitions	**THEN** there is a risk of a delay or failure to receive funding and support	**RESULTING IN** a catastrophic impact on services to patients & staff and key outcomes in the IMTP not being delivered

	Likelihood	Consequence	Score
Inherent	4	4	16
Current	3	4	12
Target	2	4	8

			06/08/24 The WAST briefing to the JCC Board Development session in Aug-24 includes coverage of five workstreams, one of which is Health Transport, which includes NEPTS and UCS.
4. Governance meeting between NCCU and WAST to manage the commissioner provider interface	Assistant Director Commissioning & Performance	02/08/23 Checkpoint Date	30.09.22 Meeting in place and meeting regularly. 12/01/23 Meetings continue. 02.05.23 These have lapsed due to pressures and sickness absence in the NCCU. HB to reboot, subject to ability of NCCU to undertake. 28.07.23 Availability remains a challenge, but there is regular informal dialogue between WAST and NCCU. 18.01.24 This specific meeting remains lapsed, but the Trust is currently meeting every two weeks with the NCCU on the development of the IMTP. As the Trust moves into the new JCC from 01 April 2024 there will be a further opportunity to address this control. 16/04/24 The new commissioning arrangements are in transition and still quite fluid at the moment. 26/06/24 Request to commissioners to re-establish this meeting. 06/08/24 Meeting now re-established.
5. Develop and roll out the Stakeholder Influencing Plan	Director of Partnerships & Engagement AD Planning & Transformation	Q2 24/25 onwards	15/03/24 This action is captured in Risk 201 on the CRR. The reputation audit being repeated in Q1 will inform the development and roll out of this plan in Q2.

Risk ID 163	Maintaining Effective & Strong Trade Union Partnerships	Date of Review:	26/09/2024	TREND	12 (4x3)
		Date of Next Review:	26/12/2024	↓	

IF the response to tensions and challenges in the relationships with TU partners is not effectively and swiftly addressed and trust and (early) engagement is not maintained	**THEN** there is a risk that TU partnership relationships increase in fragility and the ability to effectively deliver change is compromised	**RESULTING IN** a negative impact on colleague experience and/or services to patients		Likelihood	Consequence	Score
			Inherent	5	3	15
			Current	4	3	12
			Target	4	3	12

IMTP Deliverable Numbers: 1, 13, 14, 19, 22, 30, 32

EXECUTIVE OWNER	Director of People & Culture	ASSURANCE COMMITTEE	People & Culture Committee

Risk Commentary

A tailored bespoke development programme for managers and Trade Union Partners at all levels has been launched to address issues. The programme of engagement and relationship building will continue throughout 2024/25. Also, specific workforce issues related to potential respect and resolution processes have been addressed.

Work is well underway to seek to improve partnership working through the delivery of the action plan. The engagement structures below WASPT are in place and running. The Deputy Director of P&C and Head of Culture and OD have delivered workshop sessions for TU partners and managers across the organisation in senior and local roles. Personal relationships with TUPs are generally good . At a local level there are ongoing discussions on a range of organisational change issues and currently engagement and partnership working is **operating well and as a result the score has been reduced to 12 (3x4) during the quarter. However, there is a recognition that the nature of partnership working and the issues that arise mean that the level of risk fluctuates more regularly than others and will be kept under review. The Executive Owner will change from November 2024 to Director of People – same for Risk 160.**

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. Agreed (Refreshed) TU Facilities Agreement developed in partnership	1. Agreed document which states governance arrangements and the criteria for time off for TU activity etc.
2. Go Together Go Far (GTGF) statement and CEO/TU Partners statement	2. Both parties refer to the documents and are signed up/committed to it
3. IPA Workshops	3. Meetings completed with participation from TUs and senior managers. Attendance lists are available
4. Trade Union representation at Trust Board, Committees	4. Committee or Board ask TU representative for feedback or whether they have been consulted. Big issues items progress as planned because of TU partner buy in
5. Monthly Informal Lead TU representatives and Chief Executive meetings	5. Diarised meetings
6. Staff representative management in Task & Finish Groups	6. Good attendance and commitment are observed at the meetings. TU partners listed as members in terms of reference
7. WASPT re-established post stand down of cell structure post pandemic.	7. Diarised meetings with a formal agenda. Any business needed to be discussed is included in the agenda. Good attendance and commitment observed at meetings.
8. Local Co-Op Forums, and informal monthly meetings between TUs and Senior Operations Team in place and operating	8. Consistency of invitation and good attendance/commitment observed at meetings. Trade Union representations on SOT meetings
9. Quarterly Report on TU activity to People and Culture Committee	9. Report at every P& C committee meeting regarding activities TUPs involved with which is noted. Whenever Partnerships are discussed, the value of these is formally minuted in the Board and Committee minutes
10. Structures below WASPT in place from June 2023	10. Triple A reports through to WASPT and to PCC. Any escalations are appropriately noted.
11. Project plan in place to support the improvement in relationships based on the ACAS report from 2022.	11.Development of mentoring and training opportunities for TUPs to support their roles.
12. AAA report of formal Partnership Forum (WASPT) reported to PCC or Board in future (return to BAU).	12.Training for local managers and TUPs in development and diarised delivery for February / March 2024.
13. AAA from SLT Partnership Forum and Corporate Partnership Forum reported to WASPT	13.Change in senior TU personnel on a temporary basis meaning new senior TU representative needs to be brought up to speed with work on improving partnership working.
14. Externally facilitated mediation session(s) building on the IPA workshops and specifically to address the thorny issue of what happens when we fail to agree.	14. Action plan developed and shared with TUs. Implementation underway. A series of partnership working sessions (5) have been delivered to around 120 colleagues – managers and TU partners. Feedback from the sessions was captured and next steps were reviewed. There is an ACAS action plan which is a live doc and is reported to WASPT to update progress.
15. Rhythm of meetings to curate and focus on relationships	16. AAA, minutes, monthly sessions with CEO, DoPC and DoO. Informal sessions with CEO, DoPC and Branch Chair and Sec on a quarterly basis. 6 weekly meetings with DoPC on other partnership forum arrangements.

Risk ID 163	Maintaining Effective & Strong Trade Union Partnerships	Date of Review:	26/09/2024	TREND	12 (4x3)
		Date of Next Review:	26/12/2024	⬇	

IF the response to tensions and challenges in the relationships with TU partners is not effectively and swiftly addressed and trust and (early) engagement is not maintained	THEN there is a risk that TU partnership relationships increase in fragility and the ability to effectively deliver change is compromised	RESULTING IN a negative impact on colleague experience and/or services to patients		Likelihood	Consequence	Score
			Inherent	5	3	15
			Current	4	3	12
			Target	4	3	12

GAPS IN CONTROLS	GAPS IN ASSURANCE
1. Need to move back to business-as-usual footing	None identified
2. Facility to manage situations where there is a failure to agree, to avoid grievance and disputes from occurring	

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Refresh of engagement programme post Industrial Action and establish work	Deputy Director of People & Culture	30/08/23 Underway and work ongoing. Plan delivery to be completed in 2024. However, this will be subject to the national picture.	Plan agreed and being monitored via WASPT. Draft training development underway in partnership with TUPs – list of training needs shared from TUPs. Principles on engagement being developed (in part from the training) and as a result the partnership statement will be updated.
2. Continue the rollout of partnership training across WAST	Deputy Director of People & Culture	Ongoing	
3. Develop the next round of initiatives based on the output from recent sessions	Deputy Director of People & Culture	**31/03/25**	**Observation of partnership forums and further development work is ongoing regarding initiatives to support embedding partnership training across the organisation**
4. Learning and Development opportunities for TU partners e.g. shadowing, digital skills, coaching and mentoring	Deputy Director of People & Culture	31/03/25	
5. Develop consultation guidance for managers	Deputy Director of People & Culture	31/03/25	
6. Consider how we celebrate success and capture the positive learning	Deputy Director of People & Culture	31/01/25	

Risk ID 139	Failure to deliver our Statutory Financial Duties in accordance with Legislation	Date of Review:	02/10/2024	TREND	8 (2x4)
		Date of Next Review:	02/01/2025	➡	

IF the Trust does:	THEN there is a risk that	RESULTING IN		Likelihood	Consequence	Score
• not achieve financial breakeven and/or • does not meet the planning framework requirements and/or • does not work within the EFL and/or • fails to meet the 95% PSPP target and/or • does not receive an agreement with commissioners on funding (linked to 458)	the Trust will fail to achieve all its statutory financial obligations, and the requirements as set out within the Standing Financial Instructions (SFIs)	potential interventions by the regulators, qualified accounts, and impact on delivery of services and reputational damage	Inherent	3	4	12
			Current	2	4	8
			Target	2	4	8

IMTP Deliverable Numbers: 9, 12, 15, 18, 24, 25, 30, 31, 32

EXECUTIVE OWNER	Executive Director of Finance and Corporate Resources	ASSURANCE COMMITTEE	Finance and Performance Committee

Risk Commentary: Q2 2024/25The risk has now been further reviewed in conjunction with the level of financial risk detailed in the Trust's financial monitoring returns submitted to WG year to date to Month 5 of the 2024/25 Financial Year. The score is consistent with that of **Qtr. 1 2024/25** due to a presented opening balanced financial plan for 2024/25 and the Month 5 2024/25 financial performance and positive savings delivery. It must be noted though that clear monitoring of a potential financial risk around workforce re-banding of EMT staff and the ability to fund / receive income may impact on the delivery of the financial plan for 2024/25. The current challenging financial climate for all public sector organisations may also impact on WAST financial performance especially as the financial year progresses.

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1. Financial governance and reporting structures in place	1. Risk is reviewed quarterly at FPC, and a report is submitted bi-monthly to Trust Board
2. Financial policies and procedures in place	
3. Budget management meetings	3. Diarised dates for budget management meetings
4. Regular financial reporting to ADLT, EFG, ELT, FPC and Trust Board in place	4. Diarised dates for EFG and FPC and monthly reports
5. Welsh government reporting	
6. Monthly review of savings targets	6. ADLT monthly review
7. Regular review monitoring and challenge via WAST and CASC quality and delivery meeting with commissioners.	
8. Monthly ICMB (Internal Capital Monitoring Board) meetings to monitor and review progress against capital programme and engagement with WG and capital leads.	8. Diarised dates for ICMB meetings with regular monthly report
9. PSPP monthly reporting and regular engagement with P2P colleagues and periodic Trust Wide communications	9. Regular PSPP communications (Trust wide) on Siren
10. Forecasting of revenue and capital budgets	a) Monthly monitoring returns to ADLT, EFG, ELT and FPC (b) Reliance on available intelligence to inform future forecasting.
11. Business cases and benefits realisation (both revenue and capital)	11. Business cases – scrutiny and approval at senior management team which are submitted to ADLT, ELT, FPC prior to Trust Board for approval as appropriate according to value.
	External Assurances Management (1st Line of Assurance)
	5. Monthly Monitoring Returns to Welsh Government
	7. EASC management meetings. Monthly meetings with EASC and DAG for NEPTS.
	8. Bi-monthly Capital CRL meetings with Trust and WG capital leads
	9. Regular P2P meetings diarised (bi-monthly)
	10. Monthly monitoring returns into Welsh Government
	Independent Assurances (3rd Line of Assurance)
	1-10 Internal audit reviews covering
	1-10 External audit reviews

Risk ID 139	Failure to deliver our Statutory Financial Duties in accordance with Legislation	Date of Review:	02/10/2024	TREND	8 (2x4)
		Date of Next Review:	02/01/2025	➡	

IF the Trust does:	THEN there is a risk that	RESULTING IN
• not achieve financial breakeven and/or • does not meet the planning framework requirements and/or • does not work within the EFL and/or • fails to meet the 95% PSPP target and/or • does not receive an agreement with commissioners on funding (linked to 458)	the Trust will fail to achieve all its statutory financial obligations, and the requirements as set out within the Standing Financial Instructions (SFIs)	potential interventions by the regulators, qualified accounts, and impact on delivery of services and reputational damage

	Likelihood	Consequence	Score
Inherent	3	4	12
Current	2	4	8
Target	2	4	8

GAPS IN CONTROLS	GAPS IN ASSURANCE
• Lack of formalised service contracts between Commissioner and WAST as a commissioned body	**10.** None identified.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Continuing negotiations with Commissioners	Director of Finance and Corporate Resources/ Director of Strategy Planning and Performance	31/03/24 31/03/25	In line with the recent WAST financial position and monthly monitoring letter sent to WG, WAST can resource the cost of the EMS staff itself. In addition, discussions continue with commissioners to ensure WAST continue to obtain funds in relation to 111 on a spend and recover basis.
2. Embed a transformative savings plan and ensure organisational buy in	ADLT and Savings subgroup	31/03/24 31/03/25	The Financial Sustainability Program (FSP) continues to be a key vehicle for the Trust to fully identify its savings program. Over delivery was achieved for the 23/24 financial year and the point of strong delivery is further highlighted with the programs ability to fully identify the 24/25 £6.4m savings plan before the start of the financial year.
3. Embed value-based healthcare working through the organisation	Executive Leadership Team and Value Based Healthcare Group	31/03/24 31/03/25	Work to identify the PROMS & PREMS evaluation criteria for Emergency based services via the Value-Based Healthcare working group continues.
4. Foundational economy, Decommissioning, and procurement to mitigate social and economic wellbeing of Wales	Estates, Capital and Fleet Groups, NHS Wales Shared Services Partnership	31/03/24 31/03/25	The organisation utilises the NWSSP Shared Services Procurement framework to ensure contracts tendered provide best value for money while ensuring criteria within the tender docs ask bidders to highlight their ability to serve the aims of FE, Decommissioning, Decarbonisation and social as well as the economic wellbeing of Wales. Ad hoc reports are received from Shared Services on WAST's progress in switching more expenditure to Welsh suppliers to keep the Welsh pound in Wales.

Key - List of Strategic and IMTP objectives

Strategic Objective 1: Providing the right care or advice, in the right place, every time		*BAF risks*
1.	A modern, easily accessible, user-friendly and integrated digital offer	223, 224, 623, 260, 201,163, 424
2.	Rapid (111) call answering, initial triage and onward referral	223, 424
3.	Timely, high quality clinical assessment, advice and referral	223, 224, 424
4.	Seamless transfer of 111 callers to wide range of available pathways	223, 424
5.	Immediate 999 call answering, and efficient and effective dispatch of the right resource	223, 424
6.	High quality, timely, clinical triage, assessment and consultation, with personalised response	223, 424
7.	High quality, immediate or timely on scene assessment, care and conveyance where needed	223, 100, 424
8.	A range of 24/7 pathways available for further assessment or treatment, closer to home	223, 224, 424
9.	A flexible, user-centred Non-Emergency Patient Transport Service with the right capacity in place to meet demand	100,139, 424
10.	A dedicated and timely transfer & discharge service supporting HBs with their transformation agendas	223, 424
11.	A clear vision for Ambulance care services that supports wider health and care transformation	100, 201, 424
12.	A high quality, safe (NEPTS) service with improved patient experience	100, 139, 424
Strategic Objective 2: Enabling our people to be the best they can be		
13.	Culture: • Enhance and strengthen internal capacity for delivering culture change • Develop amplify employee voice to increase employee engagement • Continue the implementation of our compassionate practices approach	160, 558, 623, 201, 163, 424
14.	Capacity: • Implement our Strategic Workforce Plan • Continue to embed a culture of positive attendance management • Continue our focus on 'getting the basics right.'	100, 160, 163, 223, 224, 424, 558, 594, 623
15.	Capability: • Grow and develop our leadership and management capability • Reinforce and promote career pathways and professional development. • Create an environment centred around effective, ongoing conversations ('Check Ins')	100, 139, 160, 223, 224, 260, 594, 424
16.	Strengthen Welsh Language compliance through strong leadership, enabling Welsh language to flourish	201, 424
Strategic Objective 3: Being at the forefront of innovation and technology		
17.	The right buildings in the right place, enabling our staff to provide the best and safest care across Wales	542, 424
18.	The right fleet in the right place, enabling our staff to provide the best and safest care across Wales	139, 542, 623, 424
19.	Develop & agree Digital Plan • Everyday essentials • Security, Safety & Cyber • Digital Pioneers • Transformation • Data, Information & Insight	163, 260, 623, 424
Strategic Objective 4: Developing services in collaboration		
20.	Well-placed to influence system thinking / strategy development	100, 223, 424
21.	Meet the requirements of the Wellbeing of Future Generations Act	558, 424
22.	University Trust Status in collaboration with WG, embracing a 'democratised culture' of learning, research and innovation	160, 163, 223, 224, 424
Strategic Objective 5: Being quality driven and clinically led		
23.	Systems that meet the requirements of the Duty of Quality and Duty of Candour	224, 424
24.	Excellent clinical leadership	100, 139,160, 223, 224, 260, 594, 424
25.	A culture of quality improvement with robust quality management systems	100, 139, 160, 201, 223, 224, 424
26.	High quality Putting Things Right, Safeguarding and Health & Safety systems	160, 224, 558, 424
27.	Meaningful engagement and co-production with communities	223, 224, 424
28.	A risk management framework as a key enabler of our long-term strategy and decision making	No corporate/principal risks
29.	An integrated governance framework	No corporate/principal risks
Strategic Objective 6: Delivering exceptional value		
30.	Sustainable savings & efficiencies	139, 163, 224, 424
31.	Generate income alongside our core commissioned functions	139, 224, 424,
32.	A Value-Based approach across the organisation which is embedded in culture	100, 139, 163, 424
33.	Developing and implementing our plans for Environmental Sustainability and Adaptation	542, 424

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

AGENDA ITEM No	9
OPEN or CLOSED	OPEN
No of ANNEXES	2

AUDIT TRACKER 2.0 – SEPTEMBER 2024 (Q2)

MEETING	Audit, Risk and Assurance Committee
DATE	21 November 2024
EXECUTIVE	Trish Mills, Director of Corporate Governance/Board Secretary
AUTHOR	Trish Mills, Director of Corporate Governance/Board Secretary Alex Payne, Corporate Governance Manager
CONTACT	trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. This paper provides the Audit, Risk and Assurance Committee (ARAC) with the current position with respect to management actions for audits within the purview of the Committee, in addition to the wider progress in quarter.

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

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

4. There are 11 actions on their third revised date, which is 9.5% (3% in the previous quarter). Some of these actions have changed in quarter and this latter figure includes two actions which are on their third revised date and are yet to be completed. These are action 567 and action 613. Action 657 was discussed at the September 2024 meeting of the Committee. The Director owners of the actions on their third revised date have been invited to the Committee to speak to progress of the respective actions.

5. Of the total external audit actions four of the 14 have been closed in quarter; which is 28% (36% in the previous quarter). Of the remaining ten, eight have been given revised dates and two are on their third revised date and not yet completed. These outstanding actions are from the 2022/23 Review of Quality Governance arrangement and a position statement has been included in this report.

6. The internal audit recommendations within the purview of ARAC relate to the Risk Management (22/23), Standards of Business Conduct (22/23), and Follow Up (23/24) audits. Of the 13 internal audit actions where the ARAC is the owning Committee, five of the actions have been closed in quarter (which is 38% versus 0% in the last quarter). The action closures include the remaining actions from the Standards of Business Conduct internal audit.

7. Of these, two of the actions in quarter have been given revised dates. The remaining six actions were not due in quarter and will be reported in the remainder of 2024/25.

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

9. The current version of the Tracker is now open for Directorate review for actions due in October to December 2024. These updates will then be reported to the Committee at its meeting in March 2025, quarter four 2024/25. It is noted that the actions from the Cyber-Security and the Technical Resilience audit will be received in the closed session.

RECOMMENDATION

10. The Committee is requested to:

(a) Receive assurance that the management actions for the audits within the purview of this Committee (at Annex 1), and overall (at Annex 2), are being effectively and appropriately managed, closed off in quarter or clarity provided on dates which have moved and rationale. It is noted that the actions against the Cyber-Security and Technical Resilience internal audit will be received in closed session.;

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

Internal Audits

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

External Audits

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

KEY ISSUES/IMPLICATIONS
As set out above.
REPORT APPROVAL ROUTE
Tracker presented to ADLT at a meeting in October 2024.

REPORT APPENDICIES
Annex 1 – Tracker 2.0 —July-September 2024 for Committee Reporting – ARAC Actions Annex 2 - Tracker 2.0 —-July-September 2024 for Committee Reporting – Full Tracker

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

SITUATION

1. This paper provides the Committee with the current position with respect to management actions for audits within the purview of the Audit, Risk and Assurance Committee (ARAC), in addition to the wider progress in 1uarter. A copy of the Tracker is available at Annex 1 filtered to the actions assigned to this Committee for oversight.

BACKGROUND

2. In September 2023 the Audit Committee approved the Audit Process and Reporting Handbook. The Handbook has been further revised since this date to include Audit Wales content.

3. The Handbook includes roles and responsibilities for the various stakeholders including:

   - The Assistant Directors Leadership Team (ADLT) as the forum to agree closure of actions, taking a check and challenge role on the Tracker.

   - Different reporting for the Audit Committee and Executive Leadership Team (ELT) to that provided to Committees, with the latter focused more on individual audits, progress and impact, and Audit Committee and ELT on the broader audit framework, progress, and exposure. This will start when Tracker 3.0 is developed which will draw the agreed reporting from the tracker via Power BI.

   - The introduction of a point of contact in Directorates for audits. This person(s) steers the audit with the Director and Assistant Directors/Deputies, ensuring internal audits feature on the directorate agenda monthly, they update the Tracker, and escalate issues as appropriate.

ASSESSMENT

4. The Handbook notes that it is the responsibility of a Board Committee to:
   - Receive audits in their remit;
   - Monitor management actions to address recommendations.

5. As well as monitoring management actions for audits in their purview, the Audit Committee has the responsibility to scrutinise the progress of audits overall, escalating to the Board any issues or concerns. A copy of the full Tracker is also reproduced at Annex 2.

6. It is noted that the Quality, Patient Experience and Safety Committee, Finance and Performance Committee, and the People and Culture Committee have reviewed the management actions for audits within their purview in the last few weeks. Their AAA reports to Board will note this and there have been no escalations to Board.

Internal Audit: - Full Tracker Review

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

8. Of the total internal audit actions, 33 of the 115 actions have been given proposed revised dates in quarter; which is 29% of the total (31% in the previous quarter. There is narrative included below regarding the closure of action 470 from the 'Asset Management RAM System' internal audit and the position agreed with Internal Audit.

9. There are 11 actions on their third revised date. which is 9.5% (3% in the previous quarter). Some of these actions have changed in quarter and this latter figure includes two actions which are on their third revised date and are yet to be completed. These are action 567 and action 613. Action 657 was discussed at the September 2024 meeting of the Committee. The Director owners of the actions on their third revised date have been invited to the Committee to speak to progress of the respective actions.

Action 470 – Digital - Asset Management RAM System Internal Audit

10. The Committee's attention is drawn to action 470 from the 'Asset Management RAM System' internal audit and the narrative for the rationale for closure which has been included in the Tracker. It is noted that the actions from the Cyber-Security and the Technical Resilience audit will be received in the closed session.

11. With reference to this action 470 and in consultation with Internal Audit colleagues it has been mutually agreed that it is acceptable to close the action on the basis that this work has been accounted for within the Trust's current Digital Plan and subject to the following actions:

    - That the position be clearly articulated on the Tracker and be brought to the attention of the ARAC and FPC in the next reporting period;
    - That this position clearly state that the work is subject to funding of the relevant Tranche 2 of the Digital Plan;

- That the associated risks be held in the Digital Directorate Risk Register, in lieu of the action's inclusion on the Tracker;
- That the Corporate Governance Team ensure that the action is scheduled for review by the FPC and ARAC in September 2025 (which is the date of completion on the Tracker).

Action 567 - Operations (HART Internal Audit)

12. At the ARAC meeting in September 2024 the Committee received assurance from the Operations Directorate that the outstanding tasks required in order to close the internal audit action 567 from the HART Internal Audit would be completed by the end of October. The remaining task was the peer review of the self-assessment which was required by the Operations Directorate Senior Leadership Team. Once this self-assessment has been received by the Operations Directorate Senior Operations Team the action can be closed. This was planned for early November 2024.

Internal Audit: – ARAC Actions

13. The internal audit recommendations within the purview of ARAC relate to the Risk Management (22/23), Standards of Business Conduct (22/23), and Follow Up (23/24) internal audits.

14. Of the 13 internal audit actions where the ARAC is the owning Committee, five of the actions have been closed in quarter (which is 38% versus 0% in the last quarter). The action closures include the remaining actions from the Standards of Business Conduct internal audit.

15. Of these internal audit actions, two of the actions two in quarter have been given revised dates. The remaining six actions were not due in quarter, and updates will be reported to the Committee as its meeting in March 2025.

External Audit: - Full Tracker Review

16. Of the total external audit actions four of the 14 have been closed in quarter; which is 28% (36% in the previous quarter). Of the remaining ten, eight have been given revised dates and two are on their third revised date and not yet completed. The two actions on their third revised date relate to the 2022/23 Review of Quality Governance arrangements; they are actions 106d and 106e.

17. The ARAC will receive the Follow Up Review of Quality Governance arrangements at its meeting in March, Based on the completion of the recent 'Quality Governance Follow Up Review' by Audit Wales it has been recommended that these actions are still in progress and should remain open.

18. It has been agreed that new management actions will be developed over the coming weeks in response to this Follow Up Review and the ARAC will receive the update against these actions at its meeting in March 2025. A corresponding narrative has been included on the Tracker, for the formal record.

External Audit: – ARAC Actions

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

Management and Development of the Tracker

20. Discussions have also taken place on historical actions and those where management actions may need to be amended in view of the current operating context. There has been some traction with these, and discussions will continue with a view to closing down or revising as many as possible going forward.

21. With respect to the Committee's responsibility to scrutinise the impact of actions, in November 2023 the Committee agreed that the most effective way to improve the scrutiny of the impact of actions was by identifying actions within audits as audit reports are reviewed by the Committee.

22. The current version of the tracker is now open for Directorate review for actions due in October to December 2024. These updates will then be reported to the Committee at its meeting in March 2025. The team will work with Directorate contacts to ensure a smooth transition between Tracker 2.0 and 3.0.

23. The team continues to work on the development of the SharePoint solution for Tracker 3.0. The Team is working to implement Tracker 3.0 from Q3 onwards (with initial reporting being seen in Q4). As reported to the Committee in September, due to technical restrictions, it has been agreed that the current Excel Tracker will include for 2023/24, and that Tracker 3.0 will include actions from 2024/25 onwards.

24. There continues to be good engagement with the Directorate points of contact to support the management of the actions in the Tracker. The Corporate Governance Team have regular check-in meetings to discuss issues and provide support. The Corporate Governance Team will work closely with the points of contact as the SharePoint Tracker 3.0 development continues.

Impact of Closed Management Actions

25. The Handbook also notes that it is the responsibility of a Board Committee to scrutinise impact of actions in response to audit recommendations in terms of, for example, quality improvement, the provision of more efficient and effective patient care, improved governance, better use of resources etc.

RECOMMENDATION

26. The Committee is requested to:

(a) Receive assurance that the management actions for the audits within the purview of this Committee (at Annex 1), and overall (at Annex 2), are being effectively and appropriately managed, closed off in quarter or clarity provided on dates which have moved and rationale;

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

Internal Audits

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

External Audits

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

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Trust Ref. No.	Year/ Audit Plan	Committee assigned to	Report Title	Assurance Rating	Responsible Officer	Director	Priority Level	Rec. No.in Audit	Recommendation	Response No.in Audit	Management Response	Agreed Deadline in Report	Status - met or not met agreed	1st revised date	2nd revised date	3rd revised date	Closure Status	Where a management action has not met the agreed or revised date, Director must include here: 1. Date (of your update) 2. Proposed revised date
545	22/23	ARAC	Standards of Business Conduct: Declarations	Limited	Trish Mills	Trish Mills	Medium		4.1 Management should determine and implement a solution to ensure the completeness and accuracy of declarations of interest, including nil returns.		Initially 'decision makers' will be targeted for completing of declarations of interest and the register of those decision makers will be held centrally by the Board Secretary.	Jun-23	Not Met	Apr 24	Aug-24		Closed in Quarter	011024: (AP) The Trust decision-makers were targeted over the Summer 2024 via an MS Forms, and the declarations collated, reviewed and presented in a public register. This was published on the Trust website (on the 'Publications Page' on the 27 September 2024). The CorGov Team has a procedure in place to ensure that new Trust 'decision-makers' are targeted on a quarterly basis. Over time the Board and ELT Register of Interests will be combined with the wider 'decision-makers' register; however they are aboth avaliable in the same public location. Actions 545, 547 and 549 related and the same update is provided for each. Closure proposed within Q2 24/25. 050724: The Trust decision-makers are a known cohort and the collection of interests for these decision-makers has been sought. The Register is in the process of being built and will be finalised over the coming month. Revised date of August 2024 added in Q1 24/25 (which is now the 2nd revised date). This will close when the August Register is published. Last updated: 11/07/23 Declarations for the decision makers listed in the policy will commence from March 2024 so as not to duplicate efforts given declarations were sought from ADLT in March 2023 as part of the annual review.
547	22/23	ARAC	Standards of Business Conduct: Declarations	Limited	Trish Mills	Trish Mills	Medium		4.2 Consideration should also be given to introducing a tracking system and reporting the results, including declarations requested but outstanding, to an appropriate forum e.g., Audit Committee.		The 'decision makers' will be a finite known cohort and initially their declarations will be captured via Microsoft Forms to allow for tracking and escalation	Jun-23	Not Met	Apr 24	Aug-24		Closed in Quarter	011024: (AP) The Trust decision-makers were targeted over the Summer 2024 via an MS Forms, and the declarations collated, reviewed and presented in a public register. This was published on the Trust website (on the 'Publications Page' on the 27 September 2024). The CorGov Team has a procedure in place to ensure that new Trust 'decision-makers' are targeted on a quarterly basis. Over time the Board and ELT Register of Interests will be combined with the wider 'decision-makers' register; however they are aboth avaliable in the same public location. Actions 545, 547 and 549 related and the same update is provided for each. Closure proposed within Q2 24/25. 050724: The follow up of decision-makers declarations and escalations to Directors where not received is ongoing. Decision-makers process document developed and will ensure integration within the Trust's induction processes. Revised date of August 2024 added in Q1 24/25 (which is now the 2nd revised date). This will close when the August Register is published. Last updated: 11/07/23 There will be a known cohort to enable the tracking any outstanding declarations. The PADR form now has a prompt for the line manager to ensure staff have completed their declarations.
549	22/23	ARAC	Standards of Business Conduct: Declarations	Limited	Trish Mills	Trish Mills	High		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.		See 4.1 and 4.2 management responses above	Jun-23		Jul-23	Aug-24		Closed in Quarter	011024: (AP) The Trust decision-makers were targeted over the Summer 2024 via an MS Forms, and the declarations collated, reviewed and presented in a public register. This was published on the Trust website (on the 'Publications Page' on the 27 September 2024). The CorGov Team has a procedure in place to ensure that new Trust 'decision-makers' are targeted on a quarterly basis. Over time the Board and ELT Register of Interests will be combined with the wider 'decision-makers' register; however they are aboth avaliable in the same public location. Actions 545, 547 and 549 related and the same update is provided for each. Closure proposed within Q2 24/25. 050724: (AP) Propose closure when the August Register is published. 030624: Action reopened in Q1 24/25 in response to the completion of the 23/24 Follow Up Internal Audit report. IA stated in their report: "2.27This recommendation is considered partially implemented. However, whilst the 'complete' register of interests is not yet available, the Trust has demonstrated the extent of work undertaken, to date, towards producing the register for high-risk staff. We have therefore concluded that the recommendation remains open as the 'complete' register of interests is not yet available". Last updated: 11/07/23 The Board and EMT declarations are now centrally held. Additionally, decision makers included in the Policy will be held centrally going forward. This was closed down in July 2023 therefore and reported as such in Q3.
596	22/23	ARAC	Risk Management & Assurance	Reasonable	Julie Boalch	Trish Mills	Medium	1.1	Following the development of the risk appetite matrix, the Trust should develop and finalise its risk appetite statements	1.1	Accepted. Formal risk appetite statements will be developed in conjunction with the transformational BAF in 23/24; however, the risk consequence matrix is in place and includes risk appetite across a range of categories. The Trust sets out its risk appetite for patient harm in its annual report. This action forms part of the risk management transformation programme monitored at the Strategic Transformation Programme Board. Additionally, a Board Development Session is planned for February 2024.	Jun-24	Not Met	Mar-2025			Open	081024: A Risk Appetite session has been scheduled with the Board for 2nd December 2024. This session will inform the development of the risk appetite statmements during Q4. 050724: This activity is aligned to the IMTP delivery and will be completed by end of Q4. Revised date of March 2025 added in Q1 24/25. External consultant support has been procured who will provide us with a clear risk appetite methodology and coaching aimed at enabling us to deliver a Risk Appetite. The outputs will be Risk Appetite guidance used to complete risk Appetite statements as well as examples of how Risk Appetites enable and support the delivery of the Trust's objectives.
598	22/23	ARAC	Risk Management & Assurance	Reasonable	Julie Boalch	Trish Mills	Medium	3.1	Management should continue the rollout of risk management training across the Trust and seek to obtain feedback from attendees, including to capture views on the impact the training has had on their understanding of risk management principles and practice and to identify areas of further training need and improvement.	3.1	Accepted. Risk Management training will continue; however, the level 1 and 2 training packages will not be fully established until late 2024. Bespoke and directorate training will continue to be delivered as requested and a feedback form will be put in place at the next session. Continuous 1:1 support is delivered to Risk Officers to manage their risks.	Sep-24	Met				Closed in Quarter	081024: The feedback form has been developed. The level 1 package will be uploaded to ESR by end of December 2024 and level 2 will be rolled out when the Risk Manager has been appointed and in post. I propose to close this action now. Updated to 'closure proposed' as action complete. 110724: (JB): The Risk Officer will design a feedback form/s for colleagues to complete following training to capture their views. This will likely be level 2 training and can also be issued when directorate sessions are held or specific staff groups are trained, for example a new cohort of DOMs. Once this is complete the action can be closed. July 2024 Update: The risk management training for level one and two has been inlcuded as a deliverable in the IMTP risk transformation programme and will flow from the publication of the Risk Management Policy following approval at the March 2024 Audit Committee.
706	23/24	ARAC	Follow Up Audit 23/24	Reasonable	Carl Window	Trish Mills	Medium	1.1	The Trust should consider the inclusion of recommendations from other assurance providers within the enhanced tracker system.	1.1	This recommendation is accepted. A separate tracker will be developed to capture counter fraud recommendations. Progress will be reported to the closed session of the Audit Risk and Assurance Committee.	Aug-24	Not Met	Dec-24			Open	081024: (AP) Julie discussing action required with Carl Window and agreed that Carl would source support in the Finance & Corporate Resources Directorate to prepare the Tracker required. Revised date of December 2024 applied in Q2 24/25.

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743	23/24	ARAC	Risk Management	Reasonable	Julie Boalch	Trish Mills	Medium	1.1	The Trust should consider amending the risk assessment form to capture the strategic and directorate objectives and priorities impacted by each risk.	1.1	The RAF and BAF already have sections to capture the strategic objectives, however there was a timing issue with the new IMTP to facilitate the inclusion of such. These will be included going forward. At this stage of the risk management maturity at the Trust we will not include the directorate objectives and priorities impacted by each risk but is something we can look to do when we have an appropriate electronic risk management system.	Aug-24	Met				Closed in Quarter	081024: This action is complete. The Risk Assessment Form has been updated to encompass the priorities. This will be rolled out during Q3. The status has been updated to 'closure proposed'.
744	23/24	ARAC	Risk Management	Reasonable	Julie Boalch	Trish Mills	Medium	2.1	Risk assessment forms should be completed for all risks.	2.1	It may be that risk assessment forms do not need to be completed for all risks if they are developed directly on Datix. However, a siren notice will be issued to remind colleagues of the correct templates to use, support available and direct them to the risk management framework; and the narrative included in the Risk Management Guidelines will be updated accordingly too.	Aug-24	Not Met	Dec-24			Open	081024: Complete when Siren notice is issued 011124 to remind colleagues where to access templates, information and support. This will be completed in November 2024 and as such a revised date has been applied in Q2 24/25 to December 2024.
745	23/24	ARAC	Risk Management	Reasonable	Julie Boalch	Trish Mills	Medium	2.2	User / training requirements needed to support managers / risk owners through this transition should be considered to ensure that individuals feel competent to complete risk assessment forms and upload the information onto Datix.	2.2	Resourcing for the risk team is limited at this time, therefore the full programme of training and education will be in line with the risk transformation programme. However, the Corporate Governance Directorate will develop a virtual roadshow to senior directorate meetings and ADLT to provide information and signposting on risk management (as well as audit, policy, FOIs etc).	Mar-25	Not Yet Due				Open	
746	23/24	ARAC	Risk Management	Reasonable	Julie Boalch	Trish Mills	Medium	3.1	All risks should be uploaded and managed on Datix.	3.1	Datix is not currently fit for purpose. Therefore, agreeing that all risks should be uploaded and managed on Datix is not possible at this time. What is accepted is that there should be an agreed approach within local and directorate risk registers i.e. either all on Datix and managed there with appropriate reporting, or outside of Datix with an audit trail of identification, development, review, escalation, and closure. Resourcing in the risk team currently is challenging and it is therefore impossible in a timely way to agree to this recommendation. Propose that the MA related to the EMS local risk register is dealt with in action 4.1 with SOT and that the recommendation that all risks are uploaded and managed on Datix is deferred until such time as a way forward is agreed on whether changes will be made to Datix on an All-Wales basis, or whether Health Boards and Trusts will be procuring their own solutions.	Jan-25	Not Yet Due				Open	
747	23/24	ARAC	Risk Management	Reasonable	Julie Boalch	Trish Mills	Medium	4.1	We recommend the Trust consider arrangements to support the consistency and monitor the completeness of directorate registers.	4.1	The risk team will work with the clinical and operations team with respect to the risks set out here particularly and either develop a plan to manage these risks externally to Datix but with an appropriate audit trail whilst an electronic risk management system is procured, or to use Datix for the capture of the operations and clinical risks with appropriate and user-friendly reporting for their purposes. This will be evidenced by a record of this being agreed by SOT and the appropriate clinical directorate meeting. The data cleansing exercise to be undertaken by the Operations Directorate, as referenced at para 2.45, will also assist in managing the accuracy of the risk register.	Oct-24	Not Yet Due				Open	081024: Work ongoing.
748	23/24	ARAC	Risk Management	Reasonable	Julie Boalch	Trish Mills	Medium	5.1a	A summary risk report, similar to the format presented at Trust Board and Committees, should be developed and reported at directorate and service level.		1.It is accepted that an appropriate overarching risk report is beneficial for local and directorate risks, however the risk team will look at what reporting can be drawn from Datix currently, noting the limitations it has. This management action is closely aligned to the work that the team will do for action 4.1.	Oct-24	Not Yet Due				Open	
749	23/24	ARAC	Risk Management	Reasonable	Toni-Marie Norman	Trish Mills	Medium	5.1b	A summary risk report, similar to the format presented at Trust Board and Committees, should be developed and reported at directorate and service level.		2.Operations are developing a dashboard to be reported to SOT which highlights the total number of risks, how many risks at each level, review compliance (% in-date and overdue), and requesting all risks be reviewed so that any no longer relevant can be closed or replaced as appropriate, and up-to-date mitigation (controls and treatments) are recorded for any which are still applicable and need to remain open	Oct-24	Not Yet Due				Open	

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Trust Ref No.	Audit Wales or HIW Report	Year	Committee Assigned to	Report Title	Responsible Officer	Director	Priority Level	Rec. No. in Audit	Recommendation	Response no. in Audit	Management Response	Agreed Deadline in Report	Status	1st revised date	2nd revised date	3rd revised date	Where a management action has not met the agreed or revised date, Director must inlcude here: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. **Please add most recent update first**	Closure Status
148	Audit Wales	22/23	Audit	Structured Assessment 2023	Alex Crawford	Rachel Marsh	High	4	**Oversight of IMTP delivery** Whilst there have been recent improvements to the reporting of IMTP progress to Committee and Board, there is scope to provide better clarity on whether the actions delivered have achieved the intended impact. The Trust should ensure all plan delivery progress reports include information about the impact achieved.	4	Agreed. Consideration will be given as to how this can best be achieved, and this will be taken forward into the 2024/25 reporting processes.	Jun-24	Not Met	Sep-24			071024: (AP) Update from SPP: It has been achieved in so much as the IMTP is now reporting against the metrics set out in the plan (i.e. 'What good looks like'). A Benefits Realisation Framework has been agreed, but rather than strict compliance what has been prepared is translating the IMTP benefits realisation into an IMTP outcomes report that has been prepared for Trust Board. It still requires iteration but one does now exist, which allows us to track whether we are delivering on the ambitions in then IMTP. Closure proposed. Evidence is the Trust Board paper on IMTP delivery from September 2024 Trust Board. 100724: Revised date of September 2024 added in Q1 24/25. 100724: Update from SPP: Benefits realisation plans are being developed for the re-structured programme arrangements to deliver the Clinical Model Transformation and the Planning Team is working with Performance Team to align the 'what good looks like' measures set out in the IMTP to the deliverables. This action will be closed when this is reported to the Board in September 2024, as the end of Q2 24/25. Revised date of September 2024 proposed.	Closed in Quarter
149	Audit Wales	22/23	Audit	Structured Assessment 2023	Chris Turley	Chris Turley	High	5	**Oversight of Savings plans** The Trust does not clearly specify in its finance plans and reports whether savings schemes are recurrent or non-recurrent. To strengthen oversight of savings, the Trust specify whether schemes are recurrent or non-recurrent in its financial plans and reports.	5	Agreed. Whist not always specifically called out in the main report, the Trust is required to provide a monthly financial return to WG that details recurrent schemes. The latest return is provided as an appendix to every financial report. Consideration will be given to more explicitly calling some of this out in the main body of the report. Recognising the current and future climate for the public sector and the NHS specifically, the organisation has instigated a strategy of pursuing a Financial Sustainability Program to identify increases in recurrent savings schemes via two separate working group lenses of Achieving Efficiency and Income Generation in mitigation. This should also allow for greater clarity of the split between recurring and non-recurring savings within future financial plans. It is inevitable however that an element of any in year delivery of financial balance will include an element of non-recurrency, whether that be spend or savings.	Mar-24	Not Met	May-24	Jul-24		071024: (AP) Closure proposal accepted and updated in Q2 24/25. 071024: (AP) Update from Finance: We have incorporated further savings reporting into committee finance reports and hence I recommend this can be closed and as evidence please find the Month 5 finance report (paras 10 to 15 and appendix 5). Closure proposed. 080724: Revised date of July 2024 added in Q1 24/25 on advice from Jason Collins. Detail to be included in July Trust Board report (and then onwards with reporting), at which point the action will be closed. 170424: Update from Navin: The new financial year savings report identifying recurrent and non-recurrent savings will be produced for May Trust Board and should suffice as evidence. Jason Collins will send this to the CGT once it has been produced at the end of May. Date extended in quarter 4 to May 2024.	Closed in Quarter

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470	21/22	FPC	Asset Management - RAM System	Reasonable	Aled Williams	Jonny Sammut	Medium		The Trust should consider the requirement to use the proposed RFID system to validate assets not included in its current processes (e.g. stretchers, defibrillators, suction units, emergency lifting cushions and oxygen delivery systems) against the RAM Asset Management system and review and update its procedures as appropriate.		The Trust has considered the potential of linking RAM and an RFID system, however this would not be practical as RAM is updated on a quarterly basis and the RFID system is a live system with constant streaming updates. These two products would not align in a manner that would deliver a safe and valued output. The proposed solution will be a quarterly download from the RFID system that will be reconciled into RAM and variances investigated. RFID is currently in development, however due to operational pressures the rollout is unlikely to be completed before December 2022.	Mar-23	Not Met	Mar-24	Sep-25		Closed in Quarter	011024: (AP) Corporate Governance met with Internal Audit to discuss this action and it has been mutually agreed that the action could be closed on the basis that this work has been accounted for / included in the Trust's newly approved digital plan, subject to the following: •That the position be clearly articulated on the Tracker and be brought to the attention of the ARAC and FPC in the next reporting period; •That this position clearly state that the work is subject to funding of the relevant Trance 2 of the Digital Plan; •That the associated risks be held in the Digital Directorate Risk Register, in lieu of the action's inclusion on the Tracker; •That the CGT ensure that the action is scheduled for review by the FPC and ARAC in September 2025 (which is the date of completion on the Tracker). Closure proposed and accepted/updated status 011024. 270924: (AIW) Following internal meeting ICT have meeting arranged with supplier 16 Ocotber to plan upgrade RFID servers and develop plan to roll-out tags across identified high value assets 080724: Meeting to be arranged with internal audit for closure discussion. To be arranged. Last updated (ICT) 17/06/2024 - ICT have been in dialogue with the supplier and further investment is required of circa £25k to upgrade the software and end-of-life hardware. An internal meeting is being arranged with stakeholders to review options available. 11.03.24 As a result of ongoing issues outlined above, together with the need to divert ICT resources to CAS replacements since November 2024, the RFID tagging system is not yet live. The ICT team are looking to re-engage with the supplier and clinical teams from May 2024 onwards with a view to this system being live by December 2024. Following this, work will commence with the finance team looking to reconcile the two systems. Due date moved to September 2025 in Q4 23/24. Last updated 25.09.23 This work cannot be taken any further forward until the RFID system is fully implemented and quarterly reports become available to reconcile to RAM, this is as per the management response. The RFID system needs to be implemented at pace by the Trust, work is progressing with Fleet in the North and SE to tag items however currently a separate ICT resource is required in C&W to complete, following the previous update the ICT lead has now left the Trust, in addition ICT currently has circa 10 vacancies and is experiencing difficulties in recruiting to these posts, this is resulting in other schemes having to be prioritised over this scheme to ensure core systems function. The previous completion date of Mar 2023 shows as it is unclear due to the recruitment issues faced by ICT exactly when this action will be completed, Mar 2024 put as estimate by ICT dept.
527	22/23	FPC	Data Analysis	Reasonable	Aled Williams	Jonny Sammut	High		3.1 A programme to replace all of the Qlik reports with Power BI equivalents should be scoped and completed. Qlik should then be decommissioned and removed.		A risk-assessment will be conducted to understand the exposure to WAST of Qlik Sense being out of vendor support. This platform is not internet facing (i.e. for internal users only, not on a publicly accessible web url), and not believed to present an information security risk, but pending ICT assessment, we will devise a mitigation plan, or an options appraisal for maturity - due March 23. In the meantime, there is already a programme of work to migrate reports and dashboards to PowerBI. However, this is a lengthy and high-capacity activity, and is not prioritised highly at this current time - due March 24.	Mar 24	Not Met	Oct-24			Open	26/09/24 (LS): Qlik migration work is still on track and expected to complete early October with comms and training currently being offered to colleagues before decommissioning and to support with uptake of PowerBI platform. 12042024: Board Sec reveiew - recommended extension to October based on the update given, and that once this programme is completed and evidence received can be closed. Target date moved in Q4 to October 2024. Last updated 22/03/24: Risk assessment complete and on Datix, and monthly meeting in place between Cyber and Data Engineering experts to review the risk and track any vulnerabilities. This is managed through the 'national vulnerability management dashboard' reported through to Closed FPC. Additioanlly, a migration workstream for moving all dashboards from Qlik to PowerBI is in progress, with completion date of September 2024. Update 02/10/23: Risk assessment completed and in Datix. A 12-month secondment has been created for a PowerBI specialist to start the work of migration from Qlik before decommissioning. March-24 is likely unrealistic, but a roadmap will be developed once the secondment begins (November-23). Previous update 27/06/23: Qlik is considered a low IS risk. Work is already ongoing to move reports into powerBI but due to capacity constraints within the team will take most of 2023-24 to complete
545	22/23	ARAC	Standards of Business Conduct: Declarations	Limited	Trish Mills	Trish Mills	Medium		4.1 Management should determine and implement a solution to ensure the completeness and accuracy of declarations of interest, including nil returns.		Initially 'decision makers' will be targeted for completing of declarations of interest and the register of those decision makers will be held centrally by the Board Secretary.	Jun-23	Not Met	Apr 24	Aug-24		Closed in Quarter	011024: (AP) The Trust decision-makers were targeted over the Summer 2024 via an MS Forms, and the declarations collated, reviewed and presented in a public register. This was published on the Trust website (on the 'Publications Page' on the 27 September 2024). The CorGov Team has a procedure in place to ensure that new Trust 'decision-makers' are targeted on a quarterly basis. Over time the Board and ELT Register of Interests will be combined with the wider 'decision-makers' register; however they are aboth avaliable in the same public location. Actions 545, 547 and 549 related and the same update is provided for each. Closure proposed within Q2 24/25. 050724: The Trust decision-makers are a known cohort and the collection of interests for these decision-makers has been sought. The Register is in the process of being built and will be finalised over the coming month. Revised date of August 2024 added in Q1 24/25 (which is now the 2nd revised date). This will close when the August Register is published. Last updated: 11/07/23 Declarations for the decision makers listed in the policy will commence from March 2024 so as not to duplicate efforts given declarations were sought from ADLT in March 2023 as part of the annual review.
547	22/23	ARAC	Standards of Business Conduct: Declarations	Limited	Trish Mills	Trish Mills	Medium		4.2 Consideration should also be given to introducing a tracking system and reporting the results, including declarations requested but outstanding, to an appropriate forum e.g., Audit Committee.		The 'decision makers' will be a finite known cohort and initially their declarations will be captured via Microsoft Forms to allow for tracking and escalation	Jun-23	Not Met	Apr 24	Aug-24		Closed in Quarter	011024: (AP) The Trust decision-makers were targeted over the Summer 2024 via an MS Forms, and the declarations collated, reviewed and presented in a public register. This was published on the Trust website (on the 'Publications Page' on the 27 September 2024). The CorGov Team has a procedure in place to ensure that new Trust 'decision-makers' are targeted on a quarterly basis. Over time the Board and ELT Register of Interests will be combined with the wider 'decision-makers' register; however they are aboth avaliable in the same public location. Actions 545, 547 and 549 related and the same update is provided for each. Closure proposed within Q2 24/25. 050724: The follow up of decision-makers declarations and escalations to Directors where not received is ongoing. Decision-makers process document developed and will ensure integration within the Trust's induction processes. Revised date of August 2024 added in Q1 24/25 (which is now the 2nd revised date). This will close when the August Register is published. Last updated: 11/07/23 There will be a known cohort to enable the tracking any outstanding declarations. The PADR form now has a prompt for the line manager to ensure staff have completed their declarations.

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549	22/23	ARAC	Standards of Business Conduct: Declarations	Limited	Trish Mills	Trish Mills	High		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.		See 4.1 and 4.2 management responses above	Jun-23		Jul-23	Aug-24		Closed in Quarter	011024: (AP) The Trust decision-makers were targeted over the Summer 2024 via an MS Forms, and the declarations collated, reviewed and presented in a public register. This was published on the Trust website (on the 'Publications Page' on the 27 September 2024). The CorGov Team has a procedure in place to ensure that new Trust 'decision-makers' are targeted on a quarterly basis. Over time the Board and ELT Register of Interests will be combined with the wider 'decision-makers' register; however they are aboth avaliable in the same public location. Actions 545, 547 and 549 related and the same update is provided for each. Closure proposed within Q2 24/25. 050724: (AP) Propose closure when the August Register is published. 030624: Action reopened in Q1 24/25 in response to the completion of the 23/24 Follow Up Internal Audit report. IA stated in their report: "2.27This recommendation is considered partially implemented. However, whilst the 'complete' register of interests is not yet available, the Trust has demonstrated the extent of work undertaken, to date, towards producing the register for high-risk staff. We have therefore concluded that the recommendation remains open as the 'complete' register of interests is not yet available". Last updated: 11/07/23 The Board and EMT declarations are now centrally held. Additionally, decision makers included in the Policy will be held centrally going forward. This was closed down in July 2023 therefore and reported as such in Q3.
567	22/23	FPC	Hazardous Area Response Team (HART)	Reasonable	Clare Langshaw/Judith Bryce	Lee Brooks	Medium		2.1 The Trust should undertake a self-assessment against the NARU key lines of enquiry review document. This could support any future "critical friend" review undertaken.		The Trust accepts this recommendation and is committed to undertaking a self-assessment aginst the NARU review document	May-23	Not Met	Mar-23	Mar-24	Jun-24	Open	171024 (AP): Additional update - This will be taken to SOT on the 05 November (the 22 October was cancelled). Once it's been to SOT this action can be proposed for closure, in line with the below update. 270924 - Peer Review scheduled for 7th October on the HART Self Assessment. Findings of the peer review will be reported to Formal SOT on the 22nd October for approval of assurance. Evidence of the Agenda item and Triple A from SOT will be provided to update Audit Committee on the decisions following the Peer Review. Once this completed (by the end of October) we will propose closure. 120724: Action not yet complete. SLT requested peer review and a number of actions have been passed to SOT and EPRR team to complete prior to it going back to SLT for assurance/approval. Third revised date not met. Indicated for review by FPC and ARAC. Update will be provided to the Corporate Governance Team as soon there are updates. 270624:Current Situation - submitted self assessment as per recommendation and planned management response, Sent through SBAR, Self Assessment and agenda Bundle/Triple A. Will be going back through SOT on 2nd July and SLT on 9th as SLT have not yet seen the full self assessment (just the SBAR due to error). Will need this to remain open untill assurance provided to SLT via SOT this week. 040624: Self Assessment and accompanying SBAR will be going through Formal SOT on 18th June 2024. 160424: (AP) Self-assessment is yet to be taken to SOT. Cannot be closed in quarter. Revised date of June 2024 applied in Q4 and can be closed off once the self-assessment has gone to SOT and received evidence. Update 22.03.2024 Copy of self assessment sent to Alex Payne as evidence requested for closure. The Self Assesment is scheduled to go through SOT meeting on 9th April. Once meeting takes place, we will send over minutes of discussions for evidence of closure. Update 11.03.2024 Self assessment been completed, majority of areas compliant with. Next steps will be ongoing annual review to be carried out. Recommend closure. Update 24.01.2024 - Date set to undertake an internal review as mentioned on 22.11.2023. Date confirmed as: 19th February 2024. Update 22.11.2023 We are looking to undertake an internal review carried out by the Specialist Operations Locality Manager against the same criteria that the English Trusts are reviewed against to ensure interoperability is maintained. Update 27.09.2023 NARU still unable to support due to capacity limitations. HART uplift currently rolled out in england which is NARU's current focus. To ensure this action is undertaken an internal review will now take place in line with this action. Last Updated: 26.06.2023 NARU has been approached, but they are not able to support this at the moment due to staff shortages. Although they are supportive of the Trust in this. Proposed completion date changed from Mar23 to Mar24.
596	22/23	ARAC	Risk Management & Assurance	Reasonable	Julie Boalch	Trish Mills	Medium	1.1	Following the development of the risk appetite matrix, the Trust should develop and finalise its risk appetite statements	1.1	Accepted. Formal risk appetite statements will be developed in conjunction with the transformational BAF in 23/24; however, the risk consequence matrix is in place and includes risk appetite across a range of categories. The Trust sets out its risk appetite for patient harm in its annual report. This action forms part of the risk management transformation programme monitored at the Strategic Transformation Programme Board. Additionally, a Board Development Session is planned for February 2024.	Jun-24	Not Met	Mar-2025			Open	081024: A Risk Appetite session has been scheduled with the Board for 2nd December 2024. This session will inform the development of the risk appetite statmements during Q4. 050724: This activity is aligned to the IMTP delivery and will be completed by end of Q4. Revised date of March 2025 added in Q1 24/25. External consultant support has been procured who will provide us with a clear risk appetite methodology and coaching aimed at enabling us to deliver a Risk Appetite. The outputs will be Risk Appetite guidance used to complete risk Appetite statements as well as examples of how Risk Appetites enable and support the delivery of the Trust's objectives.
598	22/23	ARAC	Risk Management & Assurance	Reasonable	Julie Boalch	Trish Mills	Medium	3.1	Management should continue the rollout of risk management training across the Trust and seek to obtain feedback from attendees, including to capture views on the impact the training has had on their understanding of risk management principles and practice and to identify areas of further training need and improvement.	3.1	Accepted. Risk Management training will continue; however, the level 1 and 2 training packages will not be fully established until late 2024. Bespoke and directorate training will continue to be delivered as requested and a feedback form will be put in place at the next session. Continuous 1:1 support is delivered to Risk Officers to manage their risks.	Sep-24	Met				Closed in Quarter	081024: The feedback form has been developed. The level 1 package will be uploaded to ESR by end of December 2024 and level 2 will be rolled out when the Risk Manager has been appointed and in post. I propose to close this action now. Updated to 'closure proposed' as action complete. 110724: (JB): The Risk Officer will design a feedback form/s for colleagues to complete following training to capture their views. This will likely be level 2 training and can also be issued when directorate sessions are held or specific staff groups are trained, for example a new cohort of DOMs. Once this is complete the action can be closed. July 2024 Update: The risk management training for level one and two has been inlcuded as a deliverable in the IMTP risk transformation programme and will flow from the publication of the Risk Management Policy following approval at the March 2024 Audit Committee.
604	22/23	Quest	Pain Management	Limited	Duncan Robertson	Andy Swinburn	High	1.2(c)	The Trust should ensure all PGDs follow the Medicines Management policy, with a review undertaken every three years as a minimum.	1.2 (c)	The PGD development and review process is resource intensive, and pharmacist input is an essential requirement. Pharmacist Advisor availability is currently limited to 4-hours per month and does not currently meet the needs of the organisation, particularly given the uplift in advanced practitioners and extended skills (enhanced analgesia) of the paramedic workforce. We will develop an options appraisal to determine a costed and effective way forward to provide additional Pharmacist Advisor capacity.	Mar-24	Not Met	May-24	Sep-24	Mar-25	Open	071024: (AP) In line with update given in July 2024, action can only be closed when the backlog of PGDs has been reviewed. Given that and that the Pharmacist begins in post mid-Q3 24/25, requested that a revised date of March 2025 be applied to permit this to take place. Revised date of March 2025 added in Q2 24/25. 080724: Revised date of September 2024 added in Q1 2024/25. When Pharmacist Advisor recruited the role holder will be reviewing the Patient Group Directives outstanding. At that point this will be an ongoing responsibility of the PA. Action to be closed when backlog of PGDs reviewed. 050724: Proposure not accepted; post holder needs to be in post before closure. Last Updated 270624: (JL) Additional support approved and agreed at EFG 27/03/24. Lead Pharmacist role is currently out for recruitment and second Head of Medicines Management role expected to be out for recruitment in next few days. Action recommended for closure. 170424: (AP) Not clear when received at ELT so revised date in Q4 of May24 added. Last updated 04.04.2024 Recommend for closure: Options presented to Executives and recruitment commenced.

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612	22/23	PCC	Trade Union Release Time	Limited	Liz Rogers	Angela Lewis	High	2.1	A standardised process to formally request trade union time should be agreed and appropriate monitoring mechanisms put in place to ensure practices are applied and managed consistently. The process should also incorporate the method of approval and payment / TOIL as well as the management of refusals.	2.1 (c)	The comments of audit colleagues are noted and accepted. Whilst there was a template provided, reps were advised that they needed to maintain a personal record but flexibility was given on how this was to be done. The audit feedback will be shared with TU partners for information and clarification. The current spreadsheet can not be completed on an iPad. Also managers are often not able to respond to a request as soon as it is submitted due to shift patterns and operational pressure **Action:** Engagement with the senior TU partners will be undertaken with the aim of reaching agreement on implementing a standardised simplified approach (in the context of IA within WAST).	Sep-24	Not Met	**Dec-24**			Open	07024: (AP) Revised date of December 2024 applied in Q2 24/25, in line with update. 20.09.24: Request that the date is moved to December 2024 as suggested in March in line with the action 613, as the two actions are related. LR will provide further updates on her return to the Trust in Autumn 2024.
613	22/23	PCC	Trade Union Release Time	Limited	Liz Rogers	Angela Lewis	High	3.1	A standardised process to formally record facility time, and in sufficient detail, should be agreed and implemented.	3.1 (a)	WAST do not currently have the systems to record this information centrally and to do this manually will take more administrative support which is not good value for money. Most TU reps are based in Operations and are recorded in GRS. Only a handful are working outside of the GRS system. **Action:** We will review whether the information could be held in ESR effectively and what the maintenance of this would be and the ease of collecting it. It needs to be in one place for ease of reporting and management. If this is not a realistic option (in terms of cost), we will explore options for alternative methods of recording total time.	Nov-23	Not Met	Mar-24	Dec-24		Open	26.06.24 - JS - Request to extend deadline to December 2024 as previously agreed. This is being managed by Operations Directorate (Jonathan Edwards). The revised date was applied in Q1 24/25 reporting period, in line with the update provided. 20.03.24 - LR - work on electronic timesheets is ongoing. The ESR system is going to be replaced and the current options for recording time are unlikely to work well. Recommend that this is extended in line with the implementation of electronic timesheets and TUPs continue to record time and complete their Ops timesheets in the usual way and record TU activities in diaries etc until then. (Please see comments above re Social Partnership and partnership working as these are very relevant). Propose a change in date to Dec 24 re the electronic timesheet due to the sensitivity regarding negotiations with TU partners. Target date moved in quarter 3 to quarter 4 (to December 2024). Dec 23 - The management response to this item was:- 'We will review whether the information could be held in ESR effectively and what the maintenance of this would be and how easily could be be accessed and collected. It needs to be in one place for ease of reporting and managment. It this is not a realistic option (in terms of cost) , we will explore options for alternative methods of recording total time.' This is wrapped up in the wider challenges in terms of TU relationships and therefore we want to treat with sensitivity. Facility Time is recorded in GRS and Shift Track. We don't have any reps who are not using one or other of those systems. 111 and other areas are likely transferring to GRS so all will be captured in one system. Also the potential work around electronic timesheets will also impact on record keeping. There is a potential option to record TU time in ESR but we are in the early stages of exploring this but we will give it due consideration. Our ESR lead is currently away from work. Propose an extension to March 24 when we will likely have more clarity on electronic timesheets and moving all colleagues on shifts into GRS.
622	22/23	FPC	IM&T Infrastructure	Reasonable	Aled Williams	Jonny Sammut	Medium	1.1	WAST should schedule a physical stocktake to ensure the asset register is 100% accurate.	1.1	With the majority of corporate staff remote working since Covid it has been difficult to conduct a physical audit. Also given the range of equipment provided to staff for home working (laptop, dock and monitors) we will have to develop a new way of undertaking a physical audit.	Apr-24	Not Met	Mar-25			Open	270924 (AIW) - workpressures have resulted in a dely, HotH service desk go-live is now 300924. ICT are planning to utilise tools available to conduct a full audit of equipment by Q4 2024/25 080724: Revised date of March 2025 added in Q1 24/25 in line with update. 170624: ICT Update - Launch of new service desk for ICT staff will commence 01/07/2024 with a rollout of incident and problem management modules along with migration of assets into the new system CMDB. To update the asset register the Trust has invested in additional licences to allow for remote scan of equipment connecting to network and work is ongoing to reconcile this data and we will utilise this reconciliation exercise to virtually audit this equipment. We are unlikely to physically audit equipment at remote workers homes and discussions are ongoing as to the availability of non-ICT staff to undertake a physical audit of equipment located at Trust sites if this is deemed necessary. Revised date of March 2025. Work is now underway with the new system in build and is expected to go-live in Jun-24 and a review of assets will be conducted as part of this implementation. In parallel work is ongoing to undertake a physical audit of WAST sites when resources are available. However we still considering option for physical stocktake of remote workers where it does not involve a visit staff home address
624	22/23	FPC	IM&T Infrastructure	Reasonable	Wyn Morris	Jonny Sammut	Medium	3.1	The process for clearing all PRTG/system alerts should be formalised and documented. It would typically include •A shared mailbox, all alerts go to one place •Prioritisation guidelines for all calls. •Scheduled review times for technicians and managers. •Process for storing cleared alerts for periodic analysis to assist with trend /cause identification If there are too many alerts for this to be considered reasonable then the parameters for their production could be reconsidered so that a lower number of what could be considered higher priority alerts is generated.	3.1	Agreed, will look to formalise the process and provide some ownership to the defined process	Dec-23	Not Met	Jun-24	Aug-24	**Mar-25**	Open	270924 (AIW) - Service desk will launch 200924 which will see the automated vreation and managemnt of alerts. This work is therefore not yet complete and revised date requested to March 2025. Revised date to March 2025 in Q2 24/25. 080724: Revised date of August 2024 added in Q1 24/25 in line with update. 170624: ICT Update - Launch of new service desk for ICT staff will commence 01/07/2024 with a rollout of incident and problem management modules along with migration of assets into the new system CMDB. Automation of incidents form alerts is planned to be in place from mid-July. Revised date August 2024. Linked with implementation of House on the Hill ITSM software. Date moved in Q4 to June24. 20/03/2024 - This recommendation is now linked with the implementation of the new service desk software has been delayed due to contract finalisation and work associated with CAS replacement. Work is now underway with the new system in build and is expected to go-live in Jun-24 and automation of PRTG alerts is a key part of this implementation. Target date moved in quarter 3. Last Updated 06/12/23: Technical solution still to be designed but likely solution superseded by implementation of new Service Desk platform which will address this need in core requirements. Timeline June 2024. 18/12/23: Contract for new service desk software signed 15/12/23, Draft implementation plan produced with full implementation expected to take 6 months, individual modules are yet to be prioritised
625	22/23	FPC	IM&T Infrastructure	Reasonable	Tony Raine	Jonny Sammut	High	4.1	Switches should be identified within the asset register.	4.1	This work was underway prior to the audit but the member of staff is on long term sick. As our switches are configured not to respond to general network sweeps it is a manual task to collate and add this information to the CMDB.	Mar-24	Not Met	Sep-24		**Mar-25**	Open	270924 (AIW) - New service desk will launch 300924 which will include a revised asset shcedule that will include switches. This work is therefore not yet complete and revised date requested to March 2025. Revised date to March 2025 in Q2 24/25. 170624: ICT Update - Launch of new service desk for ICT staff will commence 01/07/2024 with a rollout of incident and problem management modules along with migration of assets into the new system CMDB. Switches will be included as assets in the new system Linked with implementation of House on the Hill ITSM software. Date moved in Q4 to Sept24. 20/03/2024 - Work completed and list produced and waiting on the implementation of the new service desk software which has been delayed due to contract finalisation and work associated with CAS replacement. Work is now underway with the new system in build and is expected to go-live in Jun-24.

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645	22/23	FPC	Savings & Efficiencies	Reasonable	Jason Collins	Chris Turley	Medium	2.1	A formal programme of financial training should be provided to budget holders to allow them to effectively carry out their role.	2.1	Key objective for WAST FM Team (and wider Finance teams) for 23/24 will be to undertake a series of Finance Training to Board Members, Budget Holders and other non-financial staff. This will be delivered by several methods such as face to face training, TEAMS sessions and induction.	Dec-23	Not Met	24-Mar	Jun-24	Nov-24	Closed in Quarter	071024: (AP) Closure accepted and updated in Q2 24/25. Evidence of the training materials provided. Update 021024: Advise that this is now closed as all budget holders were sent training packs for core budget manager training and for the new all wales Qliksense finance system during week ending 27/09/24. 050724: Update from JC: due to a revised NHS Wales rollout of the new Qliksense reporting tool and BI dashboard now planned for November 2024 then this training will be delayed until then to ensure all budget holders receive consistent training. Request third revised date of November 2024 in Q1 24/25. Target date moved in quarter three and four (to June24). Update 12.12.23 - this has commenced with formal training to board members / TU partners taken place in April 23 and training sessions held with Operational Managers in November 23. Training to budget managers will now be captured in Quarter 4 to include any potential updates to finance system rollouts being undertaken by NHS Wales. In the interim all budget managers have assigned Senior Finance Business Partners who support and informally train on all finance related matters. UPDATE 21.03.24 ... formal training to budget holders is slightly delayed due to the national rollout of the Qlicksense finance tool to all organisation which will incoporate BI dashboards and WAST Finance Team will deliver the formal training alongside training for this new package. Informal support continues as all Budget Holders / Managers are assigned a Senior Finance Business Partner as first line of contact.
646	22/23	FPC	Savings & Efficiencies	Reasonable	Jason Collins	Chris Turley	Medium	2.2	Training records should be maintained to confirm attendance, which should be monitored to identify non-attendance so this can be followed up.	2.1	Schedule of Training and who has attended to be recorded.	Dec-23	Not Met	24-Mar	Jun-24	Nov-24	Closed in Quarter	071024: (AP) Closure proposal accepted and updated in Q2 24/25. Evidence of the training record received. 020124 : Advise this is now closed. All training packs have been sent to budget holders and responses received via a MS forms when these are read / understood. 050724: Update from JC: due to a revised NHS Wales rollout of the new Qliksense reporting tool and BI dashboard now planned for November 2024 then this training will be delayed until then to ensure all budget holders receive consistent training. A list of those trained continues to be added too but full list will be available when Qliksense training is provided. Request third revised date of November 2024 in Q1 24/25. Target date moved in quarter three and four (to June24). Update 12.12.23 - As per audit ref 645, formal training has commenced and a log of attendees has commenced and this will be further updated during quarter 4 roll out of formal training to budget managers. UPDATE 21.03.24 ... as per audit ref 645 ... list has commenced but will be added to when formal training is rolled out to allign with new finance system
653	22/23	FPC	Records Management	Reasonable	Leanne Smith	Jonny Sammut	Medium	2.1(a)	A record management improvement plan should be developed, based on a formal assessment of records throughout the Trust.	2.1(a)	Additional fixed-term support will be sought to conduct the assessment and craft an improvement plan. The risk of not developing an improvement plan in 2023-24 will be included in the risk being developed as per action 1.1.	Sep-23	Not Met	Aug-24			Closed in Quarter	230724: (AP) IGSG received and approved the records management improvement plan at its 23 July 2024 meeting. Due to resource constraints in the records management team the dates of actions were not updated, however it was agreed that the plan was appropriate and that the plan would be a standing agenda item on IGSG until the improvement plan is completed. It was felt that that would give sufficient oversight of revised dates for the plan when resourcing issues are resolved. CLOSURE PROPOSED. Status updated to closure proposed by AP 090824. 080724: Business not taken to IGSG in June 2024 as intended; rescheduled to July 2024. Revised date of August 2024 applied in Q1 24/25, therefore. Intended that once this is received at IGSG in July this action will be closed. Last Updated 23/05/24: A records management improvement plan has been developed and prioritised, and is due to be passed through the Information Governance Steering Group in June 2024 for approval (May meeting of IGSG was cancelled).
654	22/23	FPC	Records Management	Reasonable	Judith Birkett	Jonny Sammut	Medium	2.1(b)	A record management improvement plan should be developed, based on a formal assessment of records throughout the Trust.	2.1(b)	A Digital Notice re records management will be published on the intranet to increase awareness of individual staff responsibility.	Dec-23	Not Met	Jan-24	Apr-24	Aug-24	Closed in Quarter	111024: (AP) Closure proposal accepted and status updated. 26/09/2024: LS update - IGSG received a copy of the Records Management Improvement Plan for discussion in July 2024 (evidenced by AAA), and given slippage in target dates for actions in the plan (due to unexpected long-term absence of a key Records expert) agreed to continue monitoring at IGSG with escalation route to ELT if required. This was noted in August AAA of IGSG too, and is a standing item on the agenda for forthcoming months. Propose closure of this action. 080724: Business note taken to IGSG in June 2024 as intended; rescheduled to July 2024. Revised date of August 2024 applied in Q1 24/25, therefore. Intended that once this is received at IGSG in July this action will be closed. Last Updated 23/05/24: A records management improvement plan has been developed and prioritiesed, and is due to be passed through the Information Governance Steering Group in June 2024 for approval (May meeting of IGSG was cancelled). Additionally, a training package has been published on the Digital Sharepoint site to increase awareness - this has also been delivered virtually to specific teams who required targetted training. Propose that approval of the improvement plan at IGSG in June 2024 will close this action. Update 25/03/24: a Records Managment Improvement Plan has been developed, approved by Assistant Director of Digital, and is already being progressed. This will be shared with Information Governance Steering Group for awareness in April 2024. Date changed in Q4 to April24. Target date moved in Quarter 3 to January-24. Update 18/12/23: materials have been developed to help raise awareness of records management. These are being finalised, with a plan to share and put on the Records Siren page with a living FAQ sheet. Plan to release this in January-24.
655	22/23	FPC	Records Management	Reasonable	Judith Birkett	Jonny Sammut	High	3.1(a)	A formal agreement for storage of records should be developed. This should set out the responsibilities and requirements for management of health records.	3.1(a)	Additional temporary resource to be sought (from Jan-24) to conduct review of DCC stored boxes and retention schedules. A forecast of storage requirements at DCC will be created to inform a decision on if/when it will be possible to move these records into WAST-managed storage (e.g. at VPH).	Apr-24	Not Met	Sep-24	Mar-25		Open	011024: (AP) Revised date of March 2025 in Q2 24/25 added in line with update. 26/09/2024: LS update - this work has not been able to be progressed due to long-term absence of a key expert within the Records Team. This pressure on team capacity is expected to remain until January and until this time focus remains on Records Requests (not management and storage) and maintaining compliance with regulatory targets. As such, propose to extend due date to March-25. 080724: Revised date of September 2024 added in Q1 24/25. 190624: LS Update - Due to some sickness within the small team this action has not been able to be complete. Work continues on reviewing the records held in DCC, and as per retention schedules, an instruction for disposal has been issued for some boxes. Linked with Action 657, it is believed that following a review of the storage faciltiy in VPH, as the requirement for external storage at DCC has decreased, we may be able to transfer remaining boxes to WAST storage instead. Propose that this date is extended to September 2024, and sequenced after action 657.
656	22/23	FPC	Records Management	Reasonable	Judith Birkett	Jonny Sammut	High	3.1(b)	A formal agreement for storage of records should be developed. This should set out the responsibilities and requirements for management of health records.	3.1(b)	Should [following the review at 3.1a being evaluated] we still need space at Denbigh County Council then we will pursue an agreement with them for those storage, retention and disposal. In the meantime, we will ask for the policies and procedures the Council have in place for their receipt, retention and destruction of records and confirm that this is the way they treat our records. That should provide some assurance on the issues in the matter arising.	Sep-24	Not Met		Mar-25		Open	011024: (AP) Revised date of March 2025 in Q2 24/25 added in line with update. 26/09/2024: LS update - this work has not been able to be progressed due to long-term absence of a key expert within the Records Team. This pressure on team capacity is expected to remain until January and until this time focus remains on Records Requests (not management and storage) and maintaining compliance with regulatory targets. As such, propose to extend due date to March-25.

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657	22/23	FPC	Records Management	Reasonable	Leanne Smith	Jonny Sammut	Medium	4.1	Records should be moved into the new storage area.	4.1	RSAM to review suitability of the VPH storage facility and access management arrangements. If appropriate, secure transfer of the records from Pontypool to VPH will require budget approval beyond the funds available for Records Services (to be discussed with Corporate Governance & Finance).	Jan-24	Not Met	Jun-24	Aug-24	Mar-25	Open	011024: (AP) Revised date of March 2025 in Q2 24/25 added in line with update. 26/09/2024: LS update - this work has not been able to be progressed due to long-term absence of a key expert within the Records Team. This pressure on team capacity is expected to remain until January and until this time focus remains on Records Requests (not management and storage) and maintaining compliance with regulatory targets. As such, propose to extend due date to March-25. 080724: Revised date of August 2024 added in Q1 24/25. Last Updated 19/06/2024: Due to some sickness within the small team this action has not been able to be progressed. The Records & Archives Manager plans to visit VPH in person to conduct this suitability review. Completion of this action will support with Action 655. Propose that this date is extended to August 2024, and sequenced before action 655. Date changed in Q4 to June 2024 in line with update. Last Updated 25/03/24: request for date extension to Jun-24. VPH storage facility still to be assessed for feasibility.
658	22/23	FPC	Records Management	Reasonable	Judith Birkett	Jonny Sammut	Medium	5.1	The records management improvement plan noted in MA2 should include a programme of identification and assessment of all records storage areas within the Trust.	5.1	The risk of not fully assessing storage areas in 2023-24 will be acknowledged in the risk being developed as per action 1.1. A Trust-wide request will be made to gather intel on what paper records are being stored across the organisation and where. This will inform the improvement plan of how to assure these storage areas.	Sep-24	Not Met	Mar-25			Open	011024: (AP) Revised date of March 2025 added in line with update. 26/09/2024: LS update - this work has not been able to be progressed further due to long-term absence of a key expert within the Records Team. This pressure on team capacity is expected to remain until January and until this time focus remains on Records Requests (not management and storage) and maintaining compliance with regulatory targets. As such, propose to extend due date to March-25. Last Update 25/03/24: a risk has been developed regarding the overall compliance of records management. Further risks are in development, to capture the specifics of storage areas.
606	22/23	PCC	Senior Paramedic Role	Reasonable	Greg Lloyd	Andy Swinburn	Medium	1.1	Periodic analysis of GRS data should be undertaken to ensure all SPs are adhering to the recommended split of their shifts.	1.1	A GRS report will be generated using a randomised sample of the SP group; and this report will be submitted to the SP Steering Group.	Jan-24	Not Met	May-24	Aug-24		Closed in Quarter	021024: (AP) Proposed closure accepted; evidence received; status updated. Last updated 01102024: Recommend for closure. GRS report data included in the powerpoint presentation now going through SP Steering Group. First presentation including GRS data provided for evidence to close. 040724: (AP) Revised date of August 2024 added in Q1 24/25. Last Updated 270624: (JL) Report was due to go to SP Steering Group scheduled by May '24 however meetings were cancelled. Chair (Darren Panniers) has scheduled meeting for July '24 and report to be presented then. Request extension of revised due date to Q2 for approved report to be submitted as evidence following Steering Group in July. 04.04.2024 The report has been requested but has not yet been sent to Greg Lloyd but he should get it for the steering group in April - it will likely have to be a manual report run each time as someone has to break down the shifts for the group. Report to be shared as evidence once available. Revised date proposed to May24. Changed in Q4 to May24.
608	22/23	PCC	Senior Paramedic Role	Reasonable	Greg Lloyd	Andy Swinburn	Medium	2.1(b)	A review of allocation of Ps and Ts is undertaken to ensure consistency across Wales.	2.1(b)	A review of options for reducing variances in the size of SP teams will be presented to the quarterly SP Steering Group.	Jan-24	Not Met	May-24	Aug-24		Closed in Quarter	021024: (AP) Proposed closure accepted; evidence received; status updated. Last updated 01102024: Recommend for closure. SP team size variance included in the powerpoint presentation now going through SP Steering Group. First presentation including variance data provided for evidence to close. 040724: (AP) Revised date of August 2024 added in Q1 24/25. Last updated 270624: (JL) Figures provided to demonstrate change in numbers in operational areas but report required through Steering Group to demonstrate as evidence. Request extension of revised due date to Q2 as above for approved report to be submitted following Steering Group in July. 170424: Action remaining opent until business received at Steering Group. Date revised in Q4 to May24. Last Updated 04.04.2024 Recommended for closure: the main issue was in one particular area that we have now recruited into so that has reduced the team size, the additional four SPs were allocated according to the average size of the team in each of the operational areas so size variance is now at an acceptable level. This will be monitored in the Steering Group (as per updated below) and action taken again should the levels change in future.
611	22/23	PCC	Senior Paramedic Role	Reasonable	Greg Lloyd	Andy Swinburn	Medium	3.1	Training status for all SPs should be collated and captured with regular reporting within an appropriate forum to monitor progress.	3.1	Updated reports on education progress of the SP cohorts to be brought together into a single progress report. This will be presented through the Clinical Directorate Business meeting and the Senior Operations Team.	Jan-24	Not Met	May-24	Aug-24		Closed in Quarter	021024: (AP) Proposed closure accepted; evidence received; status updated. Last updated 01102024: Recommend for closure. SP education progress included in the powerpoint presentation now going through SP Steering Group and to SOT where required. First presentation including education progress provided for evidence to close. The training statuses will continue to be reported to the SPSG and then matters escalated to the CDBM should that be required. 040724: (AP) Revised date of August 2024 added in Q1 24/25. Last updated 270624: (JL) Report was due to go to SP Steering Group scheduled by May '24 however meetings were cancelled. Chair (Darren Panniers) has scheduled meeting for July '24 and report to be presented then. Request extension of revised due date to Q2 for approved report to be submitted as evidence following Steering Group in July. 04.04.2024 Report to be pulled together (and shared as evidence for closure) for next steering group. Revised date proposed in Q4 of May24.
612	22/23	PCC	Senior Paramedic Role	Reasonable	Darren Panniers	Andy Swinburn	Medium	3.2	A training plan, and expected timeline for the required clinical skill enhancements should be established.	3.2	An Extended Skills Working Group has been established to deliver four new areas for skill development during 2024. The first meeting is in November 2023 with two priorities already agreed (sedation for post ROSC patients and the management of ABD). The workplan and draft terms of reference have been shared with Audit for information. These skills will initially be for the SP group only until an assessment and audit is completed for further consideration on safety and efficacy.	Dec-23	Not Met	May-24	Aug-24	Dec-24	Open	081024: (AP) To seek additional evidence of the training plan and timelines before closure (as it wasn't clear from the PPT evidence provided). This note was received in Q2 therefore revised date of December 2024 applied in Q2 24/25. Closure will be accepted when the training plan and associated timelines have been received. Last updated 01102024: Recommend for closure. Eximded skills information included in the powerpoint presentation now going through SP Steering Group. First presentation including extended skills plan provided for evidence to close. 040724: (AP) Revised date of August 2024 added in Q1 24/25. Last Updated 270624: (JL) ToR for working group shared with training plan timelines to go through Steering Group, Request extension of revised due date to Q2 as above for approved details and timelines to be submitted following Steering Group in July. 04.04.2024 Steve Magee is leading this group with Huw Jackson, a timeline has yet to be identified and Jen Lloyd will pick this up with the team to implement though work has started with the identified skills. Revised date proposed of May24 in Q4. 201223 - update received however further queries raised on training plan by Board Secretary

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613	22/23	PCC	Senior Paramedic Role	Reasonable	Darren Panniers	Andy Swinburn	Low	4.1	The terms of reference should be reviewed to: •Include a defined pathway for escalation of issues; •Update membership to ensure representation from each locality; andNov •Define quoracy.	4.1	The SP steering group has changed to a quarterly meeting and the terms of reference are being updated to reflect the audit findings. An Alert/Assure/Advise report will be completed and submitted to the Senior Operations Team.	Nov-23	Not Met	Feb-24	May-24	Aug-24	Open	021024: (AP) CGT not accepted closure position as the ToR revisions don't include everything that is required by the management action. Quorum not included and escalation process not explicit (although says that will provide AAA to SOT). Marked date of August 2024 as red, to indicate not completed. AP engaged wtih Clinical Directorate to provide advice and request revision of ToR; Greg Lloyd is aware of position. Last updated 01102024: Recommend for closure. SOT approved ToR on 10/09/24. AAA and ToR received as evidence for closure. 040724: (AP) Revised date of August 2024 added in Q1 24/25. Last Updated 270624: (JL) Report was due to go to SP Steering Group scheduled by May '24 however meetings were repeatedly cancelled. Chair (Darren Panniers) has scheduled meeting for July '24 and report to be presented then. Request extension of revised due date to Q2 for approved report to be submitted as evidence following Steering Group in July. GL following up with DP to confirm presentation at July SG and the following SOT. Confident this will then be completed by end of Q2. AS has given approval at Clinical Business Meeting 28.06.24 04.04.2024 Darren Panniers chairs the group and has seen the ToR but they need approval at SOT which we hope to do after the next meeting in April (and shared for evidence). Revised date proposed of May24 in Q4. Target date moved in quarter 3. 201223 - Meetings to finalise TOR in January.
614	22/23	PCC	Senior Paramedic Role	Reasonable	Greg Lloyd	Andy Swinburn	Medium	5.1	The Trust should undertake a lessons learned exercise on the development and evolution of the SP role.	5.1	A review on the evolution of the role will be completed to highlight any lessons that can be learned for future role development.	Feb-24	Not Met	May-24	Aug-24	Mar-25	Open	071024: (AP) Clarified with Clinical Directorate that this action is yet to be completed. Requested revised date of March 2025 to allow this to be completed. Revised date for this action of March 2025 added in Q2 24/25. 040724: (AP) Revised date of August 2024 added in Q1 24/25. Last Updated 270624: (JL) Discussion not yet taken place due to postponed Steering Group. Request extension of revised due date to Q2 to allow for discussion at Steering Group in July. 04.04.2024 Not yet commenced. Jen Lloyd to send reminder to Greg Lloyd for discussion at Steering Group. Revised date proposed of May24 in Q4.
615	22/23	PCC	Senior Paramedic Role	Reasonable	Greg Lloyd	Andy Swinburn	Medium	5.2	The Trust should report regularly on the impact and effectiveness of the SP role, including analysis of their utilisation across Wales and the achievement of the wider IMTP objective.	5.2	A report including number of rideouts undertaken and the outcomes (action plans/issues resolved during the shift/documentation/CPD/NQP portfolio reviews) will be developed into a regular report into the SP Steering Group on a quarterly basis.	Jan-24	Not Met	May-24	Aug-24		Closed in Quarter	021024: (AP) Proposed closure accepted; evidence received; status updated. Last updated 01102024: Recommend for closure. SP rideout data included in the powerpoint presentation now going through SP Steering Group. First presentation including rideout data provided for evidence to close. 040724: (AP) Revised date of August 2024 added in Q1 24/25. Last Updated 270624: (JL) Report was due to go to SP Steering Group scheduled by May '24 however meetings were repeatedly cancelled. Chair (Darren Panniers) has scheduled meeting for July '24 and report to be presented then. Request extension of revised due date to Q2 for approved report to be submitted as evidence following Steering Group in July. 04.04.2024 To be done for next Steering Group in April and shared as evidence for closure. Revised date proposed of May24 in Q4.
616	22/23	PCC	Senior Paramedic Role	Reasonable	Greg Lloyd	Andy Swinburn	Medium	5.3	Feedback from Paramedics and Technicians should be included as a standing agenda item on the SP Steering Group for consideration / action as appropriate.	5.3	Feedback through the Power BI reporting process will be included on the SP Steering Group quarterly meeting.	Jan-24	Not Met	May-24	Aug-24	Dec-24	Open	081024: (AP) To seek additional evidence re business on SPSG agenda. Accept closure when the additional evidence of the forward programme for the SPSG has beeen received, as required by the management action. This evidence not received in Q2 so date revised to December 2024 in Q2 24/25. Last updated 01102024: Recommend for closure. Feeback on the SP role from other staff groups included in the powerpoint presentation now going through SP Steering Group. First presentation including feedback and survey data provided for evidence to close. 040724: (AP) Revised date of August 2024 added in Q1 24/25. Last updated 270624: (JL) Report was due to go to SP Steering Group scheduled by May '24 however meetings were repeatedly cancelled. Chair (Darren Panniers) has scheduled meeting for July '24 and report to be presented then. Request extension of revised due date to Q2 for approved report to be submitted as evidence following Steering Group in July. 04.04.2024 To be done for next Steering Group in April and shared as evidence for closure. Revised date proposed of May24 in Q4.
630	23/24	FPC	Estates Condition	Limited	Richard Davies	Chris Turley	Medium	6.1	Management should report progress e.g., annually, against backlog maintenance and estate investment targets to an appropriate forum (e.g., Finance and Performance Committee), including funding variances and forecast variances to targets.	6.1	Agreed, backlog maintenance will be reported through the Finance & Performance Committee annually in line with the EFPMS submission.	Jun-24	Not Met	Sep-24			Closed in Quarter	071024: (AP) This business was taken to FPC in September as planned. Closure proposal accepted on this basis in Q2 24/25 in line with the update given in July. This evidence, with the edits to the FPC CoB is sufficient to close off this action. Updated to closure proposed. 050724: (AP) This report will be prepared and submitted no later than the 31 August 2024. This will be taken to the Finance and Performance Committee in September 2024 for assurance and will be built into the FPC CoB going forward. This report submission to the FPC, with ongoing inclusion in the FPC CoB will close this action. Revised date of September 2024 added in Q1 24/25 following discussion with Directorate.
631	23/24	FPC	Estates Condition	Limited	Richard Davies Joanne Williams Edward Roberts	Chris Turley	High	7.1	The Estates Strategy should be updated to provide a funded target solution separately to eliminate "high and significant" and overall backlog maintenance profiled by year.	7.1	Agreed, a refreshed Strategic Outline Programme is required upon receiving guidance from NWSSP as detailed within recommendation 4.	Sep-24	Not Met	Mar-25			Open	091024: (AP) Update from Estates: Further time required to allow for the review of the SOP, in line with the Estates Strategy. The Trust is waiting for the outcome of a NHS Wales capital prioritisation process from Welsh Government, which will inform the review of the SOP. Revised date of March 2025 applied in Q2 24/25 in line with the update provided.
632	23/24	FPC	Estates Condition	Limited	Richard Davies Susan Woodham Edward Roberts	Chris Turley	Medium	7.2	Revisions to the Estates Strategy should include performance indicators linked to reducing High/Significant backlog maintenance, opportunities linked to space utilisation etc.	7.2	Agreed, noting that this would form part of managing facilities and through pre planned maintenance contracts to ultimately reduce high and significant backlog maintenance.	Sep-24	Met				Closed in Quarter	091024: (AP) Evidence received and status updated to closure proposed. 091024: Estates Update: Pre-planned maintenance schedule which demonstrates how we manage our high and significant backlog maintenance is maintained. This action is not actually a revision to the Estates Strategy; it is indicating that any future revisions - which may inform changes to the estates maintenance plan - are effected, as required. The annual planner identifies any high risk maintenance which may need addressing; the performance indicator isn't a KPI - it indicates the level of risk with respect the maintenance and therefore attention required. Evidence of the planner and the items on the planner has been received. Closure proposed.
634	23/24	FPC	Estates Condition	Limited	Richard Davies	Chris Turley	Medium	8.1	Statutory, "high", and "significant" risk backlog maintenance items that remain unaddressed by investment proposals should be appropriately profiled at the corporate risk register and reported to management for acceptance and approval / implementation of mitigating actions.	8.1	As noted at MA 4, additional advice will be taken in respect of "high" and "significant" risk classifications, which may largely remove this issue. Further consideration of any residual reporting through the Corporate Risk Register will then be considered.	Mar-24	Not Met	Apr-24	Sep-24		Closed in Quarter	071024: (AP) This business was taken to FPC in September as planned. Closure proposal accepted on this basis in Q2 24/25. This evidence, with the edits to the FPC CoB is sufficient to close off this action. Updated to closure proposed. 050724: (AP) Update from RD: A number of the high and significant issues are already addressed through last years revenue investment and also through more recent EFAB funding, with a further available this year. This is considered on an annual basis within the production of the EFPMS submission. This is due to be taken to FPC in September 2024 (as with action 630). Once that report is received by FPC and evidence of ongoing review included in FPC CoB, action can be closed. Revised date of September 2024 added in Q1 24/25 following discussion with Directorate, as with action 630. Date changed in Q4 to April 2024.

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635	23/24	FPC	111 Commissioning Final Advisory Report	Not Rated	Rachel Marsh	Rachel Marsh	N/A	1.1	Noting that roles and responsibilities will have changed since the national NHS 111 Wales service has been implemented, roles and responsibilities should be clearly detailed within the National Collaboration Agreement and signed by both parties (Commissioner and Trust). Opportunities should be provided for partners to reflect on their roles and functions regularly so that the Agreement can be amended to reflect any changes.	1.1	A new Joint Commissioning Committee will come into effect from 01/04/24. The Trust wants to wait and see what develops in this space rather than commit time to a document that could cease on the 31/03/24.	Apr-24	Not Met	Jun-25			Open	30.08.2024-Collaboration Agreement: so marked as 'no further action'. We cannot proceed with this until the JCC moves from transition to a more settled state. The 111 & Ambulance Commissioner was appointed this month, so we may expect progress on Q3, but currently paused. 260724: Discussion w/HB; will discuss the position with the Interim Director for Commissioning and 111, to understand whether there will be a new collaboration agreement following the implementation of the JCC. AP to discuss with TM to consider whether - should there not be - this is acceptable. Potential action for discussion wtih IA. 050724: (AP) The Trust will revisit this recommendation in June 2025 to ensure that roles and responsibilities are clear for NHS111. Revised date of June 2025 added in Q1 2024/25. CGT to discuss with SPP; to understand how the recommendation 635-645 on the basis of the new JCC arrangements cam be progressed / closed. 260624: No further action with the collaboration agreement at this juncture.
638	23/24	FPC	111 Commissioning Final Advisory Report	Not Rated	Hugh Bennett	Rachel Marsh	N/A	2.1	Management should ensure that all operational policies and procedures that relate to NHS 111 Wales service delivery, are updated as soon as possible.	2.1	The Clinical Safety Plan and the Fire Evacuation Procedure are currently being reviewed and the other documents are old versions. The reviews will be completed and the old versions of policies removed and replaced.	Feb-24	Not Met	Jun-24	Sep-24		Closed in Quarter	151024: (AP) Following receipt of the Tracker at ADLT on the 141024 it was agreed that respective ADLT colleagues would ensure that the position with the FEP (and how it relates to/with the Fire Safety Policy) will be reviewed and that the action (as a formal action from ADLT), in addition to the ongoing management by the Policy Group, would serve as additional evidence and assurance that the risks identified here have been mitigated. 111024: (AP) Copies of the updated CSP and Fire Evacuation Procedure received. Closure proposal accepted and updated to closure proposed. 30.08.24 - HB confirmed that CSP & Fire Evacuation completed. It is on Siren and the action can be closed. HB confirmed he has chased but will chase again. 26724: Discussion w/HB; HB to review position with review of the Plans and provide as evidence. Agreed that owhen these have been reviewed and republished this action can be closed. This is being progressed by the Head of Service for 111. HB to feed back to AP asap. 050724: Revised date of September 2024 added in Q1 24/25. CGT to discuss with SPP; to understand how the recommendation 635-645 on the basis of the new JCC arrangements cam be progressed / closed. 260624: Policies updated. Action closed.(KL emailed HB to confirm the policies she had found were the most up to date versions - so these could be forwarded to Alex 27.6.24) 170424: New date added in Q4 of June 2024.
639	23/24	FPC	111 Commissioning Final Advisory Report	Not Rated	Hugh Bennett	Rachel Marsh	N/A	2.2	Once approved, policies and procedures should be circulated to all staff.	2.2	Updated policies to be placed on Siren and accompanied by Siren communications and more direct staff briefings, where appropriate e.g. fire evacuation procedure.	Feb-24	Not Met	Jun-24	Sep-24		Closed in Quarter	151024: (AP) Following receipt of the Tracker at ADLT on the 141024 it was agreed that respective ADLT colleagues would ensure that the position with the FEP (and how it relates to/with the Fire Safety Policy) will be reviewed and that the action (as a formal action from ADLT), in addition to the ongoing management by the Policy Group, would serve as additional evidence and assurance that the risks identified here have been mitigated. 111024: (AP) Copies of the updated CSP and Fire Evacuation Procedure received. Closure proposal accepted and updated to closure proposed. 30.08.24 - Publication of the above: so one is on Siren, there is a Fire Evacuation procedure on Siren, but this is the one that needs updating. 26724: Discussion w/HB; HB to review position with review of the Plans and provide as evidence. Agreed that owhen these have been reviewed and republished on Siren this action can be closed. This is being progressed by the Head of Service for 111. HB to feed back to AP asap. 050724: Revised date of September 2024 added in Q1 24/25. CGT to discuss with SPP; to understand how the recommendation 635-645 on the basis of the new JCC arrangements cam be progressed / closed. 260624: Updated and communicated. (KL to monitor response from Paul greatorex and Peter Brown re evidence in HB adbsence 28.6.24) 170424: New date added in Q4 of June 2024.
640	23/24	FPC	111 Commissioning Final Advisory Report	Not Rated	Rachel Marsh	Rachel Marsh	N/A	3.1	Develop a mechanism to enable post-implementation learning of benefits, lessons learnt and impact to service delivery to be completely captured.	3.1	Proceed with the planned "time out" for Executives who interface with the commissioning arrangements, 111 Senior Leadership Team and other Assistant Directors/Heads of Service who support the commissioning arrangements.	Feb-24	Not Met	Jun-24	Sep-24		Closed in Quarter	101024: (AP) Update from SPP: 111 commissioning has now passed to the JCC (old EASC with other things as well) and relations are mature so it is not believed that such an arrangement is still required. It is noted that a number of our Execs attending the JCC Board Development session in Aug-24, which is a form of time out. Given the position has moved on, it is proposed that this action be closed. Closure accepted and status updated. 30.08.24 - Post Implementation benefits: 111 commissioning has now moved onto the JCC, so this action relates to our old commissioners. It may be that we need a time out with the new 111 & Ambulance Commissioner, but there are no plans by either party to do so, as relations are mature and established going back to 2015. 250724: Discussion w/HB; the commissioners with whom this action was agreed no longer exist; we're not planning to have a time-out specifically, but there are planned discussions (in line with the update below on the 26 June below). Not otherwise planning to do anything in this space beyond those regular touch points around the clinical model, and there is a JCC Board Development Session in August 2024 that the Trust has been invited to. Given these arrangement, this hasn't has been proposed for closure. 050724: Revised date of September 2024 added in Q1 24/25. CGT to discuss with SPP; to understand how the recommendation 635-645 on the basis of the new JCC arrangements cam be progressed / closed. 260624: The Trust has been meeting regularly with the Interim Director of 111 & Ambulance Commissioning on the evolving clinical model (which includes 111, EMS and Ambulance Care), with the meetings being positive and supportive. 170424: New date added in Q4 of June 2024.
642	23/24	FPC	111 Commissioning Final Advisory Report	Not Rated	Rachel Marsh	Rachel Marsh	N/A	4.2	Progress with delivering the commissioning framework should be reported within the Trust.	4.2	The Trust does report progress on the commissioning framework i.e. commissioning intentions, but recognises that internal reporting is more intermittent. Re-establish regular reporting of the commissioning intentions (every quarter) to the Trust's Strategic Transformation Programme Board.	Jan-24	Not Met	Jun-24	Sep-24		Closed in Quarter	091024: (AP) Accepted closure but sought additional evidence re the reporting to STB (confirmation of forward programme). Examples of reporting to ELT has been received. 211024: (AP) ELT Forward Programme received (confirming that this is on the Planner for future ELT mtgs). Closure proposal accepted. 30.08.2024 - Reporting progress on commissioning framework: our response was that we would ensure regular reporting of progress against the commissioning intentions. HB has evidenced Q1 reporting, with Q2 not due until post September 2024. Action completed and proposing for closure. 260724: Discussion w/HB; this has been completed (in line with the June update below). AP asked that HB send over the report as evidence (in addition to the STB mins extract). AP also asked for STB work programme as evidence (if available) of future reporting against agreed commissioning intentions. HB to send additional evidence and feedback and to advise whether work programme is available. 050724: Revised date of September 2024 added in Q1 24/25. CGT to discuss with SPP; to understand how the recommendation 635-645 on the basis of the new JCC arrangements cam be progressed / closed. 250624: Reporting of commissioning intentions to STB re-established and 23/24 year end reporting to commissioners complete. Close action. (EVIDENCE - HB confirmed year end reporting to commissioners 20/05/2024. Reporting of commissioning intentions restablished are evidenced in STB minutes KL to send over extraction of STB minutes) 170424: New date added in Q4 of June 2024.
643	23/24	FPC	111 Commissioning Final Advisory Report	Not Rated	Rachel Marsh	Rachel Marsh	N/A	4.3	The Trust should obtain written confirmation of the escalation process to be followed within the current governance structure.	4.3	A letter will be collaboratively drafted and agreed between the 111 Board Chair and Trust CEO to formalise the informal escalation arrangements that do currently exist.	Jan-24	Not Met	Jun-24	Sep-24	Dec-24	Open	101024: (AP) Revised date applied of December 2024 in Q2 24/25. 30.08.24 - Escalation arrangements i.e. between ourselves and commissioners: HB has drafted a letter, which is what we agreed to do, which is now with RM, but only this week. 260724: Discussion w/HB - AP said to HB that likely still required and the new commissioning arrangements do not supersede this action (in terms of process), but AP will verify with TM that position and then feed to HB. If agreed HB will prepare the letter in order to close off the action. 050724: Revised date of September 2024 added in Q1 24/25. CGT to discuss with SPP; to understand how the recommendation 635-645 on the basis of the new JCC arrangements cam be progressed / closed. 260624: The JCC arrangements are not yet sufficiently developed for this to be actioned. 170424: New date added in Q4 of June 2024.

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644	23/24	FPC	111 Commissioning Final Advisory Report	Not Rated	Rachel Marsh	Rachel Marsh	N/A	5.1	The Trust's Corporate Risk Register should be amended to capture risks relating to the NHS 111 Wales commissioned arrangement or service delivery.	5.1	The Trust's Corporate Risk Register commissioning risks to be updated to reflect that 111 is now also a commissioned service.	Jan-24	Not Met	Jun-24	Sep-24		Closed in Quarter	101024: (AP) Closure accepted and status updated. SPP content that risk updated to reflect change. 30.08.24: Risk Register reflects 111 is now commissioned. Risk 100 on the Corporate Risk Register is now updated and therefore the action is complete. Proposed for closure. 260724: Discussion w/HB - AP to check with Julie when this will be/ has been agreed; by the end of September 2024 and reporting to Board this will have been completed (and received by all relevant forums) and can then be closed. Timing aligns to revised date of September 2024. 050724: Revised date of September 2024 added in Q1 24/25. CGT to discuss with SPP; to understand how the recommendation 635-645 on the basis of the new JCC arrangements cam be progressed / closed. 260624: Updated and complete. (EVIDENCE - HB confirmed he had updated BAF - https://nhswales365.sharepoint.com/:w:/r/sites/CORPORATEGOVERNANCETEAM/Shared Documents/General/Risk Management/BAF 130624 v1.docx?d=w17516e57ff4a435aace4a0eb4f9fc63e&csf=1&web=1&e=33eTya 170424: New date added in Q4 of June 2024.
645	23/24	FPC	111 Commissioning Final Advisory Report	Not Rated	Rachel Marsh	Rachel Marsh	N/A	5.2	The Gateway to Care Programme Board's risk register should be reviewed and updated to ensure that the risks documented remain current and there are appropriate mitigating controls in place.	5.2	Gateway to Care Programme Board's risk register to be reviewed and updated.	Jan-24	Not Met	Jun-24	Sep-24		Closed in Quarter	101024: (AP) Update from SPP: Close on the basis that this programme has now transitioned into a new programme, with some elements of G2C not moving across. For those that moved across the appropriate risk log for the relevant Clinical Model Transformation Programme workstream is now in place and structures in place to review. The CMTP Risk Register has been submitted as evidence. Closure accepted and updated to 'closure proposed'. 30.08.24 - G2C risk register to be updated: programme closed with new much bigger programme; CMT Programme now open, 260724: Discussion w/HB - The GTCP has ceased to exist, there is now a different reporting structure - the nearest replacement is the Remote Integrated Care Service Workstream. HB to check what the current arrangements are regarding developing of a Risk Register for this workstream. Action to be closed on the basis that this programme board no longer exists, however need to provide assurance that the related new workstream risks are being managed. 050724: Revised date of September 2024 added in Q1 24/25. CGT to discuss with SPP; to understand how the recommendation 635-645 on the basis of the new JCC arrangements cam be progressed / closed. 260624: HB checking with Kelsey Rees-Dykes. 170424: New dated added in Q4 of June 2024.
646	23/24	FPC	Strategy Development	Reasonable	Alex Crawford	Rachel Marsh	Medium	1.1	A refresh of the Long-Term Strategy shall be considered, clearly outlining the aspects of the long-term strategy that require updating, and specifying the new developments to be included.	1.1	Aligned to the continued development of the future clinical service model taking place in Q1 to Q2, a clear recommendation shall be presented to ELT and respective groups outlining the specific requirements (if required) to refresh the Long-Term Strategy document.	Dec-24	Not Yet Due				Open	
647	23/24	FPC	Strategy Development	Reasonable	Estelle Hitchon	Rachel Marsh	Medium	2.1(a)	The Trust should complete the work to revise engagement framework delivery plan and monitor its implementation.	2.1(a)	Continue work with the Consultation Institute and internal leads to revise and finalise the Engagement Delivery Plan. The revised plan will provide further detail of the key phases of engagement, purpose and approach of the engagement activities with re-profiled timescales for delivery.	Jun-24	Not Met	Sep-24			Closed in Quarter	091024: (AP) Evidence accepted and status updated to closure proposed. 091024: (AP) Update from JH/EH: Since the July update the Trust has formally stood up the Clinical Model Transformation Board which is overseeing delivery of our Clinical Model and is the main reporting / approvals board for the Partnership & Engagement work (where these actions sit). This has superseded STB as the place where this business is received. The relevant business was taken to CMT in SEptember, and the draft Programme Engagement Plan (PEP) was received. The PEP is the functional plan for us to deliver our engagement activities both internally and externally to support the Clinical model. This is a replacement product of its predecessor the Engagement Delivery plan (referenced previously in the audit tracker). The draft PEP was supported by the CMT Board, subject to some further tweaks; however the plan is currently 'live' and being delivered, and will be subject to continued refinement and adjustments to suit any changes in the broader landscape. Action proposed for closure. The CMT agenda and papers provided as evidence. 08.07.24 - The revised engagement framwork delivery plan is completed. Presentation to STB will be evidence of closure of this item. Date changed to September 2024 to allow this to take place. 25.06.24 - Work with the Consultation Institute concluded in May-24 having undertaken work to review the stakeholder groups and phasing as set out in the high level Engagement Delivery plan. Work is continuing to reprofile the original delivery plan that was approved by the Board in Jan 2023. This reprofiling has now led to a change in phasing to prioritise key (mission critical stakeholders) and staff, differentiated by those most affected and staff more generally affected. (EH) Revised date of August 2024 proposed in Q1 24/25.
648	23/24	FPC	Strategy Development	Reasonable	Estelle Hitchon	Rachel Marsh	Medium	2.1(b)	The Trust should complete the work to revise engagement framework delivery plan and monitor its implementation.	2.1(b)	Commence implementation of the Engagement Delivery Plan (as per the approach set out and agreed timescales in the revised and approved plan).	Jun-24	Not Met	Sep-24			Closed in Quarter	091024: (AP) Evidence accepted and status updated to closure proposed. 091024: (AP) Update from JH/EH: Since the July update the Trust has formally stood up the Clinical Model Transformation Board which is overseeing delivery of our Clinical Model and is the main reporting / approvals board for the Partnership & Engagement work (where these actions sit). This has superseded STB as the place where this business is received. The relevant business was taken to CMT in SEptember, and the draft Programme Engagement Plan (PEP) was received. The PEP is the functional plan for us to deliver our engagement activities both internally and externally to support the Clinical model. This is a replacement product of its predecessor the Engagement Delivery plan (referenced previously in the audit tracker). The draft PEP was supported by the CMT Board, subject to some further tweaks; however the plan is currently 'live' and being delivered, and will be subject to continued refinement and adjustments to suit any changes in the broader landscape. Action proposed for closure. The CMT agenda and papers provided as evidence. 08.07.24 - The revised engagement framework delivery plan is completed. Presentation to STB of the workstreams that will oversee implementation and monitoring of the internal and external elements of the plan will be evidence of closure of this item. Date changed to September 2024 to allow this to take place. 25.06.24 - Engagement activity has commenced with the key stakeholders identified with 'High Levels of Influence' including direct engagement with JCC, Commissioning Team, Welsh Government via JET & IQPD. Internal communication commenced in April with a month long internal communications campaign, further work required to embed a pipeline of regular communication activity. To date there has been no formal engagement / communications with the wider public and service users. (EH) Revised date of August 2024 proposed in Q1 24/25.

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649	23/24	FPC	Strategy Development	Reasonable	Estelle Hitchon	Rachel Marsh	Medium	2.1 (c)	The Trust should complete the work to revise engagement framework delivery plan and monitor its implementation.	2.1 (c)	Build in clear periods of 'pause and reflect' following each phase of engagement to monitor progress and delivery reporting into TSAG / ELT.	Jun-24	Not Met	Sep-24			Closed in Quarter	091024: (AP) Evidence accepted and status updated to closure proposed. 091024: (AP) Update from JH/EH: Since the July update the Trust has formally stood up the Clinical Model Transformation Board which is overseeing delivery of our Clinical Model and is the main reporting / approvals board for the Partnership & Engagement work (where these actions sit). This has superseded STB as the place where this business is received. The relevant business was taken to CMT in SEptember, and the draft Programme Engagement Plan (PEP) was received. The PEP is the functional plan for us to deliver our engagement activities both internally and externally to support the Clinical model. This is a replacement product of its predecessor the Engagement Delivery plan (referenced previously in the audit tracker). The draft PEP was supported by the CMT Board, subject to some further tweaks; however the plan is currently 'live' and being delivered, and will be subject to continued refinement and adjustments to suit any changes in the broader landscape. Action proposed for closure. The CMT agenda and papers provided as evidence. 08.07.24 - The revised engagement framwork delivery plan is completed and include periods of pause and reflect. Aligned to action 647, Presentation to STB will be evidence of closure of this item. Date changed to September 2024 to allow this to take place. 25.06.24 - Periods of 'Pause & Reflect' have been factored into the high level Engagement Delivery Plan. The plan will be monitored by TSAG (whilst in operation) pending the transition to the revised Programme structures & governance processes. The programme architecture is being revisited in line with the rest of the programme (EH).
650	23/24	FPC	Strategy Development	Reasonable	Alex Crawford	Rachel Marsh	Medium	3.1	The benefits realisation plan should be completed to facilitate monitoring of progress against the achievement of the ambitions set out in the Long-Term Strategy – Delivering Excellence: Vision 2030.	3.1	Draft Benefits Realisation Framework underway. To be finalised and approved in Q1/Q2 FY2024/25, in order to facilitate consistent and standardised approach to developing and monitoring of all Trust ambitions, including the Long-Term Strategy – Delivering Excellence: Vision 2030	Sep-24	Met				Closed in Quarter	111024: (AP) Closure proposal accepted and updated status. 071024: (AP) Update from SPP: It has been achieved in so much as the IMTP is now reporting against the metrics set out in the plan (i.e. 'What good looks like'). Evidence is the Trust Board paper on IMTP delivery from September 2024. A Benefits Realisation Framework has been agreed, but rather than strict compliance what has been prepared is translating the IMTP benefits realisation into an IMTP outcomes report that has been prepared for Trust Board. It still requires iteration but one does now exist, which allows us to track whether we are delivering on the ambitions in then IMTP. Closure proposed. 30.08.24 - HB confirmed that this action sat with him. That the action was currently on target for Trust Board in September with a draft report being held by HB.
652	23/24	FPC	Strategy Development	Reasonable	Alex Crawford	Rachel Marsh	Medium	3.2(b)	The Trust should also consider opportunities to enhance reporting to demonstrate that strategic delivery programmes are having the intended impact in terms of outcome achievement.	3.2(b)	Implement changes to the programme structures (identified following the initial review).	Sep-24	Met				Closed in Quarter	071024: (AP) Update from SPP: Programme structures are now in place and have been reported to Finance & Performance Committee. Evidence is the last paper to FPC on the 17 September 2024. 091024: (AP) JB to review the evidence provided; will feed back before finalising this action. 25.06.24 - A proposed future programme structure has been developed and is currently being consulted on, pending implementation over the next 2-3 months. During the initial phase of transitioning to the new programme arrangements TSAG will be re-set to the role of the Clinical Model Transformation Programme Board, followed by the changes to the current Programme Boards and project work streams. (JH)
653	23/24	FPC	Strategy Development	Reasonable	Alex Crawford	Rachel Marsh	Medium	3.1 (c)	The Trust should also consider opportunities to enhance reporting to demonstrate that strategic delivery programmes are having the intended impact in terms of outcome achievement.	3.1 (c)	Aligned to the Benefits Realisation Plan, respective benefits and outcomes to be mapped and regularly monitored as part of the refreshed programme arrangements	Sep-24	Not Met	Dec-24			Open	071024: (AP) Update from SPP: There is work ongoing to develop benefits realisation plans for the programme, alongside a piece of work to develop CMT Quality and Performance Metrics to support the benefits realisation plan. Not met, revised date of December 2024 applied in Q2 24/25.
655	23/24	PCC	Retention of Staff	Reasonable	Liz Rogers	Angela Lewis	Medium	1.1(b)	The 'Moving on Interview' process should be finalised and approved in accordance with Trust procedure.	1.1(b)	The team are still exploring opportunities to generate automatic triggers for managers and staff rather than relying on managers remembering to ask a colleague to complete.	Jun-24	Not Met	Sep-24	Dec-24		Open	071024: (AP) Revised date of December 2024 applied in Q2 24/25 in line with the update given. 18.09.24 - JS - There has been a delay from NWSSP, the app has now gone live and is being used, however further synchronisation is needed to generate the automatic trigger that is desired following a termination. Digital are now working to put this automatic trigger in place for the Moving On form to replace the current manual trigger. Request to extend deadline to December 2024. 05.07.24 - AP - Updated due date to September 2024 in Q1 24/25. 26.06.24 - JS - It is expected the app will be able to go live in June 24 from NWSSP, a presentation to SOT this week. May 24 - HCM - Following a pause and discussion with NWSSP colleagues, the Staff Movement Advice App will be rolled out within the organisation in June 24. This app will support the moving on process and specific elements will be included in the bite sized training. March 24 - The trigger for an email reminder for managers was to be the exception form. When the exception form is submitted, then this would trigger a reminder email to complete a Moving on Conversation. There is an intermittent fault with the button and not all emails are being generated. However, work on this continues and alongside that,NWSSP have developed a new form which will be implemented which may resolve this problem for us.
657	23/24	PCC	Retention of Staff	Reasonable	Liz Rogers	Angela Lewis	Medium	1.3	The Trust should look to develop an appropriate training package to assist managers in the use of the new Moving on Interview Process.	1.3	Guidance for managers on using the process developed and signed off	Jun-24	Not Met	Sep-24	Mar-25		Open	231024: (AP) Revised date to March 2025 applied in Q2, in line with update. 231024: (AP) Update from PCC: Propose for extension – Unfortunately due to the need to move re-prioritise team resource into manage employee relations and operational HR work, it has not been possible to complete the project as originally scheduled. Resources are currently being evaluated on how to proceed effectively and it has been requested that an adjustment of March 2025 is made to the completion date. This will allow these challenges to be addressed and appropriate capacity to be assigned to focus on the desired developments. 26.06.24 - JS - Training will be launched once the app is live. 05.07.24 - AP - Updated due date to September 2024 in Q1 24/25. May 2024 - HCM - Following a pause and discussion with NWSSP colleagues, the Staff Movement Advice App will be rolled out across the organisation in June 2024. This app will support the moving on process and specific elements will be included in the bite sized training sessions. March 24 - LR - Guidance for managers (process document) has been developed. Drop in bite sized sessions will be developed for managers to attend.
658	23/24	PCC	Retention of Staff	Reasonable	Liz Rogers / Peter Brown	Angela Lewis	Medium	2.1	The Trust should undertake, and report to an appropriate forum, an evaluation of the initiatives introduced to determine their impact and effectiveness in retaining staff.	2.1	An evaluation report will be developed in association with the 111 senior team. It is noted that not all initiatives are appropriate for other areas of the organisation based on role types, culture differences and different pressures.	Sep-24	Not Met	Mar-25			Open	231024: (AP) Revised date to March 2025 applied in Q2, in line with update. 231024: (AP) Update from PCC: Propose for extension – Unfortunately due to the need to move re-prioritise team resource into manage employee relations and operational HR work, it has not been possible to complete the project as originally scheduled. Resources are currently being evaluated on how to proceed effectively and it has been requested that an adjustment of March 2025 is made to the completion date. This will allow these challenges to be addressed and appropriate capacity to be assigned to focus on the desired developments. 18.09.24 - JS - During the development of the moving on conversation process, close working relationships with the 111 management team were had throughout the pilot, which enabled feedback from users to be incorporated into the final process. The form that has been developed as the final process has formally been rolled out across 111 and a rollout plan across WAST will commence in October.

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663	23/24	FPC	Vehicle Replacement Programme	Reasonable	David Holmes / Andrea Davies	Chris Turley	Medium	4.1	The various aspects of the procurement strategy include: (a)enhanced narrative within the business case; & (b)evaluation and approval by appropriate parties to confirm that it remains optimal (as detailed within the business case for approval) e.g. to affirm that it best aligns procurement and contractual arrangements to obtain best value from strategic partnering.	4.1	Agreed. The current narrative describing the procurement strategy will be further detailed within future business cases to better facilitate evaluation of the procurement strategy.	Dec-24	Not Yet Due				Open	27/09/24: Update from Capital Development - No further update to be provided as not yet due and relates to SOP Rewrite and next BJC. 30/05/24: enhanced narrative included in 24/25 BJC documentation. To be developed further for 2025/26 business case process. To note - December 2024 is the deadline for this but we may aim to submit the relevant documentation to Trust Board in January 2025, so the date will need to change accordingly to capture approval and evidence of this as an action. 27/03/2024: Update from Capital Development: Narrative on describing the procurement strategy will be developed for inclusion in future business cases. It is proposed that this will be submitted to the June 2024 FSDG meeting for review and approval. In the meantime, the business case template will be reviewed in April 2024 to highlight areas which will need updating.
665	23/24	FPC	Vehicle Replacement Programme	Reasonable	Trish Mills	Chris Turley	High	5.1	Contracts should be discretely authorised in accordance with Standing Orders.	5.1	Agreed. Noting that the current approach is across the Trust and not specific to fleet procurement, the Trust's Standing Orders and Standing Financial Instructions have been reviewed with regards to contract award approvals and delegated authority. As a result, a proposal to add an additional mechanism to ensure discrete Trust Board contract approval together with an amendment to the narrative relating to delegated authority for purchase order approvals will be presented to the March 2024 Audit Committee and Trust Board meetings for consideration and approval and for subsequent implementation. Such proposals will mitigate this recommendation.	Apr-24	Not Met	Jul-24			Closed in Quarter	021024: (AP) CGT updated to closure proposed. This change to the Standing Orders was taken to the Trust Board for approval in July, as stated in the update provided by the Estates Team. Evidence of papers to TB on the website: https://ambulance.nhs.wales/files/trust-board-papers/papers-25-july-2024/. 27/09/24: Update from Capital Development - understood that this was progressing for approval July 2024 and could be closed, Corporate Governance progressing and to update further and confirm. 31/05/24: Revised date added by AP in Q1 24/25 as the changes required are not due to be taken to the ARAC and TB until the end of July (25 July). As such this won't be closed off in the Q1 reporting period, and a revised date is required. 27/03/2024: Update by Estates: The suggested amendments will now be presented at the Audit Committee meeting on 30th April 2024 and the action will be closed once approved at that meeting, noting that the amended Standing Orders and Standing Financial Instructions will be adhered to as appropriate in the future. Can be closed once the revised SO are received for approval.
668	23/24	Quest	Serious Adverse Incidents - Joint Investigation Framework	Reasonable	Wendy Herbert	Liam Williams	Medium	1.1	The Trust's 'Adverse Incident and Reporting Policy' should be reviewed and updated to reflect the requirements set out within the NHS Wales policy.	1.1	The Putting Things Right Team plan was to review relevant policies following the release of the new Putting Things Right Regulations by Welsh Government in May 2024. A recent update from Welsh Government has confirmed that the release will now be Autumn 2024. At which point the review will be undertaken. The Trust has approved policies in respect of incident reporting and management and a Putting Things Right Policy which are included on the intranet site (review dates are both April 2026). Staff also have access to User Guides on the intranet site for Datix Cymru. The All-Wales Patient Safety Policy (NHS Executive) (May 2023) is also due review in March 2024 and will be updated internally when released nationally	Nov 24 On release from NHS Wales Exec	Not Yet Due				Open	What will close the action: Updated version of the Putting Things Right Policy (following release of the new Putting Things Right Regulations in Autumn 2024) and adoption of the updated National Patient Safety Incident Reporting and Management Policy (adopted by WAST in June 2023 and review is due by the NHS Wales Executive by March 2023 (awaited). What will you provide as evidence for the closure: Copies of both approved policies on the Intranet. Is date reasonable: Dependant on release date of Putting Things Right Regulations by Welsh Government and updated National Patient Safety Incident Reporting and Management Policy by the NHS Wales Executive.
681	23/24	Quest	Electronic Patient Clinical Records: Clinical Compliance (ePCR)	Reasonable	Jonathan Chippendale	Andy Swinburn	Medium	1.1	To confirm accuracy of the self-certification compliance rate, management should consider capturing the method of training delivery on ESR.	1.1	For future training, the method of instruction will be captured as part of the ESR sign-off process (for example, classroom based, individual learning using the training materials, one to one instruction using the training zone in the application).	Jun-24	Not Met	Sep-24	Mar-25		Open	021024: (AP) Revised date of March 2025 applied in Q2 24/25, in line with update. Last updated 01102024: Revised date of Q4 requested to enable the capture of this info. 110924:Ffion Timmins liaising with ESR team to arrange this. Request due date to beginning of Q4. 040724: (AP) Revised date to September 2024 added in Q1 24/25. Last updated 270624: (JL) At ePCR CRG, this item was specifically discussed. Future data will capture the method of training. Requires updates to the ESR system to accommodate. Request deadline extended to end Q2 to allow time for this change to be made. 04.04.2024 Work has yet to be commence due to meeting cycles. Will be an agenda item at the ePCR Clinical Reference Group on the 28th March (agenda to be competed on the 21st March 2024).
682	23/24	Quest	Electronic Patient Clinical Records: Clinical Compliance (ePCR)	Reasonable	Jonathan Chippendale	Andy Swinburn	Medium	1.2	Management should obtain feedback from staff to improve the training materials.	1.2	We will design a survey via the ePCR Clinical Reference Group (CRG) for ePCR users to explore the reasons for this and how training materials might be improved to enhance ePCR completion.	Jun-24	Not Met	Sep-24			Closed in Quarter	091024: (AP) Closure accepted and updated to closure proposed. Last updated 01102024: Recommended for closure. Presentation showing survey results presented and discussed at ePCR Clinical Reference Group (CRG) on 26/09/24. The timeline for the application redesign is between now and April 2025. The Trust is commencing conversations with users to fully understand what they are finding not fit for purpose (however there is no guarantee that there will be a fundamental redesign). Presentation shared as evidence for closure. 110924: SP developed survey and this is being brought to next ePCRCRG - recommend for closure. 040724: (AP) Revised date to September 2024 added in Q1 24/25. Last updated 270624: (JL) Senior paramedics invited to ePCR CRG. This will form the core group to devise the feedback survey. Meeting to be set up to begin the work. Request deadline extended to end Q2 to allow time for this activity. 04.04.2024 Work has yet to be commence due to meeting cycles. Will be an agenda item at the ePCR Clinical Reference Group on the 28th March (agenda to be competed on the 21st March 2024).
683	23/24	Quest	Electronic Patient Clinical Records: Clinical Compliance (ePCR)	Reasonable	Jonathan Chippendale	Andy Swinburn	Medium	1.3	Management should consider including a test in ESR to confirm competency before successfully self-certifying.	1.3	At the ePCR CRG WAST will discuss including a test to assess understanding at the completion of training.	Jun-24	Not Met	Sep-24	Dec-24		Open	021024: (AP) Revised date of December 2024 in Q2, as requested. Last updated 01102024: Awaiting transfer to LMS 365. Revised date of Q3 requested to determine Education team capacity and to enable this transfer. 11092024: This was discussed at ePCRCRG on 27 June 24 and agreed that training materials would transfer from learning launch pad to LMS365 with integrate competency assessment. 040724: (AP) Revised date to September 2024 added in Q1 24/25. Last updated 270624: (JL) ePCR CRG have discussed and agreed that a self-test will be included in the training materials. This will be incorporated following migration of the training materials to the LMS365 platform. Request deadline extended to end Q2. 04.04.2024 Work has yet to be commence due to meeting cycles. Will be an agenda item at the ePCR Clinical Reference Group on the 28th March (agenda to be competed on the 21st March 2024).
684	23/24	Quest	Electronic Patient Clinical Records: Clinical Compliance (ePCR)	Reasonable	Jonathan Chippendale	Andy Swinburn	Medium	1.4	Whilst we acknowledge there are different methods of training delivery, management should review lower viewed training modules, to confirm that the completed ePCRs are compliant with expectations in this area.	1.4	Through the ePCR Clinical Reference Group (CRG) we will review the lower viewed modules as set out in Appendix B of this report. This will build on knowledge discussed at the most recent ePCR CRG where a small audit has identified that the obstetric section is not being completed. However, we currently have only opened access to the Welsh GP Record (WGPR) for our cohort of Advanced and Senior Paramedics. The pathways section of the ePCR is not currently live and requires testing prior to going live, which explains the disparity reported in these sections of Appendix B.	Sep-24	Not Met	Dec-24			Open	Last updated 01102024: On track for completion in Q3 and discussed at Sept ePCRCRG on 26/09. 110924: Pathways section is now live on ePCR. The lower viewed modules will reviewed and reported back to ePCRCRG for December closure date. 040724: (AP) Revised date to December 2024 added in Q1 24/25 to end of Q3. Last updated 270624: (JL) Action has yet to commence in order to accommodate earlier actions. Request deadline extended to end Q3 to enable earlier actions to be completed Q2 and then for this is take place Q3. 04.04.2024 Work has yet to be commence due to meeting cycles. Will be an agenda item at the ePCR Clinical Reference Group on the 28th March (agenda to be competed on the 21st March 2024).

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686	23/24	Quest	Electronic Patient Clinical Records: Clinical Compliance (ePCR)	Reasonable	Jonathan Chippendale	Andy Swinburn	High	2.2	Management should ensure the tenant structure is developed to provide data at both a team and individual level to assist in identifying training needs and drive improvement in ePCR compliance.	2.2	Reporting into CIAG, we will set up a Task and Finish Group to write the plan to deliver the dashboards against the Tenant Structure. This is a complex piece and requires input from multiple directorates. It is also dependent on the capacity within teams to deliver the dashboards, therefore the output of the T&F might be a business case jointly developed between the Digital and Clinical Directorates to outline the resources required and what this would cost to deliver.	Sep-24	Not Met	Mar-25			Open	021024: (AP) Revised date of March 2025 applied in Q2 24/25, as requested. Last updated 01102024: Request for revised completion date of Q4. Project Manager assigned to work with newly appointed CCIO on this to develop the business case. The ability to role this out will be entirely dependent on capacity and funding but the Task & Finish Group will work to build up the business case for how it would be done. 11092024: Project manager assigned to this with T&F group to start October 2024. Request extended deadline for end of Q4 to produce business case. Last updated 270624: (JL) Following HI pause, leads for this work within the digital directorate have been identified. Work will commence late June 2024 to enable initial scoping to be undertaken. Request deadline extended to end Q2. 04.04.2024 Work has yet to be commence due to meeting cycles. Will be an agenda item at the ePCR Clinical Reference Group on the 28th March (agenda to be competed on the 21st March 2024).
691	23/24	FPC	ICT Contract Management	Reasonable	Robert Walker	Jonny Sammut	Medium	3.2	ICT contract management process should be applied to all ICT related contracts, with the ICT Contract Manager feeding into any management meetings within other areas.	3.2	The Contract Management [SOP] process is to be applied to all contracts listed in the contracts register.	Mar-25	Not Yet Due				Open	270924 (AIW) - Appointment made to the Contract Manager role. Last update 17/06/2024 - The contract manager has resigned from the Trust as of the 14/06/2024. Senior management will undertake necessary meeting with suppliers with priority on key and high value contracts until a replacement is recruited.
697	23/24	Quest	Seatbelt Action Plan	Reasonable	Jon Sweet	Lee Brooks	Medium	2.1	Outputs from spot checks and Quality and Support days should be formally collated and reported to an appropriate forum. This should include outcomes, issues identified and subsequent progress to implement the required actions to address.	2.1	Monitoring of themes and trends from spot checks to date and the three Quality and Support days will be collated and presented to the joint SOT/SLT meeting on 17th May 2024 and further to the wider leadership day which will follow. Any remedial actions will be implemented and monitored through SOT subsequently.	Jun-24	Not Met	Aug-24			Closed in Quarter	011024: (AP) Evidence of closure reviewed as stated below and accepted. Evidence of the checks having been completed, it having been built in to the Field Ops Group work programme, and AAA outputs of these instances. Updated the status to closure proposed in Q2 24/25. 240924 Proposing Closure:- work programme provided from Field Ops for future planning of Q&S Day monthly spot check data, Triple A provided to show Q&S Day being discussed with future triple As to incorporate the slide deck of data. 100724: Revised date to August 2024 in Q1 24/25 applied, as evidence for closure not yet available. The evidence that will close off this action is: •Evidence that it'sdded to future agendas in Field Ops to review any actions following the Spot Checks •AAA feeding into SOT from Field Ops on the monitoring of any actions. 170524: Quality and Support day results formally collated from the 3 days and presented within the SOT/SLT meeting on the 17th May. Evidence sent to Alex on 30th May.
698	23/24	Quest	Seatbelt Action Plan	Reasonable	Mark Harris	Lee Brooks	Medium	3.1	Consideration should be given to undertake a higher number of internal inspections per annum to provide sufficient coverage and assurance that the Trust is compliant with required standards.	3.1	The decision to include internal inspections has been driven internally by the Operations Directorate although capacity remains a limiting factor. Whilst the audit has highlighted the need to undertake a higher number of inspections, we remain committed to four per annum with more being undertaken should capacity permit	Dec-24	Not Yet Due				Open	
699	23/24	Quest	Seatbelt Action Plan	Reasonable	Mark Harris	Lee Brooks	High	4.1	The recommendations from the Health & Safety investigation should be formally monitored through an appropriate forum to provide oversight and assurance on the satisfactory closure of the investigation.	4.1	The Trust accepts this recommendation. ADLT will oversee the monitoring and compliance of the H&S investigation and provide assurance to ELT via the AAA reporting mechanism.	May-24	Not Met	Aug-24			Closed in Quarter	021024: Closure proposed accepted on the basis that this has been completed and evidence of ongoing monitoring (through the ADLT Work Programme) provided. Updated to closure proposed by the Corporate Governance Team. 100924: TMN provided AP with a copy of the closed AAA from ADLT and a screenshot of the ELT agenda with which it was embedded for information/discussion. The ADLT Work Programme confirms that the H&S investigation recommendations will continue to be monitored. CLOSURE PROPOSED. 090724: Revised date of August 2024 added in Q1 24/25, as closed AAA is not yet available. 040724: CGT received the ADLT work programme, the list of actions and examples of agendas as evidence. Closed ADLT agenda dated May 2024. Once the closed AAA from ADLT to ELT is received the action can be closed (based on Board Sec review). Awaiting final piece of evidence - ADLT closed AAA sent to ELT. 210624: ADLT Work Programme, Agenda and H&S ADLT Closed Actions evidence sent through today. It is hoped that this will be sufficient evidence to propose closure of the action as it will show that ADLT will oversee the actions which will then show within the AAA report to ELT. Action proposed for closure.
701	23/24	Quest	Clinical Audit	Reasonable	Jonathan Chippendale	Andy Swinburn	Medium	1.1	The Trust should ensure appropriate detail in relation to clinical audit is included and documented it within its organisational documents.	1.1	There are workshops scheduled (4th, 9th and 10th July 2024) to plan the next iteration of the Trust clinical strategy. The Clinical Directorate will ensure that clinical audit is given the space it needs to articulate the need for, and link to the guidelines on how to undertake an audit in the final approved document. Where update presentations are given up to, and including, board level meetings, the Clinical Directorate will ensure clinical audit is included. The clinical strategy will articulate clearly how clinical audit meets HQIP standards and will link to the clinical audit plan (for example, to the Clinical Audit section on the Trust intranet).	Mar-25	Not Yet Due				Open	Last updated 01102024: The development of the Trust Clinical Plan has been proposed for delay until Q4/Q1 2025 due to capacity contraints on the team. The Assistant Director for Clinical Development has informed the Director of Paramedicine of the need for reference to this in the Clinical Plan and this will be incorporated into the Plan development. Currently on track but dependent on the timing of the first draft of the Clinical Plan. 11092024: To be included in Clinical Plan 2025-2030 - to be picked up by T&F group delivering Clinical Plan adn draft to be shared when it goes to QuEST. On track for end Q4. Last updated 270624: (JL) Awaiting Clinical Strategy development days (9-10 July) to incorporate clinical audit activity.
702	23/24	Quest	Clinical Audit	Reasonable	Kevin Webb	Andy Swinburn	Medium	2.1	The Trust should link all clinical audits to either the clinical directorate risk register or Trust/Directorate priorities to support the justification for undertaking them. Where a link cannot be made, additional narrative should be included to justify the inclusion of the clinical audit within the audit plan.	2.1	Work will be undertaken to ensure relevant risks are linked to clinical audit activity; specifically, a mandatory field will be added to the proposal form to link to either a clinical risk or organisational clinical priority. This form will be submitted to CIAG for approval. The Trusts/Directorate priorities are not always clearly identifiable, but we will look to include in the 2024/25 CAP a justification linked to the IMTP/LDP.	Sep-24	Not Met	Dec-24			Open	021024: (AP) Revised date of December 2024 in Q2, as requested. Last updated 01102024: Request to revise the completion date to Q3. ADCD is attending CIAT in November which will enable justification of Trust priorities. This will be discussed at the next Business Meeting for the Directorate to align to any Directorate priorities. Additional time will enable new AD to enact this recommendation and amend clinical audit reporting to link to priorities. Last updated 270624: (JL) New actions, meeting scheduled for 29 July to look at actions and revision of forms, Some work already ongoing to draft changes to consider and to include more detail in decisions logs. Request to identify clinical priorities and risks to inform the audit plan and opportunities for clinical improvement proposed to QMG meeting in June. Further updates with actions to be completed to be provided after July meeting.
703	23/24	Quest	Clinical Audit	Reasonable	Kevin Webb	Andy Swinburn	Medium	2.2	The development of the clinical audit plan should be formally documented to provide assurance on the appropriateness of inclusion of individual audits.	2.2	The CIAT decision log and proposal form to include more detail outlining the priority of the audit activity and the justification for inclusion in the workplan, which will also be reflected in the completed audit reports. A review of the clinical audit documentation is scheduled. This will be reported for approval to the CIAG	Sep-24	Not Met	Dec-24			Open	021024: (AP) Revised date of December 2024 in Q2, as requested. Last updated 01102024: As above, request to revise the completion date to Q3. Additional time will enable new AD to enact this recommendation and review CIAT documentation for CIAG. Last updated 270624: (JL) New actions, meeting scheduled for 29 July to look at actions and revision of forms, Some work already ongoing to draft changes to consider and to include more detail in decisions logs. Request to identify clinical priorities and risks to inform the audit plan and opportunities for clinical improvement proposed to QMG meeting in June. Further updates with actions to be completed to be provided after July meeting.

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704	23/24	Quest	Clinical Audit	Reasonable	Duncan Robertson	Andy Swinburn	Low	3.1	A review of the CIAG Members within the Terms of Reference should be undertaken to ensure Membership is appropriate.	3.1	The TOR is scheduled for review by CIAG and membership will be reviewed at this time. In addition, the stated action regarding missing meetings and follow-up will be similarly reviewed.	Jul-24	Not Met	Dec-24			Open	071024: (AP) Evidence of the approval of the CIAG ToR at CQGG not yet received; although they were presented at CQGG on the 15 August 2024 approval of the ToR is not recorded. AP advised that must be returned to CQGG for approval. Revised date of December 2024 applied in Q2 24/25. Last updated 01102024: Recommended for closure, reviewed ToR provided as evidence. 11092024: Action complete, updated ToR to be shared as evidence. Recommend for closure. Last updated 270624: (JL) Amended ToR will be presented at the July 2024 CIAG.
706	23/24	ARAC	Follow Up Audit 23/24	Reasonable	Carl Window	Trish Mills	Medium	1.1	The Trust should consider the inclusion of recommendations from other assurance providers within the enhanced tracker system.	1.1	This recommendation is accepted. A separate tracker will be developed to capture counter fraud recommendations. Progress will be reported to the closed session of the Audit Risk and Assurance Committee.	Aug-24	Not Met	Dec-24			Open	081024: (AP) Julie discussing action required with Carl Window and agreed that Carl would source support in the Finance & Corporate Resources Directorate to prepare the Tracker required. Revised date of December 2024 applied in Q2 24/25.
707	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Medium	1.1	The Trust should consider options to address volunteers development. This may not be as formal as a PADR process but should demonstrate the consideration of volunteers improvement needs.	1.1	The Trust accepts this recommendation and will consider options to address volunteer development. This will be assessed during the forthcoming financial year.	Mar-25	Not Yet Due				Open	
708	23/24	PCC	Volunteers Governance	Reasonable	Duncan Robertson	Lee Brooks	Medium	1.2	The Trust should undertake a review of outcomes and measures now available through the roll out of ePCR to consider indicators which would complement the current performance activity captured.	1.2	Trust Volunteer leads and clinical leads will review and recommend clinical outcome measures for CFRs as well as recommending where these data items will be reported. This action can be held at the Clinical Intelligence and Assurance Group.	Nov-24	Not Yet Due				Open	
709	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Medium	2.1	Management should establish a link between the VSG and the Trust Policy review group to allow sight of any relevant policies and allow for volunteer input to be provided, where applicable.	2.1	The Trust agrees that VSG is an appropriate mechanism for the volunteer voice when developing appropriate and relevant policies; We will seek to design a mechanism to support input from VSG for relevant policies.	Nov-24	Not Yet Due				Open	
711	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Medium	3.1	The Trust should consider addressing the highlighted enhancements to Operations Manuals outlined above. ** Each manual includes an outline of volunteer team structure but not an outline of where volunteer responsibility sits within the Trust. The inclusion of detail relating to executive and volunteer team responsibilities would enhance the robustness of the manuals.* ** Individual volunteer agreements have been developed for each volunteer role. It includes volunteers should 'be aware of, and respectful of applicable WAST policies and procedures.' As a signed agreement there is opportunity to strengthen the wording to include an expectation to comply with Trust policies.* ** The CFR Operations Manual includes a skills matrix for clinical roles. A copy of the dispatch codes which generate CFR deployment are included as an appendix within the CFR Operations Manual, however these are not the latest version in use. It could offer greater clarity to volunteers to include a copy of the skills matrix in place of the deployment codes.* **There are triggers for non-compliance with the mandatory elements of the role, but this is not included within either manual. Inclusion of this may assist in volunteer awareness of their responsibilities and processes in place.* **The Volunteer Problem Solving process for the management of volunteer issues or concerns does not contain a timescale for the completion of any review. Examples of similar procedures identified in use in other Ambulance Trusts specified targets of between 20-28 days. The Trust should introduce a timescale related to the Problem Solving Process.*	3.1	The Operations Manuals were recently published in February 2024. The Trust will review the Operations Manuals and will incorporate any amendments into this review process.	Feb-25	Not Yet Due				Open	
712	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Medium	4.1	The Trust should ensure the distribution of received guidance in relation to fundraising to the full CFR population.	4.1	On receipt of any guidance on fundraising, the National Volunteer Manager will within one month, convene a Task and Finish Group, under the governance of the Operations Directorate. The T&FG will be tasked with cascade of any guidance to volunteers	Mar-25	Not Yet Due				Open	
713	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Medium	4.2	The development of a fundraising standard operating procedure should include consideration of the need for periodic returns on fundraising activity and use of funds.	4.2	The T&FG will be responsible for execution of the actions described at 4.1-4.4. Any issue escalation to be reported through ADLT to ELT, noting it is not yet possible to determine the outputs from the T&FG, including the risk owner.	Mar-25	Not Yet Due				Open	
714	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Medium	4.3	The Trust should consider the development of good practice documents to support donation fund management, which could be incorporated into CFR team constitutions and processes.	4.3	The T&FG will be responsible for execution of the actions described at 4.1-4.4. Any issue escalation to be reported through ADLT to ELT, noting it is not yet possible to determine the outputs from the T&FG, including the risk owner.	Mar-25	Not Yet Due				Open	
715	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Medium	4.4	The Trust should prioritise the completion of a Volunteer fundraising risk, including clarifying the ownership of the risk within the Trust.	4.4	The T&FG will be responsible for execution of the actions described at 4.1-4.4. Any issue escalation to be reported through ADLT to ELT, noting it is not yet possible to determine the outputs from the T&FG, including the risk owner.	Mar-25	Not Yet Due				Open	
716	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Medium	5.1	The Trust should incorporate Safeguarding training compliance within the established one to one reporting template.	5.1	This finding relates to refresher training compliance. The Trust will incorporate safeguarding training compliance into the established one to one reporting template.	Sep-24	Met				Closed in Quarter	111024:(AP) This action is complete and can therefore be closed. Evidence received and status updated. 270924 Recommending new deadline date for Dec24, Template for 1:1 has now embeded the safeguarding compliance within the 1:1 documentation. 1:1 scheduled for 10th December (between Lee and Judith) to discuss compliance rates and evidence of the 1:1 will be provided as evidence towards this action.

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717	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Medium	5.2	Trust management should ensure that gaps in compliance with safeguarding training are addressed for both CFR and VCS roles.	5.2	The Trust will ensure that gaps in safeguarding compliance are addressed for VCS and CFRs.	Sep-24	Not Met	Nov-24			Open	041024: (AP) Revised date of November 2024 added in Q2 24/25, in line with update given. 270924 Recommending new deadline for November24. A three stage approach is being taken to address the gaps in Safeguarding compliance. Documentation and projected timelines of the 3 stage approach will be the evidence to support this action for recommended closure.
718	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Medium	6.1	The Trust should consider mechanisms to monitor the uptake of the mentoring arrangements outlined within the CFR Operational Manual.	6.1	The Trust will consider mechanisms to monitor the uptake of the mentoring arrangements.	Nov-24	Not Yet Due				Open	
719	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Low	7.1	The Trust should introduce a process which includes responsibility for allocation of calls or timeframes for addressing these [CFR Welfare and Activity Returns].	7.1	The Trust will introduce a process which includes the responsibility to a named individual for allocation of calls and timeframes for addressing these concerns.	Oct-24	Not Yet Due				Open	
720	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Low	7.2	Where a submission has resulted in discussion of any welfare or performance concerns an entry should be maintained within the CFRs individual record.	7.2	This process will also include the documentation of any follow up action on the CFR individual record.	Mar-25	Not Yet Due				Open	
721	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Low	7.3	The Trust should consider approaches to encourage the full completion of welfare returns to include a response of thriving, surviving, or struggling.	7.3	The Trust will consider approaches to encourage the full completion of welfare returns.	Oct-24	Not Yet Due				Open	
722	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Medium	8.1	Management should ensure key dates and stages are completed within the VCS Recruitment spreadsheet. The spreadsheet should be modified to include forecast dates aligned to the six-week recruitment check completion target.	8.1	The Trust will ensure that key dates and stages are completed on the VCS recruitment spreadsheet, including the modification to support forecast dates aligned to the six-week target.	Oct-24	Not Yet Due				Open	
723	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Medium	8.2	Monitoring arrangements should include the retention of key recruitment dates for a period following recruitment to allow the review of process for any steps which cause delays or blockages.	8.2	The Trust will ensure that monitoring arrangements will include the retention of recruitment dates for a determined period to support the review process.	Oct-24	Not Yet Due				Open	
724	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Medium	9.1	As part of the migration of VCS records onto Assemble the Trust should undertake a records stocktake, and address any subsequent gaps identified.	9.1	Following the introduction of Assemble, the Trust will undertake a records stock take and address any gaps identified.	Mar-25	Not Yet Due				Open	
725	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Medium	9.2	Noting the gap in vehicle check records, there should be inclusion of a completion of vehicle check forms as part of MiST course arrangements.	9.2	The Trust will introduce a system to include the completion of vehicle check lists for VCS volunteers.	Mar-25	Not Yet Due				Open	
726	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Medium	10.1	The Trust should confirm a consistent selection criterion for the selection of claims to be validated which includes risk assessment and adequate coverage of outliers.	10.1	The Trust will agree a consistent selection criterion for validation of checks, to include risk assessment and coverage of outliers.	Oct-24	Not Yet Due				Open	
727	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Medium	10.2a	Noting the unavailability of summary and validation documents for the Central and West region management should obtain and review documents to confirm the undertaking of checks.	10.2a	The Trust will satisfy itself that Central and West records are subject to appropriate checks and validation.	Jul-24	Not Met	Nov-24			Open	041024: (AP) Revised date of November 2024 added in Q2 24/25, in line with update given. 270924 Recommending new deadline of Nov24 - spreadsheets are now in place to ensure appropriate checks and validation. Further evidence of this will be discussed in upcoming meetings for the moniroing of these checks. Agenda and summary notes will be provided before recommending closure of action.
728	23/24	PCC	Volunteers Governance	Reasonable	Jennifer Wilson	Lee Brooks	Medium	10.2b	There should also be periodic checks to ensure documents are saved in a shared accessible location.	10.2b	The Trust will ensure that periodic checks are undertaken to ensure documents are saved in a shared accessible location.	Oct-24	Not Yet Due				Open	
729	23/24	PCC	Disciplinary Case Management	Reasonable	Karen Jones	Angela Lewis	Medium	1.1	The compassionate practices action plan should be reviewed to ensure timescales are reasonable and capture both the planned changes and implementation periods.	1.1	Undertake a review of the action plan with an aim to move to implementation of several of the outstanding actions, closing those that have been completed.	Aug-24	Met				Closed in Quarter	071024: (AP) Closure accepted in line with update and evidence (receipt of the Compassionate Practices Action Plan). October Update from P&C: Propose for closure - The Compassionate Practices Action Plan has been created and updated in July 2024. There have been actions concluded and additonal actions created in line with the Employee Relations Audit. The action plan is scheduled to go to a future People & Culture Committee, but a static copy of the Compassionate Practices Action Plan has been provided as evidence to show that a review has happened and closures have taken place.
730	23/24	PCC	Disciplinary Case Management	Reasonable	Karen Jones	Angela Lewis	Medium	1.2	Revised timescales should feature within the updates provided to the People and Culture Committee to ensure awareness of any delays to plan implementation.	1.2	Ensure all outstanding actions have a realistic completion date. To provide a regular update on plan to People & Culture Committee.	Aug-24	Met				Closed in Quarter	071024: (AP) Closure accepted in line with update and evidence (receipt of the Action Plan, evidence of its receipt at the August 2024 People and Culture Committee, and inclusion in the P&C Committee Cycle of Business). October Update from P&C: Propose for closure - The Compassionate Practices Action Plan shows realistic completion dates for its actions which can be evidenced through the Action Plan document. It has been referenced in the previous People & Culture Committee (taking place in August 2024) under the Cultural Themes and Reports and the Governance Team has included this in the Committee's Cycle of Business, so that future updates are programmed as required. The Compassionate Practices Action Plan will be going to the January PCC as a whole document.
731	23/24	PCC	Disciplinary Case Management	Reasonable	Karen Jones	Angela Lewis	Medium	2.1	The Trust should review the case management tracker to identify individuals that have previously been involved in undertaking initial assessments as a priority group for attending future compassionate practices training sessions.	2.1	Managers identified requiring training will be contacted with available dates to attend. Training is sourced via HEIW and not internally delivered. Therefore, training dates are limited.	Sep-24	Met				Closed in Quarter	071024: (AP) Closure accepted in line with update and evidence (email sent to managers). October Update from P&C: Propose for closure - Training dates are scheduled and delivered by HEIW. They have provided further training dates for colleagues to attend, which have been passed on to the appropriate managers identified. This can be evidenced via emails that have been circulated by KJ to these appropraite managers with all available dates that HEIW are hosting.

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732	23/24	PCC	Disciplinary Case Management	Reasonable	Karen Jones	Angela Lewis	Medium	2.2a	Post training feedback should be sought in line with the original action, to capture attendees learning from the training and identify any changes in practice.	2.2a	Contact will be made with HEIW as the training provider to confirm evaluation process.	Sep-24	Not Met	Dec-24			Open	211024: (AP) Revised date of December 2024 applied in Q2 24/25 as position is not clear. 20.09.24 - KJ - The evaluation is a planned process being undertaken by AB Health Board, this evaluation is underway and expected to be completed this Autumn. 16.08.24 - KJ - There was a planning meeting on 31.07.24 to discuss the format of the evaluation that is planned for Autumn 2024. This is evidenced in the Compassionate Practices Action Plan and via a planning group that has already been formed. However evluation is ongoing, and action to remain open until it is concluded.
733	23/24	PCC	Disciplinary Case Management	Reasonable	Karen Jones	Angela Lewis	Medium	2.2b	*Recommendation as per 2.2a.*	2.2b	Introduce a disclaimer that all investigating Officers complete to ensure they have undertaken all relevant training including compassionate practice.	Sep-24	Met				Closed in Quarter	211024: (AP) Evidence of disclaimer document has been received and updated status to closure proposed. 211024: (AP) Update from P&C Directorate: Meeting with TU Partners has taken place and the document was accepted and signed off. Among other documents, the new disclaimer for Investigating Officers, has been sent to the People Services Team for future use, which is shown in the evidence presented.
734	23/24	PCC	Disciplinary Case Management	Reasonable	Karen Jones	Angela Lewis	Low	3.1	To enhance the thematic review of disciplinary case management the Trust should consider the inclusion of the good practice elements of sickness status/periods and reasons for delay.	3.1	Sickness status and reason for delay will be added to the tracker as per recommendation	Aug-24	Met				Closed in Quarter	071024: (AP) Closure accepted in line with the update and evidence (copy of Tracker headings). October Update from P&C: Propose for closure - A meeting has taken place on 19.08.24 where the relevant fields for KPIs have been added into the tracker to be completed moving forward, including the sickness status and reason for delay. The added KPI fields have been sent as evidence.
735	23/24	PCC	Disciplinary Case Management	Reasonable	Karen Jones	Angela Lewis	Low	3.2	For performance management, the case management tracker should incorporate the measurement of timescale compliance within the fields in use.	3.2	Time scales will be added to the tracker as per recommendation.	Aug-24	Met				Closed in Quarter	071024: (AP) Closure accepted in line with the udpate and evidence (copy of Tracker headings). October Update from P&C: Propose for closure - A meeting has taken place on 19.08.24 where the relevant fields for KPIs have been added into the tracker to be completed moving forward, including timescales. The added KPI fields have been sent as evidence.
736	23/24	PCC	Disciplinary Case Management	Reasonable	Karen Jones	Angela Lewis	Medium	4.1	Management should consider approaches to ensure timescales are met as set out within the All-Wales policy, such as provisional appeal dates being agreed at the disciplinary hearing.	4.1	The Trust will continue to monitor compliance against All Wales Policy and ensure any delays are kept to a minimum by proactively securing dates for hearings/appeals etc at the earliest opportunity and note any reason for delays. People Business Leaders will monitor compliance relevant to their Directorates.	Aug-24	Not Met	Dec-24			Open	211024: (AP) Revised date of December 2024 applied in Q2 24/25 as position is not clear. 16.08.24 - KJ - Compliance is continually monitored as dates are provided in the Employee Relation Tracker and there are meetings that are held once a month for this to be discussed.
737	23/24	PCC	Disciplinary Case Management	Reasonable	Karen Jones	Angela Lewis	Medium	4.2	The Trust should include key timescales for each process to be periodically included within reporting provided to the People and Culture Committee for assurance that cases are being progressed in line with agreed All-Wales timescales.	4.2	ER tracker will include times scale compliance against each case. Any non-compliance will be supported with rationale. This will be monitored by the Deputy Head of People Services and People Business Leaders on a monthly basis.	Aug-24	Not Met	Dec-24			Open	211024: (AP) Revised date of December 2024 applied in Q2 24/25 as position is not clear regarding the evidence. Clarifications on the evidence provided not resolved in the reporting period. October Update from P&C: Propose for closure - The relevant KPIs have been added to the tracker, which has been sent across as evidence. The relevant members of the team will continue to monitor on a monthly basis and updates are being provided to the People & Culture Committee via the Cultural Themes and Trends standing item, with the document from August PCC sent over.
738	23/24	PCC	Disciplinary Case Management	Reasonable	Karen Jones	Angela Lewis	Medium	4.3	The Trust should establish its own expected timescale for formal investigations to be undertaken and ensure the officers tasked with undertaking these are aware of this.	4.3	With the investment of three full time investigating officer roles (interviews 14/06/2024), when in post will support dedicated investigation with a focus on complexity and agreed time scales.	Aug-24	Met				Closed in Quarter	071024: (AP) Closure accepted in line with update and evidence provided (template ToR doc, which prompts the respective Officers to define the timescales and include in the final ToR for each investigation. Template ToR received). Propose for closure - The Trust now have three full time investigating officers (IOs) in place to support dedicated investigations. The expected timescales will be determined and agreed by the IO on a individual basis and is included in the Terms of Reference document that is created and signed by the appropriate IO for each disciplinary investigation. A copy of the Terms of Reference document has been provided as evidence, which shows the inclusion of expected timescales and the ability for IOs to agree and sign.
739	23/24	PCC	Disciplinary Case Management	Reasonable	Karen Jones	Angela Lewis	High	5.1	The Trust should develop a checklist to ensure the completeness of case files for each element of the disciplinary process. This should include end process retention requirements for both People Services and the employee record.	5.1	Implement a checklist to ensure all required documentation is maintained for a disciplinary process. Checklist should be signed off by the People Business Leader/ People Services Business Partner for their directorate on completion of all stages of the process.	Jul-24	Met				Closed in Quarter	211024: (AP) Closure proposal accepted, evidence received in line with update. 211024: (AP) Meeting with TU Partners has taken place and the document was accepted and signed off. Among other documents, the new checklist, has been sent to the People Services Team for future use, which is shown in the evidence provided.
740	23/24	PCC	Disciplinary Case Management	Reasonable	Karen Jones	Angela Lewis	High	5.2	Following development of the checklists, the People Services team should incorporate a periodic check of adherence of a sample of recently closed cases.	5.2	Undertake periodic audits on the compliance with checklist.	Jul-24	Met				Closed in Quarter	071024: (AP) Closure accepted in line with update and evidence provided (checklist e.g., audit schedule and example outcomes of an audit, and comms to HR colleauges). October Update from P&C: Propose for closure - An Employee Relations Audit checklist has been created, and an example of this document being completed form the last periodic audit has been shared as evidence. This led to an audit schedule being put in place which has been added to the diary moving forward, as this schedule begins it will eventually move to business as usual. All these appropriate actions have been emailed out to the team and both the schedule and reminder have been noted as evidence.
741	23/24	PCC	Disciplinary Case Management	Reasonable	Karen Jones	Angela Lewis	High	5.3	Any revision to disciplinary toolkit template documentation should retain direction that completed copies should be shared with the People Services team.	5.3	Update as required using version control for disciplinary tool kit available on Siren.	Jul-24	Met				Closed in Quarter	071024: (AP) Closure accepted in line with update and evidence (email comms). October Update from P&C: Propose for closure - An email has been sent out to the team that includes a reminder that if any documentation in the manager's toolkit is amended or updated then version control has to be used, alongside new documents being shared that have version control automatically turned on. This email to staff has been provided as evidence to show the reiteration that completed copies will be retained and shared in the People Services Team.
742	23/24	PCC	Disciplinary Case Management	Reasonable	Karen Jones	Angela Lewis	Medium	6.1	The People Services team should ensure that ESR records accurately reflect the outcome of disciplinary processes, and should review the case management tracker to identify any historic records which require amendment.	6.1	On completion of all disciplinary hearings, People Services representative to ensure that ESR accurately reflects the outcome of dismissal. Contact with NWSSP payroll may be required to make the changes to past cases ensuring accurate information is recorded.	Aug-24	Not Met	Dec-24			Open	211024: (AP) Revised date of December 2024 applied in Q2 24/25 as evidence clarifications required. 071024: (AP) Not accepted closure proposal; requested evidence of checks. October Update from P&C: Propose for closure - A reminder has been sent to the team via email and includes appropriate guidelines and docuemnts. This can be provided as evidence, and this process will continue as business as usual moving forward.
743	23/24	ARAC	Risk Management	Reasonable	Julie Boalch	Trish Mills	Medium	1.1	The Trust should consider amending the risk assessment form to capture the strategic and directorate objectives and priorities impacted by each risk.	1.1	The RAF and BAF already have sections to capture the strategic objectives, however there was a timing issue with the new IMTP to facilitate the inclusion of such. These will be included going forward. At this stage of the risk management maturity at the Trust we will not include the directorate objectives and priorities impacted by each risk but is something we can look to do when we have an appropriate electronic risk management system.	Aug-24	Met				Closed in Quarter	081024: This action is complete. The Risk Assessment Form has been updated to encompass the priorities. This will be rolled out during Q3. The status has been updated to 'closure proposed'.

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744	23/24	ARAC	Risk Management	Reasonable	Julie Boalch	Trish Mills	Medium	2.1	Risk assessment forms should be completed for all risks.	2.1	It may be that risk assessment forms do not need to be completed for all risks if they are developed directly on Datix. However, a siren notice will be issued to remind colleagues of the correct templates to use, support available and direct them to the risk management framework; and the narrative included in the Risk Management Guidelines will be updated accordingly too.	Aug-24	Not Met	Dec-24			Open	081024: Complete when Siren notice is issued 011124 to remind colleagues where to access templates, information and support. This will be completed in November 2024 and as such a revised date has been applied in Q2 24/25 to December 2024.
745	23/24	ARAC	Risk Management	Reasonable	Julie Boalch	Trish Mills	Medium	2.2	User / training requirements needed to support managers / risk owners through this transition should be considered to ensure that individuals feel competent to complete risk assessment forms and upload the information onto Datix.	2.2	Resourcing for the risk team is limited at this time, therefore the full programme of training and education will be in line with the risk transformation programme. However, the Corporate Governance Directorate will develop a virtual roadshow to senior directorate meetings and ADLT to provide information and signposting on risk management (as well as audit, policy, FOIs etc).	Mar-25	Not Yet Due				Open	
746	23/24	ARAC	Risk Management	Reasonable	Julie Boalch	Trish Mills	Medium	3.1	All risks should be uploaded and managed on Datix.	3.1	Datix is not currently fit for purpose. Therefore, agreeing that all risks should be uploaded and managed on Datix is not possible at this time. What is accepted is that there should be an agreed approach within local and directorate risk registers i.e. either all on Datix and managed there with appropriate reporting, or outside of Datix with an audit trail of identification, development, review, escalation, and closure. Resourcing in the risk team currently is challenging and it is therefore impossible in a timely way to agree to this recommendation. Propose that the MA related to the EMS local risk register is dealt with in action 4.1 with SOT and that the recommendation that all risks are uploaded and managed on Datix is deferred until such time as a way forward is agreed on whether changes will be made to Datix on an All-Wales basis, or whether Health Boards and Trusts will be procuring their own solutions.	Jan-25	Not Yet Due				Open	
747	23/24	ARAC	Risk Management	Reasonable	Julie Boalch	Trish Mills	Medium	4.1	We recommend the Trust consider arrangements to support the consistency and monitor the completeness of directorate registers.	4.1	The risk team will work with the clinical and operations team with respect to the risks set out here particularly and either develop a plan to manage these risks externally to Datix but with an appropriate audit trail whilst an electronic risk management system is procured, or to use Datix for the capture of the operations and clinical risks with appropriate and user-friendly reporting for their purposes. This will be evidenced by a record of this being agreed by SOT and the appropriate clinical directorate meeting. The data cleansing exercise to be undertaken by the Operations Directorate, as referenced at para 2.45, will also assist in managing the accuracy of the risk register.	Oct-24	Not Yet Due				Open	081024: Work ongoing.
748	23/24	ARAC	Risk Management	Reasonable	Julie Boalch	Trish Mills	Medium	5.1a	A summary risk report, similar to the format presented at Trust Board and Committees, should be developed and reported at directorate and service level.		1.It is accepted that an appropriate overarching risk report is beneficial for local and directorate risks, however the risk team will look at what reporting can be drawn from Datix currently, noting the limitations it has. This management action is closely aligned to the work that the team will do for action 4.1.	Oct-24	Not Yet Due				Open	
749	23/24	ARAC	Risk Management	Reasonable	Toni-Marie Norman	Trish Mills	Medium	5.1b	A summary risk report, similar to the format presented at Trust Board and Committees, should be developed and reported at directorate and service level.		2.Operations are developing a dashboard to be reported to SOT which highlights the total number of risks, how many risks at each level, review compliance (% in-date and overdue), and requesting all risks be reviewed so that any no longer relevant can be closed or replaced as appropriate, and up-to-date mitigation (controls and treatments) are recorded for any which are still applicable and need to remain open	Oct-24	Not Yet Due				Open	

Points of Contact, Directors and Owners of Audit Actions - Do Not Amend Any Column With a Red Header

When proposing a revised 1st, 2nd or 3rd date, include the rationale for the movement and any progress on the action to date

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106	Audit Wales	22/23	QUEST	Review of Quality Governance Arrangments	Jonathan Turnbull-Ross/ Wendy Herbert/ Hugh Bennett	Liam Williams			R8 We found that the QuESt Committee is well served with quality information, but there are opportunities for improvement. The Trust should: develop a system to triangulate learning themes (d) work with health bodies so that there are systems to determine the outcomes for patients who have received emergency ambulance services. This should particularly seek to understand the consequence and harm resulting from service failures such as long ambulance waits.		d) The Trust will continue to share information and intelligence with partners that detail the consequences of system failures. Whilst particularly evident where experience or outcome is poor and results in complaint or adverse incident. The Trust will pursue patient outcome data through development of the ePCR over 2022/23.	Mar-23	Not Met	Dec-23	Mar-24	Jul-24	October 2024: Based on the Quality Governance Review Follow Up report, Audit Wales has noted that this audit action should remain open. New management responses/actions will be developed, at which point this action will be closed and superseded by a new action in relation to the Follow Up Audit (but will remain on this Tracker for the formal record). 250424: Date changed in Q4 to July 2024 in lnie with AW timelines for conclusion of related follow up audit. 15042024: This will remain open until AW confirm as part of the current quality governance audit that it can close. Date will change in quarter (from March 2024 to new date). Update 14032024 from Duncan Robertson: The Health Informatics team are currently working with DHCW to enable a flow of data relating to out of hospital cardiac arrest. This it to test the systems and processes. When complete, this learning will be applied to other presentations for analysis. TM will engage with Audit Wales on a potential revised approach for this action. 201223: Given the comment below Board Secretary suggests a 'check in' date of 31 March 2024. Audit Wales will be doing a further review at that time and may wish to reframe this recommendation. 11.12.23 Update from Duncan Robertson: The WAST and DHCW data-sharing agreement is with the ICO and Welsh Government as part of a consultation. This will provide the legal basis to share data. No completion date has been provided, therefore the December target date will not be met. It is completely outside of WASTs gift to propose a completion date The Putting Things Right Team are strengthening the Putting Things Right Quarterly Reports to include themes, patterns and trends. REVISED DATE OF DECEMBER 2023 21.11.23: Update 121023: Work Ongoing and will take a period to complete. Conversations continue with DHCW and the Ambulance Data Set (ADS) lead in England to define the ePCR definitions. Work is also continuing with DHCW to establish data sharing to enable joining up of patient records to report on outcome data. no timeline as yet and meeting with DHCW continue to clarify some of the definitions following discussions with the lead for the ADS in England. Trust Information Governance colleagues are working with DHCW for this. 26.09.23: Duty of Quality Implementation plan includes the four quadrants of quality management system as set out in the 'road map'. Quality & Performance Management Steering Group continue to monitor and review the development of 'always on' reporting in line with the requirements of the act. Additional metrics have been approved by Trust Board for inclusion in the MIQPR including PREMS/PROMS, Duty of Candour metrics. New HI post now appointed to support MIQPR move to Power BI dashboard. Proposed Revised date 31.12.23 rationale for extension is to allow BI Dashboard work to commence to allow analysts to identify how best to report 'Patient Reported Experience' measures that add value to decision making. Historic Update: We continue to work with Welsh Government colleagues and NHS Executive in the development of the 'all-Wales' Quality Management System, including how the QMS will 'join up' and detail the impact of ambulance performance on HBs/patient care. The Trust PECI Team have also continued to develop the Civiva patient experience software, alongside HBs, to enable analysis of patient experiences of services.	Open
106	Audit Wales	22/23	QUEST	Review of Quality Governance Arrangments	Jonathan Turnbull-Ross/ Wendy Herbert/ Hugh Bennett	Liam Williams			R8 We found that the QuESt Committee is well served with quality information, but there are opportunities for improvement. The Trust should: (e)develop patient outcome measures to support its existing quality measures.		e) The Trust is often limited by data accessibility where the patient journey extends beyond the organisational boundary. The Trust will pursue patient outcome data through development of the ePCR over 2022/23, which will enable 'joining up' of patient records. Furthermore, the Trust will further consider accessibility and governance matters for wider adoption of Patient Reported Outcome Measures, and Patient Reported Experience Measures.	Mar-23	Not Met	Mar-24	Jul-24		October 2024: Based on the Quality Governance Review Follow Up report, Audit Wales has noted that this audit action should remain open. New management responses/actions will be developed, at which point this action will be closed and superseded by a new action in relation to the Follow Up Audit (but will remain on this Tracker for the formal record). 250424: Date changed in Q4 to July 2024 in lnie with AW timelines for conclusion of related follow up audit. 15042024: This will remain open until AW confirm as part of the current quality governance audit that it can close. Date will change in quarter (from March 2024 to new date). Update 14032024 from Duncan Robertson: The Health Informatics team are currently working with DHCW to enable a flow of data relating to out of hospital cardiac arrest. This it to test the systems and processes. When complete, this learning will be applied to other presentations for analysis. TM will engage with Audit Wales on a potential revised approach for this action. 201223: Given the comment below Board Secretary suggests a 'check in' date of 31 March 2024. Audit Wales will be doing a further review at that time and may wish to reframe this recommendation. Update: 11.12.23 DEVELOPMENT OF EPCR: Update will be provided by Duncan Robertson via update of item d) PATIENT REPORTED OUTCOME MEASURES: The Trust has defined standardised data to measure. Minimum dataset of approximately 600 definitions to agree with DHCW. Currently linking with England to assess available datasets and definitions. Data sharing agreements currently sit with DHCW and Welsh Government for approval. Instruction letters shared and awaiting response. (Leanne Hawker liaising with Alex Crawford on completion date) PATIENT REPORTED EXPERIENCE MEASURES: Data survey and narrative for generalised PREMs has been standardised and feeds into the MIQPR. A bespoke PREM is being developed in relation to Pain Management and Learning Disability (should be completed by end January 2024) REVISED DATE OF MARCH 2024 Update 121023: PREMS live, but in development. PLICS is due to come on stream in Mar-24. PROMS is in development and dependent on DCHW. Business Care Process and Project Management Pathway are relevant considerations.	Open
123	Audit Wales	23/24	PCC	Review of Workforce Planning Arrangements	Linda Phillips	Angela Lewis	Medium	2.1	Workforce information systems We found that there is scope for the Trust to make better use of its workforce information by ensuring data is consistent, joined up and up to date. The Trust should work to ensure that (medium priority):	2.1	Use of Power BI reporting feeding into the Integrated Technical Planning Group is in development by the workforce planning team. This will be used for reporting and maintenance of the data.	Sep-24	Not Met	Dec-24			211024: (AP) Revised date of December 2024 applied in Q2 24/25 as position not clear. 12.09.24 - LP - The team have piloted a Power BI version of the current PowerPoint Workforce Monitoring Report, however work is ongoing to finalise the final Power BI version. The HI team have been asked to link ESR data warehouse to a Power BI dashboard report and work on this link is ongoing. 30.05.24 - JK - this work is progressing with its first phase nearing completeion - delivery of an accurate status quo on Staff in Post v Budgetted Establishment. Subsequent phases will include the ablitly to goal seek, post What If analysis and forecast by varailbe manipulation.	Open
124	Audit Wales	23/24	PCC	Review of Workforce Planning Arrangements	Hugh Bennett	Angela Lewis		2.1(a)	Workforce information systems We found that there is scope for the Trust to make better use of its workforce information by ensuring data is consistent, joined up and up to date. The Trust should work to ensure that (medium priority): • Systems that hold workforce information including Electronic Staff Record (ESR), Global Rostering System (GRS) and finance systems interconnect, where possible.	2.1(a)	Alongside this we are working on Integrated Planning Nexus via the Planning and Strategy team which enables our understanding of the interconnection between workforce, fleet, estate etc. *Excel version*	Mar-24	Not Met	Oct-24	Dec-24		211024: (AP) Revised date of December 2024 applied in Q2 24/25 as position not clear. 22.08.24 - JK - THe Nexus part of the recommendation has been completed, however, confirmation has not been given as to whether the joining up of the suggested systems will be achieveable for the Trust. Further consideration is taking place. 26.06.24 - JK - Further development has taken place for the PowerBI solution, however it is not yet QA'd for release but it is being used within the ITPG. It will be refined during July 2024 with an ELT specific summary produced highlighting KPIs and any relevant sensitivity analysis. 17.05.24 - JK - Manually generated monthly report created as the forerunner of the PowerBI Monthly Workforce Dashboard - work progressing on this solution with its delivery scheduled for June 2024. 21.03.24 - LR - The Workforce Transformation and Planning Team now produce a highlight report on key workforce information. Propose an extension to this action as the work on Nexus will be longer than expected. To date the following has been undertaken. Date moved in Q4 to October 2024. Project team established. Initial mapping completed. Currently developing what the end product will look like to work backwards to the requirements Complex exercise meaning timelines are difficult to estimate. Investment in connecting GRS, ESR and Oracle would be needed to build interfaces therefore Nexus is the solution for the time being.	Open
125	Audit Wales	23/24	PCC	Review of Workforce Planning Arrangements	Hugh Bennett	Angela Lewis		2.1(b)	Workforce information systems We found that there is scope for the Trust to make better use of its workforce information by ensuring data is consistent, joined up and up to date. The Trust should work to ensure that (medium priority): • Explore ways to resource the management of a system to ensure an up-to-date establishment model.	2.1(b)	Alongside this we are working on Integrated Planning Nexus via the Planning and Strategy team which enables our understanding of the interconnection between workforce, fleet, estate etc. *Potential PowerB1 version*	Sep-24	Not Met	Dec-24			211024: (AP) Revised date of December 2024 applied in Q2 24/25 as position not clear. 22.08.24 - JK - The team are currently working on this and have access to a relevant version to share as evidence that this is ongoing. LP advises a Power BI version of the current PowerPoint Workforce Monitoring Report has been piloted and work is ongoing to finalise a final Power BI version. 26.06.24 - JK - further development of the PowerBI solution - not yet QA'd for release but being used within the ITPG - will be refined during July 2024 with an ELT specific summary produced highlighting KPIs and any relevant sensitivity analysis. 17.05.24 - JK - manually generated monthly report created as the forerunner of the PowerBI Monthly Workforce Dashboard - work progressing on this solution with its delivery scheduled for June 2024.	Open

Trust Ref No.	Audit Wales or HIW Report	Year	Committee Assigned to	Report Title	Responsible Officer	Director	Priority Level	Rec. No. in Audit	Recommendation	Response no. in Audit	Management Response	Agreed Deadline in Report	Status	1st revised date	2nd revised date	3rd revised date	Where a management action has not met the agreed or revised date, Director must inlcude here: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. **Please add most recent update first**	Closure Status
126	Audit Wales	23/24	PCC	Review of Workforce Planning Arrangements	Dee Udeze-Chibuzor / Liz Rogers	Angela Lewis	Medium	3.1	Evaluating workforce planning training We found that the Trust is strengthening workforce planning capability through training initiatives, but it will need to evaluate these to ensure they are having the desired impact. The Trust should develop an evaluation framework to measure the success of its training programme (medium priority).	3.1	We will implement an evaluation process to baseline where managers are pre and post training and post 3 months to measure improvement.	Jun-24	Not Met	Aug-24	Dec-24		211024: (AP) Revised date of December 2024 applied in Q2 24/25 as position not clear. 22.08.24 - JK - The Workforce Planning training has been moved onto Learn 365 and development is ongoing to include an evaluation and feedback facility in the future. Evidence has been provided of the training up and running on Learn 365. 04.07.24 - AP - Added revised date of August 2024 in Q1 2024/25 in line with narrative provided. 17.05.24 - JK - Workforce Planning training is being rolled out pan Trust. However, to allow the sufficient time for all areas to receive this training and commence an evaluation, it was requested that the deadline be moved to August 2024.	Open
127	Audit Wales	23/24	PCC	Review of Workforce Planning Arrangements	Dee Udeze-Chibuzor / Liz Rogers	Angela Lewis	Medium	4.1	Recruitment support We found that only the emergency ambulance services department has dedicated support from the central management team for recruitment activity, due to capacity issues. While the central team can provide support on a case-by-case basis, the Trust should review opportunities to increase the corporate support offered to other departments across the organisation (medium priority).	4.1	The recruitment team focus primarily on EMS but do offer support where needed to other services. This would need to be agreed by ELT and the Directorates as resource would need to be moved into the team from elsewhere. Report to be produced and shared with ELT.	May-24	Not Met	Sep-24	Dec-24		211024: (AP) Revised date of December 2024 applied in Q2 24/25 as position not clear. 05.07.24 - AP - Revised date of end of Q2 added in Q1 24/25, and to discuss closure evidence required with Directorate. 21.05.24 - JK - additional Fixed Term support secured in the function.	Open
128	Audit Wales	23/24	PCC	Review of Workforce Planning Arrangements	Dee Udeze-Chibuzor / Liz Rogers	Angela Lewis	Medium	5.1	Metrics for People and Culture plan monitoring The Trust has recently approved the metrics to enable monitoring progress of the People and Culture Plan, however the metrics do not include targets or milestones. The Trust should work to develop targets and milestones to enable the Committee to understand the progress against the Plan (medium priority).	5.1	Recommendation Accepted. We will build in appropriate targets and milestones into the plan which will be frequently reviewed for delivery and effectiveness of both the plan and the measures	May-24	Not Met	Sep-24	Dec-24		211024: (AP) Revised date of December 2024 applied in Q2 24/25 as position not clear. 05.07.24 - AP - Revised date of end of Q2 added in Q1 24/25, and to discuss closure evidence required with Directorate. 21.03.24 - LR - Query this action here as it was requested to be removed as it was not relevant to this audit and incorrect. However, the P&C Directorate Plan has milestones and measures for 2023/4 and will have for 2024/25. CGT have further narrative regarding this action.	Open
129	Audit Wales	23/24	PCC	Review of Workforce Planning Arrangements	Liz Rogers / Hugh Bennett	Angela Lewis	Medium	6.1	Benchmarking The Trust does not routinely benchmark its workforce performance metrics with other health bodies in Wales. Its performance benchmarking with other ambulance trusts is infrequent. The Trust should introduce regular workforce benchmarking with similar organisations and use this to inform relevant groups and committees on its performance and efficiency and to identify and share good practice (medium priority	6.1	Recommendation accepted for high level measures and will be based on what other organisations share / make available. Benchmarks need to be with ambulance sector rather than Health Boards	Jun-24	Not Met	Sep-24	Dec-24		211024: (AP) Revised date of December 2024 applied in Q2 24/25 as position not clear. 16.09.24 - HB - The 2023 EMS Demand & Capacity Review was reported to F&P Committee in a closed session on 16.07.24. 22.08.24 - JK - The Trust now have the ability to access on occassion the AACE HRD Network, which will allow us to see a shared spreadsheet with all Ambulance Services in England. As a pan Wales Trust, we do not have the ability to benchmark against another ambulance service in Wales but it will give the ability to benchmark against appropriate Trusts in England. 05.07.24 - AP - Revised date of end of Q2 added in Q1 24/25, and to discuss closure evidence required with Directorate. 26.06.24 - JK - the AACE HRD Network could be positioned to assist the Trust with this. 26.06.24 - HB - the Trust has recently received the final 2023 EMS Demand & Capacity Review, which benchmarks the Trust's performance on a range of metrics. This will be reported to F&P Committee on 16.07.2024.	Open
139	HIW	23/24	Quest	National Review of Patient Flow – a journey through the stroke pathway	Andy Swinburn	Liam Williams Andy Swinburn		32(b)	WAST must consider its current response times for patients awaiting interhospital transfers for urgent thrombectomy treatment which are classified as 'Red'. This is to ensure a thrombectomy can be completed within the six-hour timescale from the onset of symptoms.	32(b)	WAST will review this process in due course and ascertain its success and determine if any further actions are required	Jun-24	Not Met	Sep-24	Dec-24		021024: (AP) Revised date in Q2 24/25 applied to December 2024, as requested. Last updated 01102024: Request to review due date to Q3 to enable a full quarter of data collection for review of the new process. The data is being collected and can be demonstrated through Power BI but additional time would enable leads to review a full quarter data set for discussion and to develop response to recommendation. 110724: Action: 1) Review the process agreed with the Health Boards, and ascertain its success / determine if any actions required. It is noted that The process we agreed in 2022 was for the trauma desk to take the transfer requests for thrombectomy. From 30th July 2024 a new process is being introduced for all transfers in WAST (including thrombectomy), this is a new protocol called Medical Transfer Protocol Suite (MTPS) and will specifically handle transfer requests. Evidence: 1) The communication to the Health Board is evidence of the agreed process (the Commissioning Policy). The new MTPS is going live on the 30 July 2024, which includes the provision of thrombectomy transfers which are categorised as Red calls. The process was agreed in 2022 however the new MTPS process begins in mid-2024, therefore a review cannot be undertaken until later in 2024. 150724: Due to position with new system going live in July 2024, revised date added in Q1 24/25 to September 2024. Last updated 28062024: (JL) The process for requesting an interhospital transfer for patients requiring thrombectomy has been reenforced, confirming that the clinician requesting this transfer should utilise the dedicated number (not 999) where they will speak to a clinician, their request for transfer will be process as a red response and this has been communicated as required.	Open
142	Audit Wales	21/22	Charity	NHS Trust Charity Audit of 21/22 Accounts Report	Jason Collins, Jill Gill	Chris Turley	Medium	3	**Harlequin system access controls** Review of the access controls for the Charity's Harlequin financial system identified that there is no minimum password complexity requirement for users.	3	Introduce password complexity requirements for users in line with industry best practice.	Mar-23	Not Met	Jul-24			091024: (AP) Update from FinCor: Following further scoping work, along with the 30-day free trial with SAGE, it has been decided not to progress the move to this system at present. Therefore, due to the limitations within the current Harlequin system, we are unable to enhancement the complexity of passwords. However, we have implemented further controls around system user (Action 143) lessening the risk to the Charity due to the very small number of users. Advise that this action is closed. Closure proposal accepted and status updated; access reports received as supporting evidence. 21032024: AP discussion with Navin on the 21032024: This is the current position and the work is ongoing. Intention to be completed by July 2024 with the new Sage software coming in to use. Due date updated to July 2024 in quarter; update to be reviewed by Chris Turley. Date changed in Q4 to July 2024. Target date moved on Q4 11012024: Update from Navin: ICT have been approached numerous times by the Finance Assistant - Charitable Funds to arrange a date and time with the Harlequin team, to be able to update the version we have. Due to capacity issues in the ICT team this has not beenn done. The Finance Assistant - Charitable Funds has requested moving over to SAGE as its approx.. £500 per annum cheaper and is a much better accounting system than Harlequin. Currently in the process of receiving a 30-day free trial, and how SAGE can resolve this risk item. Still open likely completion in 6 months. 19.03.24 - We will be moving over to SAGE mid-June, which is when our contract will end with Harlequin following our 90 day notice	Closed in Quarter
143	Audit Wales	21/22	Charity	NHS Trust Charity Audit of 21/22 Accounts Report	Jason Collins, Jill Gill	Chris Turley	Medium	4	**Harlequin system user accounts** Review of live users on the Harlequin financial system at the time of audit identified a member of staff who left the employment of the Trust a number of years ago. The former employees should have been removed from the system when they left the employment of the Trust.	4	Remove the user from the Harlequin financial system and introduce a regular documented review of system users and their rights of access to ensure they remain appropriate.	Mar-23	Not Met	Jul-24			091024: (AP) Update from FinCor: All old users have now been removed from the system leaving only those that require access to the system (currently 3 users). Regular reviews of system users will now take place to ensure this is kept up to date. Advise that this action is closed. Closure proposal accepted and status updated; access reports received as evidence. 21032024: AP discussion with Navin on the 21032024: This is the current position and the work is ongoing. Intention to be completed by July 2024 with the new Sage software coming in to use. Due date updated to July 2024 in quarter; update to be reviewed by Chris Turley. Date changed in Q4 to July 2024. 11012024: Update from Navin: Same as above - still open linked to ICT capacity. 19.03.24 - We will be moving over to SAGE mid-June	Closed in Quarter
148	Audit Wales	22/23	Audit	Structured Assessment 2023	Alex Crawford	Rachel Marsh	High	4	**Oversight of IMTP delivery** Whilst there have been recent improvements to the reporting of IMTP progress to Committee and Board, there is scope to provide better clarity on whether the actions delivered have achieved the intended impact. The Trust should ensure all plan delivery progress reports include information about the impact achieved.	4	Agreed. Consideration will be given as to how this can best be achieved, and this will be taken forward into the 2024/25 reporting processes.	Jun-24	Not Met	Sep-24			071024: (AP) Update from SPP: It has been achieved in so much as the IMTP is now reporting against the metrics set out in the plan (i.e. 'What good looks like'). A Benefits Realisation Framework has been agreed, but rather than strict compliance what has been prepared is translating the IMTP benefits realisation into an IMTP outcomes report that has been prepared for Trust Board. It still requires iteration but one does now exist, which allows us to track whether we are delivering on the ambitions in then IMTP. Closure proposed. Evidence is the Trust Board paper on IMTP delivery from September 2024 Trust Board. 100724: Revised date of September 2024 added in Q1 24/25. 100724: Update from SPP: Benefits realisation plans are being developed for the re-structured programme arrangements to deliver the Clinical Model Transformation and the Planning Team is working with Performance Team to align the 'what good looks like' measures set out in the IMTP to the deliverables. This action will be closed when this is reported to the Board in September 2024, as the end of Q2 24/25. Revised date of September 2024 proposed.	Closed in Quarter

Trust Ref No.	Audit Wales or HIW Report	Year	Committee Assigned to	Report Title	Responsible Officer	Director	Priority Level	Rec. No. in Audit	Recommendation	Response no. in Audit	Management Response	Agreed Deadline in Report	Status	1st revised date	2nd revised date	3rd revised date	Where a management action has not met the agreed or revised date, Director must inlcude here: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. **Please add most recent update first**	Closure Status
149	Audit Wales	22/23	Audit	Structured Assessment 2023	Chris Turley	Chris Turley	High	5	**Oversight of Savings plans** The Trust does not clearly specify in its finance plans and reports whether savings schemes are recurrent or non-recurrent. To strengthen oversight of savings, the Trust specify whether schemes are recurrent or non-recurrent in its financial plans and reports.	5	Agreed. Whist not always specifically called out in the main report, the Trust is required to provide a monthly financial return to WG that details recurrent schemes. The latest return is provided as an appendix to every financial report. Consideration will be given to more explicitly calling some of this out in the main body of the report. Recognising the current and future climate for the public sector and the NHS specifically, the organisation has instigated a strategy of pursuing a Financial Sustainability Program to identify increases in recurrent savings schemes via two separate working group lenses of Achieving Efficiency and Income Generation in mitigation. This should also allow for greater clarity of the split between recurring and non-recurring savings within future financial plans. It is inevitable however that an element of any in year delivery of financial balance will include an element of non-recurrency, whether that be spend or savings.	Mar-24	Not Met	May-24	Jul-24		071024: (AP) Closure proposal accepted and updated in Q2 24/25. 071024: (AP) Update from Finance: We have incorporated further savings reporting into committee finance reports and hence I recommend this can be closed and as evidence please find the Month 5 finance report (paras 10 to 15 and appendix 5). Closure proposed. 080724: Revised date of July 2024 added in Q1 24/25 on advice from Jason Collins. Detail to be included in July Trust Board report (and then onwards with reporting), at which point the action will be closed. 170424: Update from Navin: The new financial year savings report identifying recurrent and non-recurrent savings will be produced for May Trust Board and should suffice as evidence. Jason Collins will send this to the CGT once it has been produced at the end of May. Date extended in quarter 4 to May 2024.	Closed in Quarter

AGENDA ITEM No	10
OPEN or CLOSED	Open
No of ANNEXES ATTACHED	1

TRUST POLICY REPORT

MEETING	Audit, Risk and Assurance Committee (ARAC)
DATE	21 November 2024
EXECUTIVE	Trish Mills, Director of Corporate Governance/Board Secretary
AUTHOR	Julie Boalch, Assistant Director of Corporate Governance and Risk
CONTACT	Julie.Boalch@wales.nhs.uk

EXECUTIVE SUMMARY

1. The purpose of the report is to provide an update to the Committee on the status of the Trust's policy work programme to bring key policies up to date.

2. A work programme for 2023/24 was established following the Covid-19 pandemic to address the number of policies that were not within their review date, and which had fallen to below reasonable levels during that period. A further work plan was agreed for 2024/25.

3. Whilst the work plans have been held flexibly from the outset to take account of resourcing demands, internal and external pressures, and the competing portfolios of Directorate Policy Leads; it is pleasing to report that a significant amount of work has taken place to refresh existing policies and develop new ones, with reports submitted to the Committee by exception as agreed.

4. At the last meeting in September 2024, Committee requested a fuller update to provide assurance against the progress of the policy work programmes acknowledging that detailed updates are provided to the Executive Leadership Team (ELT) following each Policy Group meeting via the Alert, Advice, Assure (AAA) reports.

5. The work undertaken to date shows that 46% of Trust owned policies are within their review date compared to 14% overall reported to Committee in July 2023 and at the time the initial prioritisation exercise was undertaken. This figure does not include those policies developed by NHS Wales or the NHS Employers Unit which are adopted by the Trust.

6. The comprehensive breakdown of the numbers of policies and their status is described in the table below:

Status	Number
Policies approved and within their review date	27
Policies due to be approved by end of November 2024	5
Policies currently out to consultation	5
Policies removed from database or superseded	4
Policies due to be reclassified as Standard Operating Procedures	4
New Policies to be developed	10
NHS All Wales Policies	30
Policies still to be reviewed – forming 2025/26 work programme	42
Total Number of Policies	**127**

7. The breakdown of the 2023/24 and 2024/25 work programmes showing the actual versus planned activity is contained in appendices 1 and 2.

8. Of the 30 all Wales NHS Policies that the Trust has adopted and only 4 of these are within their review date - equating to 18% overall. These figures and policy reviews are out of the Trust's control as the programme of policy review work sits with NHS Wales. The Trust has received a review schedule from the NHS Employers Unit and whilst 6 policies are under review, all NHS Wales employment policies remain extant.

9. A review of the policy prioritisation list was undertaken by the Assistant Directors Leadership Team (ADLT) and recommendations made to the ELT in October 2024. The purpose of this was to re-evaluate the status of those policies yet to be reviewed and determine whether these remain a priority given the context that the Trust is operating within.

10. Acknowledging that several work streams have moved on since the initial prioritisation exercise was undertaken in 2023, the revised work programme is contained at appendix 3 and provides details of the 42 policies that are expected to be reviewed or developed in 2025/26.

RECOMMENDATION:

11. **Members are asked to:**
    a) Consider the progress to bring the Trust's Policies up to date.
    b) Endorse the future work plans for the remainder of this work.

KEY ISSUES/IMPLICATIONS
12. The key issues are set out in the Executive Summary above.

REPORT APPROVAL ROUTE
13. Progress against the work plans was reported to ELT via the monthly, Policy Group AAA following each Policy Group meeting.

REPORT ANNEXES
14. Annex 1 – 2025/26 Policy Work Programme.

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

Appendix 1 – Policy Work Programme 2023/24

Policy Status	Number of Policies
Approved and within their review date	13
Due to be approved in this round of governance	5
New Policy	1
Reclassified as SOPs	2
Superseded	1
Currently under review and in the governance process	2
Reprioritised and deferred to 2025/26 work programme	3
Total identified as a priority for review or development in 2023/24	**27**

Appendix 2 – Policy Work Programme 2024/25

Policy Status	Number of Policies
Approved and within their review date	5
Due to be approved in this round of governance	1
New Policies still to be developed	2
Reclassified as SOPs	2
Superseded	1
Reprioritised and deferred to 2025/26 work programme	9
Total identified as a priority for review or development in 2024/25	**20**

Appendix 3 - Policy Work Programme 2025/26

Policy Title	Priority Number assigned in 2023/24	Priority Number assigned in 2025/26	Directorate	Policy Lead
Assessment, Failure Referral and Appeals Policy	2	1	People Services	Martin Mulholland
Bank Worker Policy	7	1	People Services	Michelle Morse
CCTV Policy	2	1	Digital	Kelly Holding
Policy For the Development, Review and Approval of Policies	1	1	Corporate Governance	Lisa Trounce
Retirement Policy	1	1	People Services	Sara Williams
Violence & Aggression Policy	1	1	Quality, Safety & Patient Experience	Nicola White

Fuel Card Policy	9	2	Finance & Corporate Resources	Gavin Lane
Information Risk Policy	10	2	Digital	Kelly Holding
Management Of Allegations Policy: When an Allegation or Concern Is Raised About an Employee or Volunteer	2	2	Quality, Safety & Patient Experience	Gwenan Jones-Parry
People Development Policy	NEW	2	People Services	Jo Kelso
Bring Your Own Device (BYOD) Policy	NEW	3	Digital	James Rowland
Colleague Experience / Wellbeing Policy	3	3	People Services	Lynda Bugonovic
Freedom of Information Policy	3	3	Corporate Governance	Lisa Trounce
Lone Worker Policy	3	3	Quality, Safety & Patient Experience	Nicola White
Tyres and Wheels Policy	10	3	Finance & Corporate Resources	Gavin Lane
Vehicle Disposal Policy	8	3	Finance & Corporate Resources	Gavin Lane
Vehicle Telematics Policy	10	3	Finance & Corporate Resources	Gavin Lane
Information Governance Policy	6	4	Digital	Kelly Holding
Information Sharing Policy	6	4	Digital	Kelly Holding
Study Leave Policy	4	4	People Services	Mubo Farukanmi
Working Time Regulations Policy	5	4	People Services	Sara Williams / Emma Morgan
Maternity Policy	3	5	People Services	Sophie James
Paternity Policy	3	5	People Services	Sophie James
Shared Parental Leave Policy	3	5	People Services	Sophie James

Trust Mobile Phone Policy	9	5	Digital	Aled Williams / Tony Raine
Management of Compensation Claims Policy	6	6	Quality, Safety & Patient Experience	Trish Gaskell
Redeployment Policy	7	6	People Services	Emma Morgan
Managing Families and Relatives Working Together Policy	9	7	People Services	Amanda Jones
Access Control Policy	8	8	Digital	Kelly Holding
Adverse Weather Conditions Policy	8	8	People Services	Bethan Davies
Bursary Scheme Policy	10	8	People Services	Sarah Davies
Work Experience Policy	8	8	People Services	Sara Minahan
Information Classification Policy	9	9	Digital	Aled Williams
Mobile Computing Policy	9	9	Digital	Aled Williams / James Rowlands
Confidentiality And Code of Conduct	10	10	Digital	Kelly Holding
Relocation Expenses Policy	2	10	People Services	Jan Cross Anna Stein
Access to Personal Information Policy	7	TBC	Digital	Judith Birkett
Children In Special Circumstances Policy & Procedure	TBC	TBC	Medical & Clinical	Ed O'Brien
High Risk Record Policy	TBC	TBC	Operations	Katie Blackmore
MPDS Quality Assurance Policy	TBC	TBC	Operations	TBC
Quality Assurance Framework for the Clinical Desk	TBC	TBC	Operations	TBC
Resourcing Policy	TBC	TBC	Operations	TBC

AGENDA ITEM No	10.1
OPEN or CLOSED	Open
No of ANNEXES ATTACHED	2

NHS Wales Procedure for the Recovery of Overpayments

MEETING	Policy Group
DATE	23 October 2024
EXECUTIVE	Chris Turley Executive Director of Finance and Corporate Resources
AUTHOR	Jillian Gill, Interim Assistance Director of Finance
CONTACT	Jillian.gill@wales.nhs.uk

EXECUTIVE SUMMARY

This report presents the All-Wales Procedure for the Recovery of Overpayments, intended for formal adoption by the Welsh Ambulance Services University NHS Trust.

KEY ISSUES/IMPLICATIONS

This Procedure has been written to bring a unified approach in how an overpayment should be handled across NHS Wales.

This All-Wales procedure will replace any existing local processes to ensure consistency by NHS Wales Shared Services Partnership Payroll Services and NHS Wales Organisations upon the identification of an overpayment.

REPORT APPROVAL ROUTE

Policy Group on 23 October 2024 – for adoption
Audit, Risk and Assurance Committee on 21 November 2024 – for adoption.

REPORT APPENDICES

Appendix 1 – NHS Wales Recovery of Overpayments Procedure (ENG)
Appendix 2 – NHS Wales Recovery of Overpayments Procedure (CYM)

REPORT CHECKLIST

Confirm that the issues below have been considered and addressed	Confirm that the issues below have been considered and addressed

EQIA (Inc. Welsh language)	Y	Financial Implications	Y
Environmental/Sustainability	NA	Legal Implications	Y
Estate	NA	Patient Safety/Safeguarding	Y
Ethical Matters	Y	Risks (Inc. Reputational)	Y
Health Improvement	Y	Socio Economic Duty	NA
Health and Safety	Y	TU Partner Consultation	Y

SITUATION

1. This report presents the new NHS Wales Procedure for the Recovery of Overpayments. The procedure is intended for formal adoption by the Welsh Ambulance Services University NHS Trust.

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

BACKGROUND

3. The revised NHS Wales Procedure for the Recovery of Overpayments was agreed by the Shared Services Partnership Committee in July 2024 and has been distributed to all Health Boards and Trusts in Wales for adoption and implementation at the earliest opportunity.

4. The procedure aims to standardise the recovery of overpayments to ensure consistency across NHS Wales. It also aims to ensure all overpayments are recovered efficiently and as quickly as possible without imposing hardship and to ensure that employees, ex-employees, workers, and ex-workers are treated fairly and consistently without any needless stress or worry.

ASSESSMENT

5. This All-Wales procedure will replace any existing local processes to ensure consistency by NHS Wales Shared Services Partnership Payroll Services and NHS Wales Organisations upon the identification of an overpayment. However, due to the time needed to fully automate the procedure, the usage of the new style of letters will commence from October for all overpayments identified after this date.

6. For adjustments to salary, resulting from the late submission of payroll forms requesting changes to pay within the month, the current local recovery arrangements will continue whilst the issue of letters and the profiling of

recoveries are automated, with the aim to have fully implemented the procedure by January 2025.

RECOMMENDED

7. The NHS Wales Procedure for the Recovery of Overpayments is noted and presented to Audit Committee for formal adoption.

GWEITHDREFN AR GYFER ADENNILL GORDALIADAU - Cyflogau a Threuliau

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

Gweithdrefn ar gyfer Adennill Gordaliadau

Mynegai

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

Atodiad A - Rolau a Chyfrifoldebau

Atodiad B – Y rhesymau pam mae gordaliadau yn digwydd

Atodiad C – Llythyr Addasiad Cyflog

Atodiad D – Templed Incwm a Gwariant

Atodiad E - Map Proses Gordaliadau

Atodiad F – Llythyr Gordaliad 1

Atodiad G – Llythyr Gordaliad 2

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

Atodiad I – Awdurdodi Didyniad Cyflog

Atodiad J – Ffurflen Asesu Atal Twyll

1. Cyflwyniad

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

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

2. Datganiad Gweithdrefn

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

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

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

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

Bydd anghenion unigol ac amgylchiadau ariannol yn cael eu hystyried.

3. Nodau

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

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

4. Cydraddoldeb

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

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

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

5. Amcanion

Amcanion y weithdrefn hon yw sicrhau'r canlynol:

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

6. Cwmpas

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

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

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

7. Proses Adennill Gordaliad

Adferiad Awtomatig

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

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

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

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

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

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

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

Proses Adennill Safonol

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Atal Twyll

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

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

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

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

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

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

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

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

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

8. Datrys Anghydfod

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

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

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

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

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

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

9. Hyfforddiant ac Ymwybyddiaeth

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

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

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

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

10. Llywodraethu Gwybodaeth

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

ATODIAD A

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

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

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

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

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

- Cywiro gwallau a nodwyd.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Rheolwyr Llinell:

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

- Cwblhau'r hysbysiadau o newidiadau cyflogai a'u cyflwyno i Wasanaethau'r Gyflogres cyn i gyflogeion/gweithwyr ddechrau eu swydd/oriau/lleoliad newydd.

- Cwblhau'r broses terfynu cyflogaeth ar yr adeg y mae'r cyflogai/gweithwyr yn ymddiswyddo.

- Ar gyfer cyflogeion/gweithwyr sy'n rhan o gynllun Pensiwn y GIG - yn unol â Pholisi Ymddeol Sefydliadau'r GIG rhaid llenwi ffurflen terfynu o leiaf 4 mis cyn terfynu.

- I ddatrys unrhyw ymholiadau cychwynnol a dderbyniwyd gan gyflogeion/gweithwyr ynghylch oriau amrywiol a delir yn ystod y mis neu dderbyn taliadau annisgwyl, gan eu cynghori bod yn rhaid iddynt hysbysu Gwasanaethau'r Gyflogres am unrhyw ordaliadau a amheuir.

- I agor a chau absenoldeb salwch cyflogai/gweithiwr ar eu cofnod ESR ar y pwynt hysbysu.

- Rhoi gwybod i Wasanaethau'r Gyflogres am unrhyw absenoldeb di-dâl.

- Cyflwyno hysbysiad awdurdodedig o Absenoldeb Mamolaeth/Tadolaeth/Mabwysiadu/Seibiant Gyrfa. Rhaid llenwi ffurflenni cais am daliad o dan y polisïau hyn a'u cyflwyno i Wasanaethau'r Gyflogres cyn y dyddiad y mae'r cyflogai/gweithiwr yn dechrau'r cyfnod o absenoldeb.

- Gwirio manylion contract cyflogai/gweithiwr trwy'r cyfleuster Hunanwasanaeth i Reolwyr a chyllidebau misol a hysbysu Gwasanaethau'r Gyflogres ar unwaith pan fo manylion cytundebol cyflogai/gweithiwr yn anghywir.

- Sicrhau bod rotâu cyflogai/gweithiwr (lle bo'n berthnasol) yn gywir yn unol â systemau E-amserlennu. Dylid tynnu sylw Timau E-Systemau Sefydliadol at anghysondebau ar unwaith.

- Sicrhau bod llyfrau gwaith cyflogres (lle bo'n berthnasol) yn cael eu cwblhau'n gywir yn unol â phatrwm gwaith y gweithwyr/cyflogeion.

- Cefnogi unigolion sydd wedi cael gordaliad.

Bydd Adran y Gweithlu/Pobl yn:-

- Gweithredu fel cyswllt rhwng gwasanaethau'r gyflogres PCGC, y Rheolwr Llinell, y tîm Cyllid a'r cyflogai/gweithiwr lle bo angen.

- Sicrhau bod rheolwyr yn ymwybodol o'u gofynion i gyflwyno data cyflogres gan gynnwys hysbysiadau newid cyflogai/gweithiwr, hysbysiadau terfynu a data e-restru yn unol â therfynau amser cyhoeddedig ar gyfer cyflwyno'r gyflogres.

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

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

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

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

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

Bydd Timau Cyllid/Cyfrifon Derbyniadwy yn: -

- Gyfrifol am ddosbarthu anfonebau i unigolion i adennill gordaliadau.

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

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

Bydd Timau Atal Twyll Lleol yn:-

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

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

ATODIAD B

Rhesymau dros Ordaliadau

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

Noder:

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

Mae atal gordaliad rhag digwydd yn hollbwysig.

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

Y rhesymau mwyaf cyffredin dros ordaliadau yw: -

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

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

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

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

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

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

ATODIAD C – LLYTHYR ADDASIAD CYFLOG

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

Preifat a Chyfrinachol

Enw
Cyfeiriad 1
Cyfeiriad 2
Cyfeiriad 3
Cod Post

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

E-bost:

Dyddiad:

PARTHED: Gordaliad Cyflog

Annwyl

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

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

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

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

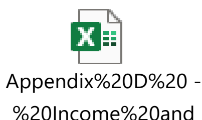
Os hoffech ragor o wybodaeth am sut yr ymdrinnir ag adennill gordaliadau, darllenwch Weithdrefn Cymru Gyfan ar gyfer Adennill Gordaliadau sydd i'w gweld ar ddolen gwefan sharepoint Gwasanaethau Cyflogres Partneriaeth Cydwasanaethau GIG Cymru Gwasanaethau Cyflogres (sharepoint.com).

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

Yn gywir,

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

ATODIAD D – TEMPLED INCWM A GWARIANT



Teclynnau a chyfrifianellau | Helpwr Arian

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

ATODIAD E – DIAGRAM O'R BROSES GORDALIADAU

Siart Llif Gweithdrefn Adennill Gordaliadau GIG Cymru

Gordaliad wedi'i nodi

A ddigwyddodd y newid/mater a achosodd y gordaliad o fewn y mis diwethaf?

DO

A yw'r gordaliad yn llai na 30% o'r cyflog gros?

DO

Tîm y gyflogres yn ceisio adennill y gordaliad yn awtomatig mewn taliadau cyflog yn y dyfodol.Anelu at adennill gordaliadau o 0-10% dros fis, 10-20% dros ddau fis ac 20-30% dros dri mis.Cyfathrebu â'r unigolyn cyn unrhyw ddidyniadau cyflog.

NADDO

NADDO

A yw'r cyflogai/ gweithiwr/cyn-weithiwr wedi rhoi gwybod am y gordaliad?

DO

Dechrau'r Broses Adennill

NADDO

A yw'r gordaliad wedi digwydd dros gyfnod o fwy na 3 mis?

NADDO

DO

A amcangyfrifir bod gwerth y gordaliad gros yn fwy na £5,000?

NADDO

DO

Tîm y gyflogres yn gofyn i'r Gwasanaeth Atal Twyll Lleol (LCFS) gynnal adolygiad cychwynnol o'r gordaliad. LCFS yn cadarnhau o fewn 5 diwrnod a fyddant yn cynnal ymchwiliad ai peidio.

NADDO

DO

Tîm y Gyflogres yn atal gweithredu ar y gordaliad tra'n aros am ddiweddariad gan LCFS

Anfon Llythyr Gordaliad 1

Tîm y Gyflogres yn cysylltu â'r Rheolwr Llinell i ofyn am fanylion ynghylch sut mae'r gordaliad wedi digwydd

A yw'r unigolyn yn dal i gael ei gyflogi gan y Sefydliad?

DO

Llythyr Gordaliad 2 - "Yr unigolyn yn parhau yn ei swydd" - yn cael ei anfon unwaith y bydd y cyfrifiad o'r gordaliad wedi'i gwblhau

Y tîm Cyllid yn codi anfoneb

Gweithdrefnau casglu dyledion lleol yn dechrau gyda'r nod o adennill y gordaliad dros y cyfnod y cafodd ei gronni. Bydd opsiwn i'r unigolyn wneud ad-daliadau trwy ddidyniad cyflog ac ymestyn telerau talu gyda chytundeb

NADDO

Llythyr Gordaliad 2 - "Yr unigolyn ddim yn gweithio i'r Sefydliad bellach" - yn cael ei anfon unwaith y bydd cyfrifiad y gordaliad wedi'i gwblhau

Y tîm Cyllid yn codi anfoneb

Gweithdrefnau casglu dyledion lleol yn dechrau gyda'r nod o adennill y gordaliad dros y cyfnod y cafodd ei gronni.

ATODIAD F – LLYTHYR GORDALIAD 1

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

Preifat a Chyfrinachol

Enw
Cyfeiriad 1
Cyfeiriad 2
Cyfeiriad 3
Cod Post

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

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

Dyddiad:

PARTHED: Hysbysiad o Ordaliad Cyflog Posibl

Annwyl

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

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

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

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

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

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

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

Yn gywir,

Rhowch Enw Arweinydd Tîm OP
Tîm Gordaliadau Cymru Gyfan

Gwasanaethau Cyflogaeth PCGC

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

ATODIAD G - LLYTHYR GORDALIAD 2

Unigolyn yn parhau yn ei swydd

<u>Preifat a Chyfrinachol</u>

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

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

Dyddiad:

PARTHED: Gordaliad Cyflog

Annwyl

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

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

Cyfnod y Gordaliad:
Rheswm dros y Gordaliad:

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

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

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

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

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

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

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

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

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

Yn gywir

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

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

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

Unigolyn nad yw'n gweithio i'r Sefydliad mwyach

Preifat a Chyfrinachol

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

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

Dyddiad:

PARTHED: Gordaliad Cyflog

Annwyl

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

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

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

Cyfnod y Gordaliad:

Rheswm dros y Gordaliad:

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

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

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

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

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

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

Yn gywir

Rhowch Enw Arweinydd Tîm OP

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

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

Tîm Gordaliadau Cymru Gyfan
Gwasanaethau Cyflogaeth PCGC

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

ATODIAD H – LLYTHYR Y RHEOLWR LLINELL

Preifat a Chyfrinachol

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

Dyddiad:

PARTHED: Gordaliad Cyflog

Annwyl Reolwr

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

Nodir manylion y gordaliad cyflog posibl isod:

Enw:

Rhif Aseiniad:

Cyfnod y Gordaliad:

Rheswm dros y Gordaliad:

Y Camau Nesaf...

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

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

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

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

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

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

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

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

Yr eiddoch yn gywir,

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

ATODIAD I – DIDYNNU GORDALIAD CYFLOG

Didyniad yn uniongyrchol o Daliad Cyflog – Ffurflen Awdurdodi

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

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

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

Rhoddaf fy nghydsyniad llawn ar gyfer y didyniad hwn.

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

Llofnod ____

Ysgrifennwch eich enw mewn priflythrennau ____
Dyddiad: _________________

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

ATODIAD J – ASESIAD CYCHWYNNOL ATAL TWYLL - GWYBODAETH ANGENRHEIDIOL

<table>
<tr><td>Enw’r Unigolyn</td><td colspan="2"></td></tr>
<tr><td>Grŵp Tâl / Rhif Tâl</td><td colspan="2"></td></tr>
<tr><td>Sefydliad y GIG</td><td colspan="2"></td></tr>
<tr><td>Teitl y Swydd</td><td colspan="2"></td></tr>
<tr><td>Gradd Cyflog / Oriau

Llawnamser/ Rhan-amser</td><td>Gradd</td><td>Oriau</td></tr>
<tr><td>Gweithle / Lleoliad</td><td colspan="2"></td></tr>
<tr><td>Gwerth y Gordaliad Atodwch manylion y Broses Ordaliadau</td><td>Gros</td><td>Net</td></tr>
<tr><td>Cyfnod y Gordaliad</td><td>Dyddiad o</td><td>Dyddiad i</td></tr>
<tr><td>Rheswm dros y Gordaliad</td><td colspan="2"></td></tr>
<tr><td>Enw cyswllt a manylion yr Adran / Rheolwr</td><td colspan="2"></td></tr>
<tr><td>Manylion cyswllt Gwasanaethau’r Gyflogres</td><td colspan="2"></td></tr>
<tr><td>Manylion cyswllt Gordaliad Cyflog</td><td colspan="2"></td></tr>
<tr><td>Cadarnhewch pa wiriadau sydd wedi'u gwneud i wirio a yw'r unigolyn wedi cysylltu â Gwasanaethau’r Gyflogres</td><td></td><td>Gwiriadau wedi’u gwneud gan:

Dyddiad:</td></tr>
<tr><td colspan="3">MANYLION PELLACH AM YR UNIGOLYN:</td></tr>
<tr><td>Cyfeiriad</td><td colspan="2"></td></tr>
<tr><td>Dyddiad Geni</td><td colspan="2"></td></tr>
<tr><td>Rhif Yswiriant Gwladol</td><td colspan="2"></td></tr>
<tr><td>Manylion cyfrif banc</td><td colspan="2"></td></tr>
<tr><td>Cwblhawyd y ffurflen gan:</td><td colspan="2">Dyddiad:</td></tr>
<tr><td colspan="3">Ychwanegwch unrhyw fanylion pellach a allai fod o gymorth i’r Tîm Atal Twyll Lleol gyda’u hadolygiad:

Peidiwch â chysylltu ag unigolion heb ymgynghori â'ch tîm Gwasanaeth Atal Twyll Lleol.

Rhowch wybod am unrhyw gyswllt pellach rhyngoch chi a’r unigolyn i'r tîm Atal Twyll Lleol ar unwaith.</td></tr>
</table>

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

AGENDA ITEM No	11
OPEN or CLOSED	Open
No of ANNEXES ATTACHED	1

NEAR MISS AND LOW HARM INTELLIGENCE REPORT

MEETING	Audit, Risk and Assurance Committee (ARAC)
DATE	21 November 2024
EXECUTIVE	Bethan Evans, Non-Executive Director and Chair of Quality, Patient Experience & Safety Committee
AUTHOR	Julie Boalch, Assistant Director of Corporate Governance and Risk
CONTACT	Bethan.Evans24@wales.nhs.uk

EXECUTIVE SUMMARY

1. The purpose of the report is to provide assurance that the Quality, Patient Experience & Safety Committee received the first report on near miss and low harm incidents recorded across the Trust, covering the period from September 2022 to September 2024.

2. The report focussed on analysis of incident data held within the Datix system including complaints and claims and which considered the relationship between harm events and near misses as well as the importance of reporting these for proactive safety management.

3. Members noted the large volume of grade 1 and 2 complaints (none or low harm categories), which after investigation, are assessed as not having resulted in harm and are near miss opportunities for learning.

4. Deeper analysis is limited at present because of the classification system of reported incidents which caters largely to secondary care services. There is scope to improve the relevance and application of the code sets to Ambulance Services through our representation at national workstreams.

5. Future reporting and analysis of near misses and low harm incidents will be included within the Putting Things Right Report.

RECOMMENDATION:

6. **Members are asked to:**
   a) Receive assurance and note the update.

KEY ISSUES/IMPLICATIONS

7. The key issues are set out in the Executive Summary above.

REPORT APPROVAL ROUTE
8. The report was received by: a) Clinical and Quality Governance Group - 30 October 2024 b) Quality, Patient Experience & Safety Committee - 05 November 2024

REPORT ANNEXES
9. Annex 1 – Near Miss and Low Harm Intelligence Report

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

AGENDA ITEM No	19
OPEN or CLOSED	OPEN
No of ANNEXES ATTACHED	1

NEAR MISS AND LOW HARM INTELLIGENCE REPORT

MEETING	Quality, Patient Experience & Safety Committee
DATE	5 November 2024
EXECUTIVE	Liam Williams, Executive Director of Quality and Nursing
AUTHOR	Wendy Hebert, Deputy Director of Quality and Putting Tings Right Claire Appleton, Assistant Director - Putting Things Right
CONTACT	Wendy.Herbert3@wales.nhs.uk claire.appleton2@wales.nhs.uk

EXECUTIVE SUMMARY

This Report provides information and analysis to the Quality, Patient Experience & Safety Committee (QuESt) on organisational low harm and near miss Concerns (Incidents, Complaints and Claims).

Heinrich's Accident Triangle Model provides a visual representation of the quantitative relationship between harm events and near misses. A near miss is 'an event that, while not causing harm, has the potential to cause injury or ill health'.

Intelligence on near miss and low harm reporting is presented from the Datix Cymru Electronic Risk Management System covering the period September 2022 - September 2024.

The Trust receives a large volume of No and Low Harm Incidents and Grade 1 and 2 Complaints, which after investigation, are assessed as not having resulted in harm and are near miss opportunities for learning.

Analysis demonstrates the overwhelming volume of delay-related incidents being recorded. Huge numbers relate to the use of the Incident Reporting System for routine data capture of operational events such as 6 and 12-hour handover delays and immediate release requests being declined. Recent improvement work on the use and scope of the Datix Cymru Incident Module by the Quality Governance and Assurance Team have reduced this type of trigger-reporting and will enable more effective analysis of incidents in future.

Deeper analysis is limited because of the classification system of reported incidents which caters largely to Secondary Care Services. There is scope to improve the

relevance and application of the code sets to Ambulance Services through our representation at national workstreams.

Future reporting and analysis of near misses and Low harm should be included within the Putting Things Right Quarterly Report.

RECOMMENDATION: That the Committee:

(1) Approves the future reporting of near misses being included in the quarterly Putting Things Right Report to Committee; and
(2) The Chair of Committee provides assurance to the Audit, Risk and Assurance Committee on the future approach.

KEY ISSUES/IMPLICATIONS
(i) Valuing near misses moves us from a reactive to proactive patient safety culture. (ii) Many of our near misses occupy the same space as incidents resulting in harm - whereby delayed ambulance responses lead to harm for some, but many others experience the same hazard but avoid harm either by self-conveyance, having a less severe health need or stronger pre-existing health status. (iii) The extraction, manipulation, analysis and visualisation of this thematic data is an area that would benefit from additional data analytics expertise. (iv) The importance of continuing to monitor lower graded incidents and complaints is recognised as a key area of activity for the Putting Things Right (PTR) Teams as the Clinical Model Transformation Programme is implemented.

REPORT APPROVAL ROUTE	
Clinical and Quality Governance Group	30 October 2024
Quality, Patient Experience & Safety Committee	5 November 2024

REPORT APPENDICES
ANNEX 1 - SBAR which provides the background for this report.

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

ANNEX 1

SITUATION

1. This Report addresses recommendations from the Audit Wales Quality Governance Review 2022 to ensure that intelligence from 'near misses' or minimal harm events is appropriately reported on and analysed.

2. The Quality, Patient Experience & Safety Committee (QuESt) regularly receives a Putting Things Right (PTR) Report which includes patient safety incident reporting but predominantly focuses on catastrophic/death, severe and moderate harm incidents where responsibilities to review and learn are explicit within the Concerns Regulations.

3. Lower graded Concerns (Incidents, Claims and Complaints) are included within thematic content of the PTR Report however this Near Miss and Minimal Harm Intelligence Report provides an opportunity to review in detail the learning arising from 'near misses' or concerns assessed as Low harm.

4. Please note that the data contained within this Report is accurate at the time of reporting. Data may be subject to change following the Investigation Process including regrading of incidents and complaints.

BACKGROUND

5. The Health and Safety Executive defines a near miss is 'an event that, while not causing harm, has the potential to cause injury or ill health'. A hazard is defined as an unsafe situation or set of circumstances with 'the potential to cause harm'. For the purposes of this paper, no distinction will be applied between hazards and near misses, as both represent valuable learning opportunities.

6. Near Miss Incident Reporting is a proactive Safety Management Practice. It involves identifying, documenting, and analysing incidents that could have resulted in injury, damage, or loss but were narrowly avoided. These incidents, often referred to as 'close calls,' provide valuable insights into potential hazards and risks within an organisation.

7. The relationship between hazard/near miss reporting and incidents resulting in harm was first explored by Herbert William Heinrich in 1931 in relation to industrial safety however the concept has been widened over time to include patient safety. Heinrich developed the Model of the 'accident triangle' (Figure 1) hypothesising that for every major injury, there were many lower harm or near miss events.

Figure 1

8. The premise of Near Miss Incident Reporting revolves around the principle that every near miss represents an opportunity for improvement. It involves a systematic process where employees report these incidents as soon as they occur, even if no harm is done.

9. A pattern of near misses provides an early warning that something needs attention. Near misses move us from a reactive to proactive patient safety culture, that values early identification of potential harm and allows us to act in a preventative way to avoid future harm rather than only learning once harm has already occurred.

10. When patient safety incidents and complaints are reported/recorded on the Datix Cymru Electronic Risk Management System, the reporter/recorder is asked to provide an initial harm grading. This is the assessed grade of potential harm caused by the health body and are based on the All-Wales Grading Framework which is part of the PTR Guidance (Figure 2).

Figure 2

Grade	Harm	Examples of concerns	Consider potential for qualifying liability / Redress
1	None	a) Concerns which normally involve issues that can be easily / speedily addressed; b) Potential to cause harm but impact resulted in no harm having arisen; c) Outpatient appointment delayed, but no consequences in terms of health;, d) Difficulty in car parking; e) Patient fall – no harm or time of work; f) Concerns which have impacted on a positive patient experience.	Highly unlikely
2	Low	a) Concerns regarding care and treatment which span a number of different aspects/specialities; b) Increase in length of stay by 1 - 3 days; c) Patient fall - requiring treatment; d) Requiring time off work - 3 days; e) Concern involves a single failure to meet internal standards but with minor implications for patient safety; f) Return for minor treatment, e.g. local anaesthetic or extra investigations.	Unlikely

3	Moderate	a) Clinical / process issues that have resulted in avoidable, semi permanent injury or impairment of health or damage that require intervention; b) Additional interventions required or treatment / appointments needed to be cancelled; c) Readmission or return to surgery, e.g. general anaesthetic; d) Necessity for transfer to another centre for treatment / care; e) Increase in length of stay by 4 -15 days; f) RIDDOR Reportable Incident; g) Requiring time off work 4 -14 days; h) Concerns that outline more than one failure to meet internal standards; i) Moderate patient safety implications; j) Concerns that involve more than one organisation;	Possible in some cases
4	Severe	a) Clinical process issues that have resulted in avoidable, permanent harm or impairment of health or damage leading to incapacity or disability; b) Additional interventions required or treatment needed to be cancelled; c) Unexpected readmission or unplanned return to surgery; d) Increase in length of stay by >15 days; e) Necessity for transfer to another centre for treatment / care; f) Requiring time of work >14 days; g) A concern, outlining non compliance with national standards with significant risk to patient safety; h) RIDDOR Reportable Incident;	Likely in many cases
5	Death	a) Concern leading to unexpected death, multiple harm or irreversible health effects; b) Concern outlining gross failure to meet national standards; c) Normally clinical/process issues that have resulted in avoidable, irrecoverable injury or impairment of health, having a lifelong adverse effect on lifestyle, quality of life, physical and mental well-being; d) Clinical or process issues that have resulted in avoidable loss of life; e) RIDDOR Reportable Incident;	Very likely

11. It is recognised that harm is not always easily quantified, particularly in the early stages of an investigation when information is still being obtained and analysed. It is for this reason that the Harm Assessment is captured at multiple stages of the Incident Investigation Pathway, to provide an audit trail around assessments made in relation to harm caused as the result of incidents occurring.

12. A single Incident Report on Datix Cymru has three fields where harm caused to the patient as the result of an incident are captured:

- Reporter's initial Harm Assessment: This is the level of harm as described by the person who reports the incident on Datix. This description of harm remains unchanged throughout the life of the Incident Report as a record of what was initially reported. This harm field is used for initial prioritisation within the reporting organisation only. This field should not be used for any external reporting as it is not subject to validation.

- Manager's interim Harm Assessment: This is the level of harm as described by a Manager following review of the initial Incident Report on Datix. This description of harm is subject to validation however it can only ever be a best estimate of the level of harm caused by an incident with the knowledge to hand at the time. This harm field is used both for internal purposes as well as triggering external reporting requirements e.g. National incident reporting, Duty of Candour incident reporting

- Post Investigation Harm Assessment: This is the level of harm as described following an investigation. This field should articulate the level of harm caused to a patient as the result of an incident occurring. This may be different to the

outcome to the patient. When completed, this supersedes the previous two initial and interim harm fields and serves as the key field which will be relied upon when discussing harm caused to the patient as the result of an incident.

13. In addition, the following fields are also completed:

- Potential harm/priority: this is a Risk Assessment of the risk of a similar occurrence happening again in the future. To complete this field, the question will need to be asked "in a similar set of circumstances to a similar patient, what is the likelihood and impact of a similar incident occurring tomorrow?" Consideration will need to be given by Senior Managers as to whether this risk needs to be included on any Departmental or Organisational Risk Register and any immediate actions needed to reduce the risk.

- Outcome to patient: this captures the overall outcome experienced by the patient. This may be the same, or different to, the harm caused by the incident.

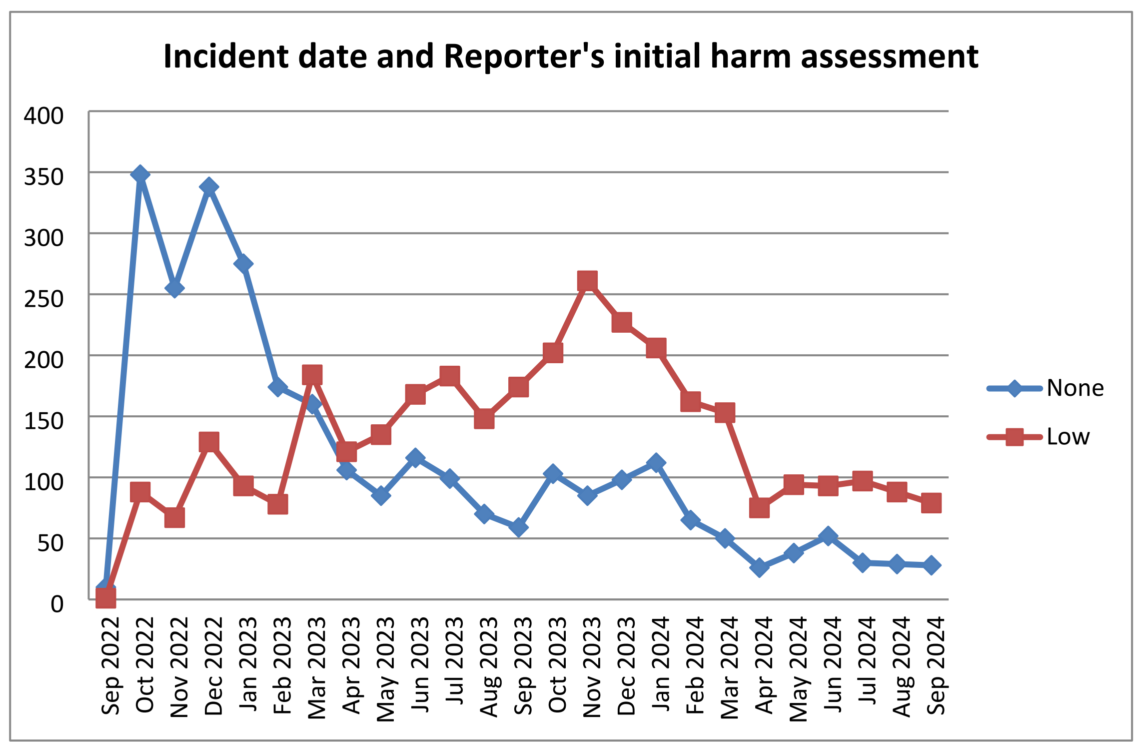
14. This Report provides information and analysis on patient safety incidents reported with a harm grading of 'None' or 'Low' and Complaints graded as 1 or 2.

ASSESSMENT

Incidents

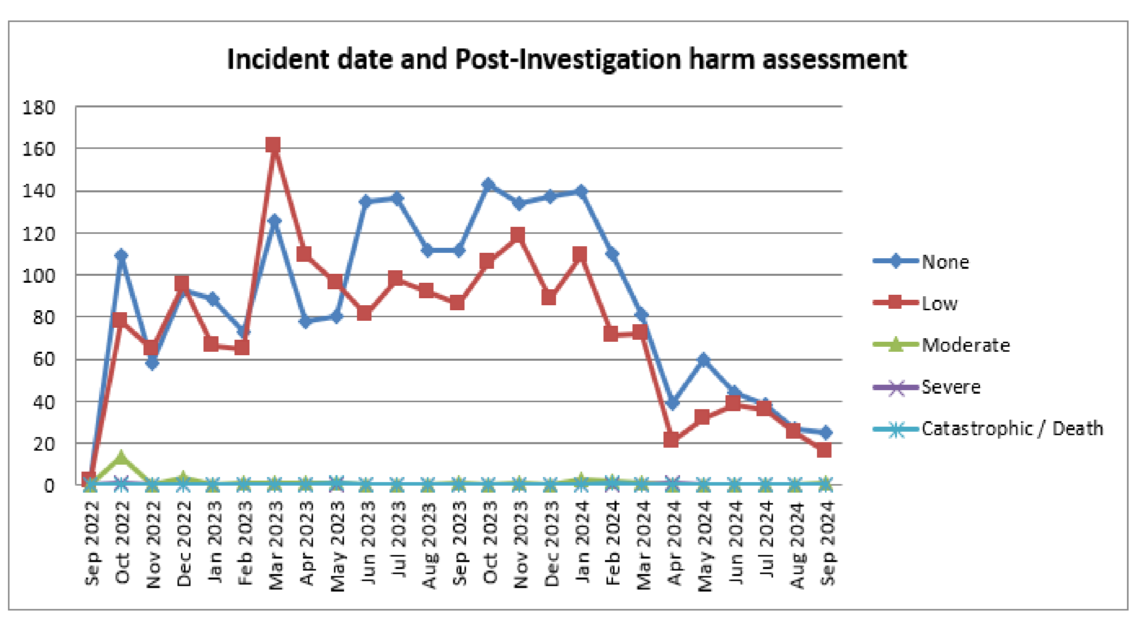
15. In most scenarios, it is generally accepted that a high rate of reporting of low-level incidents is a positive sign and indicates a culture open to learning from such reports. Graph 1 displays the number of No and Low harm incidents reported by date of incident and reporter's initial Harm Assessment. There is a reduction trend in reporting as improvement work driven through the Quality Management Group was undertaken to increase education about the type of events which should be reported.

Graph 1



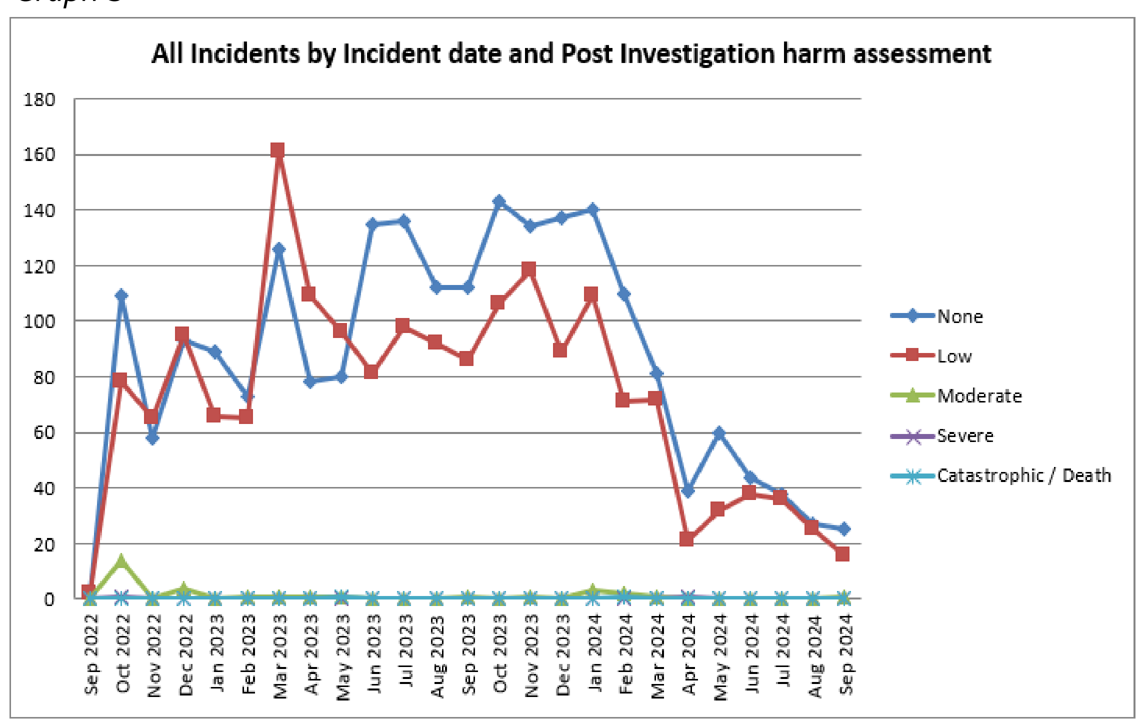
16. Graph 2 indicates that the assessed level of harm for No and Low harm incidents is graded lower at the finalisation of the investigation.

Graph 2



17. The following graph displays the post-investigation harm gradings for all completed investigations, irrespective of initial harm grading. This demonstrates the application of Heinrich's triangle hypothesis, providing a clear indication of the volume of No or Low harm incidents comparative to higher harm gradings.

Graph 3

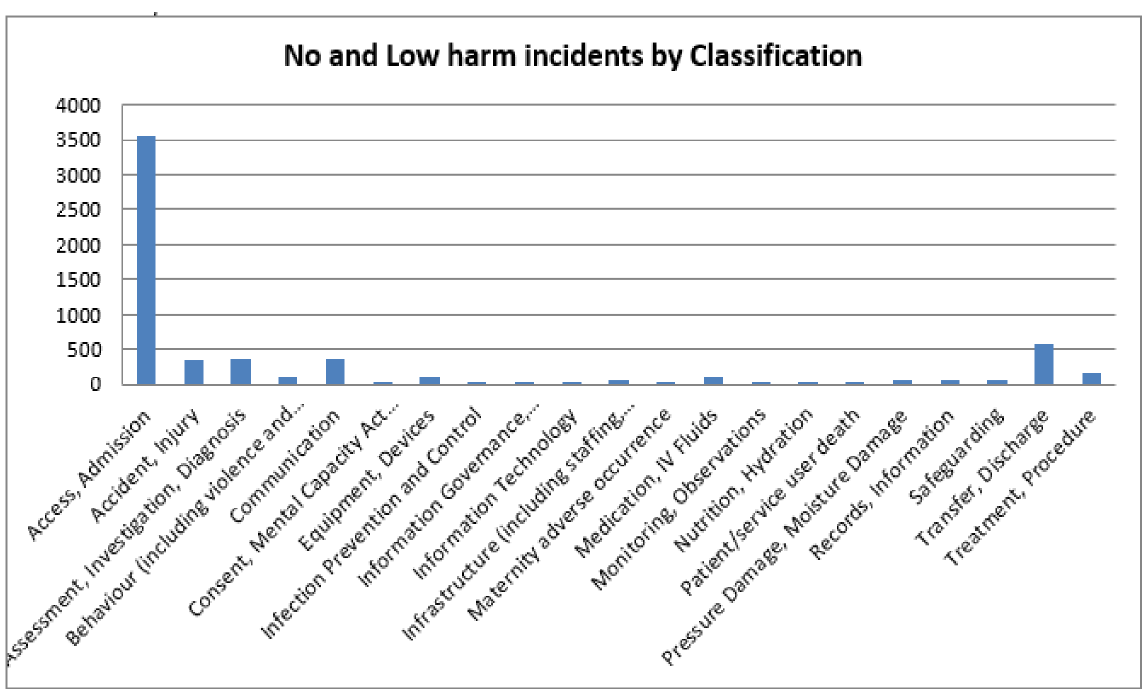


18. The two graphs of Post-investigation Harm Assessments reveal improvements required in incident management practice within the Trust to ensure that all reported incidents are reviewed and investigated in a timely manner. This is important for patient safety in terms of adhering to the Concerns Regulations, the Statutory of Candour and taking swift action to address risks.

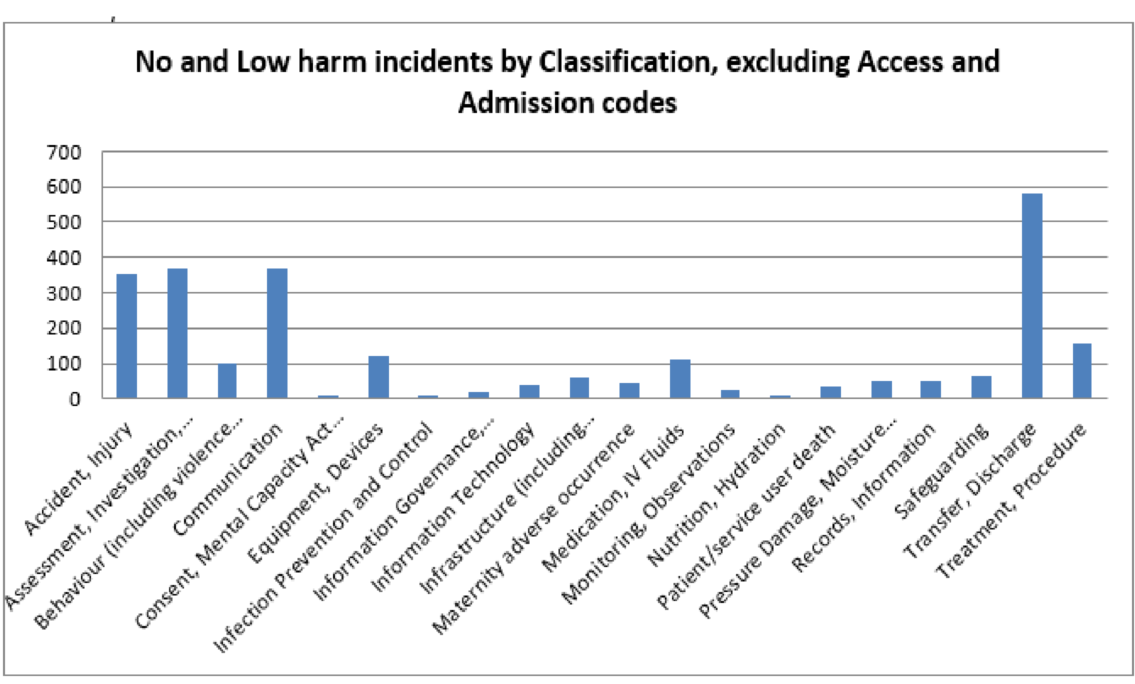
19. It is also vital that reporters receive timely feedback on the actions taken to review the incidents they report as when employees see that their reports lead to real changes and improvements, they are more likely to engage actively in patient safety activities. This feedback loop promotes near miss reporting and contributes to a positive safety culture within the Trust.

20. Graphs 4 and 5 provide a breakdown of incident categories. Graph 4 demonstrates the overwhelming volume of delay-related incidents being recorded. Huge numbers relate to the use of the Incident Reporting System for routine data capture of operational events such as 6 and 12-hour handover delays and immediate release requests being declined. Recent improvement work on the use and scope of the Datix Cymru Incident Module by the Quality Governance and Assurance Team have reduced this type of trigger-reporting and will enable more effective analysis of incidents in future.

Graph 4



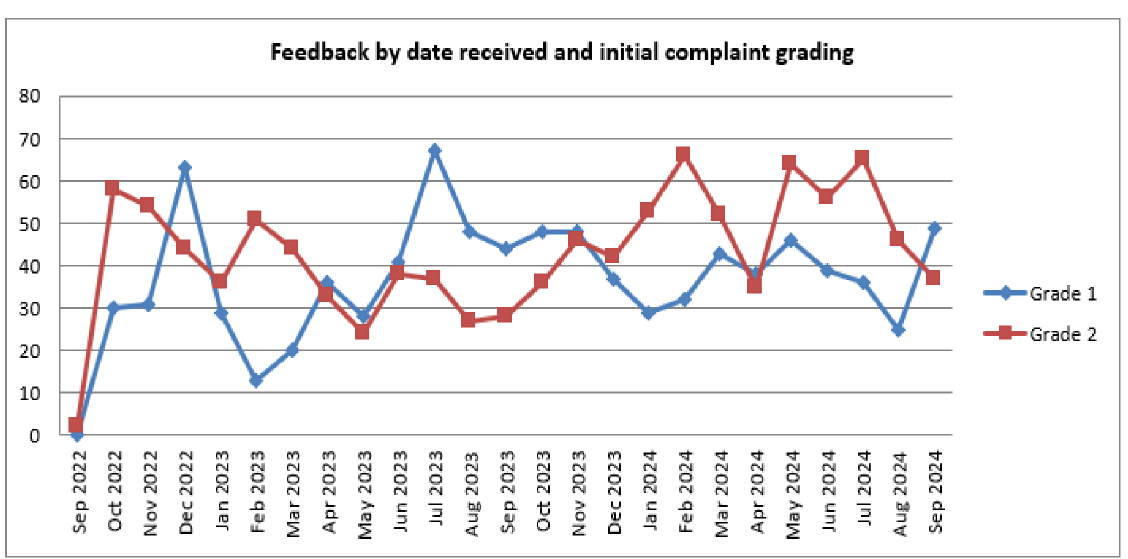
Graph 5



Complaints

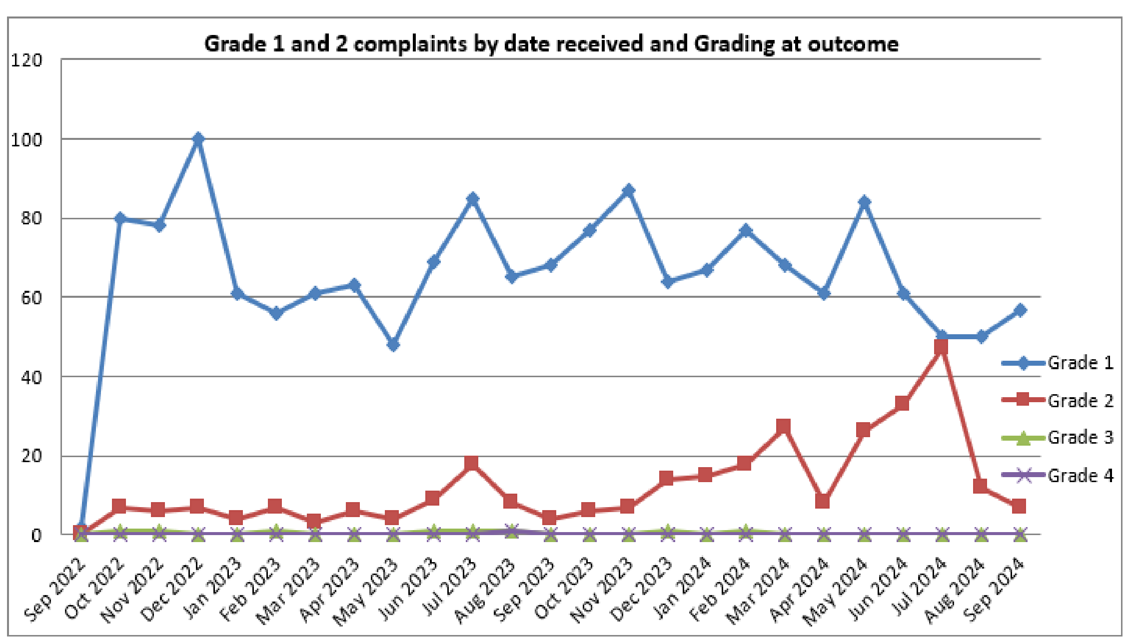
21. Graph 6 demonstrates the numbers of Grade 1 and 2 complaints received over The past 2 years.

Graph 6



22. Graph 7 indicates that the investigations undertaken are likely to find that the actual harm caused to the patient was lower than first assessed.

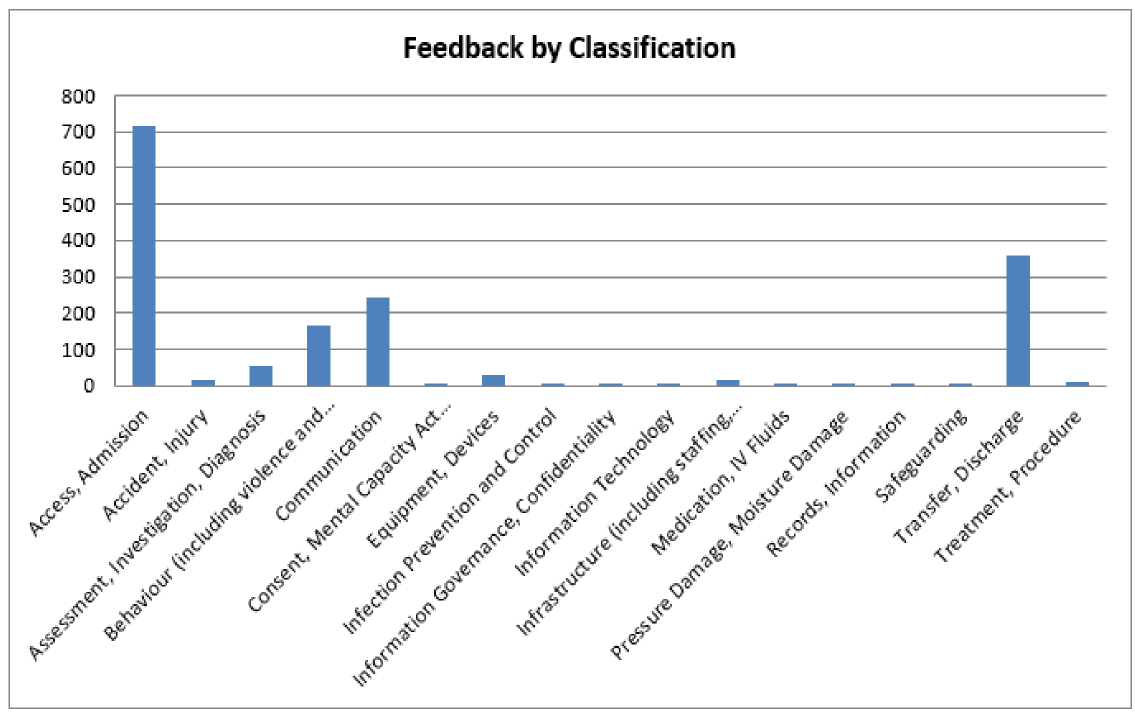
Graph 7



23. Graph 8 indicates the issues about which complaints are received. As with the profile of low-grade incidents, much of our feedback relates access and admission issues - primarily delays in reaching patients in the community

although also included are complaints relating to cancellations of non-emergency patient transport.

Graph 8



24. Thematic analysis of both No and Low harm incidents and Grade 1 and 2 complaints provides clear evidence of how the current system pressures distort the organisation's reporting profile by creating large volumes of concerns under one classification.

25. Improvement work, as detailed in the Datix Recovery and Improvement Plan to reduce the routine data collection of operational outcomes will increase the effectiveness of the Platform in being able to identify early indicators of harm and contribute to patient harm prevention.

26. This analysis reveals that many of our near misses occupy the same space as our incidents resulting in harm and this finding is also borne out by Mortality Review data as commented on in the Learning from Death Report presented alongside this paper - whereby delayed ambulance responses lead to harm for some but many others experience the same hazard but avoid harm either by self-conveyance, having a less severe health need or stronger pre-existing health status.

27. Analysis is limited because of the classification system of reported incidents which caters largely to Secondary Care Services. There is scope to improve the relevance and application of the code sets to Ambulance Services through our representation at National Workstreams.

28. The extraction, manipulation, analysis and visualisation of this thematic data is an area that would benefit from additional data analytics expertise although current capacity within the Health Informatics and Quality Assurance Teams will be allocated in accordance with the Datix Cymru Recovery and Improvement Plan that has been developed.

29. The importance of continuing to monitor lower graded incidents and complaints is recognised as a key area of activity for the PTR Teams as the Clinical Model Transformation Programme is implemented.

RECOMMENDATION: That the Committee:

(1) Approves the future reporting of near misses being included in the quarterly Putting Things Right Report to Committee; and
(2) The Chair of Committee provides assurance to the Audit, Risk and Assurance Committee on the future approach.

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

AGENDA ITEM No	12
OPEN or CLOSED	OPEN
No of ANNEXES ATTACHED	1

LOSSES AND SPECIAL PAYMENTS - PAYMENTS FOR THE PERIOD FROM 1ST APRIL 2024 TO 30TH SEPTEMBER 2024

MEETING	Audit Committee
DATE	21st November 2024
EXECUTIVE	Chris Turley, Executive Director of Finance and Corporate Resources
AUTHOR	Jessica Price, Head of Financial Accounting
CONTACT	Jessica.Price3@wales.nhs.uk

EXECUTIVE SUMMARY

In accordance with SFI's this report presents to the Committee details of Losses and Special Payments made during the six months from 1st April 2024 to 30th September 2024 (**Annex 1**)

KEY ISSUES/IMPLICATIONS

Total net Losses and Special Payments made were as follows: -

- period 1st April 2024 to 30th September 2024 -£0.186m

REPORT APPROVAL ROUTE

Audit Committee 21st November 2024 – no action required for information under SFI's only

REPORT APPENDICES

Annex 1 – Summary and details of payments made for the six months to 30th September 2024

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

WELSH AMBULANCE SERVICES UNIVERSITY NHS TRUST
AUDIT, RISK AND ASSURANCE COMMITTEE
LOSSES AND SPECIAL PAYMENTS - PAYMENTS FOR THE PERIOD FROM 1st APRIL 2024 TO 30th SEPTEMBER 2024

SITUATION

1. In accordance with SFI's all losses and special payments made are to be reported to the Audit, Risk and Assurance Committee on a regular basis.

BACKGROUND

2. This report presents to the Committee details of Losses and Special Payments made during the six months from 1st April 2024 to 30th September 2024 (**Annex 1**)

ASSESSMENT

3. Total net Losses and Special Payments made during the period 1st April 2024 to 30th September 2024 amounted to -£0.186 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 six months to 30th September 2024 reimbursements received exceeded payments made by £0.186m.

5. During August you will note the Welsh Risk Pool reimbursements amounted to £0.053m. The vast majority of which relates to the reimbursement of 1 personal injury claim in relation to a member of staff who was injured whilst moving a patient.

RECOMMENDED: That the Losses and Special Payments Report for this period be received.

Welsh Ambulance Services University NHS Trust

Losses and Special Payments

Annex 1

Summary of payments for the 6 months to 30th September 2024:

		£
April 2024		44,627.36
May 2024		23,895.81
June 2024	-	901,844.23
July 2024		492,152.45
August 2024		41,959.47
September 2024		113,626.00
October 2024		-
November 2024		-
December 2024		-
January 2025		-
February 2025		-
March 2025		-
		-£185,583.14

Losses and Special Payments Breakdown:

Payment Type	**April**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Total**
	£	£	£	£	£	£	£	£	£	£	£	£	£
Claimants Solicitor Costs	0.00	0.00	9,266.80	26,000.00	0.00	13,000.00	0.00	0.00	0.00	0.00	0.00	0.00	£48,266.80
Counsel fees	10,137.50	7,366.66	6,846.66	-1,100.00	945.00	6,540.00	0.00	0.00	0.00	0.00	0.00	0.00	£30,735.82
CRU	0.00	0.00	833.00	1,335.00	688.00	2,289.00	0.00	0.00	0.00	0.00	0.00	0.00	£5,145.00
Damages	22,500.00	0.00	-36,079.00	376,710.00	49,125.00	46,069.00	0.00	0.00	0.00	0.00	0.00	0.00	£458,325.00
Defence Costs	45.92	967.74	14,442.55	25,512.80	7,202.55	5,355.43	0.00	0.00	0.00	0.00	0.00	0.00	£53,526.99
Expert Witness	398.91	1,500.00	3,233.57	390.00	360.00	15,610.00	0.00	0.00	0.00	0.00	0.00	0.00	£21,492.48
Vehicle Repairs	11,545.03	13,521.41	73,806.43	30,444.65	36,735.27	24,762.57	0.00	0.00	0.00	0.00	0.00	0.00	£190,815.36
WRP Refund	0.00	0.00	-975,394.24	0.00	-53,138.35	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-£1,028,532.59
Property Repairs	0.00	540.00	1,200.00	32,860.00	42.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	£34,642.00
Court Refund	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	£0.00
Total	**£44,627.36**	**£23,895.81**	**-£901,844.23**	**£492,152.45**	**£41,959.47**	**£113,626.00**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**-£185,583.14**

Welsh Ambulance Services University NHS Trust

Losses and Special Payments

Summary of payments for the six months to 30th Sept 2024:

Key

MN	Medical Negligence
PI	Personal Injury
DP	Damage To Property

	£	
DP cases <£1000	15,885.12	43 CASES
PI cases < £1,000	4,935.00	9 CASES
Redress cases <£1000	950.00	2 CASES
24RT4MN0012	14.35	
23RT4MN0004	66.00	
23RT4MN0011	390.00	
22RT4MN0002	750.00	
18RT4MN0016	1,000.00	
24RT4MN0011	1,500.00	
22RT4MN0017	2,275.00	
25RT4MN0016	2,820.00	
22RT4MN0018	3,217.50	
21RT4MN0009	4,300.00	
22RT4MN0016	4,358.00	
20RT4MN0008	4,900.00	
25RT4MN0001	6,510.00	
18RT4MN0012	32,275.00	
22RT4MN0011	40,000.00	
24RT4MN0009	50,913.00	
20RT4MN0018	80,067.89	
22RT4MN0001	151,882.91	
21RT4PI0021	1,850.00	
19RT4PI0032	2,000.00	
19RT4PI0037	4,360.00	
22RT4PI0046	5,951.85	
22RT4PI0020	7,500.00	
19RT4PI0009	15,250.80	
22RT4PI0022	23,400.00	
21RT4PI0006	51,500.00	
23RT4PI0035	54,945.00	
24RT4GN0020	1,375.00	
24RT4GN0019	1,600.00	
24RT4GN0018	3,300.00	
22RT4GN0005	3,800.00	
23RT4GN0022	4,100.00	
24RT4GN0036	6,569.00	
25RT4EG0003	1,000.00	
25RT4EG0006	1,000.00	
25RT4EG0008	1,000.00	
25RT4EG0013	1,000.00	
25RT4EG0014	1,000.00	
25RT4EG0027	1,000.00	
25RT4DP0089	1,014.22	
24RT4DP0034	1,067.66	
25RT4EG0002	1,100.00	
25RT4DP0001	1,138.42	
22RT4DP0085	1,200.00	
25RT4DP0043	1,247.20	
25RT4EG0019	1,250.00	
25RT4EG0026	1,250.00	
25RT4EG0028	1,250.00	
25RT4DP0049	1,300.00	
24RT4DP0068	1,366.97	
25RT4EG0009	1,400.00	
25RT4DP0076	1,426.08	
25RT4DP0087	1,462.43	
24RT4DP0017	1,500.00	
25RT4EG0017	1,500.00	
25RT4EG0018	1,500.00	
25RT4DP0050	1,560.43	
25RT4DP0035	1,622.58	
25RT4DP0051	1,626.30	
25RT4DP0095	1,676.03	
25RT4DP0077	1,814.89	
25RT4DP0034	1,837.08	
25RT4DP0063	1,922.30	
25RT4DP0098	2,112.95	
25RT4DP0090	2,118.96	
25RT4DP0074	2,236.08	
25RT4DP0036	2,287.04	
25RT4DP0096	2,474.24	
25RT4DP0078	2,749.85	
25RT4DP0004	2,770.56	
25RT4DP0059	2,969.88	
25RT4DP0055	3,000.00	
25RT4DP0069	3,073.49	
25RT4DP0081	3,074.17	
25RT4DP0023	3,160.49	
25RT4DP0007	3,358.60	
25RT4DP0093	3,399.52	
25RT4DP0085	3,477.70	
25RT4DP0075	3,502.68	
25RT4DP0039	3,573.10	
25RT4DP0088	3,870.00	
25RT4DP0092	3,996.80	
25RT4DP0079	4,548.00	
25RT4DP0052	4,886.26	
25RT4EG0004	5,500.00	
25RT4DP0082	5,972.05	
25RT4DP0022	6,058.55	
25RT4DP0024	6,104.85	
25RT4DP0054	6,189.54	
25RT4DP0053	6,524.78	
25RT4DP0021	7,576.41	
25RT4DP0060	7,925.65	
24RT4EG0028	8,080.32	
25RT4DP0038	9,505.54	
25RT4DP0071	10,000.00	
25RT4DP0057	31,560.00	
25RT4DP0037	38,798.43	
24RT4MN0013	- 300.00	Proffessional Fees refund
20RT4MN0019	- 76,776.28	WRP Refund
20RT4MN0011	- 892,874.96	WRP Refund
21RT4PI0035	- 743.00	WRP Refund
22RT4PI0019	- 2,500.00	Overpayment
20RT4PI0008	- 53,138.35	WRP Refund
23RT4GN0036	- 5,000.00	WRP Refund
22RT4DP0013	- 7,231.05	CASE WON COSTS PAID OUT IN PREVIOUS YEARS FIRE DAMAGE TO CN18BBF
TOTAL	- 185,583.14	

Welsh Ambulance Services University NHS Trust
Aug-24

Case Reference	Details	Amount (£)
19RT4PI0060	CRU	688.00
20RT4PI0008	WRP REFUND 05.08.24	- 53,138.35
21RT4PI0006	PROFESSIONAL FEES	600.00
21RT4PI0006	PROFESSIONAL FEES	400.00
21RT4PI0021	PROFESSIONAL FEES	1,150.00
22RT4DP0013	REFUND - CASE WON	- 63,186.52
22RT4DP0013	REFUND - CASE WON	54,783.20
22RT4DP0013	LEGAL AND RISK MATTERS INVOICE 126362 AMBULANCE FIRE DAMAGE	774.78
22RT4MN0001	PROFFESSIONAL FEES	1,400.00
22RT4MN0001	SPECIAL DAMAGES SETTLEMENT	98,250.00
22RT4MN0001	HD 50%	- 49,125.00
22RT4MN0016	EXPERT WITNESS	360.00
22RT4MN0016	PROFFESSIONAL FEE	33.33
22RT4MN0017	PROFFESSIONAL FEE	2,275.00
22RT4PI0047	PROFESSIONAL FEES	500.00
23RT4PI0035	COUNCIL FEES	945.00
24RT4MN0013	PROFFESSIONAL FEE	- 300.00
25RT4DP0037	TP VEHICLE REPAIRS	- 20.00
25RT4DP0040	TP VEHICLE REPAIRS	877.14
25RT4DP0068	PROFESSIONAL FEES	28.90
25RT4DP0069	TP VEHICLE REPAIRS	3,073.49
25RT4DP0071	TP VEHICLE REPAIRS	10,000.00
25RT4DP0072	TP VEHICLE REPAIRS	693.22
25RT4DP0073	TP VEHICLE REPAIRS	988.24
25RT4DP0074	TP VEHICLE REPAIRS	2,236.08
25RT4DP0075	TP VEHICLE REPAIRS	3,502.68
25RT4DP0076	TP VEHICLE REPAIRS	1,426.08
25RT4DP0077	TP VEHICLE REPAIRS	1,814.89
25RT4DP0078	TP VEHICLE REPAIRS	2,749.85
25RT4DP0079	TP VEHICLE REPAIRS	4,548.00
25RT4DP0080	TP VEHICLE REPAIRS	- 18,819.14
25RT4DP0080	TP VEHICLE REPAIRS	18,819.14
25RT4DP0081	TP VEHICLE REPAIRS	3,074.17
25RT4DP0082	TP VEHICLE REPAIRS	5,972.05
25RT4DP0083	DAMAGE TO PROPERTY	42.00
25RT4DP0084	TP VEHICLE REPAIRS	255.00
25RT4DP0085	TP VEHICLE REPAIRS	3,477.70
25RT4DP0086	TP VEHICLE REPAIRS	470.00
25RT4EG0021	PROFESSIONAL FEES	51.66
25RT4EG0022	PROFESSIONAL FEES	138.88
25RT4PI0001	PROFESSIONAL FEES	150.00
Totals		**41,959.47**

Welsh Ambulance Services University NHS Trust
Sep-24

Case Reference	Details	Amount (£)
18RT4MN0012	COUNSEL FEES	1,837.50
18RT4MN0012	GENERAL DAMAGES SETTLEMENT	30,000.00
19RT4PI0009	CRU	688.00
20RT4MN0008	EXPERT WITNESS	4,900.00
20RT4PI0042	CRU	688.00
21RT4MN0009	EXPERT WITNESS	2,100.00
21RT4PI0006	COUNSEL FEES	1,250.00
21RT4PI0006	SOLICITORS FEES	13,000.00
22RT4MN0016	COUNCIL FEES	235.00
22RT4MN0016	EXPERT WITNESS	1,400.00
22RT4MN0016	EXPERT WITNESS	700.00
22RT4MN0018	COUNSEL FEES	2,062.50
22RT4MN0018	COUNSEL FEES	1,155.00
22RT4PI0020	GENERAL DAMAGES SETTLEMENT	7,500.00
24RT4GN0018	GENERAL DAMAGES SETTLEMENT	1,700.00
24RT4GN0018	PROFESSION FEES	1,600.00
24RT4GN0036	GENERAL DAMAGES SETTLEMENT	6,569.00
24RT4GN0037	GENERAL DAMAGES SETTLEMENT	300.00
24RT4MN0009	CRU	913.00
25RT4DP0080	TP VEHICLE REPAIRS	- 814.46
25RT4DP0080	TP VEHICLE REPAIRS	814.46
25RT4DP0087	TP VEHICLE REPAIRS	150.00
25RT4DP0087	TP VEHICLE REPAIRS	1,312.43
25RT4DP0088	TP VEHICLE REPAIRS	3,870.00
25RT4DP0089	TP VEHICLE REPAIRS	1,014.22
25RT4DP0090	TP VEHICLE REPAIRS	2,118.96
25RT4DP0091	TP VEHICLE REPAIRS	900.00
25RT4DP0092	TP VEHICLE REPAIRS	3,996.80
25RT4DP0093	TP VEHICLE REPAIRS	3,399.52
25RT4DP0094	TP VEHICLE REPAIRS	657.47
25RT4DP0095	TP VEHICLE REPAIRS	1,676.03
25RT4DP0096	TP VEHICLE REPAIRS	2,474.24
25RT4DP0097	TP VEHICLE REPAIRS	450.00
25RT4DP0098	TP VEHICLE REPAIRS	2,112.95
25RT4DP0099	TP VEHICLE REPAIRS	- 17,210.00
25RT4DP0099	TP VEHICLE REPAIRS	17,210.00
25RT4DP0100	TP VEHICLE REPAIRS	629.95
25RT4EG0023	PROFESSIONAL FEES	57.40
25RT4EG0024	PROFESSIONAL FEES	163.59
25RT4EG0025	PROFESSIONAL FEES	34.44
25RT4EG0026	PROFESSIONAL FEES	1,250.00
25RT4EG0027	PROFESSIONAL FEES	1,000.00
25RT4EG0028	PROFESSIONAL FEES	1,250.00
25RT4MN0001	EXPERT WITNESS	1,350.00
25RT4MN0001	EXPERT WITNESS	5,160.00
Totals		**113,626.00**

AUDIT, RISK AND ASSURANCE COMMITTEE
HIGHLIGHT REPORT TO BOARD

This report provides the Board with key escalation and discussion points at the last Committee meeting. A full list of items discussed appears at the end of the report to enable members to raise any questions to the Chair which have not been drawn out in the report. The papers for these meetings can be found by following this link to the Committee page on the Trust website.

Trust Board Meeting Date	26 September 2024
Committee Meeting Date	12 September 2024
Chair	Peter Curran

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

1. No escalations from this meeting.

ADVISE

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

Risk Management Transformation Programme

2. A detailed report and presentation on the next phase of the Risk Management Transformation Programme was received. Work has been undertaken, in partnership with BDO, to consider three key areas; the development of a strategic BAF that reflects more closely the Trust's strategic objectives against its long-term strategy – Delivering Excellence: Vision 2030, the development of a series of strategic risks and risk appetite statements and the options to reposition the Trust's highest scoring risks, 223 and 224. The fourth key area is the digital solution that needs to underpin both the enterprise risk and strategic risk management arrangements.

3. Members expressed support for the project's direction of travel and recognised the positive progress in its maturity journey. They acknowledged potential resource constraints given the project's scale and emphasised the importance of taking the necessary time to ensure full engagement with colleagues at all levels, ultimately delivering and embedding a high-quality product.

4. The Committee were encouraged by the benefits that the new strategic risk management arrangements will give the Board including:
   - a high level strategic tool and dashboard.
   - a map and triangulation of the various assurance activities in place across the Trust.
   - a comprehensive view of risks and a stronger line of sight to the effectiveness of the controls.
   - alignment to the latest practices and designs.

- comprehensive oversight against delivery of the long term strategy and strategic risks.
- a tool to support its future strategic decision making.

5. The Chair is conducting quarterly **continual effectiveness reviews** in line with the National Audit Office toolkit rather than waiting to the end of the year to address this. These will continue with the Non-Executive Directors, the Executive Director of Finance and Corporate Resources and the Director of Corporate Governance/Board Secretary.

6. The terms of reference from the **All Wales Audit Chairs Committee** was received and the Chair provided an update from the September meeting where audit trackers and counter fraud was a focus.

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

8. This was a hybrid meeting and because of this it was noted there was the absence of chat in the side bar which was seen as a positive step. Members **reflected** that the partnership working between the Trust and Internal Audit and Audit Wales was evident. They welcomed the maturing journey with respect to risk and the lens on all areas of audit, of risk and of assurance for this meeting in line with the Committee's name change.

ASSURE

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

Internal Audit

9. Progress against the 2023/24 Internal Audit Plan was received and members were assured that with the three audits below the plan had been completed and that the 2024/25 Internal Audit Plan had commenced. The following Internal Audits reviews from the 2023/24 plan were completed during the quarter and presented to the Committee:

   - **Volunteers Governance – reasonable assurance**. The purpose of this audit was to review the adequacy and effectiveness of the Trust's governance and operational management of volunteer activities. This review was discussed in some detail at the 30 August People and Culture Committee.
   - **Risk Management – reasonable assurance**. The purpose of this audit was to assess the effectiveness of the risk management and assurance arrangements in place within directorates.
   - **Disciplinary Case Management: Compassionate Practices – reasonable assurance.** The purpose of the audit was to assess the adequacy of the arrangements in place for the management of the disciplinary process, and to focus on the demonstration of compassionate leadership principles, in addition to compliance with the Trust's defined disciplinary processes. This review was discussed in some detail at the 30 August People and Culture Committee

   By June 2025 the 2024/25 audit programme is on track to be completed by June 2025.

Audit Wales

10. The Audit Wales Update was received. The November meeting will receive the Quality Governance

Arrangements Follow Up and the Financial Efficiencies reviews both of which are complete and going through factual accuracy checks. The fieldwork is complete for the 2024 Structured Assessment with good engagement from the Trust. A deep dive review of investment in digital systems to support service resilience and transformation is being scoped for the Autumn.

11. Attention is now turning to the financial audits / independent examination of the 2023/24 charity accounts.

12. The review of unscheduled care report part two (accessing urgent and emergency care) is underway and will come to the committee in November.

13. The implementation of the **Quality and Performance Management Framework** sits with this Committee as a priority for 2024/25. The Committee received assurance on the roll-out of the framework and the aim of embedding quality and performance at every level of the organisation. Self-assessments pilots are underway on the organisational requirements in the framework and a picture of the floor to board assurance forums is being developed. Whilst progress has been slower than had been desired it was clear that there is momentum to this programme. It is anticipated that when the Quality and Performance Management Framework Internal Audit is received by the Committee in November that it will be in a position to close the priority and transfer the review of effectiveness of the framework back to the Finance and Performance Committee.

14. The Committee has oversight of the **Trust's Policy** work plans and were advised that 45% of policies identified as a priority for review are now within their review date. The future expectation is that 52% of all Trust policies will be within their review date after the next round of governance; a significant improvement on the 14% reported post pandemic. A re-evaluation of the prioritisation list will be undertaken with the Executive Leadership Team to ensure focus remains in the right areas and based on the current operating context.

15. The **losses and special payments** made during the period 1st April 2024 to 31st July 2024 amounted to £341K net repayments. The rationale for the reporting will be reviewed, noting it is required under the Standing Financial Instructions.

16. The Committee terms of reference requires it to receive assurance on the **arrangements for whistleblowing** at the Trust. Assurances were received by way of a report from the Chair of the People and Culture Committee on the Speaking up Safely arrangements at the Trust.

17. In private session the Committee received the counter fraud update 01 June 2024 to 31 July 2024 as well as the report on **tenders and single tender waiver requests**. The **Local Counter Fraud Service (LCFS)** provided an update on its work in tackling fraud, bribery and corruption in the Trust. The report provided detail of ongoing and future Counter Fraud work against the approved work plan. The Committee noted that there are currently 37 recorded ongoing investigations, with 12 new referrals having been received. The Committee discussed the themes and trends in ongoing investigations and considered, at a high-level, the protocols informing the management of counter fraud investigations.

18. An update was received on the revised **Audit Tracker** from the Q1 2024/25 reporting period. The Committee noted that a total of 36 actions have been closed in quarter – a closure figure of 25% of all internal audit actions. The Committee noted that there were five actions on their third (and final)

revised date; these related to the Savings and Efficiencies, Records Management and HART internal audits, respectively and sought further assurances on closure arrangements for these. There continues to be excellent engagement within Directorates on progress against the actions. The Committee discussed the various issues for due dates for actions being revised and acknowledged on the importance of actions being SMART and the evidence required for closure being clear.

19. The **Committee's cycle of business** monitoring report was reviewed with no matters to escalate.

RISK MANAGEMENT

The Committee received assurance against the principal risk management activity in Quarter 2. Specific updates were provided noting that Risk 424 achieved its target score of 8 and will be managed at a directorate level. This risk is closely linked to Risk 139 (financial risk) and a specific risk may be developed in the future relating to capital funding and vehicles. Risk 619, relating to the replacement CAS system, which had previously been reported in closed sessions of the Finance & Performance Committee and Trust Board has been fully mitigated and therefore closed from all registers.

The Committee received assurance on the progress of the Risk Management Transformation Programme and a presentation on the next phase of the programme.

COMMITTEE AGENDA FOR MEETING IN JUNE		
Chair's report on continuous committee effectiveness	Internal audit progress and internal audit reports	Audit Wales update
Risk management and board assurance	Audit tracker	Policy report
Quality and Performance Management Framework	Assurance to ARAC on Speaking Up Safely arrangements	Losses and special payments
All Wales Audit Committee Chairs update	Cycle of business and monitoring report	

COMMITTEE ATTENDANCE

Name	30 April 2024	7 June 2024[1]	10 July 2024[2]	12 Sep 2024[3]	21 Nov 2024	6 Mar 2024
Peter Curran						
Kevin Davies						
Joga Singh						
Ceri Jackson						
Chris Turley						
Audit Wales	Fflur Jones[4]	Fflur Jones	Yvonne Thomas	Fflur Jones[5]		
Julie Boalch						
Judith Bryce						
Christian Fox						
Angie Lewis						

[1] Jason Killens and Jonny Sammut joined this meeting
[2] Jason Killens and Rachel Marsh joined this meeting
[3] Jason Killens and Rachel Marsh joined this meeting
[4] Darren Griffiths and Amy Lord also attended
[5] Gareth Lucy also attended

COMMITTEE ATTENDANCE						
Name	**30 April 2024**	**7 June 2024[1]**	**10 July 2024[2]**	**12 Sep 2024[3]**	**21 Nov 2024**	**6 Mar 2024**
Osian Lloyd						
Trish Mills						
Liam Williams						
Carl Window						
Damon Turner						

	Attended
	Deputy attended
	Apologies received
	No longer member

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

AGENDA ITEM No	14
OPEN or CLOSED	Open
No of ANNEXES	1

Committee Priorities & Cycle Monitoring Report

MEETING	Audit, Risk and Assurance Committee
DATE	21 November 2024
EXECUTIVE	Trish Mills, Director of Corporate Governance/Board Secretary
AUTHOR	Trish Mills, Director of Corporate Governance/Board Secretary Alex Payne, Corporate Governance Manager
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. This report updates the Committee on progress against the priorities it set for 2024/25 and progress against the agreed Cycle of Business for the Committee. There are no matters to escalate to the Committee from the Cycle of Business, however it is noted that the Chair of the Quality, Patient Experience and Safety Committee will speak to the near-miss report at this meeting.

2. An update has been provided on the position with the Committee Priorities for with a position statement on the progress against the implementation of the Quality and Performance Management Framework. The Committee is asked to take assurance from the position given in line with the recommendation.

RECOMMENDATION: -

3. **The Committee is asked to: -**
   a) **Confirm its assurance on the implementation of the Quality and Performance Management Framework (QPMF) within the Trust, noting ongoing work which will continue to evolve. This will allow for the oversight of the QPMF and its effectiveness to move to the Finance and Performance Committee;**

   b) **To note the update on the Cycle of Business Monitoring Report for the Committee.**

KEY ISSUES/IMPLICATIONS
No issues to raise.

REPORT APPROVAL ROUTE
Not applicable.

REPORT APPENDICES
Annex 1 – Audit Committee Cycle of Business Monitoring Report.

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

COMMITTEE PRIORITIES FOR 2024/25 AND CYCLE MONITORING REPORT

SITUATION

4. This report updates the Committee on progress against the priorities it set for 2024/25 and progress against the agreed Cycle of business. There are no matters to escalate to the Committee from the Cycle of Business.

5. The Committee is reminded that the priority of oversight of the development of the Quality and Performance Management Framework is reflected in this update, as it has been carried over as a Committee priority for 2024/25.

BACKGROUND

6. During the course of the effectiveness reviews, it was agreed that it is good practice for Committees to set priorities for the forthcoming year. The Committee's priorities, which are set out below, were agreed by the Trust Board in May 2024 and will be tracked quarterly.

7. The Committee's cycle of business was approved by the Committee in April 2024. The agenda is set with reference to that cycle, together with the forward planner, action log and highest rated principal risks.

8. The monitoring report is at Annex 1. The 'pre-agenda setting' key indicates that items in green show where they are cycled for a particular meeting. Items in beige indicate they are a prompt at agenda setting as they may be ad hoc items such as business cases or external reports.

9. The 'post-agenda setting' key indicates that items in blue were either on the agenda as scheduled or is an *ad hoc* item which was discussed in agenda setting and scheduled. The orange indicates where an item was programmed for receipt but has been deferred to a future meeting.

ASSESSMENT

10. The Committee priorities, and progress against them is as follows:

Priority	Progress
• Monitor the development of the Committee specific induction programme.	- This work has been added to the Corporate Governance Directorate's 'Local Departmental Plan (LDP)' for progression and will be progressed towards the end of 2024/25. - A joint Board and Committee Chairs and Trade Union retrospective induction took place on 12 June. Additionally, a committee member governance overview drop took place in August with another planned for September.
• Carry-over from 2023/24: Oversight of the development and implementation of the Quality & Performance Management Framework	<u>2024/2025 Update:</u> - Receipt of updates regarding the Quality and Performance Management Framework (QPMF) have been built into the Committee's Cycle of Business, twice a year (quarter one and quarter three). - This business was deferred from quarter one however an update was received by the Committee at its meeting in quarter two (September 2024). - At the September 2024 meeting it was anticipated that oversight of the QPMF will move to the Finance and Performance Committee, in line with the respective Committee Terms of Reference, when the internal audit was presented to this ARAC meeting. The Committee has been given a complete position statement on this priority separately (in this paper) for consideration and agreement.

	2023/24 Update: - The Committee received a verbal update regarding the implementation of the Quality and Performance Management Framework at its meeting in November 2023. - It was agreed that an update was not required for the March 2024 meeting however the reporting for this will be actively considered for early 2024/25.

Cycle of Business Monitoring Report

11. It is noted that the Cycle of Business Monitoring Report has been adapted to include the extraordinary meeting of the Committee on the 10 July 2024, to receive the 2023/24 Annual Report and Accounts. This has been reflected by the inclusion of a column in between 'Q1b' and 'Q2' and the business received at that meeting identified.

12. The Near Miss Report that was deferred from the meeting of the Committee in September 2024 has been programmed for and will be received at the November 2024 meeting. The Chair of the Quality, Patient Experience and Safety Committee will be at the meeting to speak to the item.

Committee Priority: Oversight of the Quality & Performance Management Framework

13. The Finance and Performance Committee's (FPC) Terms of Reference provision 3.12 require that the FPC "Review the effectiveness of the Trust's Quality and Performance Management Framework and receive assurance on the value of outcomes produced by the framework, noting that in 2024/25 the Audit Committee will receive assurance on the implementation of the framework".

14. As this is a key area of assurance, the Audit, Risk and Assurance Committee (ARAC) has overseen – on behalf of the Trust Board - oversight of the implementation of the Quality and Performance Management Framework (QPMF) as drawn out in the FPC Terms of Reference. Consequently, the ARAC has received updates on the position with the QPMF throughout 2023/24 and into 2024/25.

15. At the September 2024 meeting the ARAC received an update on the implementation of the QPMF, noted that the QPMF Steering Group's Terms of Reference had recently been updated and approved by the Executive Leadership Team, and received assurance on progress against the work programme to date.

16. At the September 2024 meeting the ARAC confirmed its contentment with the work undertaken on the implementation of the QPMF and agreed that, following the receipt of the internal audit, it would be appropriate for the FPC to continue to monitor the QPMF - specifically focusing on the effectiveness of the Framework - in line with the FPC's Terms of Reference.

17. The Committee's attention is drawn to the related Internal Audit Report which is before the ARAC at its meeting today – the Integrated Quality and Performance Management Framework – which has an Internal Audit assurance opinion of 'reasonable'. This audit opinion provides the ARAC with additional assurance on the status and implementation of the QPMF.

RECOMMENDATION: -

18. The Committee is asked to

c) Confirm its assurance on the implementation of the Quality and Performance Management Framework (QPMF) within the Trust, noting ongoing work which will continue to evolve. This will allow for the oversight of the QPMF and its effectiveness to move to the Finance and Performance Committee;

d) To note the update on the Cycle of Business Monitoring Report for the Committee.

PAPER	PRE or POST C'EE FORUM	FREQUENCY	Q1a	Q1b	10/07	Q2	Q3	Q4	LEAD	PURPOSE	COMMENT
AUDIT, RISK AND ASSURANCE COMMITTEE - CYCLE OF BUSINESS 2024/25											
For the rationale for this Committee's cycle see Note 8											
Annual filings											
Annual accounts planning and emerging issues report	ELT	Annually							EDOF	Assurance	
Annual report timetable	ELT	Annually							BS	Assurance	
Audited accounts	ELT and Board	Annually		→					EDOF	Endorsement	Programmed for extraordinary meeting on 10 July 2024.
Annual report	ELT and Board	Annually		→					BS	Endorsement	Programmed for extraordinary meeting on 10 July 2024.
Head of internal audit report and opinion	ELT and Board	Annually							Internal Audit	Assurance	
Audit report on accounts	ELT and Board	Annually		→					Audit Wales	Assurance	Programmed for extraordinary meeting on 10 July 2024.
Self-assessment against Governance Code 2017	ELT	Annually							BS	Assurance	
Internal Audit											
Audit Plan	ELT	Annually							Internal Audit	Approval	
Internal audit reports	ELT and C'ees	Quarterly							Internal Audit	Assurance	
Audit Wales											
Audit Plan	ELT and Board	Annually							Audit Wales	Review	Q1a: Programmed as not ready for Q4 23/24.
Update report	N/A	Quarterly							Audit Wales	Assurance	
Annual Audit Report	ELT and Board	Annually							Audit Wales	Assurance	Q1a: Programmed as not ready for Q4 23/24.
Structured Assessment	ELT and Board	Annually							Audit Wales	Assurance	
Other Non-Core Reports	ELT and Board	Various							Audit Wales	Assurance	
Losses & Special Payments/Single Tender Waivers											
Quarterly lossess and special payments report	N/A	Quarterly							EDOF	Approval	
Tender update report and single tender waiver request (closed)	N/A	Quarterly							EDOF	Assurance	
Counter fraud											
Counter fraud update report	N/A	Quarterly							EDOF	Assurance	
Counter fraud annual report	ELT	Annually							EDOF	Assurance	
Counter fraud update work plan	ELT	Annually							EDOF	Approval	
Standing Orders & Standing Financial Instructions											
Standing Orders & Standing Financial Instructions	ELT and Board	Annually							BS	Endorsement	Q2: SoRD received in April will be returned on 10 July ARAC before being taken to TB for approval.
Breach of Standing Orders & Standing Fin. Instructions	ELT	Ad Hoc							BS	Discussion/Assurance	
Governance Practice Notes	ELT	Annually							BS	Approval	
Whistleblower, Declarations, Gifts & Hospitality											
Annual report on declarations of interest	ELT	Annually							BS	Assurance	
Report on gifts and hospitality	ELT	Annually							BS	Assurance	
Whistleblower report	TBC	TBC							BS	TBC	Coming from Chair of PCC
Other											
Near Miss Report	QUEST	Annually				→			TBC	Assurance	Coming from Chair of QuEST. Programmed for Q2 but deferred to Q3.
Quality and Performance Management Framework	ELT	Bi-Annually		→					EDSPP	Assurance	Deferred from Q1 and programmed for Q2.
Policy											
Policy report	ELT	Quarterly							BS	Assurance	
Policies	Policy Group	Ad Hoc							BS	Approval	
Financial procedures	TBC	Ad Hoc							EDOF	Approval	
Risk Management											
Review of risk related elements in IMTP	STB	Annually							BS	Assurance	
Board Assurance Framework	ELT	Each meeting							BS	Assurance	
Corporate Risk Register	ELT	Each meeting							BS	Assurance	
Audit Recommendation Tracker	ELT	Each meeting							BS	Assurance	
GOVERNANCE											
Escalations from Board Committees	Board Committee	Ad Hoc							Committee Chair	Various	
Committee effectiveness reviews and annual reports	All Committees	Annually							BS	Approval	
Audit Committee effectiveness review annual report	Audit/Board	Annually							BS	Approval	
Audit Committee Review of Terms of Reference	Audit/Board	Annually							BS	Approval	
Audit Committee Cycle of Business annual refresh	Audit/Board	Annually							BS	Approval	
Audit Committee Review of Annual Priorities	None	Quarterly							Chair	Review	
All Wales Audit Committee Chair's Meeting Report	AWACC	Bi-annually							Chair	Review	Added 19.09.23
PROMPTS											
External Reports	n/a	As required							TBC	TBC	

Two Q1 meetings. Q1a is a governance meeting to take the Committee annual reports and other items as noted

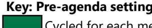
EDOF - Executive Director of Finance and Corporate Resources

BS - Board Secretary

Key: Pre-agenda setting

- Cycled for each meeting
- Ad hoc item - prompt for agenda setting
- Reporting developing

Key: Post-agenda setting

- Presented as cycled
- Ah hoc / item considered - not programmed
-  Item deferred
- Reporting developing

1	Losses and special payments	Whilst SFIs provide for approval of these, the payments are in effect already made when they are presented to the AC. All payments are made within SFI delegated limits. Further work with DOFs and Finance Academy at the next version of the SFIs to look at whether ACs should retrospectively approve such payments.
2	Whistleblowing	Staff can currently raise concerns through the traditional routes of line management and escalation set out in the All Wales Procedure for Raising Concerns, and through the sensitive issues function in Datix. A new Speaking Up Safely framework is in development by the Director of People and Culture with oversight of the implementation with the People and Culture Committee in 2023/24. The whistleblowing process and arrangements for special investigations to come to Audit Committee. Propose regular verbal updates from the Chair of the People and Culture Committee in the interim. See pages 39 and 40 of Audit Committee Handbook. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/512760/PU1934_Audit_committee_handbook.pdf Audit Committee 25 July 2023 agreed that the whistleblowing process and arrangements for special investigations will come to Audit Committee with verbal updates from the Chair of the People and Culture Committee on arrangements. Cycled in for once per year.
3	Near Miss Report	NAO effectiveness review outcomes recommends AC reviews information on 'near misses' to help determine whether the systems in place are sufficiently robust to mitigate future risk events. Propose this is a report directed by QUEST Audit Committee 25 July 2023 agreed that near misses would be monitored by QUEST. It noted that QUEST receives patient safety reporting which is predominantly based on the significant and catastrophic harm with moderate harm and near misses incorporated into thematic content. A more explicit near miss reporting will be developed, however there is limited capacity in the team to do so this year given the need to deal with the core requirements of national reportable incidents, Coroner requests and the Duty of Candour. Discussions in H&S Board Development 220224 on near misses. In Datix a report of no harm is categorised as a near miss so can start looking at developing that reporting. Cycled in for once per year to revisit.
4	Policy report	Each Committee has included in their cycles of business a report on the policies in their remit and their currency. An overarching report is being developed for this Committee's oversight. 11.09.23: The Policies Report will be taken to AC quarterly, and it will not be necessary for a separate report for each Committee to be taken providing an update. The CoB has been updated to read that the Policies Report will be taken to the Committee quarterly rather than annually, and the CoB Monitoring report has been updated as well.
5	TOR 3.2 (a) The Committee will support the Board with regard to its responsibilities for governance by reviewing: the policies for ensuring compliance with relevant regulatory, legal and code of conduct and accountability requirements.	Key corporate policies include - Counter Fraud Policy - Charitable Funds Investment Policy - Standards of Business Conduct - Whistleblowing Policy - Public Sector Payment Policy (All Wales) - Risk Policy - Data Protection Policy - Health & Safety Policy - Information Governance Policy - Information Risk Policy - Information Security Policy
6	Local Counter Fraud	Local Counter Fraud Specialists (LCFSs) are responsible for developing the anti-fraud, bribery and corruption culture within their respective health service areas and for investigating fraud cases within their own local health trusts and boards. The Welsh ministers and the NHS Counter Fraud Authority (NHSCFA) have entered into a service agreement under section 83 of the Government of Wales Act 2006, to ensure that appropriate provision is in place to tackle all matters connected to Fraud, Bribery and Corruption. It is the role of the LCFS to ensure regular engagement and reporting to senior members surrounding the work completed within this field, with the audit committee being recognised as an appropriate recipient to the status and developments of the service. Service strands of hold to account, prevent and deter, inform and involve, and strategic governance
7	QPMF	Implementation of the QPMF to be overseen by AC. Outcomes from the framework remains with FPC. Cycled in twice per year for 2024/25 when it is anticipated this work will complete.
8	Cycle of Business	The cycle has been developed to align with the duties for the Committee set out in the terms of reference. Of note, paragraph 3.5 of the terms of reference requires the Committee's programme of work to be designed to provide assurance that: a.there is an effective internal audit function that meets the standards set for the provision of internal audit in the NHS in Wales and provides appropriate independent assurance to the Board and the Accountable Officer through the Committee; b.there is an effective counter fraud service that meets the standards set for the provision of counter fraud in the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Committee and ensure all reported fraud concerns and ongoing investigations are notified to the Committee; c.there are effective arrangements in place to secure active, ongoing assurance from management with regard to their responsibilities and accountabilities, whether directly to the Board and the Accountable Officer or through the work of the Board's committees; d.the work carried out by key sources of external assurance, in particular, but not limited to the Trust's external auditors, is appropriately planned and co-ordinated and that the results of external assurance activity complements and informs (but does not replace) internal assurance activity; e.the work carried out by the whole range of external review bodies is brought to the attention of the Board, and that the organisation is aware of the need to comply with related standards and recommendations of these review bodies, and the risks of failing to comply; f.the systems for financial reporting to the Board, including those of budgetary control, are effective; g.the results of audit and assurance work specific to the Trust, and the implications of the findings of wider audit and assurance activity relevant to the Trust's operations, are appropriately considered and acted upon to secure the ongoing development and improvement of the organisations' governance arrangements; h.progress is monitored against the requirement of the Auditors' Management Letter; i.the Committee receives and reviews key Trust Annual Reports e.g., Trust Annual Report, Infection Control Annual Quality Statement; Annual Governance Statement and make recommendations to the Board for their adoption; and j.the Committee reviews the content of the Corporate Risk Register and obtain assurance that control measures are in place to mitigate all identified risks.